IN THEIR OWN WORDS

Stories About the Origins
of Family Medicine Education

At the University of Kansas School of Medicine in Wichita
And Affiliated Residencies

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FOREWORD

“In Wichita and in Kansas, teaching medical students and residents is just part of being a physician.”

About 15 months ago, I began a project that remains unfinished but from which I have learned a lot. The project was initially simple. I wanted to document the origins of family medicine education in Wichita. I was concerned that if we did not document these stories, they might be lost. Indeed, just a few months after I interviewed Dr. Gerhart Tonn for my project, he passed away at age 81.

Initially, I had conceived my project to be very limited in focus. I was just interested in the origins of the Department of Family and Community Medicine in Wichita, and the affiliated residency programs. Wichita played a key role in the national transition from the general practice internship to the modern family practice residency. Conceived by Gayle Stephens, M.D., after reading the Willard Report, the Wesley Family Practice Residency became the national model for family practice training. Conrad Osborne, M.D., who taught many of us, has been identified by Stephens as the first family practice resident in the country. There are many other “firsts” claimed by Wichita.

I discovered that it was impossible to extricate the history of family practice education in Wichita from the origins and activities of the Kansas Academy of Family Physicians, the origins of the Department of Family Medicine in Kansas City, the statewide need for family doctors and the national family practice movement. My project just kept getting larger and larger as I asked more and more questions and received more and more information. As a result, my project, now expanded, is unfinished and incomplete.

I plan for this compilation to be the first edition. I plan to print expanded versions every few years as more and more stories are compiled and interviews are conducted.

I hope that future editions will contain interviews with Drs. Jim Price and Jack Walker, whose work in Kansas was more specific to the Kansas City campus. I hope future editions will include interviews with family practice leaders from rural areas, like Don Goering, M.D., and Dick Brummett, M.D., who contributed statewide and nationally to the family practice movement.

I hope future editions will include interviews with former University of Kansas students, like Bob Graham, M.D., and Norman Kahn, M.D., who have contributed to family practice education at a national level. I hope future editions include interviews with many who wrote their stories for this first edition, such as Drs. Jim Donnell, Lew Purinton and Gayle Stephens.

I hope future editions include stories from legislative leaders of the day who influenced family practice education in the state. It should be noted here that I asked former governors John Carlin and Mike Hayden to contribute to the compilation. Both deferred to other legislators as more “expert” than they, but Governor Carlin called me to reminisce and Governor Hayden sent a nice note referring me to other resources.

I hope you enjoy some of the press clippings and documents we culled from the files that tell stories about the evolving nature of family practice training in Kansas.

There are many who were asked to contribute to this edition who did not do so (perhaps thinking that the project would never get off the ground, so why bother?). I hope that
after seeing this edition, they will contribute in future years. As our specialty matures, current “young” and “middle-aged” leaders will become “old-timers” themselves! In fact, I would offer an open invitation to any reader so moved to take pencil to paper and get started on your contribution for the next edition.

I suppose some of the physicians who tell their stories in this compilation may be guilty of some revisionist history. I suppose we have recorded some dates, names and facts that are inaccurate. If you find inaccuracies, please notify me. We want the second edition to be more definitive. But despite some technical inaccuracies that you may discover, I think this compilation captures the “feeling” of the times and the development of family practice as a specialty and an academic discipline.

The project is partially funded by the KAFP Foundation. The Foundation helped cover the costs of printing. I want to thank Carolyn Gaughan and Dick Watson who encouraged me in their roles with the KAFP Foundation. The Foundation believes that it is vital to begin a process of endowment for family practice education. I agree.

I also want to thank Kristi Solter, our secretary in the Department of Family and Community Medicine. She typed all the manuscripts. More importantly, she “reviewed” the stories as she typed. She told me how much she enjoyed them. Her support and enthusiasm kept me going forward when the editing process became tedious and when I questioned whether the project was worthwhile. Debbie Bennett, our department Administrative Officer, helped proofread and organize the stories. She had the idea for the timeline. Doug Woolley, M.D., convinced me that the project was a worthy scholarly pursuit.

A special word of thanks goes to my wife, Janet, and three children, Katie, John and James, for putting up with me when I was focusing on the stories instead of them. I’ve been fortunate to have a family who (usually!) is understanding about the atypical motivations of their husband and father.

Gayle Stephens has compared the origins of family practice to the Story of the Amazing Talking Dog. What was so amazing about the talking dog, says Stephens, was not what it had to say, but that it was talking at all! That is an apt description of the early days of the formation of the American Academy of General Practice, the Kansas Academy of General Practice, and the transition from general practice internships to family practice education as it exists today. It is amazing that so many individuals from so many diverse settings, who could have been consumed by their own individual interests, spoke as one.

The more I learned about the origins of family medicine education in Wichita, the more I learned about its interconnections with the political work of the Kansas Academy. The more I learned about the Academy, the more I began to appreciate the work of the first president of the KAGP, Dr. Clyde Miller. It is to Dr. Miller that I have dedicated this compilation.

Before I started this project, Dr. Miller was someone about whom I had no knowledge, other than to see his name at the beginning of the Academy’s list of presidents. He was leadership personified. He was 6’4” tall, with a booming voice, and charisma deluxe. Clyde Miller got the KAGP off the ground and we owe him immensely. He is described (along with some of his KAGP recruitment methods!) in the interviews with Gene Wilcox and Jack Phipps, M.D.

Other individuals stand out. The stories of Drs. Ned Burket and Gayle Stephens are intertwined. Dr. Burket was a small town doctor, who became active in family practice politics in order to find a partner who would help share his workload in Kingman.

Gayle Stephens was a Wichita doctor who philosophically worried about the loss of the doctor-patient relationship in the increasingly technologized medical care system.

Fate, more than geography, brought them together in the 1960s. Both have resumes that are long and distinguished. Suffice it to say that their contributions resulted in a Kingman, Kansas, doctor (Burket) being named to the Institute of Medicine, and a Wichita, Kansas, doctor (Stephens) being hailed as the philo-
sophic and intellectual father of family medicine.

This compilation includes a copy of Stephens’ original 1968 speech to the AAGP State Officer’s Convention, an address that both he and Burket point to as a seminal event in family practice education.

The person who kept the amazing talking dogs of Kansas, the KAGP and the KAFP, watered and well-fed was Gene Wilcox. You will enjoy his interview. His memories of different personalities in the KAFP should not overshadow the fact that he is a “personality” himself!

One of the benefits of this project is the chance to interview special people. In fact, that is one of the reasons I wanted to do the project. I thought it would be a great excuse to talk to a brand of people called “leaders.” Cramer Reed, M.D., clearly falls into that category. I had known who Dr. Reed was for many years, but had never really had a chance to talk to him, or get to know him. I am glad to have had the chance.

As I conducted Dr. Reed’s interview, I kept asking myself why he persisted in his efforts to start the medical school branch in Wichita. As he says, in his story, he was in “no man’s land.” Wichita, family practice and the state of Kansas owe a lot to this urologist. Cramer Reed is clearly the father of the medical school in Wichita.

One of the joys of the project was the chance to ask my personal teachers for their stories. I am happy that Drs. Vic Vorhees and Ron Brown, respectively my program director and faculty team leader when I was a resident, contributed. Someday, I hope to tell my story of how these two and many others contributed to my education as a physician. I am sorry that my teacher, Con Osborne, M.D., did not live long enough for me to interview him for his story.

What have I learned from this project? I have learned about leadership and dedication and perseverance. The people who started this movement called “family practice,” and the first generation of medical students who entered its residency programs, were pioneers, visionaries and leaders. They were met with skepticism, disdain and misunderstanding by many in the medical profession. They thought that concepts such as the doctor-patient relationship, continuity of care, comprehensive care, family-centered and community-based care, and the idea that the whole person was more than the sum of its parts, were important. They did not run away from the responsibilities they had to patients, individually or collectively.

The strength and heritage of our discipline remains today with over 160 practicing family doctors in Wichita, and hundreds more around the state and nation, who trained at one of the affiliated residency programs, or at the University of Kansas School of Medicine - Wichita. These graduates of family medicine training in Wichita continue the legacy as full-time and volunteer teachers of the next generations of physicians. In Wichita and in Kansas, teaching medical students and residents is just part of being a physician.

Let me close with a story about Mac Cahal that is not included in this compilation, but illustrates why these stories are important to document. Mr. Cahal was the executive director of the Sedgwick County Medical Society many years ago. He left to become the executive director of a national radiology society. During his tenure there, Mr. Cahal heard about a fledgling organization, the AAGP, and its need for an administrator. He applied and was offered the job as the AAGP’s first executive director.

The radiology society members thought he had lost his mind. Why would Cahal consider leaving a stable and thriving national radiology organization to help in the start up of this new organization of GPs? These upstarts were clearly doomed to failure! Why would Cahal leave a respected specialty organization to lead an independent minded group of generalists, who weren’t particularly skilled at any one thing? He was throwing his life away. His career would be ruined! Still, he took the job.

In 1997, at the AAFP Congress of Delegates in Chicago, Mac Cahal received the John G. Walsh Award from the Academy, for his special
contributions to the discipline to family practice. He was given extra time to make his remarks, something that is unheard of at the tightly organized and time-driven Congress of Delegates. Mr. Cahal regaled the Congress of Delegates with anecdotes of his early days with the AACP.

Then he reminded the Congress of an old Indian aphorism: “You have been warmed by fires you did not set; you have drunk from wells you did not dig.”

I hope that as you read the stories of this compilation, you will be reminded of those who set the fires which warm us... and those who dug the wells from which we drink.

Rick Kellerman, M.D.
May 1998

Post Script: This compilation was completed in May 1998. Due to computer and printing problems, publication was delayed until September 1999. In the meantime, Gene Wilcox died May 15, 1999 in Winfield. Gene served as the Executive Director of the KAFP from 1952 to 1986. During those years, membership grew from 40 to 600. If Clyde Miller lit the KAFP fire, Gene was the bellows. His goodwill, generosity, thoughtfulness and smile are deeply missed.

Rick Kellerman, M.D.
August 1999
### Family Practice Education in Kansas ... Timeline

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<td>1941</td>
<td>AMA rejects first ever call for a general practice certifying board. AMA rejects establishment of Section of General Practice.</td>
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<td>1945</td>
<td>AMA authorizes Section of General Practice.</td>
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<td>1946</td>
<td>AMA Section of General Practice meets for first time.</td>
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<td>1947</td>
<td>The American Academy of General Practice (AAGP) organized. Annual dues are $15.</td>
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<td>1948</td>
<td>Kansas Academy of General Practice (KAGP) organized and joins the AAGP. It is the sixteenth state organization to be chartered. Annual dues are $25. Clyde Miller elected first president of the KAGP. Franklin Murphy named dean of KU School of Medicine (1948-1951). His “Kansas Health Plan” to bring doctors to rural Kansas communities receives national attention.</td>
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<td>1949</td>
<td>AMA adopts resolution that postgraduate education for general practitioners be made more widely available and that two-year rotating internships for training in general practice be set up as rapidly as possible. KAGP holds first annual business and educational meeting. KU School of Medicine Dean Franklin Murphy invites KAGP to participate in Kansas Day activities at the KU Medical Center.</td>
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<td>1951</td>
<td>KAGP Committee on Education chaired by Ned Burket. Agenda includes a review of the adequacy of general practice internships. George Thorpe elected president of KAGP.</td>
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<td>1952</td>
<td>Gene Wilcox appointed first KAGP executive secretary. KAGP agenda includes discussion of a universal plan for general practice internships and residencies; decision to draw up a list of Kansas hospitals approved to provide training. Clark Wescoe named dean of School of Medicine (1952-1960).</td>
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<td>1953</td>
<td>Ned Burket elected president of KAGP.</td>
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KAGP annual scientific session includes talks on gall bladder problems, office gynecological procedures and a lecture on “Appreciation of the General Practitioner as Seen by the Surgeon” by R.L. Sanders of Memphis, Tennessee.

KAGP stresses membership recertification based on completed hours of continuing medical education courses.

1954 Jesse Rising serves on the AAGP Commission on Education (1954-1959), Committee on General Practice (1956-1960), and as AAGP Representative to the AMA Committee on Preparation for General Practice (1958-1959).

1956 AMA Committee on Medical Practice report encourages “formation of a department of general practice in each medical school.”

1957 KUMC requests a list of speakers on general practice from the KAGP.

1958 AAGP Minimum Uniform Standards in Education (MUSE) Committee reports that a lack of a certifying board of general practice hampers training program development and discourages medical students from entering general practice. The report uses the terms “family physician” and “family practice” and calls for two-year graduate training programs to replace the rotating internship. Jesse Rising serves on MUSE Committee. The AAGP Congress of Delegates rejects the report.

1959 Pilot two-year graduate general practice programs begin.

Jack Tiller serves as training director of Wesley General Practice Residency.

Renegade group of 10 AAGP members, including KAGP Past-President George Thorpe, incorporate controversial American Board of General Practice, Inc. and call for board certification. In subsequent years, the ABGP struggles for survival.

1960 AAGP Congress of Delegates adopts report “that repudiates the creation of the American Board of General Practice,” denies “responsibility for its parentage,” recommends that AAGP members decline to affiliate with it, and states it “is without official status in organized medicine.”

1961 First nationally televised medical education program, “The Family Doctor on the Air,” presents information on common health problems such as immunizations, obesity, heart disease and cancer detection.

1962 AAGP requests study to determine if “a board of general practice is feasible.”

KUMC Dean Arden Miller is keynote speaker at KAGP annual meeting on “Your Medical School.” Miller serves as dean from 1960-1966.

A report at the annual KAGP meeting reveals that there are three general practice residencies in Wichita and that only eighteen percent of medical student graduates were going into general practice, a drop from twenty-five percent the prior year.

First year of KU Medical School moves from Lawrence campus to Kansas City.

1965  AAGP authorizes “establishment of a certifying mechanism” for general practice.

KAGP members debate formation of a national Board of General Practice but remain undecided, especially in regard to “grandfather” clause.

KAGP members meet with KU Medical School officials including Dean Arden Miller, Jesse Rising, and Mahlon Delp to discuss concern about the number of general practice doctors staying in Kansas to practice.

KUMC Assistant Dean Jack Walker reports at the KAGP meeting that 125 students, the largest class of freshmen in history, are matriculating and that plans are being developed to stress general practice training.

KAGP member Lawrence Leigh heads national cervical cancer detection study developed by the Department of Health, Education and Welfare, the largest research study ever conducted at the time. Over one million women receive pap smears; one-third are examined for the first time.

1966  Liaison Committee for Specialty Boards rejects original preliminary application for establishment of a certifying Board of Family Practice because it is “premature.”

Citizens Commission on Graduate Medical Education publishes “The Graduate Education of Physicians” (Millis Report). The report observes that physician specialization is leading to fragmentation of patient care and problems with health-care delivery. It calls for the training of more “primary physicians” who provide comprehensive and continuing care of patients.

AMA Ad Hoc Committee on Education for Family Practice report, “Meeting the Challenge of Family Practice,” (Willard Report) published. It calls for a “new kind of specialist in family medicine” and asserts the American public “does want and need a large number of well-qualified family physicians.” The report calls for three or four years of post-graduate training and board certification. It also says that training should include extensive experiences in model units simulating a family-oriented process.

“The Report of the National Commission on Community Health Services,” (Folsum Report), is published and identifies the need for “personal physicians.”

AAGP Committee on Requirements for Certification report, “Core Content of Family Practice,” spells out family practice concepts such as comprehensive and continuing care. It notes that family physicians should be trained in surgery “applicable” to future practice and the behavioral sciences.
KAGP committee meets with KUMC Dean and Provost George Wolf (1966-1970) to discuss training more family physicians. Jack Walker is delegated responsibility for developing a family practice program at KUMC.

KAGP votes to provide certificates to two-year general practice residency graduates if the AAGP or hospitals do not.

Ned Burket serves on Committee on Requirements for Certification (1966-1967).

1967  Liaison Committee for Specialty Boards unanimously approves second preliminary application for creation of a Board of Family Practice as submitted by the AAGP and the AMA Section on General Practice.

Gayle Stephens establishes the Wesley Family Practice Residency Program. Conrad Osborne is the first resident to enter the program. He is believed to be the first family practice resident in the nation.

1968  Ned Burket elected president of the AAGP. He had served on the AAGP board of directors (1964-1967) and as chair of the AAGP board of directors (1966-1967).

AMA approves “Special Requirements for Residency Training in Family Practice” which spells out the requirements for accreditation of family practice residency programs.

The Family Practice Residency Review Committee (RRC) meets for the first time and accredits five programs, among them the Wesley Family Practice Residency.

Gayle Stephens establishes a model ambulatory family practice center at the Wesley Family Practice Residency. He incorporates his own patients into the practice. He uses the Willard Report as a guideline for the development of the residency model office.

Gayle Stephens addresses the AAGP State Officers Convention. His blueprint for family practice residency training becomes the national model.

1969  After two years of work, the final application to establish the American Board of Family Practice is approved by the Liaison Committee for Specialty Boards. It is the 20th certifying board in American medicine. The ABFP requires recertification every six years. It does not allow automatic grandfathering for board certification but does define “residency eligible candidates” and “practice eligible candidates.”

KAGP sets priorities of establishing a Department of Family Practice at KUMC, developing an appropriate curriculum, recruiting faculty and developing family practice residency programs. KAGP appoints Jack Phipps, Ernie Chaney, Gayle Stephens and Ned Burket to serve on a liaison committee with KUMC.

Board of Regents and Legislature approve proposal to condense medical school curriculum from four years to three years, increase class size from 125 to 200 and establish a Department of Family Practice.
Medical students Tom Simpson, Louis Forster and Milt Van Gundy are charged with securing names of medical students interested in participating in the first Rural Health Weekend.

Don Goering installed as president of KAGP; Ernie Chaney as president-elect.


1970 First American Board of Family Practice certifying exam administered in thirty-six centers in the United States. Nineteen percent of 2,078 physicians taking the exam do not pass.

RRC grants provisional approval to the 44th family practice residency at St. Joseph Hospital and Rehabilitation Center.

Lew Purinton hired as director of Medical Education, St. Joseph Hospital and Rehabilitation Center (1970-1971).

Lew Purinton and Robert Purves create the St. Joseph Family Practice Residency Program with the assistance of Victor North and Doris North.

Wesley Family Practice Residency graduates the first family practice resident, Conrad Osborne.

Gayle Stephens forms Family Physicians, P.A., by borrowing from the Small Business Administration.

Cramer Reed hired as the director of the Department of Allied Health Services at Wichita State University.

1971 AAGP changes its name to American Academy of Family Physicians (AAFP).

KAGP changes its name to Kansas Academy of Family Physicians (KAFP).


Antonio Osio becomes the first resident at St. Joseph Family Practice Residency.

Governor George Docking dedicates the St. Joseph Family Practice Residency Program.

The Board of Regents approves the creation of the Wichita State University Branch of the University of Kansas School of Medicine.

William O. Reike named vice-chancellor (1971-1973) and executive vice-chancellor (1973-1975) of KUMC College of Health Sciences and Hospital, Kansas City. This position was formerly called the "Dean" but now has responsibilities for three health sciences (medicine, nursing and allied health.)

1972  Stanley Mosier and Victor Vorhees named co-directors of the Wesley Family Practice Residency Program (1972-1980). They are the first residency-trained family physicians in the country to direct a family practice residency program.

Gayle Stephens named chair, Department of Family and Community Medicine, Wichita Branch (1972-1973).

The Wesley Family Practice Residency Program receives a $210,000 federal grant to help fund the three-year program.

The first group of full-time first year residents enter the St. Joseph Family Practice Residency Program: Reginald Goodwin, Steve Bruner, Steve Thompson, Tom Simpson, Wayne Morton, and Tom Norris.

Legislators Clyde Hill and Frank Gaines report to KAFP on legislative appropriations for KUMC Department of Family Practice in Kansas City and tour the Family Practice Center.

Legislature approves funding nine full-time faculty on the Wichita medical school campus with a total budget of $153,000.

Wichita Branch headquarters established in a cottage at 3720 E. 17th St., close to the WSU campus.


Gayle Stephens moves to Huntsville, Alabama, to become dean of the School of Primary Care at the University of Alabama.

Billy Gardner named chair of Department of Family and Community Medicine, Wichita (1973-1975).

Wesley Family Practice Residency adds rural rotations to its curriculum. Ray Cook is the first resident to perform a rural rotation in Minneola with Charles Stephens. Other sites included Belleville, Phillipsburg and Coffeyville.

Kansas "Doctor for a Day" legislative program begins.

The Wichita Branch office moves from the cottage near WSU campus to Fairmount Towers.


James Price elected president of AAFP.

1974 The Wichita State University Branch of the University of Kansas School of Medicine opens with 15 students.

Don Gessler named director and establishes St. Francis Family Practice Residency Program (1974-1983).

1975 “The Legend of the Wall” at the St. Joseph Family Practice Residency Program is born (or demolished!).

Dean Kortge named coordinator and acting chair of the Department of Family and Community Medicine (1975-1976).

Cramer Reed becomes the vice-chancellor of the Wichita State University Branch of KUSM (1975-1978).


1976 The first two St. Francis Family Practice Residency Program residents begin training; Dave Robl and Tom Alderson.

Lew Purinton serves as interim director of the St. Joseph Family Practice Residency Program (1976).


The Wesley Family Practice Residency moves to the Medical Arts Tower on Murdock St.

Dean Kortge named director of the Department of Family and Community Medicine, Wichita State University Branch of KUSM (1976-1978).


1977 Kansas Senate Bill 472 passes and promotes establishment of family practice residencies in locations other than Kansas City and Wichita. This allows establishment of the Smoky Hill Family Practice Residency Program in Salina, the only residency program created by an act of the Kansas Legislature.

Larry Miller serves as acting chair of the Department of Family and Community Medicine at KUSM-W (1978).

The Wichita State University Branch of the KUSM-W moves from Fairmount Towers to E.B. Allen Memorial Hospital.

The name of the Branch is officially changed to the University of Kansas School of Medicine-Wichita.


Bob Boyer named AAFP “Family Doctor of The Year.”

Ned Burket elected to National Institute of Medicine, Academy of Sciences, for contributions to medical education and health care delivery.


Salina Health Education Foundation, a nonprofit corporation created under the aegis of the Saline County Medical Society, established to conduct the operation of a family practice residency. Robert Brown is hired as executive director.


1979  Smoky Hill Family Practice Residency admits first three residents. As a “one and two” program, the residents perform their first year of training in Wichita at the St. Joseph Family Practice Residency.

E.P. Donatelle named chair, Department of Family and Community Medicine, KUSM-W (1979-1988).


Ned Burket receives AAFP John G. Walsh Award.

At the end of its first decade there are 6,531 residents training in 364 family practice residency programs in the United States.

1980  Smoky Hill Family Practice residents establish practices in “the dorm” or “the longest trailer house in the world.”

David M. Holden named program director of the Wesley Family Practice Residency Program (1980-1983).

Three phase, $4.5 million E.B. Allen Memorial Hospital renovation plan approved by legislature.

Gayle Stephens receives STFM Excellence in Education Award.

1981 Ernie Chaney elected president of AAFP. He has served as a member (1977-1980) and as chair (1980) of the AAFP board of directors.

James W. Shaw Memorial Fund for family practice education established in Department of Family and Community Medicine, KUSM-W.

1982 The first class of three residents graduates from the Smoky Hill Family Practice Residency Program. They are Ron Hunninghake, Bob Yoachim and Karen Nonhof.

Timothy Scanlan named program director of the Smoky Hill Family Practice Residency Program (1982-1984).

Ed Donatelle receives AAFP Thomas W. Johnson Award.

Gayle Stephens publishes The Intellectual Basis of Family Practice.


Alan Sather named Wesley Family Practice Residency program director (1984-1985).

John Listerman named program director of Smoky Hill Family Practice Residency Program (1984-1986).


Daniel Dees named acting director of Smoky Hill Family Practice Residency Program (1986-1988).

1987 The St. Joseph Residency Program establishes a third rural rotation site in Arkansas City. Other sites are in Colby and Wellington.

1988 James Price receives AAFP Thomas W. Johnson Award.
Rick Kellerman named program director of Smoky Hill Family Practice Residency Program (1988-1996).

Andrew Barclay named chair of Department of Family and Community Medicine, KUSM-W (1988-1996).


1990 Carol Johnson named Wesley Family Practice Residency program director (1990 to present).

Richard Leu named director of St. Francis Family Practice Residency Program (1990-1999).

Smoky Hill receives Family Practice RRC approval to move the first year of training to Salina.

Jane Murray named chair of Department of Family Medicine, KUSM-KC (1990-1997).

Association of Family Practice Residency Directors (AFPRD) established.

1991 KAFP publishes “Where Have All the Doctors Gone? A Report on the Shortage of Family Physicians in Rural Kansas.” The report calls for improved support of family practice training. As a result, the Gatin Bill is introduced in the Kansas House of Representatives. The bill threatens to decrease funding to KUSM-KC if a threshold percentage of medical students entering family practice is not met. The bill fails, but several measures favorable to rural family practice result.


1993 Liaison Committee on Medical Education (LCME) adds family medicine as one of the clinical education programs that must be included in the function and structure of medical schools, along with internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery.


Olathe residency track established by KUSM-KC Department of Family Medicine.

1995 St. Joseph Medical Center and St. Francis Regional Medical Center merge and become the Via Christi Regional Medical Center, setting the stage for the merger of the two residency programs.

Rural residency tracks established in Hays and Junction City. Rick Rajewski and Ron Mace serve as program directors at these sites.

Cynda Johnson appointed to board of directors, American Board of Family Practice (5-year term).


1996 Smoky Hill Family Practice Residency receives “Outstanding Rural Health Program in America” Award from the National Rural Health Association.

Ernie Chaney named chair, Department of Family and Community Medicine, KUSM-W (1996).

Don Goering named AAFP “Family Doctor of The Year.”

Karen Bruce appointed director of Topeka Family Medicine Residency Program (1996-present).

Gayle Stephens receives AAFP John G. Walsh Award.

1997 Charles Allred named program director of Smoky Hill Family Practice Residency Program (1997-present).

Family Practice RRC approves merger of St. Francis and St. Joseph residencies into the Via Christi Family Practice Residency.

Larry Anderson appointed to board of directors, American Board of Family Practice (5-year term).

Debbie Haynes elected to AAFP board of directors (3-year term).

Rick Kellerman named chair, Department of Family and Community Medicine, KUSM-W.

Mac Cahal receives John G. Walsh Award.


Richard Leu named director, Via Christi Family Practice Residency Program.

Charles Stephens receives AAFP Exemplary Volunteer Teacher Award.
Cynda Johnson elected president of American Board of Family Practice.

Hays and Olathe residency tracts closed.

Charles Stephens receives Distinguished Educator Award from National Rural Health Association.

Richard Ohmart receives Practitioner of the Year Award from National Rural Health Association.
AN INTERVIEW WITH NED BURKET, M.D.
PAST PRESIDENT, AMERICAN ACADEMY OF GENERAL PRACTICE
PAST PRESIDENT, AMERICAN BOARD OF FAMILY PRACTICE
JULY 10, 1997

Kellerman: Thank you for meeting with me for this interview, Dr. Burket. Many family doctors, including Gayle Stephens, refer to your work on behalf of the discipline of family practice in the “early years.” For our purposes, I want to get a little bit of your personal history and then focus on the things you did politically and educationally for family practice.

Burket: Gayle has quite a lot to say. Have you heard from him?

Kellerman: I have a four to five page letter from him and I want to ask you about some things he refers to. First of all, though, where are you from originally?

Burket: Kingman, Kansas. I practiced in Kingman for 32 years and during that time I became a preceptor for the University of Kansas in 1950. I was a preceptor until 1973, when I went to join the faculty of the medical school in Kansas City. That was about 23 years of precepting, and I developed ties to the school in Kansas City.

Kellerman: How long did you live in Kansas City?

Burket: I was there eight years. I was there for five years as an associate professor and then in 1978 I retired from that and just went in part-time until 1981. Between 1978 and 1981, I went in very frequently at first and then that got diluted, you know. In 1981, my wife and I moved back to Kingman and I’ve been there since that time.

Kellerman: Why did you go into medicine in the first place?

Burket: My father encouraged me. He was a dentist in Kingman and I had a great role model in my family doctor, a Dr. Haskins, who was a general practitioner and surgeon in Kingman. He had surgery training in St. Louis. He was a role model right there in Kingman. I wanted to be like him.

Kellerman: Did you graduate from KU medical school? Any particular memories from medical school or residency?

Burket: Yes, I graduated from KU in 1937. I had a good time going through school. I could tell you a lot of things about medical school, for Lord’s sake! Max Allen and I were roommates for four years. Then we went to California together. He took his internship and went to San Diego General. I went to a combination between County General Hospital and Cottage Hospital in Santa Barbara from 1937 to 1939.

I made up my mind in medical school that I wanted to do rural surgery. I was admitted for an internship at Kansas University, but I didn’t want to go there. Clendenning thought Santa Barbara was the greatest thing in the world, so I took my residency training out there. I did my internship and then I had a year of surgery residency there. A little later I had another year as a graduate assistant in surgery with Edward Churchill in Boston at Mass General. And then I was doing rural practice surgery in Kingman.
I wanted to do all that I could capably do in rural Kingman, and I wanted to “overtain” to do it. But I wanted to do general practice, too. I delivered over 3,000 babies while I was in Kingman according to the hospital records. I had a good time. I had a feeling then that I couldn’t do OB in a rural setting without being able to do a C-section. I think that one of the current problems in family medicine is to get doctors to do OB.

I was married while I was in California; married Sue. She was going to the University of California when we first started going together and we were married in 1938, when I first started my residency. Back then, you took the amount of training that you’d need for where you were going to practice. A lot of surgeons were two year surgeons, they just took two years of training to do surgery, especially in rural areas. There weren’t any boards to tell them otherwise.

The Surgery Board wasn’t formed until 1936, so they weren’t very powerful. The Surgery Board didn’t amount to much. I remember very well my old surgery mentor, Sam Robinson, out there in Santa Barbara. He was going up to San Francisco one particular weekend. He was going to take that new fangled Surgery Board, and he said “It will never amount to a damn.” I’ll always remember him saying that. Same thing we heard about family practice: “Never amount to a damn.”

Kellerman: You always knew that you were going to go back to Kingman?

Burket: Yes, that was the plan. I knew that’s where I was going to practice. Sue was born there and left when she was five years old, but she visited Kingman quite often. It was fine with her, too. It was in ideal situation.

Kellerman: Were you in solo practice then?

Burket: Yes, I was in solo practice. I had a good practice. My wife’s family came from there and I had no problems establishing an office. I knew lots of local people. I had all the patients that couldn’t pay their bills! My bank deposit the first month was $7.50. But my malpractice insurance at that time was $75 a year, and I was doing major surgery.

Somebody told me I ought to take out malpractice insurance, so I took it out! The cost of malpractice insurance didn’t go up until after World War II. Then it went up to maybe $150 a year and then slowly it progressed to where we are now. Nobody worried about malpractice then, especially in general practice, because we were close to our patients. They were our friends as well as our patients. They weren’t going to sue us.

Kellerman: Did you have any trouble treating your friends? That is one thing in a small town, you are the doctor and yet these are personal friends or your kids go to school together. Did that ever give you any conflict?

Burket: None whatsoever.

Kellerman: During the war did you stay in Kingman?

Burket: I was called up and that’s a story. In the first place when you got out of medical school in the years before the war, they offered you a First Lieutenant’s commission. Well, two of the other doctors in Kingman, one of them younger than me, one older than me, took the commission. Those two were called up because they already had commissions. They called it being “mobilized” for a year. That left me there with a bunch of old fellows in Kingman and I got razzed. Those two were going off on a year’s “vacation” and they’d be back in a year. We were good friends and I took the razzing and all. God, they didn’t get back for five years!

Then I was drafted and called up and closed my office. I didn’t like it but didn’t have any choice. I made arrangements to have my office closed. I had to be examined in Ft. Riley and then went to be sworn in. It all took about six weeks. So I went up and passed the examination. No problem. I’ll never forget the guy that drew my blood over the noon time and all the laboratory personnel were out to lunch. I
told him I had to get back to Kingman. I was busy. I couldn't stay there long. This guy said he'd draw my blood so he started in and put the tourniquet on. I had big veins then, but they "rolled." He began to sweat. He said he didn't usually do this. His job was checking urine. I told him to take hold of that vein down below and then put the needle in and he'd be all right. He did that and he got it done.

Then I went up to be sworn in at Ft. Riley and here was a doctor I knew who was Head Physician for Procurement and Assignment for Kansas and made the assignment of doctors in Kansas at that time. Here he comes running down the hall. "Oh, you can't go Dr. Burket! You can't do it! We're not going to swear you in! You can't go because two of those older doctors in Kingman are going to leave if you do. They aren't going to practice in Kingman. We're going to have to send you back to Kingman for awhile."

Once a year they would call me up to Ft. Riley and give me an exam. But, they never did get me in. Another doctor never came to Kingman, and I was delivering four babies a night on occasion. Girls would come home from camp to have their babies. They would come back to "mother" to have the baby. We would deliver them, and they would worry me to death because, about a week after they had the baby, they'd be off to camp again. They still needed their three week check up.

**Kellerman:** How many other doctors in Kingman during that time?

**Burket:** Haskins was the best - he was a good one. Weinger, who was a homeopath. There was an old fellow that did ophthalmology. And that was it. Haskins was the only one with a really good active practice. So I spent my service years in Kingman. I was physically able to go but they blocked it.

**Kellerman:** OK, so you entered into practice in Kingman and then when did you start getting the political bug?

**Burket:** After I had a well-established practice. It was kind of "the same old story" even then: you just couldn't get a partner. You couldn't get anybody trained well enough to come out there to practice with you because they were either in internship or else they were going into specialties and sub-specialties and they weren't interested in Kingman.

**Kellerman:** Was there an American Academy of General Practice at that time? Were you a member?

**Burket:** The American Academy of General Practice came along in 1947 after the war. There were just a few doctors in it then. I didn't get really interested until 1948. I joined in 1949. I felt I certainly didn't belong to the College of Surgeons, even though they were accepting doctors with two years training. I got interested and I had friends, Clyde Miller and George Thorpe in Wichita, who were general practitioners. Both of them were doing about the same kind of practice I did. So I joined. We only had a few of us - maybe 50 - in Kansas.

**Kellerman:** Was there a state organization?

**Burket:** Yes. Clyde Miller founded it in 1948.

**Kellerman:** Did you meet yearly? Did you have a medical education meeting like we do now?

**Burket:** We did, but we weren't very strong with money. So we met annually with the Kansas Medical Society. We were looked down upon by the KMS at that time. I became president of the Kansas Academy of General Practice. I was the sixth president, about 1954. That year we hit a bonanza. We were granted $3,000-$5,000 for good speakers at our annual banquet. They were good ones! And our banquet with those good speakers every year had more attendance than the state medical society did.

**Kellerman:** How did you arrange the grant?
**Burket:** A “detail man” here in Kansas got together with Gene Wilcox, who was then executive director of the Academy, and they arranged the money. They suggested that we get some good, nationally known speakers. Well, we developed enough membership that we decided to separate our meetings from the Kansas Medical Society. By that time our membership was up to around 200-300. Not all came to our conventions, but we did have enough to have good meetings. But not like you have now! You’ve got a good organization now! Has the executive secretary Carolyn Gaughan done that? She’s a goer! Has the glue to hold it together!

**Kellerman:** Yes. And we’ve had some motivated physician leaders who have all put a lot of effort and personal time into the KAFP. Were there any political issues back then?

**Burket:** Yes, hospital rights and privileges. Those of us in rural areas didn’t have to worry about it, but those in cities did.

**Kellerman:** When did the family practice specialty movement really start?

**Burket:** It started for a very definite reason. It started when I was a medical student: “Why would you want to go into general practice?”

When I was on the board of directors of the American Academy of General Practice talking to students, the students told us what was wrong. They said, “We can’t get anything but an internship in general practice. We want more education, not just an internship.” Family practice started because of the demands from the students. We finally got sense enough to ask the students what the problem was instead of trying to make it up ourselves!

So that’s when we really got interested in the issue of board certification. We knew we couldn’t have three year residencies in general practice. General practice was never to be “special.” So we were fishing around for a name. In the meantime, we finally found out that we had to get a board certificate in process to become a specialty. Then we had to get departments in a medical school. That was one of the main reasons it all started. Some said we just wanted “status.” We all felt we had as much status as we could swallow. What we wanted was something practical, such as more graduate education!

**Kellerman:** You said you were on the board of directors of the American Academy of General Practice. How did you get elected to that?

**Burket:** I was president of the Academy in Kansas and I was picked for one of the national committees of the American Academy of General Practice. I was active on that committee and I became acquainted with a lot of individuals. I received a call one night and they wanted to know if I wouldn’t run for the board of directors: “you’ve got plenty of support.” Clyde Miller was behind this. I finally did run. I hadn’t been too active in the Congress of Delegates. I’d been a delegate for only one year. It was fine and great, but being a delegate for only one year and then running for the board! But Clyde had been involved a long time and he was a smooth politician. He wasn’t on the board of directors at that time.

When I ran, I was caught in this board certification business. I supported family practice board certification. Boy, I ran into a lot of opposition from Texas. They were rabid against it because a lot of them down there were doing surgery and they were general practitioners. They had surgery and general practice internships and one year residency programs. I ran for the board of directors and I finally won by only one vote, because it became a tug of war about the board certification situation. They knew I was for board certification. That would have been about 1963. Board certification was gained in 1969.

I was chairman of the board of the American Academy of General Practice in 1966 and 1967. The AAFP officially changed to the AAFP on October 3, 1971.

**Kellerman:** What about the name change? Why family practice?
**Burket:** They kept telling us that you can't have board certification if you are a general practitioner because they can't be specialized.

**Kellerman:** How did your connection with Gayle Stephens come about?

**Burket:** In 1964, I was president-elect of the Kansas Medical Society and I was also on the board of the American Academy of General Practice. I was giving a lot of presentations at medical meetings. I kept meeting this guy by the name of Roy House, the administrator of Wesley. Roy was on the program at a lot of medical meetings and I met him there. He was telling me all about this guy down in Wichita by the name of Gayle Stephens. He had agreed with Gayle to start a three year residency program in general practice at Wesley Hospital. Well, I got interested in that, of course. So I made a point of coming to Wichita and visiting with Roy and Gayle. Actually Wesley was putting in about $200,000 of hospital educational money to support the residency. So I was able to visit with Gayle and got well acquainted with him. He was very interesting. He had his curriculum for his residents pretty well settled.

In 1966, I became chairman of the board of the American Academy of General Practice and as you know, we have a State Officer's Conference once a year. I talked them into letting this guy from Wichita talk at the State Officer's Conference about his training program. Thought he had a lot to offer. He did great! Gayle has always had energy! He did fine. I liked what he said and I'm sure he convinced a lot of those in attendance about the Wesley program he described and the need for board certification. After that, Gayle had a lot of invitations to speak to various Academy groups. He's been a good speaker and he has been a major leader in our movement ever since then, in the educational area.

By the way, at that time, the State Officer's Conference was in the fall and the Annual Scientific Session was in the spring. Turned around from the way it is now. About 1965, when I was chairman of the board, the AACP Congress of Delegates decided to change the meeting dates. Amos Johnson from North Carolina was president and we changed our meeting program of the State Officers Conference to the spring and the Annual Scientific Session to the fall because of conflicts with other medical meetings. So I was chairman of the board for 1 1/2 years and Amos was president for 1 1/2 years.

**Kellerman:** I want to clarify something about Roy House. What were the meetings about? Were they state Academy meetings?

**Burket:** They were conferences on hospital administration or medical society meetings. As president of the Kansas Medical Society, and as chairman of the board of the Academy in the same year, I was at hospital meetings all over the state of Kansas. I attended hospital affairs and medical education programs at the same time. It only took two or three meetings before Roy and I kind of drifted together and became acquainted. He knew I was interested in general practice and he was telling me about Gayle and what Gayle was going to do. That's how our conversations began.

**Kellerman:** How did medical staff members accept your ideas on family practice during those meetings?

**Burket:** I'd go around and talk to the doctors myself. I'd go around and visit with them, and I'd tell them the advantages and what other hospitals were doing. I enjoyed that but it was tough. Well, there were some of them that were sour faced. You bet.

**Kellerman:** How did the name "family practice" come up? Was there discussion about other names?

**Burket:** Not really. It just seemed to hit it right.

**Kellerman:** Another word is "primary care." What do you think about that?

**Burket:** That came up with all these national
reports that we had. One study came up with "primary care" and we didn't like that at all. That really didn't seem to fit with what we wanted in our educational program. We wanted a good name and a good organization that would stand up to the other specialties. We didn't want a term that would indicate we're lower than they are. So "primary care" didn't fit us at all.

The "family practice" name was chosen and the Congress of Delegates approved board certification. About a week later, Amos Johnson and Mac Cahal and I were thrashing around trying to find how we could apply for board certification. There hadn't been an application for a new specialty for 20 years.

Nobody on the Liaison Committee for Medical Specialties, that's what the American Board of Medical Specialties was called then, knew how to apply for a new specialty. The president of the Liaison Committee, a surgeon from New York, didn't know anything about it. But he said the secretary-treasurer of the Liaison Committee for Medical Specialties was Gus Buie. He was a proctologist at the Mayo Clinic. So we got on a plane and we hustled up to Minnesota and obtained an appointment with Gus.

We went into his office and visited for a few minutes. We wanted to know how to apply for recognition as a new specialty and he didn't know. He went through his filing cabinets and finally found an application and pulled it out. It was about a one-page application! Gus said we would have to have the Liaison Committee decide about this application. Looked awful simple to me! So we had to wait awhile until they got an approved application form for us before we could fill it out, going through all the requirements and so forth. But our meeting there with Gus was a good meeting because we were able to explain to him what we wanted to do and you know he became a convert right there! He was a good supporter of ours on the Liaison Committee for Medical Specialties.

We did the best we could to fill out the application, but on that application was a silly thing. We had to list 15 educational programs that were training this type of physician at that time. Now, how do you do that? Well, we thrashed around and I knew of Gayle's program in Wichita. His was one of the top ones. Then we had Lynn Carmichael's program in Miami. They had about four general practice residencies in California. They were only two years, but we could call them programs. Denver General had a residency program in general practice that was a two-year program.

But they didn't approve our first application. They found troubles with it. We expected that. So the year I was president-elect, we thought we had our second application just pat. Nothing to it. But they didn't approve it, either! Then it came up to my presidency year and we put in our third application. I told the House of Delegates at my President's Address, that if we don't get it this time, we should form an independent board of our own! By golly, Bill Willard was in the audience and he went into orbit! Bill was chairman of the Council on Medical Education and was really a supporter of ours. I don't know why he got so upset about my remark. Bill helped us create our Essentials eventually. Anyway, we cleared on the third application.

**Kellerman:** Bill Willard of The Willard Report?

**Burket:** He's the same man that put out the Willard Report, which was a Report of the Council on Medical Education.

**Kellerman:** Tell me about the formulation of the American Board of Family Practice.

**Burket:** Well, when we formed the Board of Family Practice, there were 15 Founders. Five members were from the Academy, five members from the General Practice organization within the AMA and five members representing specialties, an obstetrician from the Board of Obstetrics, a surgeon from the Board of Surgery, etc. That's the way it is now. We had to stagger the terms of our first board.

We drew straws for the initial staggered membership terms on the board. The terms
were for five years, but the individuals who drew less than three years could be re-elected if sponsored by their parent organization. I drew two years and was elected to a regular five years. I had seven years on the ABFP all together and enjoyed all of them.

At first, I became chairman of the Committee on Examinations and was chairman for the first five years. We divided the examination up into three parts. One was multiple-choice, one was case management and another was pictorial. We put the case management section in there because we had a feeling that men who had been out in practice would do better on that than they would on multiple-choice questions and they were going to be the ones that put up the money to support the board. So we put that in and it worked out. Practicing doctors did better on those than they did in the multiple choice. As the residents came along and took the test, they did better on the multiple choice than the case management. Test-question writers didn't have to be on the board; they were men who were prominent in medical education and were chosen by the Education Committee. They didn't have to be members of the board.

We got top flight educators to help us design the tests. We had emeritus professors for this and emeritus professors for that. Two of my favorites were Howard Lewis, who was emeritus professor of Internal Medicine, University of Oregon. He was one of our board directors. The other was Wallace Frohmeier, who was a emeritus professor at the University of Alabama for Internal Medicine. Well, I wanted Gayle Stephens to do multiple-choice questions. We put Gayle on as a test question writer, and later I wished we hadn't. He and Wally Frohmeier from Alabama became good, good friends and Wally Frohmeier talked Gayle into going down there to Alabama's Primary Medical School as Dean. Anyway, Gayle's done real well since then.

Incidentally, every time I went to one of those meetings, I had the best post-graduate education I've ever had.

Kellerman: You also served on the Residency Review Committee. How did that come about?

Burket: At an AMA meeting, I became chairman of the Residency Review Committee for Family Practice. Now I had two jobs! And I had them both for five years! As chairman of the Residency Review Committee, we had the job of developing the Essentials for residency program accreditation and getting them approved by the AMA and by the Council of Medical Education and by all the other boards who had to approve them. That was a job. We had to start from scratch. We had to get an organization and it cost some money. We had to borrow money because the board didn't have any money. We borrowed it from the Academy.

Then we had to have surveyors for the RRC, so we recruited Lee Blanchard from Stanford. His relationship to Stanford was in Santa Clara. He was on the Stanford University faculty to teach in the outpatient department. Lee was doing a regular five days a week up in the outpatient department.

But he agreed to be one of our surveyors. Worked half time at that practice and then he spent half time with us. And Lynn Carmichael from Miami was the other surveyor. Those two worked half time for us surveying the programs that put in the application. We wanted as many programs as we could, of course. The first coming in was Gayle's program. We didn't have to do much to it. It already met about every criteria anyway. It was approved.

The next Wichita program that applied was St. Joseph. Now St. Joseph's was a different matter and the Residency Review Committee sort of buckled up their backs for St. Joseph because the applicants that applied for it were Lew Purinton, an internist, and Bob Purvis, a surgeon. The RRC couldn't quite see those two fellows running a family practice program. Well, I knew both of them. And I knew Mother Mary Ann, administrator at St. Joseph Hospital. I talked to her and I knew she would also put up money for their program, so finally I persuaded the RRC to give St. Joseph a chance. When the examiner went down there
he was enthused about Lew and Bob, so we got that program.

I would like to have you do something for me before I forget it. Lew Purinton practically founded St. Joseph. Ernie Chaney made the program. But Lew founded that residency and I wonder whether they ever have given Lew Purinton real recognition for that. I meant to bring that up while Ernie was there but I kept forgetting it all the time. And then every time I see Lew Purinton at a party some place, I think about it. I don't know how many people really remember that Lew Purinton founded and was the originator of that program. Give Lew some recognition because he really is a quiet, nice guy. Doesn't ask much.

I think with St. Francis we had to bat it around before they got it approved.

Then I had a heck of a time with Smoky Hill in Salina. Bob Brown was there from the university. I knew him quite well and I knew he had experience in education and so finally they agreed to give it a try.

Kellerman: Was the problem with Salina the “1 and 2” aspect of it?

Burket: Yes, and then the size of town that Salina was, too. It was Bob Brown that finally got it approved. It was approved on a trial basis for only three years. They were re-surveyed and re-accredited in three years.

Kellerman: Then you were on the RRC for all of the Wichita-affiliated programs?

Burket: I feel good about getting in on the approval of all the residency programs here. All of them were approved within the first five years of the RRC. I was president of the American Board of Family Practice for two years from 1975 to 1977 after that.

Kellerman: So, you were on the Residency Review Committee for five years?

Burket: Yes, for five years, and chairman for its first five years. I was chairman of the ABFP Examination Committee for the first five years.

Then I was president of the American Board of Family Practice from 1975 to 1977.

Kellerman: How did you manage your practice back in Kingman when you were doing all this national work?

Burket: Well, I had a partnership out there with Sam Zweifel and Bob Boyer, two superb family physicians, and I could fly. We had another younger partner. But we had a difficult time keeping them. There were very few trained for general practice whose wives were willing to settle in a rural community.

Kellerman: I'm still interested in your motivation. Here you are in Kingman. You've obviously got a busy practice in your hometown. You are busier than you need to be and you've taken on the responsibility of doing all of this national work. I'm interested in your motivation.

Burket: Oh, I'll tell you, I had a great time. I met a lot of doctors out there. A lot of great people. And they are still my friends. A few of them have died now. The officers of the Academy were wonderful people. Sue stayed with the kids, but sometimes she went with me. We flew everywhere we went. Flew first class. We'd go at night. Sleep. Work. Back to practice. It really, as I look back, doesn't seem to be that hard; not that tough. I worked with younger men that we had to replace all the time.

Kellerman: How much sleep did you get a night?

Burket: Oh, I got enough sleep. Mac Cahal was an excellent executive director and he was a good manager. He got a lot of things done. He made it a lot easier for me. The Academy had other good people that could make some of the trips. I wouldn't trade that experience for anything. Nick Pisacano, executive director of the ABFP, was also a brilliant, energetic man.

Kellerman: You mentioned the words “our movement.” This was “a movement.” Obviously you were very committed to it.
Burket: Yes, it was. The debate about board certification was sort of a disruptive affair for the Academy really. We had some members that I think quit the American Academy of General Practice because they didn't believe in board certification. But not a large number quit. There were some that did. It didn't bother me. We were going off in the right direction.

Kellerman: Anything else about your work on the American Board of Family Practice, the Residency Review Committee and the AAFP that you remember? What did you do after? Was it after that that you went to Kansas City?

Burket: It was because of our application that the Liaison Committee for Medical Specialties changed its name and got better organized. They got on the ball. It's now called the American Board of Medical Specialties. I represented family practice on the American Board of Medical Specialties. I think I was on their board for five years. I was a representative from the ABFP. That was a political thing, too.

When they formed the American Board of Medical Specialties from the Liaison Committee, they had to get a new Constitution and bylaws. What do you do about who gets how many representatives to the ABMS? According to the numbers of diplomates? Should you match the number of delegates from specialty societies and number of votes to the American Board of Medical Specialties with the number of members who are board certified in each specialty? Well, someone woke up and realized what was going to happen. They made us come to an agreement to only admit and examine 2,000 diplomates a year for the first three years. See, they didn't want us to have the most numbers. We'd have too many votes. So, we started out at the time when I was there with only four representatives. I don't know how many they have now.

Kellerman: Any other politics that you remember back at that time?

Burket: There was the politics of hospital privileges and that was always there with us.

Kellerman: How about this department? Did it go through some rocky roads? What do you remember about that?

Burket: Sure, I remember. Cramer Reed called me when he was named dean of this medical school. He wanted to know if I would take over the chairmanship of the Family Medicine Department, but I had already committed to KU. That was about six or seven months before I actually went to Kansas City. I had already told Jack Walker that I would come to Kansas City.

Don Gessler, who was serving as interim chair, and Cramer Reed wanted to know if I could help them find somebody for chairman of the department. Well, I knew a lot of men by that time who were all interested in this thing, and about the first one I thought of was Donatelle. He was always very prominent up there at the University of Minnesota and by that time he'd taken charge of the residency programs at North Dakota, which was quite a job. He was very practical and seemed to know family practice very well. So I told them to consider Ed. He's the first one.

So I called Ed and told him I'd like to have a visit with him. Well, he was going to the American Association of Rural Health in Denver. So I said I wanted to talk to him while we were there. I didn't tell him what it was about. Don Gessler and I went out there and I introduced Ed to Don. We talked to Ed about the possibilities here and persuaded him to come down and look at the place and talk. Ed came and he liked it and, boy, we found a good one. He really stood up for family practice here and created an excellent department.

Of course, we had a recruitment advantage then, but I didn't realize it at the time. Ed told me afterwards that they were having a lot of these floods up there in Grand Forks. He told me he was sure glad to get away from all that water! We were lucky with that. Ed turned out to be a real jewel.

Now from there on, you'll have to ask the local doctors because, although I've been interested in the department, I really don't know any of the circumstances and details.
Here’s where men like Gerhart Tonn can pick things up.

**Kellerman:** Any thoughts from your faculty days in Kansas City?

**Burket:** It was difficult. When I was on the faculty in Kansas City, we had a heck of a time, but problems were not insurmountable and Dr. Jack Walker was a fine chairman. Over the years I was in Kansas City, things became easier and better organized, and the department was well accepted at the medical school, eventually.

**Kellerman:** What do you think about family practice now?

**Burket:** Oh, I think it has a great future. I don’t know where it’s going. I don’t know where all of medicine is going as far as that’s concerned. I feel a little bit concerned about family physicians being in managed care and HMO’s and those kinds of organizations. In the first place, I hated this word “gatekeeper.” That hurt us more than anything. It’s kind of quieted down now and family doctors are much in demand in managed care and HMO organizations. They hire them at ridiculous salaries! I went into this medical politics thing because I wanted to get more well-trained physicians for rural areas. That’s what I was interested in and I thought, boy, when we have three-year residencies, we’ll have it made! Now they are hiring them all to stay in the cities. But we’re getting more in Kansas. You know very well we have more rural doctors in Kansas than before we had departments in medical schools.

**Kellerman:** What about family practice education? What’s the greatest strength and what’s the greatest weakness in the educational programs right now? You mentioned the C-sections, for example.

**Burket:** Yes, well I think a rural doctor has to know C-sections if they want to do obstetrics, particularly in rural areas. To me it would be disturbing to be out there and not be able to do a C-section and take care of complications. If you have some of your residents that want to practice in rural areas, see if you can arrange some way to get them trained in C-sections. C-section is really one of the easiest major operations that you can do. They don’t have to do a lot of other things, but they should learn to do those well.

Of course you have surgery to think about. I’ve always felt that we were losing major surgery. When we formed the board, I didn’t see any way out of it because they couldn’t really become good family physicians and surgeons in three years. They would have to take another year. I don’t know whether they do that or not. Now they have to get by the Board of Surgery and I don’t think they would cooperate. At one time I thought we could get some surgery into training, but now I think it’s hopeless because I don’t think the Surgery Board would agree. They will stand for minor surgery, not major surgery. Really, we’re getting more surgeons out in the rural areas, too, so that will help. Maybe the family doctors won’t need major surgery skills.

**Kellerman:** Did things turn out the way that you were hoping and thinking in terms of your vision for family practice?

**Burket:** Well yes, except for the fact that I was hoping for more to go to rural areas. But then that isn’t entirely due to the family practice movement. Some of it is due to communities not sprucing up and really looking appealing to doctors.

**Kellerman:** We have the Medical Student Loan Program for students to go to rural areas now and residency programs have what’s called the Bridging Program. What do you think about those kinds of programs and do you have any other ideas for recruiting physicians to smaller towns?

**Burket:** Well, I really don’t. Preceptorships and organized education with a closeness to the medical schools are good. The preceptorships are well established. But if you send a student out to a rural area and if the family doctor preceptor doesn’t feel like he’s part of the medical
school, it's no good. I did research on that one time: on the value of preceptorships to rural practice and the doctors that practice. The doctors that had preceptorships when they were medical students really weren't convinced that it helped them decide to go to rural practice. That was published in a medical journal years ago. Around 1974 to 1975.

When we started our preceptorship in 1950, we went into the medical school two or three times a year. We were called in there and we had good sessions and talked and traded information. At that time, Mahlon Delp and Jesse Rising supervised it. And then Delp dropped out and it dropped off for several years, so the preceptorships lost status with the students and that may be the reason for the response that I got when I did that research. I think it's a different situation now. I think your preceptors now are officially a volunteer member of your faculty.

**Kellerman:** In general, the rural preceptorships get very high marks from the medical students.

**Burket:** Well, apparently the students feel then that they are getting something in their medical education by going out there. We did fine. I had a great time with my students the whole time that I precepted. We used to have them year round, two months at a time then. But the medical school gave the students the impression that they were going out to observe and not to learn much!!

The rural preceptors are better teachers and the medical students have respect for what they say while they are out there. I think it is a very important rotation to do.

**Kellerman:** What about the KAGP during the time in the 1950s and 1960s? Was that an active organization? What were the issues they were dealing with?

**Burket:** Gosh, I wish I could remember. There have been so many issues over the years. Are you talking about in the 60s? When we developed the boards, we were busy learning how to

create and conduct examinations, etc. Of course, hospital privileges have always been a bone of contention. Medical education: getting departments in medical schools. There was a lot of resistance at first and a lot of medical schools did not accept family practice. They were called divisions, not departments. They are all departments now. Not all of them, but in most instances.

**Kellerman:** Did you have any dealings with the legislature, meetings with the governor, or conferences with the medical school over any particular issues that come to mind or any personalities that you remember?

**Burket:** I know we had some contacts with the legislature, but darn if I can remember what they were all about now. I'm 85 years old! There were problems and a lot of them were different in different states. You can imagine they had a harder time accepting family practice in New York than in Kansas. Pennsylvania did well. They didn't have too many problems, they were a big enough state and they had a lot of rural people there.

**Kellerman:** What is your greatest accomplishment or the thing you are most proud of?

**Burket:** I'm quite proud that I was elected to the Institute of Medicine of the Academy of Sciences in 1975. And it was for all the work I'd done in creating this new specialty. I'm still a member but I don't serve on committees because I'm a senior member now. Senior members can do some work on committees but we can't vote on memberships. We can suggest, we can project, but we can't vote. We go to meetings anyway. There is an annual meeting in October in Washington.

**Kellerman:** There are not too many Kansans who are members of the Institute of Medicine!

**Burket:** There's only four of us, I think. Bob Graham is a new one. Jim Price. Roy Menninger is one. Bill Roy is one. Besides
doctors, they have Ph.D.’s and some politicians. Of course, Bill Roy was both. I didn’t agree with Bill Roy on lots of things, but we’re good friends. Bob Graham, Bill Roy, Roy Menninger, Jim Price and myself. That’s a pretty good group! I’ve enjoyed the meetings and I’ve been on study committees. I became a senior member 10 years ago. I’m old!

Kellerman: Do you have a CV that lists all of your accomplishments? I need to get a copy of that. Can you send it to me?

Burket: Yes, I have one in my files. Since I moved from Kingman over here to Wichita, I’ve lost a lot of things but I did bring my files and I have one in there. I’ll get one for you. Being elected to the Institute of Medicine is one of the accomplishments I feel good about. I feel good about being at the medical school for eight years and teaching and my relationship with students and my positions in medical organizations and societies.

Kellerman: Do you have children?

Burket: Yes, I have three children. My son is in Kingman. He’s an attorney and he practices real estate law and estate law. He has an abstract and title business there. I have a daughter, Carol, who has a master’s degree in physical therapy and is now doing house-call work for Via Christi-St. Francis. A second daughter, Christine, is married to an orthopedic surgeon here in Wichita and raising children.

Kellerman: What are your thoughts on some of the current issues in family medicine, such as medical education and managed care?

Burket: Going to rural areas is good but doesn’t fit with managed care in the strictest sense. I know very well that the ones that go to rural areas are going to individual practices or group practice. Doctors in rural areas are going to be able to do more with their education than those in managed care. So I think you ought to pay attention to how rural doctors need to be educated, not the ones in managed care. I’m not being critical of them; I just feel this way. Managed care has brought on some good salaries, regular hours, good vacations. But they are sacrificing part of their education; not applying what they are getting.

Kellerman: There is a push to meld family practice, general internal medicine and general pediatrics together as “Primary Care.” Your thoughts?

Burket: How does pediatrics get into it? They can be primary care for babies, but how can they be for families? They can’t.

Internal medicine has their own problems. They didn’t help us much politically. As individuals, some internists helped us immeasurably, forming our boards, creating our examinations. But as a body, they didn’t help us much.

Kellerman: Another political question is the situation with nurse practitioners wanting independent practice.

Burket: We could have predicted that when they began to create P.A.’s. Now I don’t think the P.A.’s are looking for independent practice. It’s the nurses that want to be prime. That won’t solve the economic part of the country’s health care problems. The nurses will just refer patients - that’s the only thing they can do, as a rule. They cannot replace a family physician.

Kellerman: Because of the increasing scientific information, procedures, endoscopy, etc., should family practice residencies be for four years?

Burket: My only chance of seeing it is to have a fourth year that can be offered and see how many take it; a fellowship, rather than make it mandatory for board certification. Residents could take their boards if they want to at the end of three years and then take this fourth year. Give it a try at first. But if you make it four years, I’m sure you’d lose so much. You’ve gained so much. Do you realize we’ve got 10,000 in training and graduate 3,000 a year?
Kellerman: Where were you born? What was your background before you became involved in the Academy?

Wilcox: I was born in St. Paul, Kansas, August 6, 1907. My father was a lineman for the telephone company. I grew up in Marion, Kansas. I played football there and came down to Southwestern College on a football scholarship. I hurt a knee in the second game and quit. I figured education was more important than pain. My degree was in English and History and Physical Education.

Following my graduation from Southwestern College in 1933, I was the manager of an ice cream plant in Arkansas City for two years.

Then I worked for the State Welfare Department in Wellington, Kansas for three years until the political change from Republican to Democrat displaced me and 20 other Republican social workers. I was hired as Welfare Director of Butler County and served until 1941 when more political changes began to occur. I moved to Baxter Springs, Kansas, and had a great experience working with the miners and unions. When that office closed, I was transferred to Wichita. I lived in Winfield but worked in Wichita for a short time.

I was sent to Strother Field, Winfield, where they were building a flying field to train cadets. That is when the Cowley County Medical Society contacted me, asking me to set up a program for welfare patients which was similar to an HMO.

I got into the state family practice academy by the back door while I was secretary of the Cowley County Medical Society. We started, here in Cowley County, the first HMO that I can remember. The Cowley County doctors had a plan where one physician served in each town in the county. We happened to have doctors in every single town in the county.

There had been a county doctor who took care of the Medicaid and indigent, but it wasn't working very well. It got to the place where he was overrun by welfare patients; they were all going to the one doctor and he was having quite a time keeping ahead of the pace. So I was called to set up another plan.

They asked me if I would be interested in setting up this program for the Cowley County Medical Society. We met with the county commissioners and we worked out a plan whereby the county paid so much for each patient on relief. This was used to pay hospital, medication and service fees. Then the doctors got what was left. A regular HMO! We set it up and started it in July of 1942. We ran it for about two years.

The doctors in Butler County thought that was working out pretty well. They came down and asked me if I would take over and set up a similar plan in Butler County. I went to the Cowley County Medical Society and asked them if it would be all right if I worked part time for Butler County and they said it was fine - just do that. I spent two days in Butler County and the rest of the time in Cowley County.

It happened that in Augusta there was a doctor by the name of Harry Lutz, who was real interested in family practice. He was supposed to put out a newsletter and he didn't know anything about it. He talked me into helping him out. Good thing.

It happened that Dr. Lutz was associated with a group of 16 doctors who were real interested in family practice. I wrote down their
names: Dr. Clyde Miller from Wichita, Dr. George Thorpe from Wichita, Dr. Arthur Fegtly, Dr. Ray Busenbark from Kansas City, Dr. Albert Harms from Kansas City, Dr. Charles White from Great Bend, Dr. Carl Siegel from KC, Dr. James Haigler from Hays, Dr. Conrad Barnes from Seneca, Dr. Ray Meidinger from KC, Dr. Lawrence Leigh from KC, Dr. Darrel Evans from Junction City, Dr. Grover Whittley from Douglas, Dr. Clovis Bowen from Topeka, Dr. Marshall Brewer from Ulysses, Dr. James Donnell.

These were the 16 men that I got acquainted with through Dr. Lutz. They had been to an AMA meeting and the matter of family practice came up. Drs. Miller and Thorpe were the wheels, the instigators of the family practice part. They came home and got this group together who they felt were interested in family practice.

They worked until around April, 1948. These physicians got together and drafted up a Constitution and some By-Laws. Dr. Fegtly drew them up since he was real interested in constitutions in such. He made a very good Constitutional Secretary. They incorporated a philosophy to promote and maintain high standards of general practice in medicine and surgery. This was practically the same philosophy that was introduced at the next meeting of the AMA.

When Miller and Thorpe got together and went back to the next AMA meeting, they got some support from some people from other states. Different states were beginning to become interested in family practice: to encourage young people to enter general practice, to defend the rights of general practice, to do medicine and surgery for which they are qualified by training and experience, to preserve the right of the free choice of patients, and to provide postgraduate medical education . . . in "big letters!" That was one of the things that they pushed above all: family practice education. The education part always came forth. They wished to advance medical science and public health.

**Kellerman:** Why those 16? Did they know each other professionally?

**Wilcox:** They just knew each other. I think a lot of Dr. Cramer Reed and he got the medical school started in Wichita. But these fellows were here before him and they had this idea of education for family practice. Back in those days, they came out of school and maybe they had one year of internship. Well, these doctors were beginning to feel that they were inadequate. They felt something should be done about a residency program for family practice and the family practice doctors. They got together for the first time at one of the state Kansas Medical Society meetings.

**Kellerman:** Prior to this, there was no general practice organization or anything? Nothing organized at all?

**Wilcox:** There was not. They got together the first time in Topeka. Dr. Clyde Miller mentioned, "Well, so and so back in Wichita was doing this," and Dr. Bowen said, "Well, I've got two or three up in Topeka that are real interested in family practice." And they just rolled together!

And they ended up with these 16 at the meeting and drafted a Constitution and By-Laws. That was the way it got started. That was held in Wichita.

I knew about it, but I didn't think much about it because I had nothing to do with it at all. I was still working in Butler and Cowley Counties. Dr. Lutz was one of those 16 and he would call me every time I went to Augusta and he would tell me all about it. I helped him set up their first newsletter. They had a one-page newsletter. It had the Constitution on it and when they would hold their next meeting.

**Kellerman:** What was the circulation of that first newsletter?

**Wilcox:** They sent it to every family doctor that they knew of in Kansas. I don't know how many. Dr. Lutz paid for all the postage. The
first one cost about $50 for the printing and postage. The second newsletter was four pages and cost $154.00 for paper, postage, letterhead and mailing.

In 1957, the board felt a need for better communications with a magazine-type journal. I was instructed to draw up a copy for one. The name Jayhawk Family Physician came to mind and was selected. The new four-page magazine was birthed.

Then in 1968, Sally Jarrott assumed the position of editor and writer. At that time the magazine was issued quarterly. Within the next few years it became bi-monthly.

My wife, Louise, died in 1972. In 1973, Sally Jarrott and I were married and she became an assistant in the office.

**Kellerman:** So, there was a real love story associated with Jayhawk Family Physician! How many other medical journals can claim that? What was the driving force of this group of doctors getting together? Were they concerned about hospital privileges? Education?

**Wilcox:** Yes, that is what they were after. More education. That was the driving force. Some of those doctors felt that there were a lot of young people that came out of school and they didn’t know what they were going to do or how they were going to do practice. They knew the clinical aspects of care, but they didn’t know the rest of it. They felt family practice was being neglected: to know people as patients and not as a body. I have always felt that one to two years of family practice before specializing was a good idea.

Family practice was the first organization to have the required number of hours of CME and required study for membership. Later, all the states accepted that and set up their programs. Kansas was the first, and they stressed education and the residency programs. The general practice doctors were also getting pushed around a little in the hospitals. Surgery, radiology and Ob/Gyn had more “push.”

**Kellerman:** Tell me a little bit about Dr. Clyde Miller, because Dr. Ned Burket mentioned that he was probably the driving force behind Dr. Burket getting on the board of directors of the AAFP.

**Wilcox:** Dr. Miller was 6 ft. 4 in. with a very commanding voice. When he walked into the room, you knew he was there. He was originally from Kentucky and went to medical school there. He came to Wichita and started his practice. He had some friends here. When he took a hold of something, why, it had to give. Dr. Miller was the leader and driving force.

Dr. Thorpe was a little quieter, but he had the same push for family practice. Then the others began to get this same thing from Drs. Miller and Thorpe. Dr. Thorpe did a lot of work on family practice. He was always button-holing somebody for something and he and Dr. Miller got the job done. Great combination.

More and more, I got drawn into it. Finally, they asked if I would help them part-time. That was in 1949-1950. I said I had some time and my other responsibilities were working out pretty well, so I tried it.

First, I wanted to know what they had and how many members. Dr. Tonn was the secretary at that time. I went to get this file box from Dr. Tonn. I went through the box and when I got through it, I found about 30 applications for members. It was a form and then they would approve it. I got those all straightened out and took them back to the next meeting. We went over the applications and they decided the thing they needed most was membership.

I wrote the county medical societies in Kansas to find out when they held their meetings. Dr. Miller and some of the other members and myself went out to those meetings and gave them a buzz and tried to talk them into filling out some applications.

The first meeting was in Harvey County. Dr. Miller and I went. He had a big sack under his arm with bottles rattling! So we went and used this as a persuasion.

Then we went to Newton and had a nice
crowd at the hospital, about 30 doctors there. Some were from Halstead, but belonged to the same society. So we got some ice and glasses and sat around and visited and got out some applications. But everyone of them was a specialist. So we gathered up our persuasion and left!

The next meeting was Coffeyville. They had a luncheon and then went into an executive session that lasted two hours. So we went home.

Then I got permission from the Butler County Society to go to their next meeting. I got their speakers for them. Clyde told them all he would match them double or nothing for an application: "If I win, you pay me $50. If you win, you fill out an application and I’ll pay your membership dues, which are $25." We got six new members that way . . . and $300! I think Clyde had a two headed coin!

Then we decided the meetings with the societies were not very lucrative. So I started calling on doctors with an armful of applications one day a week. I knew every doctor in Kansas because I had talked about our HMO program at the KMS meetings.

Dr. Franklin Murphy did a wonderful thing for the state. He got a doctor in every town of any size, in Kansas. He sent them out and if it weren’t for him, Kansas would not have the physicians they had in that day. Dr. Emerson Yoder, up north of Kansas City, said “Murphy just took me by the arm and introduced me to the mayor of this little town and said here’s your doctor.” Yoder liked everybody and stayed. It was beautiful how Murphy handled these doctors.

**Kellerman:** Did the Academy meet with the medical school or with Franklin Murphy at any time?

**Wilcox:** Yes. We were interested in the students coming out into the state. Dr. Murphy invited us up. They had their first “Kansas Day” at the medical school. It was about 1951-1952. Murphy brought in the mayors and other people from all the towns that wished to come and he would introduce them to the students in Kansas City. That way they got acquainted with the students and got together. That was the Academy’s first introduction to the medical school.

Then when the school had their orientation, Dr. Murphy assigned us a time when we could go up and meet with the students. We had a “Coke Party” for these students in the Francisco Lounge. We started holding meetings for them once a year and sometimes twice a year. When they had orientation for the students, Ob/Gyn, surgery, everybody got a shot at the students.

The next thing we did for education was to approve meetings for education. We put out quite a list which apparently was pretty well received because some of the people were always calling and asking about how many hours, etc. We stressed those meetings.

**Kellerman:** What was the relationship with the national family practice organization at this time? Did you have communication with them? Anybody at the national level that you dealt with in particular? Was Dr. Clyde Miller on the board of directors? What did he do nationally?

**Wilcox:** Clyde Miller was on the national board of directors for three years. We also ran him for president, but he was defeated. Clyde was everybody’s friend. He knew more people than anybody I knew. He was always coming up with ideas.

The national academy moved into Kansas City. They bought a building in the southern part of KC. They started having what we called SOC meetings: State Officer’s Conferences. They would take the president, the vice president and secretary from each state and they would put on a program for them. They would have people speaking on administrative work and publishing magazines. They had the department heads of universities giving presentations. They were excellent programs. We got good information from those SOC meetings. I got to meet the secretaries from all the chapters. There were 54 chapters.
In about 1952, they put out a bulletin showing the number of members in each state. We rated about 12th or 14th in total membership in comparison to the estimate of the total number of family doctors we had in the state. I started traveling and we picked up quite a few more members. We got everybody real interested in getting their friends into the academy. They found out that the academy meant something and it was going to do something for them. They were getting to the place where they wielded a little stick. In the Kansas Medical Society, they had about 1,800 doctors at that time. We had about 50-to-60 members of the Kansas Medical Society. They listened to the family doctors.

Kellerman: Ned Burket told a story about you getting one of the pharmaceutical reps to help support a state family practice conference. The KMS was not thrilled about that.

Wilcox: They were not. We got to the place where we didn't think that we had enough recognition, so we decided to set up our own meeting. We had about 100 members at that time. We put on a meeting where we had two or three speakers from out-of-state. We had good attendance, probably half the people that were there did not belong to the academy.

Oliver Ebel was secretary of the KMS at that time and Oliver got a little excited. He said we didn't need this split in the house of medicine. The KMS meetings were not too much larger than what we had. They begged us to go back and take one or two days and hold our meeting at the first part of the KMS meeting or at the end.

They gave us all kinds of opportunities to accept their proposal and asked to set up a program of our own in connection with KMS so they could advertise it. The family doctors decided they were doing so well that they just kept right on. So we were in disrepute for awhile! In later years, when we got up to 800-900 members, KMS was coming to us and wanting to know if there was anything they could do to help us.

Kellerman: Tell me about the early annual meetings.

Wilcox: The second annual meeting was held in the old Broadview Hotel in Wichita. We had two good scientific speakers and then Drew Pearson from Chicago. He was with the transportation company and quite well known. He was to do the dinner speech for us. The meeting drew a lot of attention. I sold tickets. They had two big ballrooms and they had to combine them for the meeting. We even sat 25 people in the restaurant.

Kellerman: Any recollections about Ned Burket being on the board or running for president?

Wilcox: Yes. Clyde Miller got me by the arm and he said we are going to do some promoting to get Ned elected, so we went to the Academy meeting in Chicago. We got Bruce Meeker, Thorpe and myself.

Bruce Meeker was the top surgeon in Wichita. He was a member of the Academy. He was not a member of the surgical society, but everybody admitted he was the best surgeon in Wichita at that time.

That was my first time in a big meeting, so I just followed Clyde. We stopped everybody. He'd take them by one arm and I would grab them by the other arm. We would tell them about Burket and what a man he was and what a pusher. Each chapter has just two delegates. We only had maybe 100 delegates altogether to button-hole. We button-holed day and night. Finally Burket won by just a couple of votes. Burket was the first Kansas president of the American Academy. He made an excellent president. I called him Mr. Family Practice.

Kellerman: Were there any political issues at that time? Any controversies with the academy or other organizations?

Wilcox: Politics entered into it in the 1960's. Bill Roy was in the House. Bob Dole was running against him for a Senate seat. We had a meeting in KC. I got Dole to appear on our program at a noon luncheon. Bill Roy was on
the other end of the table, with a couple of moderators in the middle. The Academy members were split between the candidates. They took it to heart. There was a debate about whom to support. But we just said good things about both of them.

**Kellerman:** Any dealings with the Legislature?

**Wilcox:** Yes, we dealt with the Legislature in getting the first family practice residency program at KU set up. Clyde Hill was the Speaker of the House. That year they wanted more family physicians to go out into rural areas of Kansas.

We visited with Vice Chancellor Bill Rieke and took Clyde Hill along and that gave us a lot of support. We thought we'd get a little more money if we did something the Legislature liked. Rieke came out and told us that they were going to set up a family practice department at KU and Jack Walker was to be the head of it. Next thing we knew, we had a house near the school with a great big sign on it that said “Department of Family Practice, KU Medical Center” and Jack Walker was installed as head of the department.

**Kellerman:** Who went to that initial meeting?

**Wilcox:** Clyde Hill and I. We went to Chancellor Rieke’s office and met with him. Also, we got our members talking to their legislators. Rural emphasis with the Academy back then was an important issue.

Our main thing was to get the students interested in family practice. We started a weekend program with the doctors, called Rural Health Weekend. The doctors would take one or two students and take them over the weekend. The students would go to the physician’s location, see patients in the office and hospital. They would make house calls, take them into their home for the weekend. Even the student’s spouse was welcome and got to see that part of it.

Dr. Alex Mitchell in Lawrence had a student. He told me they did all the rounds, office, home calls, etc. That evening, Alex and the student were sitting there talking and Alex asked him how he liked family practice. The student told him: “I’m going to be a radiologist. Family practice is too much work.”

That was academy driven - the Rural Health Weekend. That was in the 60s. Then we got them to set up these 30-day preceptor programs. Those went real well. Then a doctor out in Western Kansas had not been on vacation in a long time. This student walked in the door and the doctor just handed him the keys and walked out. Said, “It’s all yours.” We didn’t keep that doctor on our service list!

We were slowly getting around to a residency program. We had the KU one started. And the other programs were underway in Wichita. Then Smoky Hill in Salina got started.

**Kellerman:** Did the Academy have much to do with the origins of the department in Wichita and also the residency programs? Or was the focus on the Medical Center in Kansas City? How did the Academy interface at that time?

**Wilcox:** I called on the residency programs once a week in Wichita, Salina and KU to see if there was anything that we could help them with. Was there anything the Academy, as a unit, could do for them in advertising or anything under the sun? We had a good group of Academy doctors who were coming into the residencies and adding their family practice knowledge to what the residents were getting. We were teaching them some family practice.

**Kellerman:** Do you remember any particularly divisive issues or debates within the Academy? Dr. Burket talked about the board certification issue when he ran for president. Was that an issue at the state level or were there others?

**Wilcox:** Yes, this was an issue at the state level. Later on, the physician assistant was a big issue at first.

**Kellerman:** That is something I have talked to Carolyn Gaughan about that amazes me about the Academy. We have physicians from different towns, in different groups, that are
"competitors" on a day-to-day basis. When they come to the Academy and sit around the same table, they take all of that diversity and put it over to the side. They always work for the betterment of the Academy and for family practice, in general. I don't know of very many organizations that the members come together and put their personal issues to the side for the good of the whole.

**Wilcox:** I have never known a group that was so sincere about a cause. They were pioneers in medicine. They were looked down on by surgeons, radiologists and internists. The fact was that they were fighting for their lives and livelihood.

I don't know how it is now, but that was one thing that we tried to breed into the organization. It was for them! They were the organization! Nobody else. What happened to that organization is a picture of themselves. Nobody was doing it for them. They had to do it. That was the feeling we tried to instill in them.

I remember the students were real interested in what the members had to say, when we went to KU or when we talked to them in Wichita. They were interested in what that doctor was doing, why was he doing it and if he enjoyed doing it. Everybody enjoyed family practice. That was their main issue.

**Kellerman:** Is that the nature of the people that choose family practice as a discipline or the nature of the organization?

**Wilcox:** I think it was something we started in the early years of the Academy.

**Kellerman:** Any other personalities that you remember from the early years? Who from the Academy has served on the board of directors of the AAFP?

**Wilcox:** Ed Steichen was in the Kansas Legislature. Jack Phipps served on the AAFP board of directors. Lawrence “Larry” Leigh from Kansas City served on the AAFP board of directors.

Dr. Leigh served on the AAFP Cancer Program. That man did something that's well worth talking about. They had this cervical cancer screening program that the American Academy wanted to do. We appointed Larry to serve on that committee. He had me getting this and getting that, printing this and printing that. The next thing we knew, we started getting pap smear reports from the doctors. They were coming in by the hundreds and thousands. He got over a million pap smears, which was the biggest experiment that medicine had done up until that time. Dr. Leigh was the fire behind that.

**Kellerman:** So this was a service and a research project?

**Wilcox:** Yes, that was here in Kansas. If they found a positive one, they referred it back to the doctor who took care of the patient.

**Kellerman:** What year was that?

**Wilcox:** 1965-1966. Dr. Leigh was on the AAFP board. Others on the AAFP board were Richard Brummet, M.D., and Ernie Chaney, M.D. Donald Goering, M.D., was on a national committee. The KAFP should have at least one copy of every Jayhawk Family Physician that was put out and the AAFP board members were always listed.

**Kellerman:** I want to ask about continuing medical education.

**Wilcox:** KU started the “circuit courses.” We supported that. There were two circuits. One went the “northern route.” The other circuit went to Liberal and down in the southern part through Winfield. They usually had three professors who would give their time for a week at a time. It took about a week to make the trip. That was Academy driven also.

We had worked with KU about these “circuit courses” because the doctors wanted them. They didn't want to drive clear to Kansas City from out in Western Kansas. KU set these up for us and brought them out. The
professors were very good. We drew a lot of doctors from Oklahoma. We would have as many as 75-80 doctors. Ten-to-15 of them would be from Oklahoma, some from Oklahoma City and Enid. They would come to Kansas every time we had a “circuit course.” They would call me and want to know when the course was coming. KU started sending out a brochure to doctors along the state line to give them an opportunity to attend these courses.

Kellerman: What about the malpractice issue? Was that an issue for the Academy? Any legislative dealings?

Wilcox: Yes, we always were after the Legislature about the malpractice insurance issue. It was a continuous round. Every legislature, we would tell the doctors to talk to their legislators about the need for some changes in the laws. And slowly but surely, I guess they finally got some of those changes.

That was why the “Doctor for a Day Program” was started. I was up at the legislature visiting with Mr. William Bachman who was in charge of the Legislative Services in the Statehouse. He told me about a problem they had recently.

One of the legislators had a heart attack. By the time they got a doctor over here, he was a pretty sick man. Finally, they got him to the hospital, so I asked if I could set up a program and have a doctor at the Statehouse. Would they give us a room and anything else we might need? They said yes. I went back and told the board what I had in mind and they were very much in favor of it. I started out soliciting doctors and detail men for drugs. The hospital furnished a gurney. They found a desk and a couple of chairs. They had a room right over on the Senate balcony. They fixed that up for us and cleaned it all up. It had been vacant. When I was there one time riding the elevator up, someone asked me, “When are you doctors coming back again?” Well, as soon as the session starts!

The secretaries had been going up there getting their blood pressure taken every day. It sure helped. It started about 1973. I went up there about once a week to see how they were getting along. Everybody was real happy with the program. The Senators, Representatives, all their help were just real pleased.

I was up there once when one young doctor who had just finished his residency was there. Two diabetics had gone into coma and he had them both in that room, one on the gurney, one sitting down.

Kellerman: Tell me about other innovative ideas from the early years.

Wilcox: I got an idea that when the doctors completed their CME hours every three years, that they ought to have something to show for it, something on their walls in their office like a certificate. So we designed a seal and had it printed. Some fellow in El Dorado fixed it up for me. We started giving those to the doctors when they'd send their hours in. The American Academy found out what I was doing with those seals and they finally accepted it and use it as their official seal. That came from the Kansas Academy.

We were always getting plaques from the American Academy for membership. The percent of members joining that we had was jumping. We were always ranked. The first time they ranked us nationally, they sent out a big list of chapters and the number of members. We were always ranked 10th-15th. We were a little chapter. Many states were less. Some were more.

“Ask A Doctor” was a newspaper ad that we started. Calvin Openshaw, M.D., from Hutchinson was a very prolific writer. He was always writing about treatments. I visited with him and talked him into writing an article for us. We syndicated a column and ran it in every newspaper in Kansas. We'd get stacks of clippings from all the papers. The daily and weekly papers out in Western Kansas loved them. It filled in a lot of space for them. He wrote good stuff.

The first newsletter cost $56.02. That was Harry Lutz’s. The first one I put out for them cost $154 and they almost died. Our first
annual meeting, they gave me $500 to do the whole thing.

**Kellerman:** What about the Ernie Chaney campaign for AAFP president?

**Wilcox:** We decided that since Ernie had been doing so well and he made such a good appearance and so forth, that he should run. We kept talking about Ernie for president. To do this in good shape, Sally and I went up and spent 1 1/2 days with Ernie in Belleville. We went on office calls with him and went to the hospital, a little surgery to do, delivering a baby. We went to his home that evening and stayed there and had dinner with him. He flipped this big steak on the grill and we went over to the swimming pool to go swimming and turned around and the steak was gone. He had a Brittany dog, Barfie. Barfie had stolen the steak and taken it straight into his dog house.

We made up a brochure on Ernie. Everything under the sun that he did, we had it printed. It was small book. It cost some money to get it printed with all the pictures. We took that back to Boston with us and put a brochure in every delegate's hand. We had every room covered and gave trinkets away by the barrel. There is a yardstick that says "Chaney Measures Up - Kansas Academy of Family Physicians."

There were two other candidates, so there were three of them running. Ernie got up before the House of Delegates and gave one of the nicest talks. Each candidate had to give a talk - a speech. Ernie talked about the Academy and what it meant to him. I think that was one of the big reasons that they elected Chaney. He did a beautiful job.

**Kellerman:** Here are some other names and tell me your memories or impressions: Don Goering, M.D.

**Wilcox:** Don was one of the first doctors that I really got acquainted with. He was about the first family physician in Kansas who had an FP residency. He had a two-year residency at the University of Utah. He came back and was practicing at Leoti. We had a meeting in Great Bend. I'll never forget that.

I put everybody to bed and got everything straightened around and got ready for the next day. It was about 11:30 or midnight. Here I saw this fellow sitting over at the counter in a little restaurant, close to where the big meeting was to be held. I walked over there and sat down beside him. It was Don.

We got to talking and I fell in love with Don. He was my idea of a family physician. We sat there and talked until 2:00 a.m. in the morning about family practice and what he'd done and what I'd done ... things that we believed in.

Don was one of the first doctors that had a residency. I knew all the other doctors and all about them. I was friendly with them and liked them and they liked me, and we did things for them and they did things for me, but I got close to Don on a personal level.

**Kellerman:** What about Gayle Stephens, M.D.?

**Wilcox:** Gayle had the first family practice program at Wesley Hospital in that old house over there on the north side. Vic Vorhees and Stan Mosier were Gayle's first residents. Con Osborne was the very first one and then Vic and Stan along right after that. They worked at the old Sedgwick County Hospital.

**Kellerman:** How about James Shaw, M.D.?

**Wilcox:** He was active in the Academy and a very good member. He is no longer alive.

**Kellerman:** Jack Phipps?

**Wilcox:** A quiet man, but I guess he had to be as he was a partner of Dr. Clyde Miller. He was about the size of Dr. Miller, over six feet and commanded attention. He was always available to assist with any program and offered many good suggestions to promote the Academy.

We had planned to run Dr. Phipps for president-elect following his term on the AAFP board of directors, when he became ill and had to withdraw. He was an avid hunter and
fisherman and was in charge of our trap shoot which we held each year with our annual meetings.

**Kellerman:** How about Ned Burket, M.D.?

**Wilcox:** I like him. Dr. Burket and I always got along fine. He was my idea of what a family physician should be. When we first started, I used to call him “Mr. Family Doctor”... a very good friend. He lived in Kingman. I went to see him and he lived next door to a friend of mine with whom I was in college. My friend was Dr. Burket's neighbor and they hunted and fished a lot.

**Kellerman:** Comment on this picture (of medical students Larry Anderson, Greg Thomas, Lou Forster, Tom Simpson, Bill Ciskey, Milt Van Gundy, Dave Graham and Jim Burke).

**Wilcox:** We went up to KU and picked those six kids when they were students. Ciskey, Anderson, Greg Thomas, Tom Simpson, Lou Forster and Milt Van Gundy, and then Dave Graham and Jim Burke. Those students were the nucleus of the student interest group because we went up there and picked these six students and had a meeting with them. We asked them if they would like to start a family practice student group at KU Medical Center. We took them over to Dr. Lentz's place and fed them a big steak and we played golf one afternoon. Those were the six or eight students that we selected to start the student family practice group.

**Kellerman:** This picture is a result of that? Where are they now?

**Wilcox:** Dave Graham left. He didn’t practice in Kansas. Van Gundy went to Iowa. Lou Forster is here and Larry Anderson is in Wellington. Greg Thomas is in McPherson. Tom Simpson is in Sterling.

After we picked them, they really started to hold meetings and we’d go up there. I got an “in” with Dick Dickinson, who was right hand to Ewing Kaufman over at Marion Laboratories. He said he could help anytime we wanted, so we started having pizza parties for those students. Marion would furnish the pizzas to us.

We had 75-80 at a time. All members of the Academy. It cost $5 at that time for a student membership in the Academy. That was the group that started our students going.

**Kellerman:** Another name - Ed Donatelle, M.D.

**Wilcox:** Ed took over as head of the Department in Wichita. I’ll never forget the time that he got into an argument with another doctor, shaking their fingers at each other across about three rows of people. It was our annual business meeting. It was over a medical assistance program. It was hot and heavy. I thought I was going to have to go down there and separate them. They were both standing up just shaking their fingers, first one and then the other one, yelling at each other. Everybody else was just sitting back watching. The other doctor said, “You can’t come down here from North Dakota and tell us what to do here in Kansas!”

**Kellerman:** Another name - Jack Walker.

**Wilcox:** Jack Walker, mayor of Overland Park. We had an annual meeting in Overland Park. Jack had just been elected mayor of Overland Park. He was also head of the Family Practice Department. We had an open air place and we had a picnic. They had some kids straightening up the grounds, mowing, cleaning, etc. Jack was welcoming everybody to the meeting. It began to be very late and the clean-up crew got restless. Then here came a streaker, then another streaker. Three of these kids had stripped and run across in front of everybody. I thought Jack was going to turn inside out. He got red in the face, stumbled around. Everybody laughed. Jack was “the wheel,” like he was the driver.

**Kellerman:** What about Jim Price?

**Wilcox:** Jim Price is a prince. He came from a cowtown in Colorado: Brush, Colorado, ... the biggest feed lots around. He did a good
job with FP at KU. He got family practice to
the place where it wasn't subjective to Kermit
Krantz and some of those other boys up there.

*Kellerman:* How about Jim Donnell?

*Wilcox:* I knew Jim for quite a while because he
married a girl from my hometown. He did a
lot for family practice in Wichita.

*Kellerman:* Who are some leaders that we
ought to comment on?

*Wilcox:* We lost a good doctor shortly after he
was president, John David Huff. That man had
a sense of humor. I don't think there was any
body like him.

He was telling me one time about making
house calls. He said, "Last house call I made
before I came to this meeting was down by the
river on the bluff in Kansas City. This boy was
living in a cave. I went down there to see him.
I got him out of the cave and got him into this
place, a homeless shelter, where they were
looking after people. Sure took a lot of work,
but I got that home call made!" He had a little
patch over by Tonganoxie, a little acreage over
there. He was running a big mower that you
cut brush and stuff with. He hit a stump and
fell off and that thing ran over him. It killed
him.

*Kellerman:* What about Bob Boyer?

*Wilcox:* Bob Boyer was Big Bob. He was quite
a president. Everything had to be "so and so."
He and Sam Zweifel were over there with
Burket.

*Kellerman:* Sam Zweifel.

*Wilcox:* He was real interesting, real nice guy.
Shortly after he was president, he decided to
leave the state. He went with the administra-
tion as a doctor for the Ambassadors in
Washington, D.C. He moved around the
country and around the world. He was a
doctor in five or six different countries.

I was down in Phoenix about two years ago
to see my son. I ran into Sam and he had just
left the Embassy program because of his
eyesight. He was almost blind. He had some
trouble with his eyes before he left Kansas.
They left Washington headquarters and moved
down to Phoenix. They bought a home down
there. I tried to call him when I went down to
see my son six months ago.

*Kellerman:* How about Jack Tiller?

*Wilcox:* Now, there was a family physician.
Jack was on the Kansas Academy Board of
Directors for two years. He flew an airplane.
I went to several meetings with him in Kansas
City. I would drive up to Wichita and he'd get
his plane out. He had a dog that always rode
with him. I flew with him to two-three meet-
ings in that two years. He was a good pilot.
He was a real nice guy and he loved to hunt
and fish. He had a cabin and a restaurant a
little east of Beaumont. They have a landing
strip there. You could eat steaks on a Sunday.
You'd see half a dozen planes lined up across
from the restaurant on the road. He'd hunt
and fish over there every weekend.

He was killed in a plane accident. He had
his wife and daughter and her husband with
him. They went out to Washington to see
another relative. He flew into a mountain out
there and killed all of them.

He's buried over there at Beaumont. He
loved it over there around Beaumont - could
hear the quail calling and the birds. He was a
very good doctor. I found that he was very
gentle and I liked Jack real well.

*Kellerman:* How about Dick Brummet?

*Wilcox:* The first time I saw Dick, he was
crawling into his car in Hutchinson during the
middle of the annual meeting. I asked him
where he was going because the meeting was
not over yet. We had another day. He said,
"Well, it's not going to hold her up. I'm having
twins."

He was on his way home. His wife was
having twin boys.

When Dick was president, we used to fly.
He was a Navy pilot. We flew out to several meetings around Garden City and that district. He'd pick me up at Strother Field. We'd go out there for a meeting. It sure made the traveling real easy.

Kellerman: How about Rod Bradley and Melvin Waldorf? Were they active?

Wilcox: Yes. They were real nice, both of them, family physicians. I got to know Dr. Waldorf. He had some relatives that Sally knew real well. We were always visiting these relatives, or at the meetings, I would see him. They were out there in Greensburg and they practiced good medicine. That town was very supportive of their family physicians there.

Kellerman: Ray Meidinger?

Wilcox: Ray Meidinger was a very good family physician. I didn't know him as well as many of them. He was always there when you wanted something that he could give. He responded.

Kellerman: How about Herb Doubek?

Wilcox: Herb Doubek is a good one. He was Dr. Chaney's partner in Belleville. Big old Herb! He always wanted to do something for you. He would come around in meetings and want to know if there was anything he could do to help you out. He has a daughter, Deb, who is in medicine. She practices in Manhattan.

Kellerman: How about Phillip Godwin?

Wilcox: Phillip Godwin is a dandy! He's always been family practice. He supported us in anything that we attempted and made suggestions. He and Alex Mitchell were both at Lawrence. Phillip was always available if I wanted to have a committee.

Kellerman: Phil Hostetter?

Wilcox: Then there was Hostetter. He is also a photographer. He made his way through medical school by taking pictures. He was a good photographer and he had good cameras. He was always coming up with wanting to do something for the Academy.

He would always make suggestions; like if we had a program - he'd tell me a better way to do it!

I'll never forget we had some speakers at one meeting. Somebody was running the slide projector and it stuck. The next thing I knew, he was over there telling them how to run that slide projector and pushing whoever was running it away so he could get down to work on it. He played tennis and we always had to have some players and some prizes for tennis players.

Kellerman: How about Giles Freeman?

Wilcox: A KU alumnus if you ever heard of or saw one. On Friday, Giles puts on his blue pants and red coat and his hat with KU stuck all over it and goes to Lawrence to the football games. Never fails. We drove by Pratt going some place and I stopped to see him one Friday. He was all dressed up, getting ready to go to Lawrence to the football game.

He was president one year and we had the meeting in Wichita. Most of the KAFP presidents told me what they wanted and then they just left it up to me. After so many years of doing it, they didn't worry about it and I took care of it. But Giles was a worrier. I had this entertainment at the end of the dinner - always had an annual dinner, installed officers and always had entertainment, so I got the idea to have this tribe of Indians that had a dancing group. Lee Two Hatchet told me about this Indian dancing group. We had a big ballroom with a special floor to dance on.

During the middle of the dinner, Giles came around to me and said, “Gene, I didn't know if you were going to get entertainment tonight for us, so I got a group of Indians to dance for us.” Now we had two groups of Indians to dance! I told Giles: “Next time, Giles, listen and leave it to me!” I went out and visited with the two tribes. Each had
six-eight in each group. I figured a way to pay them all. I went back and told Giles they didn’t scalp me but they were still looking for him!

Kellerman: How about Kernie Binyon?

Wilcox: Kernie pulled some weight around Wesley and had many friends in the administration up there. He was a good friend of Jack Phipps and in the driver’s seat. If you wanted something done at Wesley, you could go through that group and get what you wanted.

Kellerman: How about Ben Barker?

Wilcox: Ben was a good family physician. He was always boosting the Academy. But he was self-conscious at times. I rode to several meetings with him. I always rode with the president to be sure I got them there. We were meeting in Emporia at the country club. He was talking and waving with both hands and driving. I looked up and we were on the wrong ramp, the one going out instead of coming in from the turnpike. He was from Wichita, practiced with Wineger and those doctors in the building south of the MSSC. Ben Barker had Lou Gehrig’s Disease.

Kellerman: What was your connection to Cramer Reed, M.D.?

Wilcox: He was always asking me about something that the Academy was doing or would like to do. He was a good friend. He was friendly to the Academy and supportive of family practice.

Kellerman: He previously talked to me about starting the medical school. He said he got a lot of flak from the FP’s in Wichita. The residencies had been there for some time. When the medical school came in, there was concern on the part of the family docs in Wichita that he was going to do away with family practice or that the residencies would come under the aegis of the medical school. People didn’t want that because they were community-based programs. Did you know anything about that?

Wilcox: No. I told everybody that I didn’t know anybody in Wichita or Kansas who could have started that medical school outside of Dr. Reed. I think he was the only one down there that could have started KUSM-W. I thought there were other people down there besides family practice that were not too happy with the school. I thought the FP’s were real happy over it and supportive.

In Wichita, they got what they should have gotten from the beginning. In Kansas City, there would be a professor with six “trailers” (students) going around from patient room to patient room. In Wichita, they have two “trailers,” one on each side of the professor. It’s more one-on-one - personal.

You can get some things out of a book. What you can get in Wichita, you can’t get out of a book. Personal contact is the way to do it. When they opened the Wichita branch - when they brought students over to Wichita - then we went to Wichita besides going to Kansas City. The KAFP had student parties there, too.

Kellerman: Did the Academy have any influence on the medical school or any stance or policy on the Wichita branch?

Wilcox: We always got good support from Murphy and Rieke. They were always very nice to us. We treated them the same way. There were times when you’d send patients up there and the doctors griped about it.

Maybe two months later you heard from KU about the patient. The communication back and forth was poor. Every time we got around them, we’d tell them that. That’s when they started sending out the circuit courses to help us out.

Kellerman: Looking back, what are you the most proud of with what the Academy accomplished?

Wilcox: I was proud of what the Academy accomplished by requiring continued study for membership, being recognized as an organization that insists on continuing medical education.
Kellerman: Is there anything you wished could have been accomplished for the Academy that was not during your tenure as executive director?

Wilcox: No, I think for the times that the Academy met my expectations for everything that I would have had it do. I felt that it was an organization that was going to last. It was not going to just fold up because I was leaving. I saw a lot of good things coming of that Academy. I really believed and I am still a believer in the Academy.

Kellerman: What is your feeling about the status of family practice today? Any particular problems that you see or issues to be dealt with?

Wilcox: It seems to me that family practice needs a little more “get up and go” about it. I think we need some people like Clyde Miller to push them. I find that there are two different eras. When I started with the Academy, it was the old “family doctor” type of program and organization. Doctors still made a house call now and then. They didn’t look at a big car and a new house. That was not their prime interest. So many of the young ones that I have come into contact with are most interested in the hours they work. Most of the doctors back in the early days, if they had to work 12-14 hours a day, they worked it. But now it is more or less a 9-to-5 job.

I still feel that every physician should have a year or two in family practice before specializing. You get the feel of the people and their thinking.

Sally Wilcox speaking: I say that Gene gave family practice good basics to work from. We were old fashioned. When we quit was just about the time that computers came into being. There is a completely different type of communications than when we were doing this. Ours was more person-to-person.

But you still must establish that solid foundation. That's what it takes. Because if you didn't have that solid foundation, by the time you get into the computer age, you don't have anything. Gene always answered his mail the day it came. Everything was personal, either by letter or phone call or visit. Lots of visits. That’s what it took to take that handful of members in 1946-1948 to 1,100 members before we retired. It was Gene that did it.
AN INTERVIEW WITH CRAMER REED, M.D.
FORMER DEAN, UNIVERSITY OF KANSAS SCHOOL OF MEDICINE - WICHITA
July 7, 1997

Kellerman: Thank you for meeting with me, Dr. Reed. We're doing a history of family practice education in Wichita and to do that we need some broader background on the origins of the medical school in Wichita. I want to get your perspective.

Reed: O.K. Stan Friesen's book on the KU Medical Center has a chapter that I contributed to which capsulizes the early beginnings of the school. As you know, Rick, it came into being as many new things do, "in the dark." You never quite know how such ideas ever get off the launching pad, if they do, but this one happened to.

The idea of a "Wichita medical school branch" was originally proposed in 1972 by WSU President Clark Ahlberg as the "Wichita State University Branch of the University of Kansas School of Medicine." There is a formica sign that says that. It's the only piece of memorabilia I know of from that era.

At any rate, we started with the premise that Wichita had an abundance of clinical material, almost pristine clinical material, because no other professional health education school had become established here. Wichita had been a site for a few core medical clerkships for some time. At the same time, there was a shortage of clinical "material" in Kansas City because of the number of undergraduate students and competition from the University of Missouri in Kansas City School of Medicine.

In Ob/Gyn for example, it was apparent to Dan Roberts, M.D., that Wichita had a great potential for "hands-on" clinical training purposes rather than having to use mannequins which, we understood, were used at times in Kansas City for some obstetrical clerkships. I don't know if all of our information was correct. My indirect understanding was that a few students on the Kansas City campus did not get to do a hands-on delivery because of an insufficient number of obstetrical cases.

Surgery constituted another medical center clerkship with similar student problems, and with George Farha's entrepreneurial tendencies and interest in the surgical preceptorship concept, it was another discipline that lent itself to having some medical center students to be assigned here for clerkships.

The pediatrics clerkship was viewed in a similar manner. Originally, three or four students would be assigned to Wichita for limited periods of time for their respective clerkships.

Early on, we attempted to provide some kind of respectable, cost effective, short-term rental housing for the students while making a very special effort to provide a good clinical clerkship. I think for the most part, we were successful. I believe the students that came down here felt they got a "good run for their money" in those disciplines.

Out of that came the idea from Clark Ahlberg, President of Wichita State University, and some other local folks that the local Wichita doctors had never really been involved in any formal teaching experience outside of residencies in St. Francis, St. Joseph and Wesley hospitals. The residencies kind of operated on their own with each hospital providing its respective medical education director. Generally speaking, Wichita physicians never had the responsibility of trying to take a young medical student and provide him/her the kind
of experience that they really needed during their time of clinical training.

So we didn’t know how it would work, but we soon found that local practicing physicians felt this was a wonderful opportunity and that practicing physicians could and would provide a good experience for them and they would like to be a part of it.

About the same time, WSU President Clark Ahlberg and KU Medical School Provost Dr. George Wolf, as long-time academic friends, held discussions about the possibility of establishing a more formal relationship between the two campuses. Out of those discussions came the germination of the idea that Wichita could be a base for a limited number of students serving their clinical rotations on a scheduled basis.

At the same time, we began talking with local hospitals about their potential roles with “new” medical students. For example, might they offer reduced membership fees for the Wesley W.E.L.L. Club (now Health Strategies). In addition, we offered various other amenities but we really didn’t mean to try to do anything that was terribly different from Kansas City. We simply wanted the students to feel welcome. We didn’t realize that we shouldn’t provide meals and certain other perks that Kansas City was not doing even though Wichita hospitals were willing to go ahead and provide them. Obviously, such perks would be totally non-reimburseable today.

The decision was reached that “yes,” we could have 30+ students down here for clinical clerkships. Many of the faculty on the Kansas City campus did not go along with the idea of a Wichita clerkship. They didn’t see how it could be done or why it was necessary. They worried about what it might do to their budget; another medical school campus would likely reduce their budget allocation(s). Could they have an academic clinical campus in Wichita with community physicians who weren’t trained as academicians, etc.?

There was lots of heartburn over these kinds of issues, Rick. There was much distrust of me, which I attempted to resolve over time. Fortunately, Archie Dykes saw the political ramifications of a Wichita campus of KUSM. Later on, Bill Rieke as vice chancellor at KUMC came along and he was very supportive of the concept. Had it not been for the input of those people, and the friendship of Clark Ahlberg, George Wolf and Governor Bennett, it simply could not have happened; there would have been too much against it. But with those men all in place, we began talking more formally about what we could really arrange down here for the clinical medical school years.

We wanted to do our own curriculum, which, I’m afraid, caused a lot of angst for our colleagues in Kansas City. But with periodic meetings in Emporia and Kansas City, many of their concerns were overcome. Besides, we had some pretty good people here, such as Ernie Crow, Dan Roberts, George Farha, and others who were good in their own specialties. These physicians could have made it wherever they might have decided they wanted to “do their thing.” I think that was gradually recognized by Kansas City.

And I believe it finally began to register with the faculty in Kansas City that we were not really out to try and move all the KUMC file cabinets down here. I guess if I’d have been on the KC campus, I might have thought the same thing; but starting our own school was never our idea. There was never any intent to make a four-year medical school out of this campus. I was accused of harboring such thoughts, but that was never even a consideration. We wanted to have good third and fourth year programs, period.

We wanted to make sure the lottery ran in our favor instead of against us. We had some trouble early on with the lottery. There were a few Kansas City faculty who lobbied against us. We heard from students that they were advised: “Don’t go down there. You will ruin your career.” “You’re an intelligent person, why would you want to go to Wichita and ruin your life?” We had to put up with a lot of that kind of talk in the beginning. All we wanted was a fair break.

Even though we recognized our curriculum was a little different from Kansas City’s, we believed it had to be a little different in a
community-based medical school.

And so we planned programs like “Introphase,” which is still done. The head of the Student Services, Dr. Joe Dominick, was a former 16th century literature scholar. Our Outreach person, Dr. Dean Kortge, was a European history Ph.D. Dean Kortge was a “cowboy” with a beard and boots. I haven’t seen Dean in recent years but I hear he is clean shaven - no cowboy boots, wears suits and he is still a very good guy.

He was very good with his boots and his beard “out West.” He knew how to relate with rural physicians. It was he who actually got the Wichita preceptorships and family practice program off the ground. The students and physicians liked him even though he did not have the usual “tickets” for a medical school educator.

Then we, of course, had Dr. Gayle Stephens during a crucial period of our development. Gayle was a big help in getting the curriculum in line with what other places were doing in family practice at that particular time. So it was a real blow when he decided it was time for him to leave to develop another community-based school.

When Gayle resigned, he left a real void because he was so conscientious and so committed to family practice that it was a real loss. When I attempted to interest other family practice physicians in the departmental chairmanship, they were just not that interested.

In fact, there was a fair bit of opposition to the medical school at the beginning. At one time, I was “brought before” the medical society because some MSSC family and general practice members were convinced that I was trying to destroy family practice here and that I wasn’t going to keep it after Gayle left. None of that was true, but I knew we had a perception problem because we couldn’t find anybody that we felt had anything like the same level of commitment that Gayle had.

Ultimately, we approached Bill Gardner of Harper. Bill was kind of a reluctant cowboy; bright as the dickens; smart guy; ran quite a successful and large clinical practice in Harper. We finally coaxed him to accept the chairmanship on a part-time basis because we needed a teacher in family practice. He didn’t want to dress up in a suit and come to Wichita, but he did. I have to commend him for doing it as well as he did when his head and heart were 54 miles away. He flew his own airplane to see patients in Southern Kansas - Sedan, Cherryvale, Independence, etc.

We recognized that family practice was a key discipline, but I had trouble keeping it going. At one time a female Ph.D. sociologist temporarily filled the position. It was tough to find the right person who would come in and run the program.

**Kellerman:** I looked at some of the records and there were letters to you from family physicians that were really negative on the idea of the medical school.

**Reed:** I recall that none had any interest in leaving their practices to assume the chairmanship.

**Kellerman:** What was the origin of all that?

**Reed:** In the case of some, I’m not sure they really believed that the concept of a community-based medical school was valid. We had never done it before! They were very much involved in their practices.

Of course, family practice wasn’t nearly as orderly and well defined as it is now. There was a fear that the school would take over all the residencies. What is going to happen to family practice? With a former urologist as the head of this “thing,” is he going to want to do away with family practice? That was never my thinking, but I was accused of it. However, I can appreciate their concerns.

At the same time, George Farha, M.D., as chairman, was making surgery a major thrust. Certainly Dan Roberts was making a very big thrust out of Ob/Gyn. Both were good, strong proponents of their respective disciplines. And when we successfully recruited Dick Guthrie, who “pushed” for Pediatrics and diabetes, it seemed as if everybody was jockeying for position in whatever discipline they represented.
Each was out to be the “top gun.” What we hoped would be that things would “even out” across the board. Ultimately, they did. So, in those early days, I’m sure there was a major league twist to every new “song” with the family physicians. I ought to look at those letters again!

**Kellerman:** Yes, I was real surprised when I read the records.

**Reed:** The family physicians didn’t trust KUMC and initially were distrustful of the “new” medical school activity. Some thought it probably would ultimately go away. Kansas City had a great distrust for us and many local physicians had an equally great distrust for Kansas City. The Wichita physicians were fearful that Kansas City would stop our curriculum efforts and send their people down here, which so far as I know, Kansas City never thought of or wanted to do.

So, distrust was on both sides and it was only after a number of meetings at Emporia (half way) and having a few retreats together that we all finally began to get down to business and realize that this could and must be a mutually cooperative venture. We had to take some “orders” from Kansas City because we were part of KUSM. Later on, we realized it didn’t mean the branch couldn’t be “OK” for both campuses.

**Kellerman:** Personal question: here you are - stuck between Kansas City and fighting battles here on the home front . . . why persist? Why put up with it?

**Reed:** The truth is it must have been the right time for reasons I don’t really understand. In spite of all the vicissitudes and the vagaries that go into the “battles” you just alluded to, what I believe is that sometimes “right” wins. It was “right” for this to happen. And we had a lot of good luck. Many times when I went home at night, often late, after a meeting with various groups, I wanted to say, “this is not worth it.” But on further reflection it seemed like the effort and trials were worth it. So, we would regroup and move on.

At least we had the understanding and support of a few good people. Remember the name Dr. Scarpelli, the pathologist at KUMC? We never got any help from him. Finally, after a period of time, I began to recognize where our support really was. A man by the name of Brown, who was chairman of physiology, was supportive. Max Allen, Stan Friesen, Bill Larsen and a few others would come along and put us on the back after a “lousy” day in Kansas City. That helped.

There were many faculty/staff meetings in Kansas City at 8 a.m. We had to drive up because initially we had no budget to fly. Couldn’t afford a motel, so we had to drive up that morning. Lorene Valentine, our director of finance, and I spent lots of time on the turnpike before the sun came up to get to the medical center meetings. What also helped was not having a wife who wanted fur coats and “things” which I couldn’t buy after giving up practice. It just seemed like the venture was a worthwhile thing to do.

**Kellerman:** How about the support of the hospitals? Were the hospital administrators supportive?

**Reed:** Yes. Wesley, which had a long history of involvement in residency programs, was probably the strongest supporter and that, perhaps, had something to do with my earlier long-time friendship with Jack Davis, the Wesley CEO. But St. Francis was not far behind in its support. St. Joseph, at that time, was not into medical education as much as they are now. But there were no serious disruptive problems from any of the hospitals. George Lappin at the Wichita VA Hospital was most helpful and a good friend.

**Kellerman:** Did you have any models on which to base the branch?

**Reed:** Rockford and Peoria, Illinois, back in those days, were getting established as community-based clinical schools. Bob Manning was at Norfolk, Virginia. While he was at
KUMC, he supported our cause. We had some things to draw on, to check what we were trying to do with what others had done. We found most of us were making about the same mistakes!

**Kellerman:** How about the budget early on? Did you have to go to the legislature?

**Reed:** Those were not easy times. We tried to involve the Sedgwick County Delegation, consisting of Senate and House members. Unfortunately, they were never as "strong" as we hoped they might be; I'm not certain that outside of Wes Sowers and Ben Foster that the Sedgwick County Representatives saw the potential.

The county came through. Fortunately, one or two of the county commissioners "saw the light" and pulled for the branch.

Originally, WSU President Ahlberg made the fifth floor of Fairmount Towers dormitory available to us at no cost. Later on, the county commissioners made the 1010 N. Kansas facility available to Chancellor Dykes. That would never have happened had it not been for Commissioner Tom Scott, now deceased. He was a big booster of mine and for the fledgling school. He made it possible for us to get the building on a lease if we didn't initiate/require remodeling of the building. Except for Scott, the county continued to nurture the idea of turning it back into a hospital someday. Scott was a realist. He was very helpful.

Sedgwick County Manager Kim Dewey was not against the idea and he went along with Scott; this helped a lot. My office was in a converted dressing room for the main operating room.

There was lots of politics. Kansas City wanted us to move out of Fairmount Towers because it was too close to Wichita State, though the Branch wasn't identified with Wichita State except for a brief time in 1973 or 1974. Clark Ahlberg allowed us to stay there and, as a matter of fact, through Clark Ahlberg's close involvement with some members of the Kansas Legislature, he attracted the attention of several legislators from rural areas such as Rep. Clyde Hill from Yates Center.

One Saturday afternoon, an unidentified legislator came unannounced with President Ahlberg while I was doing some paperwork at my WSU office in a little house on Roosevelt, to talk about the branch. We talked for a while and then he asked whether we could use a building that would cost about $4 million to be built on the WSU campus. Here I was in a converted bedroom (my office) in this five-room house! To think about a $4 million building was absolutely beyond my comprehension. Sounded great, but I never thought anything would come of it - perhaps it was a cruel joke.

A few months later, we and WSU staff were requested by the Legislature to work with architects to perform space studies. Later, we actually got into the planning process for what is now Ahlberg Hall, the College of Health Professions building on the campus of Wichita State.

Ahlberg Hall was to be the first of two pods that were to be built adjacent to each other. One pod was to house basic sciences along with clinical research. The second building was never built because "ownership" of the clinical branch moved away from WSU involvement.

For a very brief time, we were known as the "Wichita State University Branch of the University of Kansas School of Medicine." I never thought it would or should become the "Wichita State University School of Medicine." Some people in Kansas City, and perhaps some in the legislature, thought that was the next step, but those of us working on the curriculum never gave that serious consideration.

Let's go back to your original question, which was what we did about funding. I think my total first year budget for the branch was $150,000. Legislator Mike Hayden became interested in us, I believe, partly because of our obvious interest in rural medicine. Chancellor Dykes was never really against it and I believe at times was very much for the Branch... that helped.

Some of the Sedgwick County legislative delegation gradually came along but they never spoke with one voice for the branch.
Senator Wes Sowers, who chaired the Ways and Means Committee at that time, became a vocal proponent for the branch and continued to recommend supporting it, but overall support didn’t come easy. Wichita often seemed to get what was left over from the medical school and I don’t know that that was wrong, but it certainly made it harder to move along predictably.

Kellerman: How did the name “Wichita State Branch” come about?

Reed: It was never my idea. I couldn’t support or oppose it at that time. That title was proposed by President Ahlberg. About this time it had been decided that the first building would be built sometime in the next one - two years. So why wouldn’t it be a good title? Obviously, this did not set well with the KU folks. It also put me in a big bind with KU and WSU. Clark Ahlberg is still a good friend of mine. I see him often, but we simply don’t discuss such matters now.

Kellerman: Were there any bad feelings about the name change to the University of Kansas School of Medicine - Wichita and the change in location?

Reed: Yes, there were some bad feelings. At that time, I was also the Dean of the College of Health Professions at Wichita State University.

It soon became evident that I couldn’t perform both administrative functions in a timely manner. So they elevated me to the title of vice president for Health Education at Wichita State University and initiated a search for a dean of the College of Health Professions.

President Ahlberg didn’t want me to leave WSU. We talked about the fact that Chancellor Dykes had urged me to transfer over to Kansas University because of my medical school involvement. I was dancing back and forth between two universities and it finally became apparent that I really couldn’t be affiliated with both campuses even though they hired another person, Dr. Sid Rosenberg, to be Dean of the College of Health Professions at WSU. That helped.

Then eventually, because of the time requirements of starting the medical school in Fairmount Towers, I had to relinquish the vice president for Health Education position and became a full-time administrator with the University of Kansas.

Kellerman: So, initially, you were employed by Wichita State University, then both Wichita State University and Kansas University, and then Kansas University only?

Reed: Yes, that is correct. It was my belief that I was viewed with much suspicion because several of the KU medical school administrators mistakenly thought I really “worked” for WSU.

The truth is I was trying to function in a “no man’s land.” I was beginning to be viewed as having no loyalty to either university.

Kellerman: I have heard that Wichita always wanted a dental school or a medical school.

Reed: A few local dentists thought they ought to have a dental school in Wichita since there was none in Kansas. I was invited to attend some of their meetings prior to the medical school discussions. It appeared to me they never had a real leader to push their agenda as I look back on the situation now.

The Legislature thought a Wichita dental school could be a possibility. At times, I’m sure relationships with the Missouri dental school and the Kansas Legislature were not the best, and so apparently somebody in Topeka said, “Why don’t we throw a little bit of action to Wichita which is growing and doesn’t have a medical school? Why don’t we start a dental school down there?” I believe that’s the way early discussions must have gone. I was never privy to or attended any related meetings until they advanced to the point of the medical school branch discussions.

Two prominent Wichita surgeons, Dr. Leo Crumpacker and Dr. Jim Hibbard, were in practice here before Dr. George Farha came along. They wanted the medical school to be
in Wichita because they perceived Wichita to be the better site. But to move the medical school never made any political or financial sense. There were only a few proponents of this kind of radical change. It has been my presumption that some of the branch opposition emanating in Kansas City, Topeka and Lawrence started with the early Wichita medical school talk.

**Kellerman:** How about family practice? Billy Gardner served as chair for a period of time. It seems like he would have been in a tough situation. He’s down in Harper, 54 miles away from Wichita.

**Reed:** Do you ever see Bill Gardner? One learned quickly that you never talked disparagingly about Billy Gardner around Harper, Anthony or Medicine Lodge. He was a guy that took care of his patients - really took care of people; he cared about people. They were never accustomed to him being head of a department “at a medical school in Wichita.” So Bill really only accepted the acting chairmanship of family medicine to help out.

I must admit I put a little pressure on Bill, out of a long-time friendship, because we simply couldn’t recruit a family practice academician after Gayle Stephens left. He was never a very willing “bride.” This was after Stan Mosier and Vic Vorhees and other family physicians turned it down.

**Kellerman:** Was there a period of time when Larry Miller served as chair? A couple of months?

**Reed:** I believe so, for a very short period about the time I left the medical school in 1978.

**Kellerman:** What about Dean Kortge?

**Reed:** Kortge left before all this. He was there when we were getting the clinical branch started. He was a European history specialist with a Ph.D., a cowboy hat and a beard. He really served the Branch well and helped Bill Gardner a lot. He worked so hard that a lot of people thought Dean Kortge was the head of family practice. He never would have claimed such a title, but because of his strong commitment to and involvement with the successful rural outreach program, he was perceived to be the “chairman.”

He was also the person responsible for getting family practice rotations set up in rural areas. He knew the physicians, both M.D.’s and D.O.’s, in the rural areas. He traveled around the state to check on the rotations and “put out fires.”

That’s where his real interest was. He would “fight” publicly with George Farha and Dan Roberts over the relevance of family medicine.

In those days, there were many agnostics regarding family practice. “Who the hell said we ever needed them?” After all, surgery, internal medicine and Ob/Gyn respectively were the most important disciplines to George, Doug Voth, and Dan, depending on which one you were talking to. Dean stood up to them and he did it pretty darn well, and I think he left the school with their support and their approval, in spite of their obvious academic differences.

**Kellerman:** I saw a letter from Stan Mosier and Vic Vorhees to you after Kortge announced he was leaving. They sent you a letter that was very nice and they both commented about how he’d done a great job.

**Reed:** My recollection is that in the beginning, they were opposed to having a non-M.D. “fronting” for family medicine. He was a very clever, sincere, honest, what-you-see-is-what-you-get guy. They finally realized that here was a non-M.D. who really supported their “deal.” They really had a champion. Dean Kortge never was against them.

I thought it was fortunate that we had a Dean Kortge because there were only so many things that Billy Gardner could do as a half-time chairman. They ultimately recognized that Dean was a decent person trying to do a good job for family practice under trying circumstances.
Kellerman: What was Kortge's title?

Reed: I believe his title was Director of Community Outreach or Rural Outreach. In that capacity, he organized the family doctors and students on rotations that he arranged in rural areas. He had a big hand in selecting the physician preceptors, some of whom are still on the participating list. He picked well, considering he wasn’t an M.D., but he worked at trying to “think” like an M.D.

Kellerman: Were most of the family practice rotations at that time rural preceptorships? Were there rotations here in Wichita?

Reed: There were family practice rotations here, but the branch specialized in rural rotations because we believed in them and that’s what the Legislature really wanted us to emphasize. We deliberately worked hard on the rural aspect. Besides, the three family practice residency programs here weren’t particularly interested in student involvement.

Kellerman: Any other people back then who stood out?

Reed: Bob Brown in Salina and Jack Walker at the medical center. Bob Brown was very good and helped all he could.

Kellerman: Bob Brown is still in Salina and he still helps with the residency there. We refer to him as the “guru” of the program, the “godfather.”

Reed: Bob Brown was a very good guy to the Branch and he served a very important role in our early evolution. He was respected on both campuses. He was a big supporter for the Wichita campus to get family practice out in the state; he believed it wouldn’t come from Kansas City. Say “hello” to Bob Brown for me. I owe him a lot.

I should mention Ned Burket in the same context when speaking of Bob Brown and Jack Walker. Ned was a booster in a little different way. He was in a small community practice but had a big influence throughout the state. He and Paul Wunsch, a legislator from Kingman, contributed much in getting the clinical branch off the ground.

Kellerman: Other people who helped out?

Reed: Ernie Crow was as good and as valuable as they come. He was supportive of our efforts and he worked hard on the curriculum. He recognized that family practice was necessary in the rural areas. I tried on more than one occasion to entice him to serve as chairman of Internal Medicine.

It is my opinion that internal medicine as a discipline didn’t do what it could have for the rural physician shortage back then and family practice took the initiative to get practitioners out in the state. Internal medicine seemed intent on promoting its sub-specialties instead of preparing generalists. I think that’s one of the big reasons family practice evolved as a new discipline. Ernie recognized all that in the early days, and with the passage of time, I believe he’s appreciative of the fact that there is a separate, totally different role for family practice.

Jack Walker in Kansas City was most appreciated by all of us in Wichita. He intervened, as did Bill Rieke, on many occasions in our behalf.

Bob Manning was always good and he appreciated what we were trying to do. He was “good” for us because he was “Kansas University,” yet he supported Wichita. He was in tune with what needed to be done. He had hands-on experience with community-based schools from his Norfolk experience.

Marvin Dunn, Stan Friesen and Bob Hudson at the medical center provided encouragement. It was good just to have someone who didn’t oppose us, let alone support us as they did.

Kellerman: What about the role of family practice in this day and age with managed care, etc.

Reed: Today, I believe family practice’s roles are in primary care and geriatrics. Family
practice has to have a principal role in managed care. They have the best crack at it, the best potential for understanding it and utilizing it in an appropriate way that is best for the patient. I believe it is a disservice to refer to the family physician as the “gatekeeper”; they are much more. Wichita is blessed with an abundance of highly qualified, ethical family practitioners.

**Kellerman:** What about the continued relationship between Kansas City and Wichita. How has that evolved over the years?

**Reed:** Rick, as you know, initially a number of the medical center faculty were not thrilled with the evolving Wichita campus and they continued to have some distrust in our ability to perform academically. It was troublesome that increasing numbers of students wanted to come here for their clinical rotations.

I was viewed as the guy that was behind all of it because I did fight for more autonomy for Wichita. I truly believed it would not work over time if the “branch” had to be a mirror image of Kansas City. I said this often to Dave Waxman, the vice chancellor, and Bill Rieke. “If you want this community-based school to succeed, you’ve got to give us our day in the sun. You’ve got to let people recognize that while this campus is a part of KU, allow the Wichita faculty to be recognized for doing a good job on their own.”

Initially, Kansas City had to approve all of our curriculum changes. This was understandable. They had to grant all the academic faculty appointments in Wichita. This, too, was necessary but awkward for us. I don’t believe Archie Dykes was ever sure where Cramer Reed was coming from, even after I resigned my Wichita State appointment. I buttonholed legislators and continued to “push” for the Wichita campus. From time to time I’d say: “This is a worthwhile project; allow us to develop pride and reasonable autonomy.”

When I resigned in 1978, I knew it was time to move on. It was apparent to me that I was a detriment to future growth and well-being of the Branch.

In the meantime, Dick Walsh had come here as associate dean. Dick was a very bright guy, a surgeon from New Mexico, but I didn’t think he really worked well with the local medical community. That seemed to suit them in Kansas City, because they were looking for “their” man down here.

Cramer Reed was not their man. They saw me as an outsider, the guy that pushed for the title of “Wichita State Branch of the University of Kansas School of Medicine.” As mentioned earlier, this had not been my idea.

In any event, the Kansas City folks wanted their own person. Dick Walsh filled the role. Bob Kugel, who came from New Mexico, was the new vice chancellor in Kansas City and he was a friend of Dick Walsh’s and was responsible for him coming to Wichita.

But Dick appeared to be more interested in Dick Walsh than in the Branch. A few Wichita people became aware that I was getting gun shy by this time. Dr. Walsh wanted to be dean. I understand better today than I did at the time what was going on. So over time, Kansas City prepared to work with Dick more than they did with me. It was obviously time to leave.

**Kellerman:** Your leadership role - did you get thrust into it? Did you take it on?

**Reed:** At the very beginning, I was dean of the College of Health Professions at Wichita State University. Clark Ahlberg and the Provost, George Wolf, at the medical center began having discussions about how to utilize Wichita as an undergraduate teaching site. Eventually, I was included in the discussions. I had been aware of some of the KC student issues and the short supply of “clinical material” on the Kansas City campus through Bill Larson and others. Ultimately, arrangements were made for selected Kansas University students to come down for certain clerkships as previously described.

Clark Ahlberg certainly was all for it. Had I known all the eventual vicissitudes, I probably would have declined involvement several times but I didn’t and naively thought Wichita deserved a chance to produce good
practitioners to help address the physician shortage. Looking back now, it seems worthwhile.

Kellerman: Any other memories? Anything to add?

Reed: Lorene Valentine was our financial person and she knew a lot about setting up an accounting/finance department. Fortunately, Marlin Rein, then with the Legislature, respected Lorene’s business abilities and integrity. Lorene ultimately became Associate Dean of Business Affairs after earning her MBA. She ran the numbers right and she was always ready with her spreadsheets, etc. Marlin obviously felt that she had the correct information when he needed it.

Marlin was a stern but fair advocate of the Branch. His approval was very important. I suspect Lorene would know and could recall many things that I have failed to recount.

Kellerman: OK. Thank you, Dr. Reed. This has been great. I have learned a lot. This is going to be real interesting and will add to this history.
FAMILY MEDICINE PRESENTATION AT THE "MATCH PARTY"
CHRISTOPHER A. BEST, MS4
1996-1997 PRESIDENT, FAMILY MEDICINE STUDENT INTEREST GROUP
APRIL 10, 1997

I would like to take just a moment to look at tonight from a different perspective, and that is the perspective of tradition. Kansas has a history of medical excellence and I use the word "tradition" because I believe that the medical excellence of the past will be continued now and in the future, giving us not only a history, but also a tradition of excellence.

The reason I mention any of this, is that if people do not know and appreciate their history, they will lose sight of their place in it.

Dr. Kellerman and Dr. Woolley have been putting together a library of books and writings from key figures that have played a role in the development of family medicine in Kansas. Their goal, as I understand it, is to get personal anecdotes, experiences, and thoughts from the pioneers that paved the way for us and shaped medicine and medical education in Kansas, as we know it.

According to Thomas Bonner in his book, The Kansas Doctor, two hallmark characteristics of the Kansan include idealism and a pioneering spirit. Early physicians in Kansas were literally pioneers who settled in the 1850s. The pioneering spirit and idealism of Kansas physicians, however, was maintained much longer.

A classic example of that pioneering spirit is Samuel Crumbine, a physician from Dodge City, who pioneered the nation in public health. From 1904 to 1923, he reigned over the Kansas Board of Health. He was quoted in newspapers throughout the country and was considered the national authority. As Bonner describes in his book (much more thoroughly than I have time for here), Kansas life expectancies were four to five years longer than the median for the nation, the highest in the country. Our incidences of TB, cancer, Bright’s disease, diarrhea and heart disease were all considerably less than any other state. Kansas had the highest proportion of men fit for wartime duty in WWI. Kansas-educated scientists and physicians were winning an impressive list of positions in the world of science. Kansas had come of age in the medical world.

More recently, Kansas was a leader in the efforts to develop family medicine as a specialty. There are many people who worked to develop family medicine in Kansas and the nation, too many to name, but I would like to name a few. Gerhart Tonn, M.D., was involved early in the transition from GP to FP.

A Kansan named Dr. Gayle Stephens became a spokesman and organizer at the national level. He set up the Wesley Family Practice Residency in 1968, one of the first four in the country. Dr. James Donnell later started the St. Joseph program.

Ned Burket, M.D., a physician from Kingman, helped define family medicine as we know it through development of family medicine residencies. He is also a former president of the AAFP. Dr. Burket served the first five years on the Family Practice Residency Review Commission; he is here tonight.

I asked Dr. Burket to come tonight to thank him for his contributions to family medicine and also because he is a living, breathing example of the idealistic and pioneering spirit which typifies the Kansas family physician. I’d like to read a few sentences about Dr. Burket.

"Every would-be reformer needs a sponsor... someone who will take an interest and promote opportunities for one to be heard. That person for me was George (Ned) Burket, Kingman, Kansas, past president of the AAFP. He gave me my first professional opportunity as a speaker at the Academy's State Officers Conference in Kansas City in 1968. Ned had a legitimate parochial interest in Kansas and knew what we were trying to do at Wesley in Wichita. He became my patron in gaining an entree for me into the national forums where the characteristics of family medicine as a new discipline were being debated and hammered out. An accomplished writer and speaker himself, Ned is responsible more than anyone else for my development as a spokesman for family practice."

We are part of something larger than ourselves. We are part of the University of Kansas School of Medicine - Wichita. We are part of the State of Kansas, and we are part of the medical history and traditions of our state. Luckily, we have a history of excellence. The mold has been shaped and it is our privilege to continue in the tradition of the Kansas physician.

Dr. Burket, thank you for coming. Your work over the years is appreciated and you are truly an inspiration to us all.
"...a tremendous new specialty."
by DEAN KORTGE, Ph.D.
FORMER DIRECTOR
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE
MAY 2, 1997

Dr. Cramer Reed always had a clear vision for the Department of Family and Community Medicine, even before students actually reached the Wichita Campus . . . the Wichita "Branch" as we then referred to it.

I was hired in 1973 as Director of Special Projects. Two projects immediately came on line: 1) a joint project with the Sedgwick County Health Department . . . a Model Cities Health Clinic project with several clinics in the inner city; and 2) a Mobile Hypertension Screening Project. It was our vision that medical students would somehow be involved in these projects to get a "hands on" experience with community needs. However, that vision never became reality. Still, those two projects did give the Department of Family and Community Medicine and "The Branch" some well-recognized citywide presence.

In 1975, I became coordinator of the preceptorship program for the Wichita campus. We scheduled all students for a four-week rotation with a practicing family practice physician somewhere in Kansas. There was some concern among the faculty that we used only family practice docs.

I believe it was in 1975 that we organized an education project whereby we would take guest lecturers (mostly faculty members) from Wichita to sites around the state for a continuing education program. This originated with having had additional contact with the preceptors and their students and as a more formal link with other physicians at "The Branch."

We also, about the same time, developed the Harper Project with Dr. Bill Gardner. This was a special preceptorship project whereby medical students and physician assistants and nurse practitioner students would be assigned to a simultaneous rotation. Later, Dr. Walt Forreider joined with Dr. Gardner in Harper.

In 1976 (I believe), I became director of the Department of Family and Community Medicine. We had difficulties in attracting a full-time physician to this position and Dr. Reed appointed me primarily as the administrator of the Department.

Those early years . . . the first years when students actually were in Wichita for their clinical rotations . . . were very sensitive times.

Each departmental chairperson wanted to garner as much time as possible for his/her rotation. Through the persistence of Dr. Reed, Family and Community Medicine was made a mandatory four-week rotation.

This rotation was questionable in the eyes of some because we . . . The Branch . . . did not "control" the residency programs. The family practice residency programs preceded the establishment of the Wichita campus and almost all of their funding came through other than state sources. It soon developed into some tense times over payment to those residency programs for their involvement of training for medical students and the "control" of those programs. Mostly, through 1978 when I left the Wichita campus, we were using private practicing family physicians as our "faculty."

Students for that four-week rotation would be assigned to a family doc and would work in their office. We would then have scheduled group activities for the entire rotation where we would discuss such topics as a complete
H/P, communication skills, dietary needs, costs of a hospitalized patient and other "soft" topics.

The other department heads were concerned about the amount of time being devoted to family medicine, because with the preceptorship program and the required rotation, every student effectively had an eight-week family medicine rotation.

There was the over-laying tension created by funding issues from Topeka. In the 70's, the cry was... how do we get more doc's practicing in rural Kansas? Legislative questions were being continually raised.

We did a project to help communities understand, from the perspective of a newly trained physician, what would be needed to recruit them to practice in a specific area. We took this "road show" to approximately 15 rural Kansas communities. It was mostly family practice residents whom we took to answer the community's questions.

From the vantage point of today, some 20 years later, it seems clear to me we were well in the forefront of including medically social issues into the training experience of medical students. I look back with a deep sense of pride of having been involved in a tremendous new specialty. I was able to attend national Family Medicine Society meetings and had wonderful experiences, and it is clear that Dr. Reed's leadership and vision held this program together in its formative stages.
"It was to be a community-oriented medical school . . ."  
by LORENE R. VALENTINE  
FORMER DIRECTOR, BUSINESS AFFAIRS AND PERSONNEL  
UNIVERSITY OF KANSAS SCHOOL OF MEDICINE-WICHITA  
AUGUST 18, 1997

In 1968, there was political pressure to increase the number of physicians trained in Kansas. This pressure prompted suggestions for expanding medical education programs in the state, and a proposal for a four-year medical school in Wichita surfaced. In 1969, the University of Kansas drafted a proposal which was approved by the Board of Regents and the legislature to accomplish the following:

1. Condense medical education from a four-year to a three-year curriculum.

2. Increase the class size at the University of Kansas School of Medicine from 125 to 200 medical students.

3. Establish a Department of Family Practice.

4. Extend residency programs to all campus sites.

The KU Medical Center requested approval for expansion and the development of health education programs in Wichita and Topeka to counteract the doctor shortage. In November 1970, the Board of Regents took the proposal under advisement. During the spring and summer of 1971, discussions were held between the Medical Society of Sedgwick County, Wichita hospital officials, Dr. D. Cramer Reed, who then was dean of the Wichita State University College of Health Related Professions, and Dr. William Rieke, executive vice chancellor of the University of Kansas Medical Center. These discussions resulted in the formation of a Medical Society Advisory Committee to investigate the feasibility of a medical school in Wichita.

In September 1971, the Board of Regents authorized the creation of the WSU Branch of the University of Kansas School of Medicine, as it was called then, and recommended funding a year’s budget. Dr. D. Cramer Reed was named as dean of the new branch. The development of the Wichita Branch in conjunction with increased student population and curriculum changes at the KU Medical Center was an overall effort to increase the number of Kansas physicians in training. By December 1971, the Board of Regents had given approval to Drs. Rieke and Reed to begin development of the organizational structure of the branch. It was to be a community-oriented medical school, utilizing the excellent clinical facilities available in Wichita.

Dr. Gayle Stephens, founder and director of the family practice residency program at Wesley Medical Center, was appointed the first faculty member at the Wichita Branch. He was named chairman of the Department of Family Practice.

Dr. Reed indicated at the time that Dr. Stephens’ appointment would permit early development of a curriculum to introduce students to the principles of health-care delivery by the primary physician. Dr. Stephens was quoted by The Wichita Eagle as indicating that he would like to develop a program in which students would get a portion of their training in cities and rural areas outside Wichita.

I remember Dr. Stephens as director of the Wesley Medical Center Family Practice
Residency Program. I don’t believe he was with the Wichita Branch more than a year or so before he moved on to pursue other activities.

Dr. Dean Kortge joined the Wichita Branch in 1973. He served as special projects director and later on as associate director for outreach. He had a faculty appointment in the Department of Family Practice and started the first community-based services for the medical school. He was instrumental in developing the Model Cities Program in Wichita and later served as president of the Health Systems Agency of Southeast Kansas.

Sometime prior to July 1977, Dr. Bill Gardner, a family practice physician, was appointed chair of the Department of Family Medicine. He served in that capacity for a brief time before he left to do a residency in pathology at Wesley Medical Center. Dr. Kortge was appointed interim, or acting chair, of the Department of Family Practice, around 1977 or 1978. This was a little unusual since he is a Ph.D., rather than an M.D.

In 1977, the medical school was on the move, both literally and figuratively. The medical school moved from Fairmount Towers across from the Wichita State University campus to E.B. Allen Memorial Hospital, which is the current location. The move to E.B. Allen was to be temporary, pending completion in 1979 of the new Health Science Building on the WSU campus. In December of 1977, the Board of Regents decided that the medical school should remain at E.B. Allen, rather than move into the Health Science Building at Wichita State University. Plans to share the building with the College of Health Related Professions had proved unfeasible due to continuous growth of both institutions.

Over the next several months there was an increasing number of differences of opinions over the operations of the Wichita Branch. One of the points of contention was the naming of a new director of the Wichita Branch’s Outreach Program. At this point in time, Dr. David Waxman was executive vice chancellor of the medical center in Kansas City. Dr. Joseph Meek was vice chancellor of Health Care Outreach and the KU Chancellor was Archie Dykes. As the tension built and the level of frustration increased, Dr. D. Cramer Reed asked not to be reappointed as head of the University of Kansas School of Medicine - Wichita, which was the official name of the medical school as of June 1977. In June 1978, Dr. Reed resigned as vice chancellor and dean of the medical school.

Chancellor Dykes and Dr. Waxman appointed Dr. Richard Walsh to replace him. During Dr. Walsh’s short tenure as dean there was a lot of turmoil. Chancellor Dykes made several trips to Wichita over the next two years. After an extensive search for a family practice chairman, Dr. E.P. Donatelle was appointed.

Discussions were ongoing with officials at Wesley Medical Center regarding the family practice residency program. Jack Davis and Bill Kimble were the principals at Wesley Medical Center who had discussions with Dr. Donatelle, Dr. Walsh and eventually Chancellor Dykes. In January, 1980, the University of Kansas School of Medicine - Wichita assumed full educational responsibility for the Wesley Family Practice Residency Program in the Medical Arts Tower at 3243 E. Murdock. Dr. Walsh resigned in July 1980, and Chancellor Dykes resigned in August of 1980. However, the Department of Family and Community Medicine at the University of Kansas School of Medicine was on its way to becoming one of the major departments at the medical school.
"... accomplishment of this mission required a strong department ..."
by E. P. DONATELLE, M.D.
FORMER CHAIR
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE
JULY, 1997

After almost 18 years since I arrived in Wichita in 1979, and with all of my personal records and files long since destroyed, it will be extremely difficult to add to what is in the department files that should yield a good history. With that in mind, I thought I would review the chronology of the department's development in its early stages with respect to a newly developing medical school from a personal perspective.

I will include in my dissertation how I became involved, persons instrumental in the department activities, some problems encountered, accomplishments and finally, the need for continuance of family medicine as a necessary and vital force in efficiently providing good health care, not only for Kansans, but also other Americans and indeed, internationally.

The question that probably should be asked is why Ed Donatelle was asked to head the Department of Family and Community Medicine in Wichita.

It all began as I was completing my sixth year as head of the Department of Family Medicine at the University of North Dakota School of Medicine. We were successful in developing a four-year medical program from a two-year medical school in less than five years. Family Medicine, the largest clinical department, had developed a strong undergraduate program and four family practice residencies throughout the state. Dean Walsh of the University of Kansas School of Medicine visited me in North Dakota and had me detail how we were able to accomplish the feat in such a short time.

Later that year, at a national meeting, Drs. Don Gessler, Gerhart Tonn, Jack Phipps and a contingency from Wichita asked me to sit in at a breakfast meeting and discuss the new medical school in Wichita. This was quickly followed by an invitation from Dr. Gessler, then program director of the newly developed St. Francis Family Practice Residency, to speak at their first resident graduation. I later discovered that my wife, Marion, was also invited to accompany me. While in Wichita I was asked to meet with the department chairman of the medical school consisting of Dr. George Farha, Dr. Dan Roberts, Dr. George Dyck, Dr. Richard Guthrie and several other clinical chairman.

Following these meetings, I was asked to consider chairing the Department of Family and Community Medicine in this newly developing medical school.

After almost 25 years in practice in Minneapolis, and having experienced the pleasure of developing a new clinical medical school in North Dakota, I was intrigued by the challenge of developing yet another clinical department in a new medical school in Wichita. Thus, Marion and I accepted the position and moved to Wichita.

At the time I arrived, St. Joseph and St. Francis had independent community family practice residencies and Wesley Medical Center, with Jack Davis and Dr. Cramer Reed, working closely with Dean Walsh, had a community family practice residency tied with the University of Kansas School of Medicine. Undergraduate involvement in family practice was literally nonexistent.

The medical school was housed in a
portion of the old E.B. Allen Hospital. My departmental space was in the corridor of the old surgical suite, tiled walls and all, with two operating rooms serving as our department offices. My staff consisted of Lee Two Hatchet and Jerry Acres. It was my understanding that Dr. Billy Gardner and Dr. Don Gessler had served as acting chairmen at various times during the previous few months.

After a superficial indoctrination, Dean Walsh introduced me to the executive officers of all the hospitals and the clinical department chairmen. Within a week, Dean Walsh asked that in one month, I should make available to him an outline of short-term and long-term goals for the department. This outline should include the integration of Community Medicine and define a mutually beneficial relationship with the three currently existing family practice residencies. Needless to say, the task was formidable. I indicated that it could take as long as one year and certainly no less than six months to accomplish the task. We agreed on a six-month deadline.

Within two weeks, I received the resignation of the program directors of the Wesley Family Practice Residency. Drs. Stan Mosier, Vic Vorhees, Ron Brown and Terry Stryker had decided to resign as soon as the new department chairman arrived, and this they did. Dean Walsh was unaware of this. After much discussion, I agreed to take over the program with Dr. Ron Brown and Dr. Stan Mosier as paid managers for the program on-site.

Senior residents David Miller, Carol Johnson and Rick Kellerman were valuable in assisting me in implementing the program. Funds were made available to hire another program director for the Wesley Family Practice Residency and for more staff support in the department.

It was at this time that the E.B. Allen Hospital was being evacuated of all remaining patients and renovated into its present medical school structure. Fortunately, the renovation began at the lowest floor level and our department was on the highest floor level. Dean Walsh's office and my cubbyhole were situated right above most of the action in the renovation. With the hammering, dust, and dust all about us, little staff, practically no office equipment, no permanent home and much flowery projected promises, the department was initiated.

Despite the horrendous obstacles, we were able to quickly put some thoughts together and develop an outline for the department with a mission, goals, as well as the terminal objectives that would be required to meet such goals. Briefly, this outline stated that the primary mission of the department was "develop undergraduate and graduate academic programs in family and community medicine, to meet the need for family physicians in the State of Kansas and the Mid-West."

The accomplishment of this mission required a strong department that could compete with the other clinical departments in the medical school. The plan began with the pre-clinical years and was nurtured during the third and fourth years of undergraduate student education. It was recognized that one must influence and guide students toward family practice early on in the educational process.

To accomplish the task required that certain objectives be met. Since I had previously developed such a concept at the University of North Dakota, and actually implemented the family practice undergraduate program, as well as assisting in the development of the concept at the University of Minnesota, I was able to formulate a structured program that could be applied to Wichita. I listed several basic objectives:

1. Human behavioral curriculum must be taught in the first and second years during the time that the students were involved in basic science education. It must be taught by faculty, which included family physicians. These items included:
   a. Medical communication
   b. Physical diagnosis
   c. Introduction to patient care

2. Clinical experience rotations are made a requirement in ambulatory care units, physician offices, nursing homes, etc.
3. Rotations in rural and urban physician's offices are made a requirement.

In this regard, we discovered that none of the above items were being addressed at KU. In the succeeding years, we were able to include many, if not all, of these objectives in our curriculum in Wichita. This involved structuring Introphase, a two to three week crash program in medical communication, physical diagnosis and introduction to basic care after the students arrived on the Wichita campus.

In the graduate area, my long-range goal was to develop an academic relationship with the three existing community residencies. As such, the department would have some control of the quality of faculty through University faculty appointments. It would also ensure that all programs met the requirements of the Accreditation Council for Graduate Medical Education. Within the scope of this relationship, research programs could then evolve. My outline specified a community public health experience with the Department of Public Health, which was situated across the street from the medical school.

Finally, I indicated a keen department responsibility for developing and implementing programs of continuing medical education for all family physicians in the State of Kansas. This would allow Kansas physicians, as well as others, an opportunity to easily avail themselves of CME credits necessary to maintain board certification. The introduction of the concepts of geriatrics in the medical school curriculum followed over the course of time. It was my intent that a program for residency training be developed in the Salina area.

Over the course of approximately fifteen years, much of the outline I presented to Dean Walsh has been accomplished. This required long hours of hard labor and diplomatically working with other department chairmen. These included Drs. George Dyck in psychiatry, Richard Guthrie in pediatrics, Dan Roberts in Ob/Gyn, George Farha in surgery, Douglas Voth in internal medicine, as well as others. I developed a good relationship with the hospital administrators, as well as the members of the administrative staff at the Department of Health. The most difficulty we had in developing our programs was in trying to relate these programs in a community of medical providers who were extremely competitive. Fortunately, we were able to establish goals and objectives that were common to most of those involved in our program. Also, we were able to select good faculty to implement our undergraduate, graduate, community medicine and CME programs.

We were able to draw national attention not only to our programs but also to our faculty and school of medicine. As you know, I was involved in developing the undergraduate curriculum that is currently being used as a guide at the national level. Also, I co-edited several texts in family medicine. I received the Thomas Johnson Award from the American Academy of Family Physicians. Ernie Chaney, M.D., Anne Walling, M.D., and Rick Kellerman, M.D., have been very functional on a national level, which also reflected favorably on the department.

I know I barely sketched my involvement with the department and the medical school in Wichita. As I stated earlier, there are reams of material from other contributors that will flesh out the historical documentation.

Please know that my, and Marion’s, experience at the University of Kansas School of Medicine - Wichita, and also at KU, is cherished. We hope our involvement in the school at Wichita and in the state of Kansas left the state a little better for our having been there.
"...energy, dedication and creativity to the principles of the discipline..."
by BEVERLY J. COOVER, FORMER ADMINISTRATIVE OFFICER
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE
AUGUST, 1997

On June 4, 1980, I joined the Wesley Family Practice Residency as an accountant. I received one-half day training when my instructor, the person I was replacing, left. What I was soon to discover would prove to be a real test of endurance.

The Wesley Family Practice Residency Program was using an outside billing agency. As patients began service with the residency, they were assigned an account number. When we were close to using up the allotted numbers, the office manager was responsible for ordering additional account numbers from the billing agency. Apparently, in this process, a duplicate set of existing account numbers was reissued. This mistake was not caught. These existing duplicated numbers were assigned to new patients as they arrived for service. Over three hundred of the same numbers were reassigned to new families. All was well and good until the statements were mailed to these unsuspecting folks. My telephone began to ring off the wall. Questions poured in like "I don't have a daughter named Mary Ellen" and "we were not in to see the doctor on May 2" and "we do not doctor with Dr. XYZ, we use Dr. ABC." After a dozen or so such calls, I realized we had a big problem right here in river city!

What the billing system had done was combine families, over six hundred families, with shared billing numbers. My job for the next three months was to sort out who belonged to whom. This was compounded even more when the second family was seen on the same account number, the second family's address was added to the name of the first family. Well, it was a giant-sized mess and we couldn't send any more statements until it was cleaned up. This presented a real incentive to get the problem fixed.

Two more people were hired to help me with the problem solving. Take a normal sized office, add two more desks, two more bodies and three telephones ringing constantly within feet of each other and you have the setting for real chaos! The following days were long and sometimes impossible, but slowly we started digging ourselves out.

Outside of our immediate office, things were happening as well. The office manager was relieved of her responsibilities for not catching the issue of duplicate numbers. This left us on our own for a while to figure out how to resolve the crisis. But we did bring closure, and statements were mailed again and the puzzle was solved. You may have heard the old saying, "Opportunity is often disguised in hard work?" Well that turned out to be the case for me!

One day the residency director, David Holden, M.D., approached me and asked me if I would agree to be the interim office manager, until they could hire one. I had been handling a lot of the business flow already, since we had no acting manager, so I agreed. At least I would get paid more. As I look back on it, I find it strange as I had quit an account manager job to take the residency accountant job, and here I was back with more responsibility.

In the following months, Doug Hanson was hired to be the office manager, but very soon after he was moved to the KU Medical School location to manage the MPA clinic at 1010 N. Kansas. Administration renamed the position at Wesley Family Practice Residency to an
office coordinator and asked me to take that position on a permanent basis. I agreed and became the office coordinator.

July 1, 1980, the State of Kansas officially took over the management of the Wesley Family Practice Residency, which lasted until 1996, when it went back to Columbia Wesley Medical Center.

Looking back shows that the “pendulum” swung back on two occasions. 1) I worked with Rick D. Kellerman, M.D., when he was a resident and a faculty member at Wesley Family Practice Residency in 1981. Again, I was able to work with him in 1997 when he became chairman of the Family and Community Medicine Department. 2) I was there when the Wesley Family Practice Residency went to state management in 1980 and then that arrangement changed back sixteen years later in 1996.

In 1982, the first managed care began in Wichita, Health Care Plus. I remember the challenges the residency had in working with those concepts early on. One of our more challenging cases was triplets being born to a patient cared for by one of our faculty. When they were born at 25 weeks, the costs involved with that particular case were astonishing. Each of the babies had multiple surgeries and the costs went on and on like there was no end in sight. Today, 1997, we are many “hybrids” down the evolution path from that first managed-care organization.

In 1984, I was offered the opportunity to move to the Department of Family and Community Medicine located at the 1010 N. Kansas address, and work for the department chairman, Ed P. Donatelle, M.D. I accepted the position and worked there through the two chairmen to follow him.

Upon arriving in my new position, I discovered that the person I was replacing had left in an angry state of mind. She had emptied all the files from the desk and dumped them in large cardboard boxes. The first six months of my new job was sorting out the contents of those files and trying to piece together the “crime scene.” A lot of late hours were worked once again solving the puzzle!

Again, there was no one to give me any training relating to my new responsibilities. It was a matter of asking lots of questions of the right personnel. There were times I almost said, “forget it,” but I didn’t. Finally, it started to fall together.

In Family Medicine, there was always something new happening back in those days and more often than not, it hadn’t been done before. We were always blazing new territory.

There were five years in a row that we moved every summer. We either were adding office space, moving across the hall or tearing out divider walls. Once we had a desk and chair for a fellow in a space barely large enough for a copier. The space was a large closet with no door.

When I arrived at the medical school, the major renovation of the entire campus was in full swing. The state purchased the old E.B. Allen Hospital from the county and a $5 million renovation was begun to give the medical school a permanent home. The medical school had been housed temporarily in a small house on the WSU campus and finally at the 1001 Minneapolis address, which they changed to 1010 Kansas Street so the school would face the I-135 highway. Starting in the basement, they renovated each floor. Family Medicine was located on the third and top floor, so we got to endure the noise and dust all the way through, which seemed like years and years at the time! But finally it was finished and a dedication was held to celebrate in 1985.

One significant change that took place in our department that I recall happened in 1985. We were struggling with our limited state funding and trying to come up with possible solutions. Anne D. Walling, M.D., and I were discussing the dilemma over lunch. I suggested we write a grant to someone for extra funding. Before the afternoon was over, Dr. Walling had contacted Health Resources and Services Administration (HRSA) in Washington, D.C. and had an application being sent to her. The problem was that the deadline for submitting an application was only two weeks away. With her determination and a lot of burning of midnight oil, Dr. Walling made the deadline, and a few months later, we received notice that we
had been awarded and funded for $390,000 over a three year period. That began the whirlwind of grant activity that would continue over the next thirteen years.

Beth Alexander, M.D., faculty, was successful in writing an adolescent grant for $252,312; a $75,000 supplement for Sports Medicine was awarded PI John Hart, M.D.; a Community Medicine grant was awarded to Anne Walling, M.D., PI; and we also received a research grant which enabled us to hire a staff that established the Research Education Development Unit (REDU) of the department. Ken Kallail, Ph.D.; Randy Krehbiel, LSCSW; Connie Thomas, secretary and medical journalist, were hired to begin the REDU.

With all this grant success, the department grew from five to 20, with a number of Fellows completing training over a three-year period. Fellows completing extra training were Drs. Tari Ernst, Russell Bush, John Wills, Scott Henderson, Paul Jaster, David Dye, Katie Mroz and Wesley Schmidt.

Dr. Donatelle stepped down from the chair position in 1988, but remained on faculty two more years before retiring. A new chair, Andrew M. Barclay, M.D., was successfully recruited and lead the department until May 1, 1996, at which time he stepped down and went into group practice in Andover, Kansas.

An interim chair was appointed, Ernie J. Chaney, M.D., who worked with the department for nine months until Dec. 31, 1996. Rick Kellerman, M.D., was then successfully recruited to the chair position and he began on January 1, 1997.

When E. P. Donatelle, M.D., stepped down, a scholarship was set up to award a student interested in family practice who would emulate Dr. Donatelle. The department also has a Ned Burkett Sr., M.D., award. Honoring a pioneer and advocate for family practice, this award is given to the best senior student.

Conrad Osborn, M.D., was the first family practice graduate at Wesley and first in the nation. An award in his honor is presented for outstanding Junior Student achievement. The Doug Parks, M.D. (former rural volunteer), rural preceptor teaching award is set up to honor a rural physician for outstanding volunteer teaching.

The Department established, in 1980, an Annual Family Practice CME program to be held the first weekend of December at one of the Wichita hotels. December 1996 marked the 16th annual program. This acts as a meeting place for alumni who attend every year. The program averages 200 in attendance and continues to be a favorite place to meet colleagues and old classmates and pick up needed CME credits.

In 1995, the KU School of Medicine celebrated twenty years in Wichita, Kansas. The school sponsored three lectures for the community at Century II, an open house at the medical school, and concluded the week of activities with a lovely banquet at the Wichita Marriott Hotel. I had the privilege of being chair for the committee planning the banquet.

The Sedgwick County Forensic building was built and completed in 1996. We witnessed the additional expansion of the school's campus with the Primary Care building.

Two of the Family and Community Medicine department faculty, Ken Kallail, Ph.D., and Anne Walling, M.D., were key writers of the grant to the Kansas Health Foundation, the funding agency for the $15 million grant for the Primary Care Physician Education Initiative.

In 1997, the old North Mental Health building was razed and plans are to build additional parking for the campus.

A new grant called the Standardized Patient, Objective Standardized Clinical Evaluation (OSCE), was awarded to the Department in 1997. This will allow us to focus on establishing a pilot project with student evaluations of a standardized patient. Three exam room simulations will be set up in the department with cameras and microphones in the exam rooms. Patients will be hired and trained to present with certain symptoms. The encounter will be viewed on the monitor by a preceptor. The student will be graded for interpersonal skills with the patient encounter. This project will be used to evaluate third year clerkships and the ambulatory/geriatric
medicine clerkship.

My observations of the Family and Community Medicine Department down through the years have been to watch the energy, dedication and creativity to the principles of the discipline by the individuals employed within the department. The visions and ideas that have sparked from our faculty have blazed a path of progress, not only for our department and the discipline of family practice, but also for the medical school as a whole.

We have all heard that family practice physicians are the “Gate Keepers.” I have witnessed that we not only are the “Gate Keepers,” but we have opened the gates with vision, energy and hard work and many have followed through into the future.
A BIOGRAPHY of
JAMES W. SHAW, M.D.
As told by RICHARD SHAW, M.D.
AUGUST 25, 1997

James Wallace Shaw, M.D., was born in Holton, Kansas on Sept. 5, 1898. He died in Wichita, Kansas on Nov. 16, 1981. His family endowed the James W. Shaw, M.D., Memorial Fund with the Department of Family and Community Medicine, KU Medical School-Wichita in 1981. The purpose of the fund is to bring the community of family physicians from Wichita and around the state together in order to discuss issues of common interest. The fund has been used to bring national family practice education leaders to Wichita for speaking engagements, to serve as a resource to support volunteer preceptor activities, and provide faculty development.

James W. Shaw was raised in Holton and attended Cooper College (now Sterling College) in Sterling, Kansas. He received his undergraduate degree from the University of Kansas, where he participated in ROTC during World War I.

After college, Dr. Shaw taught biology and coached football at Eskridge, Kansas. Legend has it that he left Eskridge after a local antivivisectionist protested because Dr. Shaw's high school biology class dissected a cat. He subsequently taught in Cottonwood Falls, Kansas.

Dr. Shaw entered Rush Medical School at the University of Chicago, graduating in 1928. When he decided to enter medical school, Dr. Shaw boarded a train heading east, uncertain whether he would attend Rush Medical College or Johns Hopkins. He became bored while riding the train, and when it stopped in Chicago, he enrolled in Rush Medical College. He began his studies as a medical student on the very next day.

Dr. Shaw's decision to enter medicine may have been motivated by his uncle, Joseph Shaw, M.D., who performed some of his training in Europe. On the boat back from his European training, Dr. Joseph Shaw read a treatise about appendectomy. One evening, while in practice in Topeka, he was called out to a farm house. Under what was probably chloroform anesthesia, Dr. Joseph Shaw performed the first appendectomy in Kansas on the farm's kitchen table.

Although internships were uncommon in the 1920's, Dr. James W. Shaw performed an internship in Chicago. During his training, he worked with Drs. Banting and Best, the discoverers of insulin. One of Dr. Shaw's jobs was to go to the Swift Packing Plant each week with a small bucket to pick up animal pancreas. In return for the pancreas, he left a deposit (in the days of Prohibition) of ethanol. For his work, Dr. Shaw was elected to the Research Honor Society at Rush Medical College.

Dr. Shaw married Amelia Dent Cowen from Decatur, Illinois, in 1928.

Subsequently, the Shaws returned to Kansas where Dr. Shaw took a position as assistant surgeon at the Santa Fe Hospital in Mulvane. He held the position for three years during the Depression. While in Mulvane, to make ends meet and to earn extra money, Mrs. Shaw mended linen for the hospital. She would patch holes and sew up tears in the sheets and pillow cases. As partial payment for services rendered by the doctor and his wife, the couple was provided living quarters in the hospital.

Dr. Shaw subsequently moved to Wichita where he practiced for 40+ years. He was
located in the main doctors’ offices in downtown Wichita at Douglas and Main (then called the Schweiter Building; now called One Main Place). After moving to Wichita to establish his practice, one of his first devoted patients in Mulvane told Dr. Shaw that he, the patient, would “throw banana peels on the sidewalk” in an effort to stimulate business.

During World War II, Dr. Shaw and his medical school classmate Dr. Jim Menehan’s father, another Wichita physician, had a long discussion well into the night. They decided to both enlist in the Army. However, when they went to volunteer, they discovered they were too old to be accepted.

Dr. Shaw saw over 100 patients a day in Wichita during World War II. His son, Richard Shaw, remembers that while growing up, Dr. Shaw was already at work in the morning when he left for school and worked late into the night. He performed surgery in the morning and was in the office during the afternoon. He made house calls each morning and night. He delivered the first set of triplets in Wichita and practiced obstetrics until in his 70’s, when he finally discovered that staying up all night was too tiring!

Having successfully treated the owner of the Thompson Turkey Farm, Dr. Shaw received payment in a large number of turkeys. The family had to rent a cold storage “locker” and turkey became the main course of the Shaw household dinners every holiday for a long period of time.

Dr. Shaw rarely “philosophized” about medicine with his family. Rather, he was a role model. He did discuss patients he had seen during the day and took the Shaw children to the hospital - not to make rounds but to enjoy wicker wheelchair races in the hospital basement!

Dr. Shaw was a supporter of medical education in Wichita. In fact, he would hire partners directly out of internship, get them started in practice, and hope that they would stay in Wichita as his “competition,” unloading his patient care burden.

He enjoyed his work with interns. On one occasion, his family remembers that he was talking to an intern on the phone. At the end of a rather long convoluted conversation, he asked to talk to the nurse exclaiming: “OK, now, tell me what is really going on!”

Years ago, Hawks Pharmacy (now Cummings Pharmacy) would have an annual party for physicians. Dr. Shaw would routinely give some money to the interns so that they would have something with which to gamble.

When he retired, office visit charges were $3. Dr. Shaw just didn’t feel it fair to his patients to raise his fees any higher. Ironically, on one occasion, Dr. Shaw was faced with an overload of obstetric patients. In an attempt to control his practice volume, he raised his fees for obstetrical delivery, whereupon he discovered that he had more patients than ever. He surmised that patients perceived the best doctor to be the one with the highest fee!

On two occasions, Dr. Shaw was called by Utilization Review agents employed by insurance companies in Topeka. On the first occasion, the reviewer was a physician. Although slightly perturbed, Dr. Shaw was understanding that this was a doctor who was just doing his job. On the next occasion, however, a secretary called Dr. Shaw and questioned his medical treatment. Dr. Shaw’s response was that he didn’t have to answer to any secretary and he immediately retired from medicine.

Richard Shaw, now a Wichita plastic surgeon, went to medical school with the idea of becoming a family physician and eventually joining his father in practice. He remembers one conversation with his father who recommended against a career in plastic surgery. Dr. Shaw reasoned that patients would spend their money on other doctors and wouldn’t have anything left over to spend on plastic surgery. Richard did not take his father’s advice!

Dr. Shaw was active in the community, serving in the Sedgwick County Medical Society, Kiwanis and the Chamber of Commerce. He made many business recruitment trips with the Chamber of Commerce supporting efforts to recruit new businesses to Wichita. He was an active golfer. When asked to describe his father, Dr. Richard
Shaw stated, he was a “typical family doctor who loved his patients and kids - that was his life: taking care of patients.”

Dr. Shaw retired in 1973 at age 75. He died in 1981. He is survived by a daughter, Georgiana, who is a music teacher in Lakewood, Colorado; a son, James, a pathologist in Hutchinson; and Richard, a plastic surgeon in Wichita.

Two of Richard’s three sons are physicians; a plastic surgeon and a general surgeon. One of James’s daughters is a medical student. All three of James W. Shaw’s grandchildren went to the Kansas University Medical School and completed their last two years at the Wichita Campus.
AN INTERVIEW WITH JACK PIPPS, M.D.
FORMER DIRECTOR, AMERICAN ACADEMY OF GENERAL PRACTICE
BOARD OF DIRECTORS, 1972-1974
JANUARY 29, 1998

Kellerman: Thank you for meeting with me, Dr. Phipps. I am interested in your background, how you got into medicine and how you became involved with the academy. What was the driving force? And I want to know about your work on the board of directors of the American Academy of General Practice.

Phipps: Why did I become interested in medicine? My mother was a nurse. I had some interest all along as a youngster but there was no way I could go to college back in those years. My father died when I was thirteen and there wasn’t any way to go to college. Still, there was always that respect for the medical profession.

Kellerman: Where did you grow up?

Phipps: Russell, Kansas. I was drafted into the Medical Corps. After basic training, I went to “prep school.” This is the only service that I know of that had a “prep school” previous to Officers Candidate School so I went to “prep school” for a month, which was just an attempt to intimidate you, wash you out or break you. They were pretty good at it! Then I went to Officers Candidate School. Then we went overseas, first to India.

I was responsible for the food for a 1,000 bed hospital. We had a thousand patients, 86 nurses, 54 officers, 450 enlisted men. The rank that was established for that position was captains. We then went to Okinawa and during this period of time I was working with the doctors and that fueled my interest in medicine all the more. I thought I would love to do what they do.

When I got back to the states, the GI Bill of Rights was a godsend to me. I was 26 at that time and I thought about what school to attend. I wanted to be in the Midwest; there would be no question about that, so I decided to look at Fort Hays. I went to Hays and they said most assuredly “we have a pre-medical program.” So I went to school at Fort Hays.

And then from Hays I went to KU Medical School. I completed 114 credit hours, applied to medical school and got in. At that time that could be done. I had gone to school all the school term and then all the summer, save August. The GI Bill didn’t pay us in August. I worked in a drug store during all of my college days.

Of course, all the doctors in my hometown were family physicians. When I was in the Army, I respected all the doctors: oral surgeons, surgeons, internists, but I really wanted to be a family doctor, and all through medical school, it was “family doctor” for me!

Then we came to Wesley in 1953 for internship. About halfway along that year, there were doctors looking for associates because there was a doctor shortage in 1953 after the war. One of the doctors was a man very much interested in family practice, Clyde Miller.

Kellerman: I wanted to talk to you about him. We don’t have much history on Clyde Miller, M.D., and we need to document his story. In talking to Ned Burkett and Gene Wilcox, they really complimented his leadership. Where was he from, his background, how did he get to Wichita?

Phipps: Clyde Miller was an impressive man.
He called me up and wanted to know if I wanted to practice with him. I said, "Well, once I become acquainted with you, perhaps so." So he started referring patients into me during my internship. Eventually, I went into practice with him, Dr. Bruce Meeker, Dr. J.M. Donnell, who later on was mayor of Wichita, and Dr. Les Nicks in a building on Minnesota. I practiced with Dr. Miller for 20-plus years. When I started, the office calls were $3.00; house calls were $5.00. I occasionally got paid for them!

I started delivering babies for $85.00. That included all of the prenatal care and post-op care. If it were a little boy and they wanted him circumcised, it was an extra $10.00.

Clyde was very much interested in forming the American Academy of General Practice. It started in 1948. When 1953 rolled around, it was just barely making it. Dr. Miller used to go from town to town talking with the doctors on his own time. He would go to these various towns talking with the family physicians, buying them dinners, whatever he could do in order to get an opportunity to talk with them. Slowly, the Academy grew.

He was active in the Kansas Medical Society, and served as president. He was active in the Sedgwick County Medical Society and was a delegate to the American Academy of General Practice.

Clyde was from Kentucky and graduated from Louisville. He took his internship down there, and I forget now what they used to call going to see a doctor’s patients before he graduated, out in the hills of Kentucky.

Clyde had a very strong personality. He seemed gruff to some, but he was generous to a fault. He didn’t have much use for someone that didn’t stand up for themselves. He was willing to give every effort he had available to a cause. He was big, strong, dynamic, forceful and never let up. He worked hard, worked very hard.

Clyde was a basketball player in college; big, strong, good looking fellow. I really don’t know what brought him to Wichita. Anyway, he went into the service and came back in 1946.

In the service, there were opportunities for considerable experience. He came back to Wichita and he worked like all the others did, going to all three hospitals, working sun-up to sun-down. Of course, when I started, I went to all three hospitals. I have had women in labor in all three hospitals at the same time. They all cooperated! That didn’t happen often, but it did happen.

I think Clyde’s appearance, backed by his ability and no nonsense way of doing business, his directness, his forcefulness, his honesty, his true friendship, exemplified the kind of man he was. His patients loved him. He didn’t sit around and mamby pamby them. He would have made a lousy psychiatrist!

**Kellerman:** How tall was he by the way? People have commented about that.

**Phipps:** Just about a pinch shorter than I am. Clyde was 6'3″. I was almost 6'4″, but I’m not any more, I don’t think. I am not going to get measured! When I started with Clyde, he was probably under 200 pounds.

The hall where we practiced on North Minnesota was a long hall. He had three rooms up here and I had three rooms down there. There were times when we’d be crossing in the hall. Now you might imagine that one would pause, step aside and let the other one pass. No way! KERWHAM!! The patients would open the door and look out, and we would say, “it’s all right, it’s okay!” Then he would laugh.

We would hunt together, though not very often, because in those days you minded the store. Clyde loved to hunt, fish and golf. He belonged to two country clubs.

Clyde had heart disease. He had atrial fibrillation. He had an abdominal aneurysm but had that repaired. He had arthritis, hypertension and coronary artery disease. He got along all right under treatment. His blood pressure was reasonably well controlled but you didn’t control Clyde Miller! He took fairly good care of himself.

**Kellerman:** What year did he die?
**Phipps:** 1983, in his sleep. His wife called in the middle of the night. I went over there and Clyde was lying on his left side just as peaceful as you could ever imagine it. He was 73 years old when he died.

When I was an intern, Clyde was sending these people into the hospital for me to admit. True to Clyde, he would just send them over and tell them to call Dr. Phipps. We had no arrangement. In that day and time, if you got the responsibility for a patient, you were so very pleased, because there weren’t many. So, naturally, I was pleased.

I saw one of Dr. Miller’s patients, made notes of the history and I wrote up the working diagnosis and the laboratory we needed, etc. I had it pretty well in line and I called him. I said “Dr. Miller, I am seeing your patient, Mr. Jones, and he’s sick and these are the findings I have and these are some of the things I would like to do.”

Clyde replied, “Oh, no, doctor! You don’t need to do all those things!”

I said “Dr. Miller, if you want me to take care of this patient, I would be most pleased. If you don’t want these things I want to do, you come over here and take care of him yourself!”

The laugh! You should have heard the laugh! You didn’t need the telephone! He would just love that sort of thing. He couldn’t have been a better friend the next 20 years if he would have tried.

**Kellerman:** I was going to say, it was probably that episode and your straightforward approach that he respected.

**Phipps:** That clinched it. He liked to know where you stood.

**Kellerman:** Tell us about Bruce Meeker.

**Phipps:** Bruce was a “grandfather” that everybody loved. He was a gentleman. He didn’t really have any hobbies, just work. He did a lot of surgery. He was a fellow of the American College of Surgeons and he did a beautiful job.

He was a real family doctor: patient, caring, kind. He worked by appointment for about half of the day and the rest of the day, anybody sick: come on, and Bruce would be there for as long as it took.

He did some surgery in Nashville, Kansas, and other outlying areas. After he had done it awhile, they had instruments there for him. But to start with, when he went to those little hospitals, he would take his own instruments. They could do the pre-op and post-op care, but they needed Bruce or somebody with his capabilities to do the surgery.

I scrubbed with him many, many, many times. He did thyroidectomies, tonsillectomies, mastectomies, pelvic work, modified radicals, gastrectomies, all sorts of intestinal work. He didn’t do vascular work, chest work, radical mastectomies, or orthopedic work. He did general surgery and he did it very well. Many times, they were not his patients, but they needed to be seen and cared for. He would see them.

**Kellerman:** He was a family physician, in the Academy, and yet he was a Fellow of the American College of Surgeons?

**Phipps:** Yes. No problem! To be a Fellow of the American College of Surgeons in his day, you got your cases together, and you documented them and then submitted them for a board review. You and the cases you submit and the proof thereof will determine if you will either be a member or you won’t.

**Kellerman:** But philosophically, he was still a member of the AAGP?

**Phipps:** Oh, you bet! Oh, he was! He was president of the Kansas Chapter. Oh, yes, you could be a GP and about anything else. Yes, you sure could. Bruce Meeker was a gentleman. I know I would meet him in the mornings at 7:00 or before. We’d have a case and he was all smiles. He’d say “Working today!“ And “working“ to him was a surgical procedure. And then buzz, buzz off to the office. Get out sometime that afternoon or night.

Clyde and Bruce would both leave town.
“Glory be!” I would see patients for Clyde and myself. Bruce’s nurse, Manetta Bertram, was “everything.” She would get four or five patients in the rooms and get them all set and find out what the matter was with them and then she would come over, because I was in a suite in the building, and she would come over and say “Can you see a patient now?” and I’d say “Sure,” and I knew what I would get into!

So I go over there and there would be four or five patients. I’d see them and back to my suite I’d go. She didn’t put in anything that would take forever to see. But I didn’t mind that at all, because that was the sort of arrangement we had.

Bruce would do anything for me. I would call in the middle of the night from St. Francis and I could hardly get out what I wanted him for and he would say “Hey, Jack, where are you?” “At St. Francis.” “Where?” “Surgery.” “Okay, I will be there.” He didn’t ask me anything else. And he didn’t have to question if I would be there to help him on a surgical case or see his patients in the office! He didn’t have to ask if or why, because he knew I would be there. It was just the knowledge you had that when you needed something, there was no hesitation.

Bruce Meeker died at age 73. He was going out to the airport to meet some folks and he had a stroke. Bruce Meeker. There was a gentleman.

Kellerman: How many were in your internship class? How many came in at the same time?

Phipps: We all came in as a group and after all considerations, elected to apply at Wesley. I think 13 of us went to Wesley in one “fell swoop.” Leo Cawley was the resident in pathology, and there was one resident in internal medicine, and one in orthopedics. Wesley went from having no help to all of a sudden, here were a group of physicians.

Bert Stofer was the doctor in charge. We got the schedule of weekends and how we would work, etc. I looked at it and I found I was on call 28 weekends and I didn’t think that was quite fair. So I went back to him and said “Dr. Stofer, there is something here that isn’t exactly right, at least as far as I’m concerned. I am working 28 of 52 weekends.”

“Oh my,” he said. “It is difficult for me to figure out those schedules. Would you gentlemen like to figure them out? Plan it out like
you want it. We know you will give us good coverage. You just organize it.”

Jack Perkins from Hutchinson was always good with that sort of thing, so I said, “Jack, you’ve got the schedule.” Well, then they made me liaison with the administration when there was trouble, and I had no capabilities along those lines! Anyway, we didn’t have any trouble. We figured out our schedule to everybody’s satisfaction. See, we were all together at school and we moved into internship together. Everybody knew everybody. It just worked out fine.

When I was on urology, Dr. O’Donnell said he would get me a case, and he found a case for me, and I did a total prostatectomy, under his tutelage, and I really did it. I can remember very well peeling this prostate out. The patient got along all right, but lo and behold, he turned up to have diabetes and we hadn’t had any evidence of another illness.

It was a patient that Dr. O’Donnell didn’t know before and he did it gratis and the hospital forgave his hospitalization bill. It was a “case” for the intern and Dr. O’Donnell wanted me to have something to do on his service. He wanted me to know something about what urologists do.

I kept that patient in the hospital for a lot of weeks because of his diabetes and multiple medical problems. His hospital bill was atrocious, almost $800 for the whole hospital bill. Armor Evans, who was the hospital administrator, asked me “Was he a good patient for you, doctor?” I said, “Mr. Evans, that person was a practice; his blood pressure went to pot, heart disease, diabetes, the whole ball of wax.”

I took care of that patient for years after that. I never could get the diabetic diet across to him. I tried my best every way. He would come in and I’d ask “Vernon, what did you have for lunch today?” He’d say, “Peaches!”

Kellerman: Tell us how you got involved in the American Academy of General Practice.

Phipps: I thought one ought to be a “medical citizen,” not only a good physician, but a “good medical citizen,” so I became interested in the Academy. As you may know, I had all kinds of jobs in the local society and in the Kansas Academy and then I served as a delegate to the American Academy of General Practice. After I don’t know how many years as a delegate, I decided to run for the AAGP board of directors. Of course, I had to get support from Kansas and I was elected to the board in 1972. I served from 1972 to 1974. In 1972, I became ill, quite ill actually. We were in the Bahamas and we had a window air conditioner and it was moist and I got the worst lung infection you can ever imagine. I treated myself, foolishly, but in those days the ethic was work.

So I worked while shoving the antibiotics and all of a sudden I couldn’t breathe. Lowell Rhodes took me to the hospital. I had a right decortication and four months later I went back to work. It really knocked the strength right out of me!

The Academy is run by a commission form of government. There were five commissions and a member of the board is the chair of each of those commissions and members are appointed to each commission. Well, my job was to chair the Health Care Services Commission for two years. Then the stage was set for me to run for president.

But there was no way I could do that with the way I felt and the time I had lost from practice. I didn’t have the stamina. I knew I couldn’t give what I should and what I wanted to give, so I went no further. I wanted somebody to do the president’s job, very, very well. I didn’t honestly, sincerely feel that I could serve as president-elect, president, and immediate past president. My children were young. I just didn’t think that was the thing for me to do. Dr. Miller wasn’t feeling all that well at that time and somebody had to mind the store.

Kellerman: Who were the Kansas delegates to the AAGP at that time?

Phipps: Ken Lohmeyer and Lawrence Leigh.

Kellerman: Who were the other two AAGP
board members elected during your year?

**Phipps:** Carl Hall from West Virginia and George A. Rowland from Pennsylvania. Roger Tusken was a very, very capable executive director at that time. And Mac Cahal was superb, a superbly gifted individual, an attorney and he took to the Academy from its inception. He was a leader! Roger was Mac’s pupil. The AAGP grew from a few thousand to more and more thousands.

**Kellerman:** Did you know Cahal when he was here in Wichita?

**Phipps:** No, but was privileged to know him later.

**Kellerman:** Those of my generation were surprised when we found out at the Congress of Delegates last year that Mac Cahal had been the executive secretary of the Sedgwick County Medical Society.

**Phipps:** You bet. We used to have the Sedgwick County Medical Society Sports Day. We had skeet, rifle, pistol shooting, bowling, golf, and afterwards we’d have a big dinner. We had a great time.

One year, they played a joke on me. They went to the dog pound and got the scruffiest dog they could find. The dog had the scruffiest fur that you could ever imagine. There’s no way he could have been a worse looking dog.

They put him in a cage which wasn’t air tight. It was wrapped such that the dog could have plenty of air, but I couldn’t tell it was in there. They presented this to me, nicely wrapped, after a little ceremony. So there I was up at the speaker’s table unwrapping this animal, and Oh! I was speechless!

Of course everybody just thought that was the best joke! I didn’t know what to do! Later, they asked me why I didn’t just let it out when I left the building. Well, I couldn’t do that, so I took it home. I put it in the garage. I fixed a place for it to sleep. I had to keep my little daughter away from it because she just thought any puppy or dog was just the greatest thing. I said, “No, you can’t touch this dog.” He died. That’s how sick he was!

I had a whole fistful of trophies and one plate I have back in my study commemorating trap and skeet. We had some great times.

**Kellerman:** You said that you felt like physicians should not be just physicians but “good medical citizens.” Why do you feel that way?

**Phipps:** When I started, general practitioners didn’t have all that many privileges. There weren’t that many of us then. Early on, the society was small. We knew everybody. There weren’t that many of us. Privileges weren’t handed out. You had to prove yourself and you needed some help.

Clyde Miller and Bruce Meeker helped me. Without them, I wouldn’t have all the privileges I finally received. Those individuals were interested in the welfare of medicine, specifically as it could be helped by a family physician organization. So I could see very well that an organized group of family physicians could be a real force. And if that force was properly directed, honestly directed, and directed for the benefit of the patients, then it would be a great force and that’s what we tried to do.

**Kellerman:** Were hospital privileges the primary issue?

**Phipps:** I think probably they were. I went in the Academy in 1955, and at that time, at Wesley, every standing committee, by the rules, bylaws and directives, had to have a family physician or a general practitioner as a member. Every one. Why was this, people would ask? Well, what better liaison could you have but to put an interested individual on those committees, not to obstruct anything, but to give them the ideas that family physicians had and take back to the family physicians those problems that were faced by the surgeons and the obstetricians. About every three years, somebody wanted to decide that family physicians couldn’t use forceps. Well now, that is asinine! It never came to pass.
I think now would be a good time to say something that previously might have offended some members of the other specialties. The aspects of my practice of which I am most proud would be the cadres of physicians I choose to call for patient consultation. That individual knew that if I had a patient that needed his services, the need was there. It wasn’t something that I would just say, “Well, I don’t know anything about this, I will just refer.” I used the same consultant, same doctor, all the time, and when I called up, we had a jovial conversation, an enjoyable experience and he made time for my patient. It worked beautifully. I tried my doggonedist to have everything the consultant would need ready for them. You might remember that little tip.

Kellerman: I think that is something we should try to teach our residents - the art of consultation, how to get things done.

Phipps: You bet, and it works beautifully. The family physician can work so well. In that day and time we were looking for obstetrical privileges and surgical privileges. At one time, I had a number of major surgical privileges. But I scrubbed with two good people for 10 or 12 years before I ever decided to ask for privileges. Everybody knew what I could do. There wasn’t any “push” about it. Patients came first. I told the guys that came in with me after Dr. Miller retired, one of the things I tried to impress, was that if you as a family physician will take very good care of your patients, you need never have worry because the patient will take care of you. And it has worked out fine that way.

Kellerman: So immediately after your internship, you didn’t necessarily apply for all of your privileges? There was a continued time of learning while in practice where you proved yourself and then you applied for privileges?

Phipps: You had a goodly number of privileges to start with. But nobody was going to let an individual just out of his internship go do tonsillectomies by any stretch of the imagination. But what I am trying to get across is that by training, experience and demonstrated ability, the privileges could be granted.

I had just taken over the care of the people of one of the companies in town and one of their people had a bilateral inguinal hernia and he just couldn’t see fixing one and waiting the appropriate period of time and having the other one fixed. He wanted them both fixed. I said “All right. I’ll fix them.” And I don’t know why and I don’t know how, but he got a wound infection on one side. No big deal. We handled it. It was all right. But that’s the only thing I can remember very honestly, fortunately, thankfully, that ever happened.

Kellerman: What are your memories of the origins of the family practice residency?

Phipps: Well, I suppose you could say it started with Jack Tiller. Jack was trying to get a group together and he worked hard in training them. Jack had well-rounded capabilities. I liked him. He was a hard worker and he loved to teach and he could teach.

Nationally, the growth and concept of the family practice residency was developing. The family practice residency at Wesley that Gayle Stephens and Bill Osoba developed was one of the first. For a long time, as you well may know, it was the best ranked residency in the United States. Those boys did a beautiful job and we all pitched in.

I told them that I didn’t envision myself as a teacher. I don’t know why, I just didn’t. I said I will do whatever I can and I will help you with whatever I can do. So when I had a resident, I just tried to do that which I felt would help them. It just kind of grew nationally.

As the concept of family practice grew, it grew at Wesley. At that time, the credentials for family practice residency programs nationally were being developed. A lot of work went into that.

Kellerman: Were you on committees that had to do with that?
Phipps: I was a little late for that. When I got there, the vote was being taken by the Congress of Delegates on the acceptance of the credentials. Would they back such a group of credentials? That is where I entered in.

We all knew that if we could agree on credentials, it would be something that we could get our teeth into and something we could put forward. It was a sterling accomplishment. Of course, it was accepted.

Then I think it sort of hiked itself up, every residency that developed pushed the standards a little higher. Then the Academy developed liaisons with other specialty groups. The liaison that the Academy had with the federal government was something else. As chair of the Health Care Services Commission, I was the liaison with the American Academy of Pediatrics and American College of Physicians. I also represented the Academy at the AMA.

Kellerman: Tell us about the work of the commissions.

Phipps: The Academy’s governing body included five commissions: Education, Environmental and Public Health, Health Care Services, Legislation and Public Policy, Membership and Credentials. Can you imagine what was referred to my commission as Health Care Services? “Everything” it seemed! The Legislation Commission was very important and we were fortunate that some doctors were very capable and interested in what could be done legislatively for the Academy. I met with the director of HUD because of the concept the Academy had of co-payments at one time. They asked me to go with the chairman of the Legislative Commission to meet with the health care authorities in Washington.

The Education Commission, of course, you can imagine the work they had to do with the beginning of residency concepts and furthering that and leading it, putting it together. All the reports to all these residencies. The trouble the residencies had with acceptance in hospitals. And that is where I come in a little bit. Maybe more than that. With the concept of hospital privileges, I wrote one impassionate speech one time on “involvement,” because that is where it has to start. You start in a hospital, and I don’t care where the hospital is or what it is. You have to start with involvement of the family physician in the functions of that hospital and the relationship of the hospital and the medical staff. Very fortunately for me, we had Jack Davis at Wesley. What a beautiful, beautiful person he was and what a capable man. He was the essence of capability insofar as the relationship between doctors and hospital governance.

Experience, training, demonstrated ability. At the national meetings, members from a given state or the staff of a given hospital would come to the Academy asking what they could do to get privileges in their hospitals: “What can we do? What can we do?”

Well, it was my privilege, as well as my duty, to talk with these people. It’s simple: you have got to get together! You know you have great strengths when you organize. Well, there has to be a foundation somewhere.

Ours was based on honesty and demonstrated ability, and it worked. I never had a backfire on any one of these groups I talked with from New York to California.

I remember a group from Texas, and a group from Idaho. I just never could figure out why Idaho was having trouble. There was a strong group there.

In the East, there were no privileges. I said, “there are no privileges in the East because you have let it be that way! Now, whether you can get them back or not, I don’t know. But don’t blame anybody but yourself!”

Serving on the Board was enjoyable for me and I don’t remember or don’t think about or didn’t hear many unpleasant things. It wasn’t all peaches and cream, but, you see, I don’t remember any of that. I just remember all of the good parts and the fact that there were so many good people involved in what has become family practice. Really good people. With very few exceptions they are willing to put their abilities on the line for anybody to look at.

The real good family physicians of today are not asked to do anything they can’t do. So
I'm most grateful, most grateful, that some of my friends are family physicians. I have talked about this frequently. I am really grateful we had the opportunity to do what we did. Some weren't as active in the citizenship part of medicine as I choose to call it. So great, not everybody can. There are a lot of things I couldn't do. But whatever our involvement was in setting the tone for the practice of medicine today, nine years after I retired, I can still, with feeling, say how very grateful I've been to do what I got to do. You know not everybody can go through their working adult years and not wish they'd done something else. Oh, boy, that was precious.

*Kellerman:* That's true. What about family practice today? What do you see as its future, where are our problems, and do we still have organizational strength?

*Phipps:* The same factors exist today as existed 20 to 30 years ago. It all boils down to the care of people. You take care of people, people will take care of you.

Now we will get to something not nearly as important, and that is to say that the family physicians in a given area, hospital or office have to meet and join their ideas and their expectations and their desires. They must organize based on honesty and a demonstration of what they can do and what force they can be in a given area. This is no different than 30 years ago.

Now if these people, who have had the benefit of this beautiful residency education we did not have, take that and then organize proudly with those of like interest and work for the benefit of their hospital, then pretty soon you won't be "Dr. Kellerman" when you meet with the board of trustees, you will be "Rick." Because they don't care what letters follow your name. They want to know what you can do and how interested you are and where you have your values.

It is no different than 30 years ago in one way and all together different in another. I feel there is more consultation going on today than years ago, by quite a little bit. I found out when Ray Cook joined me that there were not many residency graduates interested in surgery. Soon there weren't as many interested in ob/gyn and I don't know why that was except that they were busy and they didn't want to do it because they could do it just as well. My daughter-in-law is delivering 200 babies a year. So you can do anything you want to do. But today you've got this beautiful residency, and you organize together and you decide how you can affect that hospital so that it will be a better place to practice medicine. The benefit will be to your patient.

Obviously, medicine is changing. We must adjust and respond. Our foremost interest in patient care, our continued improvements, and our respect for our profession must never diminish.

*Kellerman:* What year did you retire?

*Phipps:* 1989. I was 68.

*Kellerman:* Do you have any suggestions for today's residents, comments, words of wisdom?

*Phipps:* I think over and above what we have already talked about, I would hope they would be judicious in the responsibilities they accept. To start with financial responsibilities, I would hope they would be judicious and realize they have benefited from a beautiful education. They need to give much thought to whom they align themselves with and whom they consult. After giving considerable thought to individual consultants, they need to understand the fact that, in medicine, there will be those who may have interests different than theirs. They need to form beneficial relationships.

And then in regard to your family, I hope you recognize that your family is the most priceless thing in life. Enlarge your vista's. Include others of like interests and aspirations. Enjoy the practice of medicine. At my venerable age, there's still nothing like it.
DEDICATION OF THE ERNIE CHANEY CONFERENCE ROOM
by RICK KELLERMAN, M.D.
FEBRUARY 13, 1997

We want to welcome Ernie and Margie back to Wichita. Thank you to the KAFP Foundation and the KAFP for their contributions to this room dedicated to Dr. Chaney.

Everyone has their own “Ernie” story and I will tell one of mine. I first met Ernie when I was on my rural rotation in Mankato, Kansas, 18 years ago, with Dr. Richard Kimball. We had a lady in labor and it was clear at about 3 a.m. that she would need a C-section. So we mobilized the troops and at about 4 a.m. a healthy baby boy was born. Ernie provided anesthesia, Richard Kimball was the primary surgeon, Herb Doubek was the first assistant and wide-eyed medical student Rick Kellerman was the second assistant.

Somewhere in Jewell County this year, there is a high school student who will graduate because of the work we did that night. I noticed then that Ernie was smart, skillful, energetic and good teacher. I notice now that he had more hair then.

There is a legend about this room that we are dedicating to Dr. Chaney. The Family Medicine Department previously had a conference room that wasn’t much bigger than a closet. It had a large table and chairs and just enough room to shuffle between the chairs and wall to get into the room.

One day, Ernie was found to be moving tables, projectors and plants into the room. He then called a meeting of about 15 people, including Dean Meek. Several minutes into the meeting, someone mentioned how small and cramped was our little conference. This was Ernie’s entée.

He asked Dean Meek why Family Medicine had such a small crowded conference room. Dr. Meek gave his permission to remodel the room. Ernie knocked out a wall to enlarge the room and the KAFP Foundation and the Academy contributed funds for a state of the art learning center and here we are today. So, Dr. Meek, I’m warning you now...I learned the art of negotiation from a master!

But we are not dedicating this room to you, Ernie, because you knocked down a wall. We are dedicating it to you because you knocked down walls throughout your career. Dr. Chaney was the 34th president of the AAFP. He was the first president of the AAFP Foundation. He is one of only a handful of people who have been the president of both of those national organizations!

Last week, we had a faculty meeting and it became apparent that we have both a “little d” department and a “Big D” Department which includes our affiliated residency programs — Smoky Hill, Via Christi St. Francis, Via Christi St. Joseph and Wesley. And part of our “Big D” Department are our preceptors around the state who teach our students and residents. Some of those preceptors are here today — Diane Klingman, Dick Watson and Larry Anderson. This Department is 204 miles wide from north to south and 411 miles long from west to east.

It is the vision of KUSM-Wichita to be the “Gold Standard” for community-based primary care education among all medical schools. We in the Department of Family and Community Medicine believe that we are already the “Gold Standard” for community-based family medicine education. That is what makes my job easy. All I have to do is tell people about it! Ernie, this room is dedicated to
you because of your contributions to that “Gold Standard”...in Belleville, in Wichita, at the state and national level with the AAFP and AAFP Foundation, to the Department and to the medical school.
Family Medicine Education

A Kansas Historical Review, 1967-1982

JACK D. WALKER, M.D.,* Kansas City, Kansas

KANSAS has long been recognized as a national leader in Family Medicine Education at the post-MD level, beginning with the establishment of one of the first family practice residency training programs in the country at Wesley Medical Center in Wichita in 1967 and culminating with the establishment of a fifth training program at the Smoky Hill Family Practice Center in Salina in 1979.

This paper reviews the historical development of the five Family Practice residency programs, the track record in terms of the graduates from the programs, the contribution to undergraduate health professional education, and the impact of the programs on health services to Kansans.

Wesley Residency

The Wesley Family Practice Residency Program in Wichita was begun in 1967 by Dr. Gayle Stephens, M.D. In 1968, Dr. Stephens developed a model ambulatory family practice center, drawing from his own private patients. In 1969, the specialty of Family Practice was recognized for the first time with the formation of the American Board of Family Practice. That same year, a residency review committee for the specialty met for the first time and accredited five programs, among them the Wesley program. Dr. Stephens, later to become president of the Society of Teachers of Family Medicine, saw the Wesley model, with few modifications, accepted as the national standard for family practice graduate education.

In 1972, Stanley Mosier, M.D. and Victor Vorhees, M.D., both 1971 graduates of the Wesley program, became co-directors. Drs. Mosier and

The five Family Practice Residency Programs in Kansas augment the health care delivery systems in several Kansas communities. These programs have combined to produce a total of 233 graduates, 135 of whom now practice family medicine in Kansas.

Vorhees at that time became the first residency trained family physicians in the country to direct a family practice residency program. In 1980, David M. Holden, M.D. became Director of the program.

In 1980, the Wesley program became an integral part of the Department of Family and Community Medicine at the University of Kansas School of Medicine-Wichita. The proper name today is the Wesley/UKSM-Wichita Family Practice Residency Program, and all faculty hold full-time appointments to the medical school and participate in teaching undergraduate students during the Family and Community Medicine clerkships.

Eighty-one family physicians have graduated from the Wesley program and 49 of them (60%) are practicing in Kansas. Currently there are 24 residents in training. In order to provide the educational base for the residency training program, the Wesley program utilizes two ambulatory clinics and admits

* Professor, Department of Family Practice, The University of Kansas School of Medicine-Kansas City; Associate Editor, The Journal of the Kansas Medical Society. Formerly Associate Dean of the School of Medicine 1963-71; Chairman of Family Practice Department 1971-1982.
to the Wesley Medical Center Hospital. Approximately 20,000 ambulatory visits, 480 hospital admissions, and 300 obstetrical deliveries (and newborns) comprise the annual contribution to the health care delivery system for the Wichita area.

The Wesley Family Practice residency program participates in several areas of health professional education in addition to post-MD training including third and fourth year medical students on clinical clerkships from UKSM-Wichita, nurse clinician students from Wichita State University, and dietetic students from Kansas State University.

St. Joseph Residency

In June, 1970, the Residency Review Committee for Family Practice granted provisional approval to the St. Joseph Hospital and Rehabilitation Center, Wichita, for a Family Practice Residency Program, making it the 44th Family Practice Residency Program in the United States. At that time, Lew W. Purinton, M.D., Director for Medical Education and Robert Purvis, M.D., Assistant Director for Medical Education were the responsible persons for the residency program in the absence of a named Director.

James M. Donnell, M.D. was named the first residency program director in 1971. Subsequent directors have been Dr. Purinton — Interim Director, 1976-77; Lawrence Miller, M.D., 1977-79; and R. E. Riederer, M.D., 1979-present.

Fifty-six family physicians have completed the training program at St. Joseph Medical Center and 25 (45%) are practicing in Kansas. Currently there are 22 residents in training.

St. Joseph’s Family Practice Ambulatory Center was opened in December 1971, has been enlarged twice, and is now scheduled for a third enlargement. Planning is underway for a 3,600 square-foot addition to be built in 1983. This addition is needed for increasing out-patient care activity and full-time teaching staff with a portion of their time in patient care. Approximately 28,000 ambulatory visits, 1800 hospital admissions, and 400 obstetrical deliveries (and newborns) annually form the educational basis for this residency teaching program.

The Family Practice Residency Program became affiliated with UKSM-Wichita in 1975. This affiliation has been strengthened with the development of a management contract with the school effective July 1, 1982. This contract calls for input into the goals, objectives, faculty selection, curricular development, and overall program direction. The program remains under day-to-day management by its staff, which is funded by St. Joseph Medical Center. The program name has been changed to St. Joseph Medical Center Family Practice/UKSM-Wichita Residency.

The Residency has provided an elective rotation for fourth year medical students. Student nurses from Wichita State University and St. Mary’s of the Plains Nursing Schools have had office experience with the Center. Nurse Clinicians have had portions of their training there.

St. Francis Residency

The St. Francis Regional Medical Center Family Practice Residency, Wichita, was established in 1975 and had its first resident trainees in July 1976. Donald J. Gessler, M.D. became the initial full-time Program Director on April 1, 1975, and continues as the present Director.

The Program has graduated 23 family physicians and 19 (82%) are practicing in Kansas. Currently there are 16 residents in training.

The 10,000 square foot Family Practice Center is housed in a remodeled nursing home approximately 1½ blocks north of the main hospital complex. The clinical population for the residency teaching program comes from approximately 12,000 ambulatory visits, 650 admissions to St. Francis Regional Medical Center Hospital, and 284 obstetrical deliveries (and newborns). In addition, the residents provide medical services to the Parallax Drug Program, hold two Family Practice clinics per week at the Indian Health Service Clinic, and provide occupational medical services for a local packing company. The residents also are involved on a part-time basis in providing health care for various high school sports activities and other civic activities as requested. Dietetic students from Kansas State University receive clinical experience with the residency program, and Medical Assistant students from the Bryan Institute also train there on a part-time basis.

The residency program at St. Francis is not under the administrative control of UKSM-Wichita; however it does have an educational affiliation.

Medical students in a required Family Practice rotation from UKSM-Wichita are with the residency training program six months of each year.

UKSM-KC Residency

The Family Practice Residency Program at the University of Kansas Medical Center in Kansas City was established in 1971 and received formal approval in early 1972. The first three resident trainees began on July 1, 1972. Jack Walker, M.D. was the first Director of the program and Chairman of the Department of Family Practice at the Medical Center. Dr. Walker served in that capacity until June 30,
1982. James G. Price, M.D. was recently named Chairman of the Department and Director of the Residency Program.

Seventy family physicians have completed the program and 40 (57%) are practicing in Kansas. Currently there are 36 residents in training.

For a number of years the Kansas University Medical Center program operated two Family Practice Ambulatory Clinics to provide the educational base for residency training. In March 1982, the two clinics were combined into a single ambulatory clinic located on the ground floor of the new Bell Memorial Hospital. Approximately 30,000 ambulatory visits, 445 admissions to the hospital, and 188 obstetrical deliveries (and newborns) annually contribute to the health care delivery system for the Metropolitan Kansas City area.

The program at Kansas University Medical Center contributes to several areas of health professional education in addition to resident training. Faculty and residents participate in several undergraduate medical student courses including the first year Introduction to the Clinical Process, the second year Physical Diagnosis course, and a fourth year Family Practice elective. Graduate students in medical social work and graduate nursing students receive a part of their clinical experience with the Family Practice Center.

Smoky Hill Residency

The residency training program in Salina is the newest of the five programs in Kansas. It is unique in that it is the only residency program that was actually created by an act of the Kansas Legislature.

With the passage of S.B. 472, the 1977 Legislature established as a state policy the promotion of family practice residency programs at locations in the state other than Kansas City and Wichita. The programs are formalized through affiliation agreements between UKSM and qualified medical care facilities or non-profit community operations. The enabling legislation authorized the School of Medicine to enter into such agreements. The act prohibited entering into such agreements in any county with a population greater than 200,000.

Negotiations with interested groups in Salina led to the eventual signing of an affiliation agreement effective July 1, 1978, with the Salina Health Education Foundation (SHEF) for operation of the Smoky Hill Family Practice Program. The foundation is a nonprofit corporation whose membership includes all physicians in the Saline County Medical Society (approximately 80). The foundation is governed by an 11-member executive board. The Board employed Robert Brown, M.D. as executive secretary and medical education director, and Acting Director of the Family Practice Residency Program. Apart from its principal responsibility for conducting the family practice residency training program, SHEF also sponsors continuing medical education programs, supports and encourages development of medical library resources, and provides some coordination of medical preceptorships and other residency rotations in Salina.

The residency program is under the administrative direction of the Department of Family and Community Medicine at UKSM-Wichita.

The residency program is an affiliated program with the St. Joseph Family Practice Residency in Wichita. The first year takes place in Wichita, and

<table>
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<th>TABLE I</th>
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<tr>
<td><strong>CURRENT RESIDENT PHYSICIANS IN TRAINING</strong></td>
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<table>
<thead>
<tr>
<th>Program</th>
<th>R-1</th>
<th>R-2</th>
<th>R-3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wesley</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>KUMC</td>
<td>12</td>
<td>13</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>St. Francis</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Smoky Hill</td>
<td>4†</td>
<td>4</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38</td>
<td>35</td>
<td>35</td>
<td>108</td>
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* July 1, 1982.
† (at St. Joseph)

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<thead>
<tr>
<th>TABLE II</th>
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<tbody>
<tr>
<td><strong>APPROXIMATE CLINICAL HEALTH SERVICES</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Program</th>
<th>Ambulatory Visits</th>
<th>Hospital Admissions</th>
<th>Obstetrical Deliveries</th>
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</thead>
<tbody>
<tr>
<td>Wesley</td>
<td>20,000</td>
<td>480</td>
<td>300</td>
</tr>
<tr>
<td>KUMC</td>
<td>30,000</td>
<td>445</td>
<td>188</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>28,000</td>
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<td>400</td>
</tr>
<tr>
<td>St. Francis</td>
<td>12,000</td>
<td>650</td>
<td>284</td>
</tr>
<tr>
<td>Smoky Hill(Salina)</td>
<td>6,400</td>
<td>250</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>96,400</td>
<td>3,625</td>
<td>1,222</td>
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</table>

the second and third years of training take place in Salina.

The Smoky Hill Family Practice Program got underway in the summer of 1979 with the admission of three first-year residents into St. Joseph's residency training program.

The program graduated its first three in June 1982, and two (66%) are practicing in Kansas. Currently there are ten residents in training—four in the first year in Wichita, and six in the second and third years in Salina.

On September 1, 1982, Timothy Scanlan, M.D. was appointed Program Director for the Smoky Hill Family Practice Program.

The residency program is based in the Smoky Hill Family Practice Center located on the campus of Kansas Wesleyan University, and the residents receive training and admit patients to St. John's Hospital and Asbury Hospital in Salina.

Forming an educational base for the second and third years of the residency are approximately 6,400 ambulatory patients, 250 hospital admissions, and 50 obstetrical deliveries annually.

The residents participate in the operation of the drug and alcohol detoxification unit at St. John's Hospital, and plans are being developed for participation of residents in the emergency medical services of the two local hospitals. Residents are assigned two afternoons per month to the City/County Health Department where they participate in the care of obstetrical and gynecological patients; they also see patients at local nursing homes on a regular basis.

**Summary**

The distribution of residents in training at the five programs as of July 1982 is shown in Table I. Table II defines the clinical services provided by each of the residency programs from July 1, 1981 to June 30, 1982.

Graduates of the five Family Practice Residency Programs in Kansas are producing a significant impact upon the supply of family physicians for Kansas. One hundred thirty-five (57%) of the 233 graduates are practicing in Kansas (Table III).

Graduates of the five programs are now practicing and teaching family medicine in 50 Kansas communities (Figure 1). The survey includes only family physicians who are graduates of the residency training programs in Kansas. A number of other residency trained family physicians who received their training in programs outside of Kansas are also practicing in Kansas communities.

In addition to the primary educational mission of training family physicians, the residency programs contribute significantly to the health care delivery system for Kansas citizens (Table II). The programs contribute to the undergraduate education of medical students and other health professional students. The
programs provide health services to a sizable number of patients, both outside the hospital and within hospitals. A number of Kansas communities have benefited by having new family physicians located in their areas. A continuous cadre of new family physicians will annually emerge from the programs. The programs have both a direct and indirect —

immediate and future — impact upon the economy of the State of Kansas.

The national movement to educate more family physicians which began in the late 1960s is paying off in Kansas, and the five Family Practice Residency Programs based in Kansas are making a significant contribution.

**CORRECTIONS**

The article entitled, “Nausea and Vomiting: Its Management in Cancer Chemotherapy,” by Roy H. Hart, M.D., published in the January issue of the Journal, contains an error. On page 13, left hand column, the final sentence should read as follows: “Short-term EPS, which excludes the long-term complication of tardive dyskinesia, seldom looms as a problem to the neuropsychiatrist, since there is a wide enough selection of drugs to control it.”

The Drug Information section was inadvertently omitted from the contents in the January issue. That section, presenting a discussion of isotretinoin (Accutane), may be found on page 30.

The Journal sincerely regrets these errors and any resulting confusion.
The History of the
Kansas Academy of Family Practice

1948-1975

Presented at the 25th Annual Scientific Meeting
Manhattan, Kansas, June 6-8, 1975

compiled by
Sally D. Wilcox, editor
Jayhawk Family Physician

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List of Diplomates of the American Board of Family Practice Page 29
List of Fellows of the American Academy of Family Physicians Pages 30-31

Photos courtesy of Philip Hostetter, M.D.
The Kansas Academy of Family Physicians
From GP to FP
1948 - 1975

In April, 1948, a group of Kansas physicians who practiced general medicine met at the Hotel Kansas, Topeka, to form an organization to promote the interests of general, or family, practice. Eight or ten general practitioners, as they were called then, discussed the advantages of such an affiliation and, following a consensus that it was desirable, applied for a charter from the American Academy of General Practice, an organization established two years previously. This handful of Kansas Academy pioneers included Drs. Clyde W. Miller, George L. Thorpe, and Arthur Fegly, all of Wichita; Ray Busenbark, L. B. Gloyne, and Albert C. Harms, Kansas City; Charles L. White, Great Bend; and Clovis W. Bowen, Topeka.

Following their decision to form a chapter of the national organization the men drew up their constitution and bylaws and a charter was issued to the Kansas Academy on May 6, 1948. The eight men who signed this charter were Drs. Eugene A. Reeves, Clyde W. Miller, Ray Meidinger, Albert C. Harms, Conrad M. Barnes, Carl D. Siegel, James P. Haigler and Ray Busenbark.

In their constitution the men stated five things as their object and purpose. They pledged themselves to the promotion and maintenance of high standards in the general practice of medicine and surgery. Furthermore they were to encourage young persons to study and enter the field of general practice. They vowed to defend and maintain the right of the general practitioner to do medical and surgical procedures qualified for by training and experience and to preserve the right of free choice of the patient.

Postgraduate study was emphasized and assistance in providing this was a fourth objective. A final determination was to advance medical science and private and public health.

A non-profit organization, the new chapter was to hold no capital stock nor contemplate pecuniary gain or profit to members.

Qualifications for membership were the same as for the American Academy of General Practice. Rules regarding meetings, officers and affiliation with component societies were set forth. Affiliate member groups could be formed in counties or regions of Kansas or from contiguous areas.

Standards of ethics, rules regarding elections, admission fees and dues and the duties of the officers, directors and committees were listed in the bylaws.

At that time the admission fee was $10 and dues were $25. Of this amount the American Academy received the $10 membership fee and $15 in annual dues.

Officers for the fledgling organization were elected at a second meeting November 14, 1948, in Wichita. Dr. Clyde W. Miller was elected as the first president; L. B. Gloyne, president-elect; Charles L. White, vice-president; Albert C. Harms, secretary; and George L. Thorpe, treasurer at this first organizational meeting.

Interest in the new chapter had grown for there were 16 physicians at this meeting. The new constitution was presented by Arthur W. Fegly and was accepted and signed by all members present following a few changes.


Directors and delegates were also elected that first year with Drs. L. E. Leigh, L. A. Donnell, and W. M. Brewer serving as directors. A. W. Fegly and D. L. Evans were elected delegates.

Six committees were formed to function immediately and report in sixty days. The following doctors served as the first chairmen: Earl R. Mills, membership and ethics; L. A. Donnel, education; Grover G. Whitley, public relations; Clyde W. Miller, medical coordination and hospitals; B. N. Lies, program; and William M. Brewer, auditing.

Other early business included informing Kansas physicians who were already American Academy of General Practice members about state dues. A letter offering cooperation was sent to the University of Kansas Medical School and Dean Murphy was made an honorary member of the new chapter and later an honorary member of the American Academy.
First AACP President Dr. Clyde W. Miller, Wichita, 1948-9.

A second board of directors' meeting on January 9, 1949, found 26 new member applications, and an application for the Wyandotte chapter was approved.

The new board of directors met again in February and April, 1949, with membership as a primary objective. Even more interest and enthusiasm was generated when Drs. Fegley and Thorpe reported on the national meeting at the final board meeting of the year.

First Annual Meeting

The first annual meeting found Dr. L. B. Gloyne, Kansas City, elected as president; Charles White, president-elect; Clovis Bowen, vice-president; A. C. Harms, secretary; and George L. Thorpe, treasurer. Drs. George F. Davis and Darrell Evans were elected as delegates. Dr. Miller was presented with a gold past-president's key and this has been an annual observance for all past-presidents since.

Bill Vaughn Speaks

The after-dinner speaker for this first annual meeting was Mr. Bill Vaughn, a Kansas City Star writer and reporter. Dr. R.B. Robins, from the American Academy, gave a talk on the status of compulsory medicine. An afternoon scientific session was held. Forty-one physicians attended this first annual meeting.

Membership continued to be the prime objective for the early KAGP's with Dr. Clyde Miller one of the most ardent recruiters. Though their number was small the board of directors continued to meet at regular intervals at cities over the state. All amendments to the national constitution and bylaws were given thorough consideration and delegates were instructed about the wishes of the chapter in voting.

Ways of promoting membership were discussed almost constantly. A state news bulletin was ruled out because of the expense but Mr. Oliver Ebel, Kansas Medical Society executive secretary, offered space in the Journal to the Kansas Medical Society and Sedgwick County promised a space in their bulletin. However a good opportunity to promote membership arose when Dean Murphy, Kansas University Medical School, invited the Kansas Academy to participate in Kansas Day activities there. Dr. Lawrence E. Leigh was to be the speaker for KAGP. The Kansas Medical Society was also to be contacted to participate.

Following a decision on associate memberships by the AACP the state chapter voted to include these members with a dues fee of $2.

After the annual meeting on May 17, 1950, the new chapter went to work on membership with added zeal. Dr. Charles L. White, Great Bend, was installed as president and other officers were Drs. George L. Thorpe, president-elect; Albert C. Harms, vice-president; and Clovis Bowen, secretary-treasurer.

Primarily this meeting was for business and educational purposes concerning AACP and KAGP policies. It was thought that some revision of the constitution and bylaws was necessary and a committee was appointed to review and revise them.

In the early part of 1950 KAGP members continued to be undecided about the time and place of business meetings, with indecision whether to have sectional meetings in conjunction with other established medical meetings and when to have an annual business meeting. It was finally determined to have the next state meeting in Wichita on April 15, 1951. Drug companies were to be contacted concerning sponsorship and a program and solicitation of members to attend was delegated to the program committee. The sum of $500 was allowed for expenses.

Education a Prime Concern

Education and postgraduate study were also prime concerns. The Southwest Clinical Society meeting was acknowledged for credit and arrangements for circuit course study were made. Approval of credit was granted circuit courses in September, 1951.
A year's subscription to the AAGP Journal was sent to the Kansas Medical Society libraries in St. Francis, Wichita, and Belhaven, Providence and St. Margaret's hospitals, Kansas City for interns and residents. The General Administration was installed as president at this meeting. Other officers elected were Drs. Albert C. Harms, president-elect; George E. Burket, Jr., vice-president, and Clotis W. Bowen, secretary-treasurer. Dr. Arthur W. Eggly was elected as delegate to the national meeting and A. C. Harms was the alternate.

Following this successful venture the Academy decided to continue having its meeting separate from any other. They decided on Kansas City, Kansas, and April 28, 1952, as the date and place for the next one.

The First Newsletter

In September, 1951, the members decided to establish a newsletter to promote membership and to get news of the Academy to KAGP doctors. A quarterly letter was started with Dr. Harry Lutz, Augusta, as chairman and editor. Drs. Gerhart R. Tonn and Ray Busenbark were to be his assistants. The first issue was dated February, 1952. It contains the president's message and the membership study requirements. News items were solicited. This first issue was $28.05 for printing plus $27.97 for mailing. A second issue of four pages went to all 1800 Kansas physicians and cost a total of $154 for letterheads, printing and mailing.

Approval of circuit courses for postgraduate credit, renewal of the GP Journal to hospitals, substantial donations to the National Building Fund and a group insurance program were some additional areas of business during the year.

The second annual scientific meeting found the KAGP well under way with fifty members there. It was decided to consider having this meeting during the Kansas Medical Society annual convention in 1953.

Drs. A. C. Harms, Overland Park, was installed as president, with Drs. George E. Burket, Jr., president-elect; Lawrence E. Leigh, vice-president; and Gerhard R. Tonn, secretary-treasurer. Dr. George L. Thorpe was delegate and Drs. Henry B. Sullivan and Thorpe were elected directors.

Following the business session an afternoon scientific program was presented. Dr. Bayard T. Horton, Mayo Clinic, presented lectures on "Headache Mechanisms" and "Migraine and Tension Headaches." Dr. Thomas Findley, Ochsner Clinic, had "Vein Section as a Therapeutic Procedure" and "Placebos and the Physician" as his subjects. A panel discussion on "Thromboembolic Diseases" was moderated by Dr. Fred Helwig, with Drs. Findley, Horton and Maxwell Barry participating.

On the light side several social activities were planned. The ladies were entertained at a brunch with a book review and a cocktail hour and dinner-dance completed the day. Bill Vaughn, editor of "Star Beams," the Kansas City Star, was the guest speaker. Following this members danced to music by George Tidonna.
Executive Secretary Hired

The next year found officers struggling to keep up with accumulated KAGP interests and duties. In November, 1952, Dr. Clyde Miller suggested the appointment of Mr. Gene M. Wilcox, Winfield, as the executive secretary on a part-time basis. This was passed by unanimous vote. Mr. Wilcox was to assume all secretarial duties and assist with soliciting members. In the next three months he contacted county medical societies regarding their meeting dates and he and some of the officers met with Butler, Franklin and Allen counties, as well as several others. The new secretary was also to help set up the annual state meeting and assist with the newsletter.

Membership continued to be a vital part of the KAGP program and new members were solicited by sending the book “Dear Doctor” to all Kansas physicians.

Another concern was to provide a universal plan for general practice internships and residencies in the state. It was decided to draw up a list of approved hospitals.

To help with finances for the national office a “Century Club” was formed for members who donated $100 each to the National Building Fund.

Nine Courses Approved

During this year nine different medical meetings and courses were approved for credit. They were the meetings of the Kansas Medical Society, the Kansas Academy of General Practice, the Kansas City Southwest Clinical Society, the Oklahoma City Clinical Society, the Dallas Clinic Society, the Omaha Clinical Society, circuit courses and postgraduate courses of the Kansas University Medical School and the Kansas Medical Society, all American Cancer Society programs and the general practice sessions of the American Medical Association.

These and rules for approved credit hours for publication or scientific papers were listed in the newsletter. New members were also listed during the year.

According to Dr. A.C. Harms, the third annual scientific meeting at Broadview Hotel, May 4, 1953, proved to be the ultimate in stimulating prospective members. The scientific program at this meeting included a discussion of “Gall Bladder Problems,” by Dr. R. L. Sanders, Memphis; “Office Procedures in Obstetrics and Gynecology” by Dr. C. Gordon Johnson, New Orleans; and a lecture on the “Appraisal of the General Practitioner as Seen by the Surgeon,” by Dr. R. L. Sanders, also of Memphis.

Alex Dreier Speaks

The banquet that year featured Mr. Alex Dreier, Chicago. So many persons attended that, to quote Dr. Harms, “the last comers had to settle for bacon and eggs.”

Pee Wee Hunt and his band played for the dinner-dance that followed.

Dr. George E. Burkot, Jr., Kingman, was installed as president at this meeting. His fellow officers were Drs. Harry Lutz, president-elect; Clovis W. Bowen, vice-president; and Harold L. Low, secretary-treasurer. Dr. Bruce Meeker was elected director and Dr. A. W. Fegly delegate.

It was later reported that approximately twenty percent of the Kansas members attended the national meeting in St. Louis that year.

The Academy continued to grow and the Sedgwick County chapter was approved in July, 1953. However membership drives weren’t stressed as much as promotion of member recertification. Every newsletter carried reminders or rules regarding certification, plus lists of accredited courses. This effort resulted in a very optimistic report by Dr. Floyd Dillenbeck which showed that 100 percent of the Kansas members had responded by turning in their hours. To promote recertification Dr. Dillenbeck designed a sticker carrying the current recertification date to attach to membership certificates. This sticker was later adopted for use by the national office.

In November the resignation of Dr. Harry Lutz as president-elect was accepted with regret and a nominating committee was appointed to replace him.

Reports indicated that approximately fifteen percent of the KAGP members attended the national meeting in Cleveland that year and that Kansas rated fifth nationally in the percentage of membership increase in spite of not having an active drive. It was felt that possibly the membership form in each newsletter as well as personal contacts by the executive secretary and individual physicians contributed to this.

Once again this year members discussed pros and cons for the time and place of the annual meeting. Following a suggestion that members be polled regarding their preferences it was found that sixty percent preferred having it during the Kansas Medical Society meeting. Forty percent favored a fall meeting or didn’t care when it was held. Mr. Oliver Ebel and the Kansas Medi-
KAFP Members and Families

Top row: Dr. and Mrs. Gaylord P. Neighbor, Dr. Robert F. Moore (Caney), Dr. De Witt S. Lowe, Dr. Philip H. Hostetter, Dr. Jack Philp. Second row: Dr. Emerson Yoder, Mrs. Virgil E. Brown and Dr. Brown, Dr. Royal A. Barker, Mrs. Lawrence E. Leigh, Dr. Albert C. Hermes, Mrs. Hermes. Third row: Drs. Alexander C. Mitchell, George E. Burkett, Jr., Phillip A. Godwin, and Robert W. Hughes, Jill Bunker, Dr. and Mrs. Herbert L. Bunker, Jan Bunker. Fourth row: Dr. and Mrs. Thomas F. Taylor, Drs. Nova L. Morgan, Richard J. Stratrup, O. L. Hamm, Duane L. Scotti, and William R. Lents, and the 1974 SOC display from Kansas.
cal Society Council were contacted regarding having the KAGP section on Monday before the Kansas Medical Society meeting. This suggestion received enthusiastic endorsement so the fourth annual scientific meeting was set for May 3, 1954.

Advance programs were distributed by Wyeth detail men when they called on physicians. This eight-page program had the picture of the president, Dr. George Burket, Jr., and a schedule of meetings and social functions. It included biographies and pictures of Drs. Bernard A. Watson and James R. Cook, the scientific lecturer, and of the Honorable Walter H. Judd, Minnesota congressman and practicing surgeon and former medical missionary, who was the banquet speaker. Scientific subjects included the "Office Treatment of Obesity," "Hormone Therapy for Cancer," and "The Hypometabolic State as the Cause of Fatigue."

A social hour preceded the dinner. Music for dancing was played by George T'Donna and his band.

Dr. Clovis W. Bowen, Topeka, was installed as president at this meeting. His fellow officers were Drs. Lawrence E. Leigh, president-elect; Conrad M. Barnes, vice-president; and Floyd E. Dillenbeck, secretary-treasurer. Dr. Harold L. Low was elected as director and Dr. G.L. Thorpe was delegate. Alternates were Drs. George N. Burket, Jr., and Clyde W. Miller.

During this year Dr. George Thorpe introduced a resolution regarding the establishment of Fellowship status in the AAGP with requirements similar to other specialties. Academy members continued to study and vote on any changes in the AAGP and offered a resolution concerning honorary members and one which stated the primary purpose of the AAGP assembly was to be scientific and educational in nature.

Late in 1955 Providence Hospital, Kansas City, submitted a request for approval of general practice intern and residency training. Dr. Gaylord P. Neighbor was instructed to inspect the hospital and report his findings. The hospital was later approved.

Other items of business included pricing for forty areas of Blue Shield fees, and supporting the national Academy. It was found the National Building Fund had been so successful that a $35 donation from each AAGP member would complete it.

The Baker Hotel, Hutchinson, was chosen as the site of the fifth annual scientific meeting. The theme of the one-day program was pulmonary disease. Drs. Frank F. Albritten, Kansas City; Colonel James A. Wier, M.C., Denver; and Dr. William J. Reals, Wichita, were the speakers. A round table discussion followed with Dr. Clovis Bowen presiding.

Dr. Kenneth McFarland Speaks

Dr. Kenneth McFarland, nationally known educator and lecturer for General Motors, was the banquet program. A native Kansan and resident of Topeka, Dr. McFarland's witty talk enthralled the audience.

Dr. Lawrence E. Leigh, Overland Park, was installed as president at this meeting. The other officers were Drs. Conrad M. Barnes, president-elect; Bruce P. Meeker, vice-president; and Floyd E. Dillenbeck, secretary-treasurer. Dr. Gaylord P. Neighbor was elected to a three-year term as director and Dr. Clyde W. Miller to a two-year term as delegate. Alternates were Drs. Clovis A. Newman and Clovis W. Bowen.

1955-6 Dr. Laurence E. Leigh, Overland Park.

301 Members

Interest in the Academy continued to grow with 301 members reported in 1956, putting the KAGP in thirteenth place nationally.

Other institutions recognized the Academy's worth too, and more and more it was looked to for help in medical areas. The KAGP was invited to participate with the Postgraduate Planning Committee of the University of Kansas in planning courses for the coming year. The Mead-Johnson Company asked that the Academy present Dr. Leonard Podrebarac with their company's General Practice Award. Dr. Clyde Miller was in charge of this presentation.

Two new sections called "Keeping Up With the Quickies" and "The G. P. Reader" were added to the newsletter, listing quotes and recommending articles from current news and scientific publications.

Some discussion arose concerning changing the name of the Academy but nothing was finalized.

The AAGP meeting in Washington, D.C., found Dr. Clyde Miller defeated in his race for
director. During this assembly the Kansas Chapter members and their wives entertained their senators and representatives with a breakfast at the Mayflower Hotel. Some of the doctors visited Congress afterward.

Sixth Annual Meeting

The sixth annual scientific assembly was held in Topeka at the Jayhawk Hotel, April 30, 1956. A Circuit postgraduate course luncheon was moderated by Dr. Victor B. Buheier, a pathologist from Kansas City and president of the Missouri State Medical Society. Sessions on "Conservative Treatment of Cervical Pain," and "Conservative Treatment of Low Back Pain" by Dr. Paul C. Williams, Dallas; and "The Art of the Practice of Medicine" by Dr. Wyatt Norval, New Castle, Kentucky, were followed by a round table discussion with Dr. Lawrence E. Leigh presiding.

The guest speaker for the banquet was Mr. Orville Roberts, public relations consultant for the Sinclair Pipe Line Company, Independence, Kansas. A native Kansan with a degree in political science, Mr. Roberts received the first Master's Degree in public speaking to be awarded by the University of Kansas. While at the University he won three national championships as a public speaker. His experience in adult education and industrial training as well as his position as an instructor in speech and parliamentary procedure for the National Steel and Credit Unions made his talk a most interesting and educational program.

Dr. Conrad M. Barnes, Seneca, was installed as president with Dr. Bruce F. Meeker, president-elect; H. B. Sullivan, Sr., vice-president; and Cloyce A. Newman, secretary-treasurer. Dr. Robert W. Fernie was elected as director and Dr. Lawrence E. Leigh as delegate. Drs. Charles E. Vestle and Floyd E. Dillenbeck were alternates.

1956-7 Dr. Conrad M. Barnes, Seneca.

Representation to the state and national Academies from districts within the state was approved in 1957. It was thought that better representation and more voice in Academy affairs would result from this type of plan. Six districts were formed with their representatives appointed by the Board of Directors for the coming year. After that representatives were to be elected by members in the districts.

Hospital discrimination against general practitioners seemed to be on the rise and much information regarding this was presented the Academy by Dr. Jack DeTarr from AAOG.

Again the Academy was recognized by KUMC and approached for help. This time the request was for a list of speakers on general practice and the list was made up.

Dr. Fegly Gets Award

Dr. Clyde Miller was made a member of the national nominating committee and Dr. Arthur W. Fegly received the Outstanding Physician Award from the Kansas Medical Society. This was only the second time the award had been presented.

A highlight of the year for board members was a meeting on July 1 at Dr. Barnes' home in Seneca, where Dr. Barnes cooked steaks for the group.

Six University of Kansas circuit courses to be presented at eight locations in Kansas once a month from December to April were approved for 33 hours of credit in Category I.

Since there continued to be conflicts with the Kansas Medical Society functions at the state meeting some changes were made for the seventh annual meeting. This meeting was held on Sunday afternoon and Monday morning at the Broadview Hotel, Wichita, May 5 and 6, 1957. It not only avoided a conflict with the afternoon sports events and evening sports banquet, but prevented overcrowding of the number of scientific sessions the following day, or possible conflicts with business meetings.

Reports at the annual meeting included one about an insurance annuity plan being studied by a committee with Dr. George Burkett, Jr., as the chairman.

The guest speaker for the annual dinner was Dr. Fount Richardson, chairman of the board of directors, AAOG; A business meeting followed the dinner.

On Monday Dr. Jesse D. Rising, associate professor of medicine and pharmacology, KUMC, spoke on "Are Doctors Outsmarting Themselves Therapeutically," and Dr. Charles A. Ryon, Denver, gave a talk on "The General Practitioner as His
Own Psychiatric Consultant," Dr. Richardson lectured on "Some Facets of Geriatrics," and all three speakers participated in a round table discussion with Dr. Barnes as moderator.

Dr. Bruce Meeker, Wichita, was installed as president of this meeting. Other officers were Dis. Henry B. Sullivan, Sr., president-elect; Cloyce A. Newman, vice-president; Florian Freeman, secretary-treasurer; Gerhard Tonn, board; Clyde Miller, delegate; and Lawrence E. Leigh, alternate.

Dr. Bruce P. Meeker, Wichita, president.

Mortar and Pestle Award
Interest and attendance at the state officers' conference had grown and sufficient enthusiasm at this meeting led to Kansas receiving one of the "Dutch Mortar and Pestle Awards" given by the Rexall Drug Company. This award is an appropriately inscribed reproduction of an authentic sixteenth century Dutch mortar and pestle.

At an editors' conference held at SOC that year, Mr. David Haberman, Creighton University, gave critiques and suggestions for approval of state publications. Secretary Wilcox and Mrs. Wilcox attended that meeting.

Since many KAGP members also attended the national meetings it was decided to have a courtesy room at the AAGP meeting in Dallas with Dr. Lawrence Leigh making the arrangements. The following year the Kansas chapter combined their courtesy room with that of the University of Kansas Alumni and both organizations shared the expense. This has been continued since.

Following the death of Dr. H.B. Sullivan, president-elect, in January, 1958, two members were nominated by the board to fill that office. These men were voted upon at the annual meeting and Dr. Floyd E. Dillenbeck, El Dorado, was elected.

Drew Pearson Speaks
The eighth annual scientific meeting at Kansas City was definitely the highlight of the year. Mr. Drew Pearson, Washington D.C.'s top reporter, was the banquet speaker. Mr. Pearson wrote the syndicated column "Washington Merry-go-round" which started a new era in journalism. He staged the Freedom Train project, helped with the Freedom Balloon campaign, and the Democracy Letters to Italy campaign. A Saturday Review of Literature poll picked Pearson as the columnist whose writings exerted the greatest influence in the nation.

The ladies were presented with AAGP compacts at this dinner with the compliments of the Kansas Academy.

The scientific program presented two physicians as speakers. Dr. Walter J. Reich, one of Chicago's foremost gynecologists, presented papers on "Pelvic Pain" and "The Practical Approach to Diagnosis and Management of Common Gynecological Problems." Dr. Alfred R. Sugg, AFA, Oklahoma, talked on "Pertinent Points for Practitioners" concerning urology.

Dr. Floyd A. Dillenbeck was installed as president at this meeting. His fellow officers were Dis. Cloyce A. Newman, president-elect; J. Allen Howell, vice-president; Gaylord P. Neibor, Secretary; Bruce P. Meeker, board; L.E. Leigh, delegate; and Jesse D. Rising, alternate.

1957–8 Dr. Bruce Meeker, Wichita.

1958.9 Dr. Floyd A. Dillenbeck, El Dorado.
Business and Pleasure and People

Top row: Drs. J. Warren Jaks, Leo F. Cooper, Jack D. Walker and Mr. Clyde Hill, legislator. Dr. and Mrs. Alexander C. Mitchell. Second row: Dr. George E. Burkett, Jr., AAAP president, at his inauguration. William R. Lentz, Dr. and Mrs. F. Giles Freeman, Dr. and Mrs. Emir J. Chaney, Dr. Kenneth L. Lohmeyer, Dr. and Mrs. Richard R. Brummett and Shirley Blank. Third row: Dr. Edward F. Steichen, Dr. and Mrs. William R. Burney, Dr. and Mrs. Elvin C. Attenbernd.
Dr. Floyd Dillenbeck started his year by expressing his gratitude to the physicians and nurses who had helped in the El Dorado following a bad tornado there in June.

KAGP membership continued to grow, with Kansas placing fifteenth in the nation by having fifty percent of their prospective members enrolled. Twelve more Century Club members brought this total to thirty-five.

Changes in the state and national constitutions required much consideration. Drs. A.W. Fegley and George L. Thorpe presented changes in the wording of the state constitution concerning officers so that the office of secretary and treasurer was officially combined and to include a secretary who may or may not be a member. Registration of members at the annual meeting, quorum for business meetings, submission of written reports of officers and committee chairmen, and duties of delegates were added.

Safety Award

Dr. Yale E. Parkhurst, safety chairman, received a citation from the Association of State and Provincial Coordinators for the KAGP's safety contributions. Plans for a one-day meeting fall of 1959 proceeded.

Kansans continued to be interested in national policies and changes in eligibility requirements for the AAGP were studied thoroughly by a committee. Again a name change for the national organization was defeated and two-year internships for new general practice physicians were recommended.

A centennial theme was adopted for the ninth annual meeting honoring the Kansas Medical Society's one hundred years of service.

The scientific seminar presented Drs. Malcolm A. McCannel, Minneapolis ophthalmologist, and Dr. George H. Thiele, a Kansas City proctologist, who gave programs on office management of patients with problems in these areas.

Rabbi Ferdinand M. Isserman, St. Louis, was the banquet speaker. His topic was "Many Races, One Humanity; Many Nations, One World; Many Religions, One God."

Dr. Cloyce A. Newman, Topeka, was installed as president, with Drs. J. Allen Howell, president-elect; Gaylord P. Neighbor, vice-president; Norman H. Overholser, secretary-treasurer; William Chappuis, board; Clyde Miller, delegate, and Floyd Dillenbeck, alternate.

The 1959-60 season was particularly significant in that the Academy finally moved their meeting to a fall session. Initially a plan was formed to have a symposium in Wichita in November to test attendance and this symposium was a marked success. A panel of speakers on trauma was headed by Dr. Jack G. Phipps as moderator. Speakers and their subjects were Drs. Francis M. Forster, Madison, Wisconsin, "Diagnosis of Head and Spine Injuries." Thomas H. Burford, St. Louis, "Diagnosis of Chest Injuries." and N. Frederick Hicken, Salt Lake City, "Diagnosis of Abdominal Injuries."

Afternoon round table discussions were broken into three categories with Drs. Larry E. VinZant, Arthur L. Ashmore, and Edward S. Britton acting as moderators. An evening reception followed.

Six Districts Formed

Another major consideration this year was the definite confirmation of six districts throughout the state and rules regarding representatives. Two-year terms were set, with no representative succeeding himself. Their duties were outlined as representing their membership at board meetings, keeping their membership informed about the work of the Academy and KAGP, calling district meetings or making personal contacts, promoting interest and attendance at postgraduate training courses and stimulating contacts by members with prospective applicants for membership.

The tenth annual meeting was held in Hutchinson at the Baker Hotel on October 18 and 19, 1960. It opened with an "Oyster on the Half Shell and Keg Party."

Drs. John M. Knox, Baylor University pathologist, and William J. Brown, Houston, presented scientific programs concerning "Problems of Modern Management of Syphilis," and the "Epidemiology of Syphilis." Dr. Osgood S. Philpott, University of Colorado Medical School, presented "Hereditary and Congenital Skin Diseases." Afternoon round table discussions were moderated by Drs. Cloyce A. Newman, Yale E. Parkhurst, and Norman H. Overholser. A final panel using all three speakers was presented the next morning with Dr. Floyd C. Beelman moderating.

Don Fortney's orchestra provided the music for the dinner dance that followed.

Dr. J. Allen Howell, Wellington, was installed as president. Officers elected at this meeting were Gaylord P. Neighbor, Shaw-
nee Mission, president-elect; Norman H. Overholser, vice-president; Yale E. Parkhurst, secretary; William G. Chappuie, board; Lawrence E. Leigh, delegate; and Jesse D. Rising, alternate.

1960-1 Dr. J. Allen Howell, Wellington.

The theme "We can each get one in '61" was adopted by KAGP for the 1960-61 year. At that time there were 418 active members plus eighteen out-of-state members, placing Kansas twentieth in the nation.

On the national level a mortgage burning celebration honored 2300 Century Club contributors. Also a television show on the National Education Channel featuring six programs called "The Family Doctor of the Air" presented common health problems of tension, obesity, immunization, headache, heart disease and cancer detection.

District organization continued to be a high priority and it was decided to hold a meeting in each unorganized district with the executive secretary, district representative and at least one board of directors member present. Also hereafter each district was to be represented in the House of Delegates with at least five members.

Interest had grown in the Academy in the larger districts, namely Districts I and III, with programs attracting members and non-member physicians. A special lecture on "The Tired Mother Syndrome" was presented by Dr. Leonard L. Lovshin, head of the department of internal medicine, Cleveland Clinic, for Sedgwick County.

On the local level Dr. Parkhurst resigned as secretary in April and Dr. Clyde Miller was elected to complete this unexpired term of office.

In addition to the usual business the annual meeting on October 3, 1961, also heard reports from Dr. Robert Twinek about a Mo-Kan Civil Defense Alert set for Kansas City in April; and from Dr. Jesse Rising who reported that his committee had processed thirty-six courses for category one credit with a total of 544 hours.

It was suggested that a medical audit committee for hospitals be formed with the cooperation of the Kansas Hospital Association.

The scientific program for this eleventh annual session concerned endocrinology, surgical problems in children and office gynecology. Drs. Edwin C. Jungck, assistant clinical professor of endocrinology, Medical College of Georgia; Felix A. McPharland, attending pediatric surgeon, Minneapolis General Hospital; and Charles E. Flowers, Jr., professor of obstetrics and gynecology, University of North Carolina School of Medicine, were the speakers. Drs. G. P. Neighbor, Russell Frink and William G. Chappuie moderated the round table discussions that followed.

Mrs. Harry T. Hidakt was in charge of a style show luncheon for the wives.

Following the annual banquet Norman Lee and his orchestra played for a dance.

Dr. Gaylord P. Neighbor, Shawnee Mission, was installed as president at this convention. Drs. Norman Overholser was elected president-elect; Floyd C. Beelman, vice-president; Galen W. Fields, secretary; Charles E. Vestle, board; Floyd E. Dillenbeck, delegate; and George E. Burket, Jr. alternate.

1961-2 Dr. Gaylord P. Neighbor, Shawnee Mission.

Two things were listed as primary goals for the 1961-62 year. More attention was to be placed on the principal purpose of the Academy, that of postgraduate education. With less than twenty-five percent of young doctors going into general practice support of the national academic program M-O-R-E to interest qualified young men and women in studying medicine was also urged. A booth supporting this effort was set up at the annual meeting.

Membership Increase

Membership had a ten percent increase, with 440 physicians enrolled. Since sixty-two more members would place Kansas at fifty percent of their potential, the slogan "Get 62 in 62" was adopted.

National health care policies began to receive more attention and members were urged to write their legislators regarding the King-Anderson Bill.

The AAGP meeting in Las Vegas found 140 physicians and their wives attending the KU Alumni reception. Dr. George Burket, Jr., was elected as delegate to this AAGP meeting to replace Dr. Dillenbeck who had resigned.

The deaths of Drs. Arthur W. Fegley, Albert C. Armitage, Henry S. Dreher, Sr., and Charles E. Vestle were noted and letters of condolence sent to the families.
The twelfth annual scientific meeting at the Town House Hotel, Kansas City, October 8 and 9, had Dr. Albert Burke, New York, as the dinner speaker. His TV program, "A Way of Thinking," was carried by sixty stations throughout the country.

Dr. Burke spoke on "Ideas in Conflict," a program designed to make Americans think.

Dr. C. Arden Miller, dean of the University of Kansas Medical Center, was the keynote speaker for the conference. Dr. Miller talked on "Your Medical School."

Scientific sessions included a lecture on the diagnosis and management of rheumatic fever by Dr. Robert A. Tidwell, professor of pediatrics, University of Washington School of Medicine, Seattle; and a symposium on "Emergency Care of Trauma" by Drs. Richard W. Booth and Richard J. Fangman, Creighton University; and Jerome P. Murphy, cardiovascular and thoracic surgeon, Omaha.

Dr. Norman H. Overholser, El Dorado, was installed as president. The other officers were Drs. Floyd Beelman, president-elect; Galen Fields, vice-president; John Blank, secretary; Alexander Mitchell, board; J. Allen Howell, board; Lawrence E. Leigh, delegate; and Clyde Miller, going into general practice, a noticeable drop from the twenty-five percent reported the year before. Concern about this trend prompted the board to prepare a resolution encouraging the government to exempt young physicians who were going into general practice from military service. They also presented resolutions encouraging a continuing program of psychiatric service and one to support the student chapter of the American Medical Association at KUMC.

That year an added attraction arose in connection with the annual meeting. The thirteenth annual scientific meeting in Topeka overlapped with the Mental Health Congress held there, enabling the two groups to have an interesting exchange of ideas. This first state congress followed the first National Congress on Mental Illness and Health held by the AMA in October, 1962. Many physicians and their wives attended this meeting and physicians who desired to do so made rounds at the Veterans and Topeka State Hospitals.

![1963 Dr. Norman H. Overholser, El Dorado.](Image)

The election of Dr. George N. Burkett, Jr., to the AAGP Board of Directors was one of the highlights of the year. Academy members journeyed to Chicago in April to support their candidate with their presence and a hospitality suite open to all national delegates.

**Safety Project**

During the year a number of new interests were added to existing projects. The format of the newsletter was changed to a magazine which was printed on both sides and had pictures. The safety film "Knowing Is Not Enough," better known as the Yellow Flag film, was purchased and sponsored. It carried a heading stating that it was a KAGP sponsored project. This film was used extensively during the next few years by the Hutchinson Safety Council, the Kansas Jaycees and similar agencies throughout the state. It proved to be both interesting and helpful to the thousands of persons of all ages who saw it.

The King-Anderson Bill continued to concern physicians and members were urged to "present our side of the story better and louder to congressmen and the public."

"A Guide for Maternal and Child Welfare Standards" published by the Maternal and Child Welfare Committee of the Kansas Medical Society was also approved and the name of the Academy was placed on the cover along with the other sponsoring agencies.

During the year the rural health committee was discontinued. Two new ones, the occupational health and school committees were formed. Drs. H. E. Roberts and B. E. White were appointed chairman of these committees.

**Three GP Residencies**

A report at the annual business session revealed there were now three general practice residents in Wichita hospitals, and also that only eighteen percent of medical school graduates were

The theme of the KAGP scientific symposium was "Doctor—Watch Your Step." Three outstanding speakers presented programs. Dr. Walter G. Alvarez, professor of medicine emeritus of Mayo Foundation, talked on "Diseases of Medical Progress."
More KAFP's

First row: Dr. Herman W. Hiesterman, Dr. and Mrs. Earl Merkle. Mrs. Hiesterman, Dr. Kerrie W. Binion, Dr. Kenneth D. Wedel and Mrs. Peter K. Vienna. Second row: Drs. Donald D. Coering and Ernie J. Chasey, Dr. Victor J. Vorhies, Roger Sheshel, Dr. Gayle Stephens and Dr. and Mrs. Alexander C. Mitchell. Drs. Everett C. Brown, T. L. Wylan and David Coe. Fourth row: The 1974 Board of Directors. Dr. and Mrs. Kenneth L. Lohmeyer and daughter, FP residents (front row) Drs. John Diller, Ray Cook, Teal Copening, Don Chasey. (Back row) Vern Smith, Roger Sheshel, Mike Brheiner and Tony Mehaffey.
Dr. Elmer Key Sanders, Houston, spoke on "Iatrogenic Surgical Problems," and Dr. Loran F. Pilling, Mayo Foundation, spoke on "Iatrogenic Invalidism." The afternoon round table discussions were rotated so that each speaker could spend an hour with the audience.

Dr. Robert Kazmayer, a nationally acclaimed lecturer, was the after-dinner speaker at the Friday night banquet. His subject was "Kazmayer Analyzes the Future," and his insight and knowledge of conditions in worldwide business and political areas made this a most interesting evening.

A block of tickets was reserved for the Saturday Kansas University-Oklahoma State University football game and this proved to be a popular conclusion for a meeting.

Dr. Floyd C. Beeiman, Topeka, was installed as president at this meeting. His officers were Drs. Galen W. Fields, president-elect; John N. Blank, vice-president; Sam Zweifel, Jr., secretary; Jack G. Phips, board; Clyde W. Miller, delegate; and Floyd E. Dillenbeck and Norman H. Overholser, alternates.

The shortage of general practitioners remained a vital concern to area physicians. Splinterization to the specialties continued and Kansas Academy members kept looking for ways to overcome this trend. Their resolution concerning military school graduates who went into general practice was presented at the national AAGP meeting and copies were sent to the Kansas Medical Society and to AMA delegates.

Districts VII and VIII added

To further their efforts and to improve interest more district meetings were held. District III had a party for interns and signed up several as associate members. A highly successful pilot meeting of the fourth district was held in Hutchinson. Because of the size of the area involved it was decided to divide Districts IV and V, forming Districts VII and VIII. Delegates from all districts were entitled to vote at the annual meeting.

14th Annual Meeting

The fourteenth annual meeting at the Broadway Hotel October 22-24, 1965, featured "Doctor, Know Your Patient" as the theme. Speakers for this occasion were Drs. Charles A. L. Stephens, Jr., Tucson; William P. Williamson, Kansas City; and Max Kaplan, Denver. Their subjects, "The Comprehensive Treatment of the Arthritic Patient," "Neurosurgical Disorders Seen in General Office Practice," and "Office Ophthalmology and the Busy Practitioner," were followed by round table discussions. Moderators were Drs. Sam Zweifel, John N. Blank and Galen W. Fields.

The banquet speaker was Dr. Paul Williamson, Bellaire, Texas, who was the editor of the magazine "Practice."

Drs. Galen W. Fields, Scott City, was installed as president. His fellow officers were Drs. John N. Blank, president-elect; Sam Zweifel, Jr., vice-president; and Ben W. Barker, secretary. Dr. William R. Lentz was elected delegate, with Dr. Lawrence E. Leigh alternate.

District representation with meetings held in the various districts continued throughout 1964-65. The two new districts, VII and VIII, held their meetings following circuit courses in Garden City and Colby. These and the pheasant hunt also held in Colby were hailed with enthusiasm by the board members.

The question of the possibility of a national Board of General Practice also received much attention. Kansas members were undecided about this, particularly about the eligibility of older members.

New Cancer Study

The new cancer committee headed by Dr. Lawrence E. Leigh was making progress with a successful pilot study in District I and promised participation from Shawnee and Butler counties. This program was set up to secure Pap smears in physicians' offices and was promoted by the Department of Health Education and Welfare.

A growing concern was the promotion of doctors in general practice staying in Kansas. A meeting was held with the four deans of the medical school, Drs. C. Arden Miller, Jesse Rising.
Mahlon Delp and Jack Walker. Three concrete proposals were brought out: that basic research in patient care could be a real boon to medicine and that general practitioners are equipped to perform this function; that AAGP members close to the Medical Center should be called upon to assist in the home care teaching program; and that the Kansas Chapter should inform its members about what was taking place on the national level in regard to the future of family practice and board examination.

Some changes were made in the format of the annual meeting. The new officers were installed by Dr. Francis L. Land, vice-president, AAGP, at the annual banquet. A handmade gavel and block made by Dr. James Shields, El Dorado, was presented to the Academy.

Fifteenth Annual Meeting

The fifteenth annual scientific symposium in Great Bend on October 28-9 presented “Cancer Detection in Office Practice” as the theme. Drs. Hoyt C. Blaylock, Wichita dermatologist; Marjorie S. Sillage, assistant clinical professor of medicine, KUMC; and Robert L. Newman, assistant clinical professor of ob-gyn, KUMC, were the speakers. Their subjects were “Cancerous and Precancerous Lesions of the Skin”; “Laboratory Procedures of Value in Detection of Malignant Diseases and the Follow-up Care,” and “Cancer Detection in the Female Genital Tract.”

A quiet walk featuring concealed mats and triggered clay pigeons was added to sports day activities.

On the social side, pianist May Lou Menke entertained at the cocktail hour and Dr. John B. Jarrett, Hutchinson orthopedist, showed slides coving his experiences working for Medico in Jordan and about his visit to Project Concern in Hong Kong.

Special recognition was given to Dr. George E. Burkett, Jr., chairman of the board of directors, AAGP, and president of the Kansas Medical Society, Dinner music was presented by the Hays State College “Impromptu’s.”

Dr. John N. Blank, Hutchinson, was installed as president. Drs. Sam Zweifel, president-elect; Ben W. Barker, vice-president; Kenneth L. Lohmeyer, secretary, John O. Austin, board; Clyde W. Miller, delegate; and Jack G. Phipps, alternate, were his fellow officers.

1965-6 Dr. John N. Blank, Hutchinson.
Burkett Elected as AAGP Pres-elect
The nomination and election of Dr. George N. Burkett, Jr., for president-elect of the American Academy was a definite highlight of the 1965-6 year. Dr. Burkett’s campaign was directed by Dr. Clyde W. Miller and other Kansans who attended the AAGP meeting in Boston. In fact so many Kansans went to support their candidate that Kansas was given a plaque for second place in increased attendance at the national meeting.

A hospitality room featured short ties as favors for AAGP delegates and coin purses and scarves for their wives. Gentle- men who arrived at the hospitality room wearing unacceptable long ties had them removed and replaced with special short ties by two very efficient hostesses, Mrs. Kernie Binyon and Mrs. Jack Phipps. This theme carried over into the state meeting the next fall where many Kansans received the same short tie initiation.

Cancer Study Continues

Participation in the cervical cancer program reached a peak during the year, with all KAGP districts participating in the survey. Ten centers had been established in Kansas and were reporting to HEW. A midyear report in April showed eighteen carcinoma-in-situ found in the 7800 tests from Kansas so far. At the year’s end a report revealed that 200,000 cases had been forwarded to HEW nationally, the largest single report of cases ever.

Work continued at the educational level with the Academy voting to give two-year general practice residents a certificate at the end of their training. Dr. Jack Walker, assistant dean, KUMC, reported the largest class of freshmen medical students in history, with 125 starting in September. Dr. Walker said that plans were being made to stress general practice more in the future.

Miss America Visits

The sixteenth annual scientific assembly was also a decided success. Catalytic or informative, the meeting had everything. All who attended the morning scientific symposium and afternoon round tables felt the general information on “Cancer Detection in Office Practice” was studied with pearls. Dr. Maxwell G. Berry presented “The Generalist and Cancer Detection.” Dr. James Baehner, an orthopedist, talked on “Is It Cancer, Doctor?” and Dr. Sidney Rubin spoke about “Roentgen Diagnosis of Neoplasm on the Ambulatory Patient.” These discussions, plus the round table, were accepted for ten accredited hours.
Miss America Banquet

Soft lights from red and white candles in star candle holders cast a glow on table decorations of nearly fifty Miss America dolls dressed in red, white or blue taffeta formals. Red and white carnations on the head table and a centerpiece Miss America doll with a KACP seal in the background completed the picture. This theme was accentuated by the presence of Miss Debbie Bryant, Kansas’ own Miss America for 1966. Miss Bryant told members about her year as Miss America and of her future plans to study medicine.

To complete the evening the talented Browning Family from Overland Park presented instrumental, vocal and dance numbers in a variety of styles.

Dr. Sam Zweifel, Kingman, was installed as president at this meeting. His fellow officers were Drs. Ben W. Barker, president-elect; Kenneth Lohmeyer, vice-president; Donald G. Goering, secretary; Jack Tiller, board; Clavis W. Bowen, delegate; and Lawrence E. Leish, alternate.

Debbie Bryant Miss America, 1966, with Dr. Ben Barker, Jr., and Dr. Sam Zweifel, left.

Membership in the Academy stood at 500 at this time and ways to improve this total and attendance were studied. Lack of communication because of distances involved was listed as one of the reasons for these problems. It was also thought that securing the services of Mr. Gene Wilcox on a full-time basis might be of some help in these matters as well as to alleviate the work load in other areas.

Two resolutions were introduced, one to promote the direct billing of patients and the other

Emphasis on education was continued during Dr. Zweifel’s year as president. A committee met with Dr. George Wolf, dean and provost of KUMC, to discuss training more family physicians and the establishment of more postgraduate education. Dr. Jack Walker was delegated the respon-
Academy Fun Times

Top row: Stewart Mossman, Winfield, as Mark Twain. Drs. John N. Blank and Jack G. Phipps and the Fountainbleu Hotel, Miami. Mrs. Ernie J. Chaney, Mrs. Kermit W. Binyon and Dr. Chaney. Mrs. Chaney, Mrs. Binyon, Mrs. Phipps and Mrs. Blank at Miami. Center: Dr. Clyde W. Miller, Dr. and Mrs. John D. Huff, Dr. and Mrs. Ernie J. Chaney, Mrs. Philip H. Hostetter and Mr. and Mrs. Robert Hostetter at the 1973 SOC. Second row left: The St. John’s Totemisten and a Cow-Cow Club initiation. Bottom row: SOC, 1974, “Dr. Walby” Mr. Robert Young, and Mrs. Gene (Louise) Walsh at Manhattan KACP.
to protest a dual fee schedule.

The Academy also voted to provide certificates to two-year general practice residency graduates if the AAGP or hospitals did not.

The seventeenth annual scientific assembly was held in Wichita at the Holiday Inn, on October 5 and 6, 1967. A sports day on Thursday featured the usual golf tournament and a skeet shoot at the Ark Valley Gun Club.

First Past-Presidents’ Breakfast

The first past-presidents’ breakfast was held prior to the Thursday business meeting. The ladies were entertained with a luncheon and a program on interior design and accessories. Harold Enley, “The Fisherman’s Friend,” was the Thursday evening sports banquet speaker.

Three physicians presented the scientific program on Friday. Drs. Kermit E. Krantz, professor and chairman of the department of gynecology and obstetrics and professor of anatomy at KUMC; Thomas F. Frawley, professor and chairman of the department of internal medicine, St. Louis University School of Medicine; and William P. McGuire, Wichita pediatrician, presented papers on “Frigidity and Impotency,” “New Facts and New Concepts in Endocrinology,” and “Inhalation Therapy.” The afternoon round table discussions were moderated by Drs. Kenneth L. Lohnmeyer, Donald D. Goering and Ben W. Barker.

The “Sing Out America” group entertained the guests at the annual banquet following the installation of officers by AACP president Dr. George E. Burket, Jr. Dr. Ben W. Barker, Wichita, was installed as president. His fellow officers were Drs. Kenneth Lohnmeyer, president-elect; Donald D. Goering, vice-president; Ernie J. Chaney, secretary; John McCullough, vice-president; E. W. Phillips, delegate; and John Blank, alternate.

The importance of legislation and the restriction of federal control continued to concern members during 1967-8, with opposition to House Bill No. 1758 which pertained to the inclusion of chiropractors and optometrists in government and insurance programs. Also resolutions were submitted stating opposition to payment for welfare patients except directly from the state and one to support diploma schools of nursing.

A pilot seminar on office psychiatry was approved to be held at the Minninger Foundation the following year. Enrollment was to be limited to twenty-five KAGP physicians.

Consideration of a state comprehensive health planning agency and legislation concerning non-profit organizations, abortion bills and licensing of foreign physicians were presented by Dr. Hugh Dierker, director of the Kansas State Health Department and Dr. Edward Steichen, state legislator from Lenora and KAGP member. These men emphasized the importance of participation and adequate public relations with legislators to present the best interest of physicians in governmental affairs.

Board certification for general practitioners still remained questionable and it was apparent that good residency programs could not be established without this. However, board certification was turned down by the AMA. Students at KUMC were advocating preceptor programs that were longer and in larger towns, and a change in the curriculum.

Academy dues were increased to enable hiring Mr. Gene Wilcox as a full-time secretary.

Dr. Lawrence Leigh reported forty-eight percent of the KAGP members were participating in the cancer program, making a total of 274.

The Academy presented Dr. George Burket with a camera upon his retirement as national president.
The eighteenth annual meeting was held in Emporia at the Ramada Inn on October 6-8, 1968. Following a business meeting and past-presidents' breakfast sports enthusiasts participated in a golf tournament at the Emporia Country Club, and in shooting, both trap and live, on a local game preserve. Trophies for these events were presented by Dr. Richard R. Brummett at a banquet that evening. Mr. George C. Moore, director, Kansas Forestry Fish and Game Commission, was the after dinner speaker.

The scientific meeting featured Dr. Oscar P. Hampton, St. Louis, who spoke on “Handling of War Casualties in Viet Nam,” “Trauma to the Urinary Tract,” by Dr. Laurence E. Green, Mayo Clinic; and “Office Practice of Psychiatry,” by Roy W. Menninger, Topeka. Round table discussions and a panel followed.

Miss America, 1968, Visits

Miss Debra Dene Barnes, Moran, Miss America of 1968, was the banquet speaker. Miss Barnes presented a short talk on her experiences during the year and a program of piano selections. Her family doctor, Dr. James R. Nevitt, KAGP member, was also present.

Dr. George Burket, Jr., installed Dr. Kenneth L. Lohmeyer, Emporia, as president at this banquet. His fellow officers were Drs. Donald D. Geering, president-elect; Ernie J. Chaney, vice-president; J.W. Jacks, secretary; G. Gayle Stephens, board; Norman H. Overholser, delegate; and Lawrence E. Leigh, alternate.

1968-9 Dr. Kenneth L. Lohmeyer, Emporia.

With the recognition of the Board of Family Practice in 1969 as the twentieth specialty group the Kansas Academy still had to obtain three more objectives. Departments of family practice had to be established in medical schools, department heads and instructors found, and a high level residency program had to be established. Kansas members went to work with zeal to accomplish these goals. To this end Drs. Jack Phipps, E. J. Chaney, Gayle Stevens and George Burket, Jr. were appointed to serve as a liaison committee with KUMC. Their main objective was to discuss curriculum for a family practice section.

Other areas of interest continued unabated. The cervical cancer program was expanded to include breast cancer detection. At this point Kansas had submitted 58,000 reports to HEW. Sixty-four members took the Core Content Review Course made available by the Ohio and Connecticut academies to prepare for board examinations. A pilot public relations program was set up with the AAGP to be a model for other states. Dr. Thomas Taylor was appointed liaison between the Academy and the Comprehensive Health Planning Program. An insurance plan was adopted for KAGP members on official business, and a new format was given the newsletter by changing to an eight-page magazine. This magazine was to be sent to all Kansas physicians.

At the national level Dr. Lawrence E. Leigh was nominated by Kansas to run for the AAGP board of directors. A committee headed by Dr. John Blank, Dr. Jack Phipps, Dr. N.H. Overholser and Dr. George Burket, Jr., was appointed to handle the campaign. Dr. Blank was also the chairman of the SOC program for that year.

New Legislative Program

A legislative program featuring a one-to-one relationship with all legislators was set up and this has evolved into a permanent legislative program at the state medical society level. District meetings continued and were well attended.
Nineteenth Annual Meeting

The nineteenth annual meeting was held at the Statler-Hilton Inn, Salina, October 12-14, 1969. Following a sports day and presentation of golf and shooting trophies by Dr. Kenneth Wedel, Mr. Jerry Mays, defensive end, Kansas City Chiefs football team, spoke to the group.

The Tuesday scientific session featured Drs. Robert W. Weber, Salina, who spoke on "Antibiotic Complications;" Victor R. Hildyard, Denver, who talked on "Diagnosis and Treatment of Serous Otitis Media in Children" and "Diagnosis and Treatment of Common Ear Problems;" and Frederic Speer, Shawnee Mission, who presented "Food Allergy in General Practice" and "Contact Dermatitis in General Practice." Round tables were moderated by Drs. J. W. Jacks, Ernie J. Chaney and Donald D. Goering.

Judge Gilliam Speaks

The banquet speaker was Judge Philip B. Gilliam, Juvenile Court, Denver. In serving as Judge of Denver's Juvenile Court for thirty-two years Judge Gilliam had heard over 150,000 juvenile delinquency cases, more than any previous judge in history. His talk was "A Time to Weep and A Time to Laugh."

Dr. Donald D. Goering, Salina, was installed as president. Dr. Ernie J. Chaney was elected, president-elect; Dr. J. Warren Jacks, vice-president; Dr. William R. Lentz, secretary; Dr. David A. Leitch, board; Dr. Jack G. Phipps, delegate; and Dr. John N. Blank, alternate.

In February, 1970, the first American Board Examination was given at thirty-six centers throughout the country. Eighteen percent of the 2,078 physicians in the United States who took the examination passed and a second series was set for February, 1971. The new specialty was well on the way.

Medical students meet with Dr. John Huff, Gene Wilcox and Don Goering.

With the establishment of the new specialty student interest in the Academy increased visibly, and thirty enrolled as student members. A special dinner for medical students and their wives was held in Topeka. The film "Someone You Can Trust—Someone You Can Be" was purchased for use in high school career days and for other interested groups.

Twentieth Annual Meeting

Proposals for a three-year medical school program proceeded and the family practice weekend preceptorship was born to encourage young men and women to enter the field by becoming acquainted with Kansas physicians and their life styles on the job. Students Milton Van Gundy, Louis Forster and Thomas Simpson were in charge of securing the names of interested students and physicians who wished to participate.

1969-70 Dr. Donald Goering, Salina

While the main thrust for the year concerned educational efforts, other KAGF members continued to expand their efforts to secure members and proper legislation relative to fees, chiropractors and other health matters. The cancer and publications committees, district representatives and other committees also worked hard and had continued success.
KAIP Sportsmen

The twentieth annual meeting was held at the Holiday Inn, Lawrence, September 18-20, 1970. Dr. Edward J. Kowalewski, president of the AAFP, was the honored guest of this meeting. Following the usual sports day theme, trophies were presented at the Friday evening banquet after which members were brought up to date on matters concerning the AAFP, KUMC, legislation, and the Wesley family practice program. Short talks on each of these areas were given by representatives from each group.

Tickets were obtained for the KU-Texas Tech football game for those who wanted them and the Saturday banquet entertainment was Mr. Stuart Mostman, Winfield, who presented "An Evening with Mark Twain."

The Sunday scientific session featured a program on sports medicine. Dr. John D. Leidholdt, Denver, presented a paper on "Ligamentous Injuries of the Knee," Dr. Lynn O. Litton, Columbia, Missouri, talked on "Ligament Injuries of the Ankle;" and "Back Injuries in Athletes;" and Dr. Donald L. Cooper, Stillwater, spoke on "Erogenic Aids and Drugs in Athletics."

R. Brummett, secretary; Alex Scott, president; Norman H. Overholser, delegate, and Lawrence E. Leigh, alternate, were his fellow officers.

New FP Department
KUMC

Growth in educational efforts for family practice was highlighted during 1971 with the opening of the new Family Practice Center, KUMC, with Dr. Jack D. Walker chairman of the department. Student interest was spurred with a cook party for the ninety-three freshmen who enrolled in the fall. KAFP members Drs. Lawrence E. Leigh, Philip Hostetter and Donald Goering attended and spoke to the students informally, telling them about family practice as they knew it.

Phipps Wins at Miami

The election of Dr. Jack G. Phipps at the national meeting in Miami was promoted by the Academy. A special edition of the Jayhawk Family Physician was printed to be given to all AAFP delegates. The Jayhawk Family Physician had been enlarged to an eight by ten format, with Mrs. Sally D. Jarrott, Hutchinson, as staff editor.

Another KAGP member who received honors was Dr. Floyd C. Beelman, editor of the Jayhawk Family Physician, who was given the Pfizer Award of Merit for his leadership in disaster medical services. To celebrate this Topeka's mayor Gene Martin declared a "Dr. Floyd C. Beelman Day" and presented the physician with the Golden City Medallion, the city's highest honor. Dr. Mary Glasson received similar recognition with a "Dr. Mary Day" at Phillisburg.

National Committees

At the national level Dr. Lawrence E. Leigh was reappointed to the AAGP Cancer Committee and Dr. Jack G. Phipps was reappointed to the Hospital Committee.

The state Commission on Education continued to work actively with KUMC and the legislature to increase medical school class admissions, to fund the new department of family practice and to get review courses for the board examinations. A committee on drug abuse headed by Dr. Kermit Binyon studied the ever increasing problem of addiction and set up guidelines to try to solve this perplexing situation. Dr. Binyon's committee consisted of six KAGP members and three psychiatrists.
The twenty-first annual meeting held at the Ramada Inn, Manhattan, September 10-12, 1971, featured learning disabilities as the scientific program. Three nationally known educators in this area, Wesley P. White, M.D., Eldee Dotson Thomas, M.D., William K. Van Osdol, Ph. D., all of Oklahoma, presented papers on “The Physician Looks at School Failure,” “Symptoms of the Learning Disabled Child in School and at Home,” and “Child Study Approach to Evaluation of Learning Disabilities.”

To keep the legislative pot boiling Kansas congressmen Sen- ator Robert Dole and Representative William R. Roy also attended the meeting and brought members up to date on health legislation.

A significant action was a resolution to change the name of the Academy to the Kansas Academy of Family Physicians.

During these meetings members’ wives were instructed in a special workshop for crewel embroidery by Mrs. Gene Wilcox and two assistants.

Dr. Lotterhos Visits

Dr. William E. Lotterhos, AAFP president, Jackson, Missis- sippi, was the honored guest at this meeting and installed the new officers. Tickets for the Utah State-Kansas State University game were secured and the annual sports day was held. A select group of former and present “Singing Quakers” from Friends University, Wichita, comprised the banquet program.

Dr. J. Warren Jacks, Pratt, was installed as president by Dr. Lotterhos. The following officers were elected: Drs. John D. Huff, president-elect; Richard R. Brummett, vice-president; Alexander C. Mitchell, secretary; Kernie W. Binyon, board, John N. Blank, delegate; and Kenneth D. Wedel, alternate.

1971-2 J. Warren Jacks, Pratt, president.

Kansans continued to take national honors during the next year. Dr. Jack Phipps won the election for AAFP Board of Directors and Dr. George E. Burket, Jr., was elected to the American Board of Family Practice Board of Directors. Kansans turned out in force for the Miami meeting and hosted a hospitality room that would long be remembered.

Efforts at the state level included a new public relations program which featured radio and TV spots, news releases and “The Doctor’s Answer,” a Medical column carried in over forty Kansas newspapers. Kansas received the first-place award in the Idea Fair at SOC for this and the student program.

Second Annual Coke Party - 157 Join

Students were wowed with the annual coke party and 157 joined as affiliate members by September, 1972. Drs. Jacks, Goering and Walker spoke to the
group at this family practice party night and Dr. Jacks remark about "some men walk a mile for a camel, but I drove 300 miles for a coke" goes down as the quote of the evening.

The work of the Academy went on. The cancer committee continued and seminars were held in nearly all of the eight districts during the year. A new family practice department was opened at St. Joseph's Hospital, Wichita.

Thirty-seven Fellowships

Thirty-seven Kansas physicians received their fellowships at the New York meeting in September, 1972. Dr. Donald D. Goering was appointed to the KUMC admissi
d committee and Dr. Ernie J. Chaney was re-elected to the board of directors, Kansas Division of the American Cancer Society. Dr. E. C. Altenbernd, District 1 representative, was elected president of the Kansas Tuberculosis and Health Association, and Dr. Galen W. Fields served two months on the Ship Hope in Kingston, Jamaica.

The Jayhawk Family Physician enlarged its readership to include all Kansas physicians, KUMC students and Kansas legislators. Participation and support of the Kansas Medical Auxiliary's Health Careers Bus was voted and a panel depicting family physicians was put in the bus. This vehicle is to travel to all areas of Kansas and is to be shown to schools, clubs and other interested groups.

A highlight for board members occurred when they held their January meeting at Meade. A pheasant hunt there hosted by Dr. Jerome Wildgen, AAFP president, was the honored guest.

The Browning Family presented the banquet entertainment.

Tennis was added to golf, skeet and trap on sports day and an oyster and keg party was followed by a trip to see the Kansas City Royals play the Minnesota Twins. Dr. John D. Huff, Kansas City, was installed as president. His fellow officers were Drs. Richard R. Brummett, president-elect; A.C. Mitchell, vice-president; Philip H. Hostetter, secretary; F. Giles Freeman, board; Norman H. Overholser, delegate; and Donald D. Goering, alternate.

Dr. William Orrison netted hunters more than twenty-five birds.

The twenty-second annual meeting held at the Ramada Inn, Kansas City, September 8-10, 1972, featured emergency medicine as the theme. Two physicians, Drs. Ralston R. Hannas, Jr., Evanston, Illinois, and Don M. Benson, Pittsburgh, Pennsylvania, presented papers on "Resuscitation in Acute Airway Care" and "Management of Trauma." Dr. Richard A. Brose, Ph.D., Kansas City, spoke on "Pre-hospital Care—What You Can Expect."

Legislators Clyde Hill and Frank Gaines brought members up to date about the appropriation for KUMC and a tour of the new department of family practice followed.

While the out-of-phase graduates from KUMC may have had difficulties for students who had to wait several months for their internships to start, this system proved to be of value to the Academy in that members who wished to do so could hire these students for this period. The Academy encouraged their members to employ them for it was felt that at least some would remain in the state if they could see what family practice in Kansas was really like. Many were filling the slots in family practice residencies in Wichita and Kansas City and this program was gain-
KAFP Fellows, and the Education Committee

ing with every stride.

On October 9, 1972, the Kansas Academy participated with the AAFP in a three-hour TV special called "VD Blues." This VD awareness show included a national hook-up with Dick Cavett as host followed by a local program of ninety minutes duration. Dr. J. Warren Jacks moderated a panel assisted by Drs. Jack G. Phipps and Val J. Brown. Drs. John Huff, Ben Barker and Robert Wilson manned telephones and answered questions.

During this year the Jayhawk Family Physician went bi-monthly to get news to members faster. A booth was set up at the Kansas Medical Society meeting to secure memberships, and bylaws were changed to include osteopathic physicians.

Pheasant Hunt

Drs. George Marshall and Floyd Smith hosted a pheasant hunt in Colby at the time of the December board meeting. Mrs. Louise Wilcox, wife of the executive secretary, died late in December and a loan fund was established in her memory.

Quarterly dinner meetings in District I proved to be very successful with good member participation and many medical students attending. In February, 1973, nineteen Academy members joined other Kansas Medical Society members on a trip to Spain and returned full of enthusiasm for such adventures. Dr. George E. Burkett, Jr., accepted a post as associate professor in the Department of Family Practice, KUMC, and Dr. Floyd C. Beelman resigned as editor of the Jayhawk Family Physician.

Meeting Changes

This was a short year for President John Huff as the annual meeting was changed to June. The twenty-third annual meeting was held at the Highland Manor Motel, Great Bend, June 22-24, 1973. The meeting opened late Friday with a social hour and Hawaiian Luau by the pool followed by reports from the deans of the medical schools, family practice department and residency programs.

Saturday's sports day added tennis to the list of athletic endeavors and the ladies had a tour of the Loyall Tower home which was beautifully furnished with antiques.

Dr. Stanley A. Boyd, speaker of the house of delegates, AAFP, was the honored guest at the meeting. Following a dinner and installation of officers the audience heard a program presented by the Great Bend Singers.

Learning Disabilities

The scientific program for this meeting featured "Pediatrics and the Family Physician." Drs. Burton A. Dudding, KUMC; Paul C Laybourne, KUMC; Robert T. Hall, Kansas City; and Richard A. Guthrie, Wichita Branch KUMC; presented papers on "The Health Care of Children of Kansas," "The Battered Child Syndrome," "Management of High Risk Newborn Infants," and "The Management of Diabetes in Children." A round table discussion was moderated by Dr. Jack D. Walker.

Dr. Richard R. Brummett, Neodesha, was installed as president at this meeting. His fellow officers were Drs. Alexander C. Mitchell, president-elect; Philip H. Hosier, vice-president; Anol W. Beahm, secretary; Floyd L. Smith, board; E. J. Chaney, delegate; and Kenneth L. Lohmeyer, alternate.

Dr. Brummett shows off the membership award.

The Preceptorship program and student members continued to be a major thrust during the 1973-74 year. Wesley Hospital added rural preceptorships to their program, sending residents to Minneola, Belleville and Coffeyville. The Department of Human Ecology, KUMC, set up a similar program and sent senior students to areas of southeastern Kansas. These two-month tours proved to be interesting and profitable with several young doctors settling in Kansas.

Fellowships, too, were high on the list in member interest.
Ninety-three KAFP members were eligible for fellowships at the Denver AAFP meeting. One hundred twenty-four Kansans attended this meeting.

Two former KAFP presidents were appointed to national committees and commissions. Dr. J. Warren Jacks was placed on the Committee for Constitution and Bylaws, and Dr. Kenneth L. Lohmeyer was selected for the Commission on Legislation and Public Policy.

A new concept in education was advanced when the Wichita Branch of KUMC was opened with fifteen students. It is thought that having these students farther out in the state may contribute to some of them settling there.

**District IX Added**

Student interest in the Academy had advanced and the Family Practice Club was changed to District IX of the Kansas Academy. This interest contributed to Kansas receiving a third-place award for the percentage of student membership at the SOC meeting. They also received third place in the Idea Fair.

Four of Wesley's twenty-two family practice residents graduated in June, 1974.

PSRO continued to concern members and much discussion was carried out about this matter.

Kansas FP's took more honors in the state that year. Dr. John N. Blank was installed as president of the Kansas Medical Society, with Dr. Emerson Yoder as his first vice-president and Dr. Phillip A. Godwin as the constitutional secretary. Dr. Edward G. Campbell, the treasurer and the AMA delegate and alternate were Drs. George E. Burket, Jr., and Alex Scott. Drs. Burket, Blank and Huff are all past-presidents of the Kansas Academy.

Convention time for KAFP members found them rounded up in Western style. A lakeside Western dress barbecue started things off in good style at the Glenwood Manor Motel, Overland Park, followed by short talks from representatives of the medical schools and residency programs on "What's Happening in Family Practice in Kansas."

The scientific topic for this twenty-fourth annual meeting was VD, and Drs. Kermit E. Krantz, KUMC; Peter E. Dans, University of Colorado School of Medicine; and Arnold L. Schoreter, Mayo Clinic; talked on "Clinical Aspects of VD in Women," "Clinical Aspects of VD in Men," and "The Epidemiology of VD."

Senator Robert Dole and Representative William Roy spoke at a noon luncheon. The honored guest for this meeting was Dr. Herbert A. Holden, president-elect AAFP. Dr. Alexander C. Mitchell, Lawrence, was installed as president at this meeting. His fellow officers were Drs. Philip H. Hostetter, president-elect; Anol W. Beahm, vice-president; F. Giles Freeman, secretary; Kenneth Wedel, Board; Lawrence Leigh, delegate; and Donald Goering, alternate.

1974-5 Dr. Alexander C. Mitchell, Lawrence

Education in all its forms and ways to train family physicians and to keep them in Kansas occupied top priority in the 1974-5 year. Preceptors were evaluated and added and Kansas physicians continued to invite medical students for weekends and to hire out-of-phase graduates for the interim period between their graduation and internships or residencies. These things, plus avid interest in District IX and student activities maintained a high level of student interest in the family practice specialty.

35 More Fellows

Kansas FP's continued to apply for and receive AAFP Fellowships with thirty-five Kansans among the 3,000 who received this honor in Los Angeles.
22 Board Members
Twenty-two American Board of Family Practice Diplomates were admitted from Kansas early in 1975.

Educating the public in neonatal care and the establishment of a new neonatal plan by KUMC and Wesley Hospital, Wichita, received enthusiastic support from Academy members and several of their members are currently working with this plan. Districts have been inviting the Wichita neonatal van as a meeting program and members are cooperating with the establishment of secondary and primary care centers.

Howard Clinic
A further effort at establishing medical care in rural areas is being carried out by St. Joseph's Hospital, Wichita, with the opening of a clinic at Howard. A resident physician in family practice at St. Joseph's is flown to Howard three times a week. The clinic is the former office of Dr. J. Gordon Clapool who was in practice in Howard prior to his death in 1967. Additional programs of this type are being worked out by KUMC and the Wichita Branch of the medical school. Hopefully such programs will not only provide care in understaffed areas but will also encourage young physicians to settle in them. Two other FP residents, Drs. Tom Simpson and Rolin Duncan, alternated weekends in Sterling to give Dr. Jack Dysart some time off.

Little by little this type of exposure is resulting in new physicians for our state.

During this year Kansas enrolled in the pilot study for computerizing credit hours in the AAFP office. Physicians now carry computer cards to the meetings and their hours are automatically added.

25th Scientific Meeting
As this history goes to press to be distributed at the twenty-fifth annual scientific meeting in Manhattan, June 6-8, plans have been formulated for all three days. The fun theme of the meeting will be "The Pioneer Physician" with everyone encouraged to dress up in costume for the sports' night dinner. Prizes will be given for the best "Doc Adams and Kitty."

A hobby display will feature a gun collection belonging to Dr. Floyd L. Smith, Colby, and members are to bring their own hobbies to show off.

The End

The Kansas Academy of Family Physicians wish to express their appreciation to the following firms for sponsorship of various programs during the twenty-seven years the Academy has been organized.

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Office management of patients by family physicians has been chosen as an over-all scientific topic with discussions on treatment of alcoholism, pharmacology, religion in family practice and related subjects.

Dr. Phillip A. Godwin, Lawrence, will have "I understand all that, doctor, but how does it work?" as his subject. Dr. Godwin will illustrate the use of the audiovisual teaching devices that he uses in his office practice. Dr. Donald D. Goering and Fr. Willys E. Neustrom, Salina, will talk on "Alcoholism, A feeling Disease." A lecture on Pharmacology will be given by David H. Boeder, PhD., and a speaker on medicine and religion will be on the program.

Honor Guest
The honored guest for the occasion will be Dr. Carl Hall, AAFP president-elect. Banquet entertainment will be a melodrama called "Curse You, Jack Dalton" given by the Manhattan Civic Theater Group.

Dr. Philip H. Hostetter will be installed as president at this meeting and the other 1975-6 officers will be elected.
Coke Parties, Preceptees and District Meetings

Top row left: Student coke party. Dr. Fred E. Brown and preceptee Bradly Sheck. Second row: Dr. Thomas Dechairo and preceptee Edward Wood. Richard H. Brummett and preceptee Robert Haskins. Students at a coke party and a District I meeting. Third row: Dr. Kenneth M. Boeser, and preceptees Jean and George Lummens. Dr. George E. Barker, Jr. and students, and KUMC Students at a District I meeting.
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MEDICAL EDUCATION — WHERE AND BY WHOM?

GEORGE E. BURKET, JR., M.D.

IT IS INDEED AN HONOR FOR ME TO BE INVITED TO GIVE THIS PRESENTATION THIS EVENING IN A LECTURESHIP DEDICATED TO ONE OF THE FINEST CLINICAL TEACHERS THE UNIVERSITY OF KANSAS HAS EVER KNOWN. THOSE OF US WHO WERE PRIVILEGED TO KNOW DR. BOHAN RECOGNIZED IN HIM A MASTER OF BOTH THE SCIENCE AND ART OF MEDICINE. HIS INFLUENCE TRULY GUIDED OUR DESIRES TO BE GOOD PHYSICIANS. IT IS QUITE POSSIBLE THAT WHAT I HAVE TO SAY THIS EVENING IS SHAPED, IN PART, BY HAVING LEARNED FROM AN OUTSTANDING CLINICAL TEACHER.

I HAVE CHOSEN FOR A TOPIC "MEDICAL EDUCATION—WHERE AND BY WHOM"

THIS IS A TIMELY SUBJECT, I BELIEVE, BECAUSE OF CERTAIN CONCERNS RELATING TO THE DELIVERY OF HEALTH CARE AND THE EXPANDING ROLE OF MEDICAL EDUCATION. ALTHOUGH IT HAS NOW BEEN OVER SEVEN YEARS SINCE DR. RICHARD MAGRAW PUBLISHED "FERMENT IN MEDICINE", THE CAULDRON STILL BOILS AND WE HAVE HAD NO REAL GUIDELINES TO DETERMINE OUR DIRECTION OR WITH WHICH TO CHART A SAFE AND CERTAIN COURSE TO THE FUTURE.

ONE CANNOT BE SURE AS TO THE CAUSE OF OUR DILEMMA BUT CERTAIN THINGS SEEM RATHER CLEAR. WE LIVE IN ANTICIPATION OF, AND PARTIALLY IMMOBILIZED BY,

WHAT A BENEVOLENT GOVERNMENT MAY DECIDE IN RELATION TO BOTH HEALTH CARE DELIVERY
AND MEDICAL EDUCATION REALIZING THAT DECISIONS MAY WELL BE INFLUENCED BY POLITICAL EXPEDIENCY OR BY EXTREMELY BIASED OPINIONS. ALL TOO OFTEN WE READ AUTHORITATIVE ARTICLES IN OUR JOURNALS AND LAY MAGAZINES ON HEALTH CARE DELIVERY BY, PERHAPS, WELL-INTENTIONED INDIVIDUALS WHO HAVE NEVER PRAC-
TICED MEDICINE. WE SEE AND HEAR THEORIES PROPOUNDED ON MEDICAL EDUCATION BY MANY WHO HAVE HAD NO RELATION TO, OR REAL INTEREST IN, TEACHING. AND, FINALLY, WE BECOME DISMAYED AND ALARMED BY THOSE IN RESPONSIBLE POSITIONS WHO SEEM TO BELIEVE THAT QUALITY HEALTH CARE SERVICES SHOULD BE PURCHASED FOR AN AMOUNT 50% BELOW THE REST OF THE ECONOMY.

TO BE SURE, THE GREAT VARIETY OF THEORIES AND OPINIONS THAT HAVE BEEN THRUST UPON US HAVE BEEN MOST CONFUSING AND HAVE TENDED TO KEEP "DR. MAGRAW'S FERMENT" BREWING. HOWEVER, IN SPITE OF THE ILLUSION THAT WE SEEM TO BE HEADING IN MANY DIFFERENT DIRECTIONS, THE DEMOCRATIC PROCESS IS NOW SLOWLY GRINDING OUT APPARENT SOLUTIONS. THE ANSWERS LIE IN PROPERLY CORRECTING CERTAIN DEFICIENCIES AND FILLING GAPS IN OUR HEALTH CARE DELIVERY SYSTEM PLUS CHANGES IN MEDICAL EDUCATION. THE SOLUTIONS COME SLOWLY BECAUSE OF THE VERY HUMAN TRAIT OF RESISTING CHANGE. THOSE OF US WHO ARE COMFORTABLE BELIEVE THAT WE CAN SOLVE MOST PROBLEMS WITH THE STATUS QUO. OTHERS WHO ARE
UNHAPPY WOULD, WITH A RESTLESS DISCONTENT, RAPIDLY TEAR DOWN OUR ENTIRE
HEALTH CARE STRUCTURE AND START OVER WITH THEORIES AND BLIND FAITH. IT
TAKES TIME AND CERTAIN SOCIAL AND ECONOMIC PRESSURES TO GENERATE INTELLIGENT
AND LOGICAL SOLUTIONS. ORGANIZATIONAL STRUCTURES ARE NOW GRADUALLY DEVELO-
PING WHOSE GOALS ARE TO EFFECT UNITY OF PURPOSE AND COMMON OBJECTIVES.

THE OFFICE OF EDUCATION OF THE UNITED STATES IS IN THE PROCESS OF
GRANTING AUTHORITY TO THE RECENTLY ORGANIZED COORDINATING COUNCIL FOR MEDICAL
EDUCATION TO COORDINATE ALL MEDICAL EDUCATION. THIS INCLUDES THE ENTIRE SPECTRUM
OF UNDERGRADUATE, GRADUATE, POSTGRADUATE, AND ALLIED HEALTH PERSONNEL EDUCATION.

REPRESENTED ON THE COUNCIL ARE THE AMERICAN MEDICAL ASSOCIATION, THE ASSOCIA-
TION OF AMERICAN MEDICAL COLLEGES, THE AMERICAN BOARD OF MEDICAL SPECIALTIES,
THE COUNCIL OF MEDICAL SPECIALTY SOCIETIES, THE AMERICAN HOSPITAL ASSOCIATION,
THE FEDERAL GOVERNMENT AND THE HEALTH CARE CONSUMER. THE COUNCIL WILL OPERATE
THROUGH FOUR LIAISON COMMITTEES. ONE FOR UNDERGRADUATE EDUCATION, ONE FOR
GRADUATE EDUCATION, ONE FOR POSTGRADUATE EDUCATION, AND ONE FOR ALLIED HEALTH
EDUCATION. THIS ORGANIZATIONAL STRUCTURE IS CERTAIN TO HAVE A PROFOUND INFLU-
ENCE ON MEDICAL EDUCATION AND HEALTH CARE DELIVERY IN THE FUTURE. TIME WILL

NOT ALLOW FOR DISCUSSION OF HOW THESE COMMITTEES FUNCTION.
AN UNFORTUNATE DEVELOPMENT THROUGH THE YEARS HAS BEEN SORT OF A
QUASI SEPARATION OF MEDICAL EDUCATION FROM OUR HEALTH CARE DELIVERY SYSTEM.

THIS DID NOT SEEM SO APPARENT IN THE YEARS BEFORE THE INFLUENTIAL FLEXNER
REPORT WHEN OUR POPULATION WAS MUCH SMALLER AND INADEQUATE COMMERCIAL MEDICAL
SCHOOLS WERE PUTTING OUT A LARGE SURPLUS OF POORLY EDUCATED PHYSICIANS. HOWEVER,
WHEN THE COMMERCIAL SCHOOLS WERE CLOSED, AND MEDICAL EDUCATION WAS
PROPERLY BROUGHT UNDER THE INFLUENCE OF THE UNIVERSITY, EVENTS BEGAN TO OCCUR
WHICH BROUGHT US TO THE SITUATION IN WHICH WE FIND OURSELVES TODAY. WITH THE
REDUCTION IN THE NUMBER OF MEDICAL SCHOOLS, WE BEGAN TO TRAIN FEWER PHYSICIANS
BUT THE GRADUATE WAS FAR SUPERIOR TO HIS PREDECESSOR FROM THE COMMERCIAL SCHOOL
AND HE WAS MORE EFFICIENT. THE BASIC SCIENCES BEGAN TO OCCUPY MORE PROMINENCE
IN MEDICAL EDUCATION. MORE EMPHASIS WAS PLACED ON THE SCIENTIFIC ASPECT OF
MEDICINE AND, AFTER 1946, BEGAN A WHIRLWIND SURGE TO BIOMEDICAL RESEARCH AND
SUB-SPECIALIZATION. THIS BROUGHT A MARKED REDISTRIBUTION OF PHYSICIANS WHICH
NOW LEAVES LARGE GAPS IN THE HEALTH CARE DELIVERY SYSTEM. THOUSANDS OF PEOPLE
IN THE UNITED STATES DO NOT HAVE AVAILABLE ADEQUATE HEALTH CARE. THIS FACT
HAS BEEN DENIED IN SOME QUARTERS BUT THOSE WHO BELIEVE IT TO BE TRUE NOW
FAR OUTNUMBER THOSE WHO DO NOT.
THERE ARE ALSO INDIVIDUALS WHO CONTENT THAT WE DO NOT NEED TO TRAIN
MORE PHYSICIANS BUT MERELY, IN SOME MYSTERIOUS FASHION, REDISTRIBUTE THE
NUMBERS WE NOW HAVE. NOTHING COULD BE FURTHER FROM THE TRUTH. WHILE WE MAY
HAVE OVERTRAINED IN A FEW SPECIALTIES AND SOME ATTEMPT AT BETTER DISTRIBUTION
IN THESE AREAS MIGHT BE MADE, WE NEED THOUSANDS OF MORE PHYSICIANS TRAINED
NOW AND IN THE FUTURE.

THE SUGGESTIONS BY MANY THAT WE MERELY PROVIDE LARGE NUMBERS OF LESS
TRAINED SUBSTITUTES TO FILL THE GAPS IS TO ME INTOLERABLE. THE EDUCATION OF
ADEQUATE ALLIED HEALTH PERSONNEL TO SUPPLEMENT A WELL STRUCTURED AND COMPLETE
RETICULUM OF PHYSICIANS MAKES MORE SENSE. IF THIS MAKES ME A PHYSICIAN CHAU-
VINIST PIG, SO BE IT!!!

THE VERY NATURE OF THE SCIENTIFIC MEDICINE WE PRACTICE TODAY REQUIRES
MORE PHYSICIANS AND MORE TEAM EFFORT. THE NUMBERS GAME WHICH WE HAVE BEEN
PLAYING FOR SO LONG WITH PHYSICIAN–POPULATION RATIOS SHOULD BE DISCARDED. WE
ARE NOW IN A DIFFERENT BALL PARK, WITH DIFFERENT PLAYERS WHO HAVE DIFFERENT
NAMES. EXAMPLES WOULD BE GYNECOLOGIC ENDOCRINOLOGIST, NEONATOLOGIST, PERINATAL
FETOLOGIST, NUCLEAR MEDICINE, PEDIATRIC NEPHROLOGIST, ETC., ETC., AD INFINITUM.

THESE ARE ALL VERY IMPORTANT SUBSPECIALTIES IN OUR MODERN HEALTH CARE SYSTEM,
BUT HOW DOES ONE FIT THEM INTO THE GENERAL, BROAD PHYSICIAN-POPULATION RATIO
REFERRED TO IN THE PAST AND STILL USED BY MANY STATISTICIANS AND ECONOMISTS
IN DETERMINING HEALTH MANPOWER REQUIREMENTS.

THE FLEXNER REPORT, OR A REPORT TO THE CARNEGIE FOUNDATION ENTITLED,
"MEDICAL EDUCATION IN THE UNITED STATES AND CANADA" PUBLISHED IN 1910, HAS
BEEN WIDELY QUOTED AND MISQUOTED BUT PROBABLY SELDOM READ IN RECENT YEARS.
IT IS A SUPERBLY WRITTEN DOCUMENT AND REPRESENTS THE THOUGHTFUL OPINIONS OF
INTELLIGENT, WELL-INFORMED MEN. THE REPORT CONTAINS RECOMMENDATIONS, THE
IMPLEMENTATION OF WHICH FORMS THE FOUNDATION OF MEDICAL EDUCATION AS WE KNOW
IT TODAY. IT BROUGHT ALL MEDICAL SCHOOLS UNDER UNIVERSITY INFLUENCE, MADE
THE BASIC SCIENCES AN INTEGRAL PART OF THE CURRICULUM, AND IN THE CLINICAL
YEARS, BROUGHT THE STUDENT TO THE BEDSIDE OF THE PATIENT ELIMINATING THE
DIDACTIC LECTURE AS THE SOLE METHOD OF CLINICAL INSTRUCTION. ALL PHYSICIANS
BECAME EDUCATED MEN RATHER THAN THE PRODUCTS OF COMMERCIAL SCHOOLS AND "QUICKIE"
DIPLOMA MILLS. WITHOUT THE FOUNDATION FOR MEDICAL EDUCATION thus CREATED IN
1910, THE SCIENTIFIC EXPLOSION IN THE BIOMEDICAL SCIENCES WHICH WAS TO OCCUR
SOME THIRTY-FIVE YEARS LATER WOULD HAVE BEEN UNLIKELY.
IT WAS NOT UNTIL THE 1960'S, OR AFTER 50 YEARS HAD PASSED, THAT ANY
FURTHER CONCERED ATTEMPT WAS MADE TO STUDY HEALTH CARE AND MEDICAL EDUCATION
IN THE UNITED STATES. THE SIXTIES BROUGHT THE MILLIS COMMISSION REPORT OF
THE AMERICAN MEDICAL ASSOCIATION, THE COGGESHALL REPORT OF THE ASSOCIATION
OF AMERICAN MEDICAL COLLEGES AND THE FOLSUM REPORT OF THE FEDERAL GOVERNMENT.
THE FORMATION OF THE COORDINATING COUNCIL FOR MEDICAL EDUCATION AND THE
EMPHASIS NOW BEING PLACED ON PRIMARY MEDICAL CARE ARE, IN GREAT PART, A RESULT
OF THESE STUDIES.

THE TOTAL RESULTS OF THESE EFFORTS CANNOT, AS YET, OF COURSE, BE
MEASURED; BUT ONE THING SEEMS CERTAIN. ADEQUATE DISTRIBUTION OF HEALTH CARE
WILL NOT OCCUR UNLESS MEDICAL EDUCATION AND THE HEALTH CARE SYSTEM FORM A
MORE INTIMATE RELATIONSHIP. IT SEEMS MOST REASONABLE AND URGENT THAT MEDICAL
EDUCATION AND OUR HEALTH CARE DELIVERY SYSTEM BECOME ALMOST INSEPARABLE WITH
EACH BEING ACUTELY RESPONSIVE TO THE OTHER.

NOTHING IN THE FLEXNER REPORT INDICATES THAT MEDICAL EDUCATION SHOULD
BE CONTAINED ENTIRELY WITHIN THE WALLS OF THE MEDICAL SCHOOLS. THE REPORT
RECOMMENDED THAT MEDICAL EDUCATION BE REMOVED FROM THE DOMINANCE OF COMMER-
CIALISM AND PLACED IN THE MAINSTREAM OF HIGHER EDUCATION BY AFFILIATION WITH
UNIVERSITIES. AT THAT TIME, MEDICAL EDUCATION AND HEALTH CARE WERE MORE
CLOSELY ALIGNED BECAUSE THERE WAS VERY LITTLE SPECIALIZATION AND 90% OF
MEDICAL SCHOOL GRADUATES ENTERED PRIMARY CARE. ALTHOUGH MEDICAL SCHOOLS
WERE DEPARTMENTALIZED, THE MAJORITY OF THE FACULTY WERE VISITING CLINICAL
TEACHERS AND MOST DID SOME PRIMARY CARE.

TODAY, AN ENTIRELY DIFFERENT SITUATION EXISTS. WE HAVE IN OUR
VAST HEALTH CARE DELIVERY SYSTEM THREE AREAS OF CARE: PRIMARY, SECONDARY,
AND TERTIARY CARE. EACH IS AS IMPORTANT AS THE OTHER; EACH PROVIDES ITS
OWN UNIQUE LEVEL OF SERVICE WITH SOME OVERLAPPING AT THE INTERFACE, AND
EACH HAS ITS OWN INTELLECTUAL CHALLENGE PLUS PERSONAL GRATIFICATION IN THE
CARE AND PREVENTION OF THE ILLS OF HUMAN BEINGS. AT THIS POINT IN TIME, THE
AREA OF SECONDARY CARE IS THE MOST DIFFICULT TO IDENTIFY. IN SOME INSTANCES
IT BLENDS INTO THE PRIMARY AREA WHILE IN OTHER SITUATIONS, IT INVADES TERTIARY
CARE ACCORDING TO THE INDIVIDUAL PHYSICIAN'S TRAINING AND INTEREST.

THE PRIMARY AREA IS THE ONE WHICH OFFERS MOST INDIVIDUALS ENTRY INTO
THE HEALTH CARE SYSTEM WHILE THEY USUALLY ARRIVE AT TERTIARY CARE BY REFERRAL.
PATIENTS GET TO SECONDARY CARE BY THEIR OWN INITIATIVE IN SOME INSTANCES AND
BY REFERRAL IN OTHERS. ONE OF THE MAJOR PROBLEMS IN ANY ATTEMPT TO CORRECT
DEFICIENCIES IN HEALTH CARE IS IDENTITY. MANY PHYSICIANS DO PRIMARY CARE BUT CLAIM ANOTHER SPECIALTY AND SINCE A MINORITY OF PHYSICIANS ARE BOARD CERTIFIED, IT MAKES ACTUAL DETERMINATION OF DEFICIENCIES DIFFICULT EXCEPT IN PLACES WHERE THERE ARE NO PHYSICIANS AT ALL.

REGARDLESS OF THE DIFFICULTY SOMETIMES IN IDENTIFYING THE INDIVIDUAL PROVIDING SECONDARY CARE, THIS AREA OF MEDICINE HAS THE GREATEST RESPONSIBILITY IN MEDICAL EDUCATION. IT MUST NOT ONLY PROVIDE THE EVENTUAL MANPOWER FOR TERTIARY CARE, BUT ALSO MAKE MAJOR CONTRIBUTIONS IN THE TEACHING ARENA OF PRIMARY CARE. IT SEEMS QUITE IMPORTANT, THEN, THAT THIS AREA OF MEDICINE IDENTIFY ITSELF MORE CLEARLY AND CONCENTRATE ITS EFFORTS MORE EFFICIENTLY IN MEDICAL EDUCATION RATHER THAN MOVING INTENTLY TOWARD THE DELIVERY OF BOTH PRIMARY AND TERTIARY CARE.

DURING THE PAST 30 YEARS, THERE HAS BEEN A GRADUAL SHIFT OF PHYSICIANS FROM THE PRIMARY AREA TO THE SECONDARY AND TERTIARY AREAS LEAVING THOUSANDS OF INDIVIDUALS WITHOUT READY ENTRANCE TO THE HEALTH CARE SYSTEM AND THEY ARE FORCED TO SEEK CARE IN HOSPITAL EMERGENCY ROOMS WHERE THEY GO IN AND OUT OF THE SYSTEM LIKE A YO-YO. HERE THEY PROBABLY RECEIVE GOOD EPISODIC CARE, BUT OFTEN IN A DEPERSONALIZED FASHION AND LACKING THE SATISFACTION OF THE CONTINUITY OF CARE BY A PERSONAL PHYSICIAN.
DURING THESE THIRTY YEARS, MEDICAL SCHOOLS HAVE BEEN BECOMING MORE
AND MORE INVOLVED WITH RESEARCH AND ENGULFED IN WHAT WE LIKE TO CALL THE
"SCIENTIFIC EXPLOSION". IN TRUTH, WE HAVE BEEN EXPERIENCING A SCIENTIFIC
BONANZA WITH MORE MAJOR DISCOVERIES IN THIS CENTURY THAN IN ALL THE REST
OF RECORDED HISTORY. AS A NATURAL CONSEQUENCE, MEDICAL SCHOOLS HAVE TURNED
MORE AND MORE TO TERTIARY CARE AND AS REFERRAL INSTITUTIONS FOR DIFFICULT
DIAGNOSTIC PROBLEMS AND SOPHISTICATED TECHNICAL PROCEDURES. AMBULATORY
CARE IN THE OUTPATIENT DEPARTMENTS WHERE PRIMARY CARE AND SOME SECONDARY
CARE IS EMPHASIZED HAS, IN MANY INSTITUTIONS, DETERIORATED AND OCCUPIES A
POSITION OF DOUBTFUL STATUS.

IN THIS ENVIRONMENT, WE HAVE BEEN EDUCATING UNDERGRADUATE STUDENTS
WITH VERY LITTLE EXPOSURE TO MEDICINE AS IT IS PRACTICED IN COMMUNITIES AND
VERY LITTLE INDOCTRINATION TO COMMUNITY HEALTH CARE NEEDS. THE STUDENT IN
RECENT YEARS HAS BEEN INADVERTENTLY DEPRIVED OF THE INFLUENCE OF LARGE
NUMBERS OF VISITING CLINICAL TEACHERS WHO, IN A WAY, BROUGHT THE COMMUNITIES
TO THE SCHOOL AND HELPED TO DETERMINE THE FUTURE CAREERS OF MANY YOUNG PHYSI-
CIANS. HOWEVER, HAVING SPENT THIRTY YEARS IN CLINICAL MEDICINE, I AM NOT SO
NAIVE AS TO BELIEVE THAT THE DECLINE IN THE NUMBERS OF VISITING CLINICAL
TEACHERS HAS BEEN ENTIRELY THE RESULT OF A CHANGING POLICY IN MEDICAL
EDUCATION. THE YEARS HAVE SEEN FEWER AND FEWER COMMUNITY PHYSICIANS
WILLING TO CONTRIBUTE TIME FROM A BUSY PRACTICE TO DEVOTE TO TEACHING.

UP TO THIS POINT, WE HAVE PRIMARILY DISCUSSED PROBLEMS AND HAVE
REALLY ONLY 'BRUSHED THEM LIGHTLY'. NOW, I WOULD LIKE TO TURN TO THE
PROSPECTS OF SOLUTION.

ONCE AGAIN, IT SEEMS PROPER TO STATE THAT THE MOST EVIDENT SOLUTION
LIES IN THE CLOSE ALLIANCE OF OUR HEALTH CARE DELIVERY SYSTEM AND OUR MEDICAL
SCHOOLS. MEDICAL EDUCATION, HISTORICALLY, HAS GONE THROUGH THE PRECEPTOR
SYSTEM TO THE DIDACTIC SCHOOL AND FINALLY TO A SCIENTIFIC DISCIPLINE. IT
NOW SEEMS EVIDENT THAT ANOTHER MAJOR STEP MUST AND IS ABOUT TO OCCUR. MEDICAL
SCHOOLS ARE SLOWLY EXPANDING BEYOND THEIR WALLS AND INTO COMMUNITIES WHERE THE
MAJOR PORTION OF MEDICAL CARE IS DELIVERED. MANY EXAMPLES OF THIS CAN BE CITED.
THE UNIVERSITY OF INDIANA WHERE THE ENTERING CLASS NUMBERS 300 HAS EXTENDED
ITS CLINICAL YEARS INTO SEVERAL DIFFERENT COMMUNITIES THROUGHOUT THE STATE.

IN ALABAMA, UNDERGRADUATE MEDICAL EDUCATION HAS EXPANDED FROM BIRMINGHAM INTO
HUNTSVILLE, MOBILE, AND TUSKALOOSA. THE ILLINOIS PLAN CARRIES MEDICAL EDUCATION OUTSIDE OF CHICAGO TO MANY COMMUNITIES SUCH AS SPRINGFIELD, ROCKFORD, AND CARBONDALE. HERE AT HOME, THE UNIVERSITY OF KANSAS UNDERGRADUATE EDUCATION HAS GONE TO WICHITA WITH AFFILIATED GRADUATE EDUCATION SPREADING TO GARDEN CITY AND TOPEKA. THE INSTANCES MENTIONED ARE BUT A FEW. THE WAVE OF MEDICAL SCHOOL INVOLVEMENT IN COMMUNITIES IS DESTINED TO BECOME COMMONPLACE IN THE FUTURE EXTENDING THROUGH PRIMARY, SECONDARY, AND TERTIARY CARE. ULTIMATE SUCCESS WILL DEPEND UPON THE WILLINGNESS OF MANY COMMUNITY PHYSICIANS TO BECOME CONSCIENTIOUSLY INVOLVED AS PART-TIME TEACHERS WHILE, AT THE SAME TIME, ACCEPTING THE PHILOSOPHY OF UNIVERSITY INFLUENCE. THE IMPORTANTANCE OF THE LATTER WHICH WAS SO CAREFULLY DOCUMENTED BY THE FLEXNER REPORT IS JUST AS VALID TODAY.

ALL OF THIS — TOGETHER WITH AN ENLARGING AND MORE UNIFIED POSTGRADUATE EDUCATION SYSTEM — WILL INCREASE MEDICAL SCHOOL SENSITIVITY TO NEEDS IN THE HEALTH CARE DELIVERY SYSTEM AND IT WILL DIFFUSE THE BENEFITS OF RESEARCH MORE RAPIDLY AND COMPLETELY IN THAT SYSTEM.

IDENTITY OF THE AREA OF MEDICINE IN WHICH EACH PHYSICIAN PRACTICES IS CERTAIN TO RECEIVE ATTENTION. THE GOALS AND PRIORITY STUDY OF THE NATIONAL
BOARD OF MEDICAL EXAMINERS COMES CLOSE. THIS CONTROVERSIAL REPORT SUGGESTS
THAT AN EXAMINATION UPON GRADUATION FROM MEDICAL SCHOOL GRANT YOUNG PHYSICIANS
LIMITED INSTITUTIONAL LICENSURE. AT THE INTERFACE BETWEEN GRADUATE EDUCATION
AND PRIVATE PRACTICE, A SECOND EXAMINATION WOULD BE GIVEN TO GRANT FULL LICEN-
SURE. AND, FINALLY, ADDITIONAL EXAMINATIONS WOULD BE GIVEN AT INTERVALS OF
PERHAPS SIX TO TEN YEARS FOR CONTINUED CERTIFICATION. EXACT IDENTITY WOULD
RESULT.

SUCH A SUGGESTION IS NOT LIKELY TO BE ADOPTED IN THE NEAR FUTURE
BECAUSE, FOR ONE REASON, IT REPRESENTS TOO RADICAL A DEPARTURE FROM THE
CUSTOMARY. IT WILL, HOWEVER, PLANT THE SEED WHICH WILL GROW TOWARD PRESS-
SURE IN THAT DIRECTION IN YEARS TO COME. RECERTIFICATION FOR SPECIALTY
BOARDS IS HERE TODAY. RE-LICENSURE ON A PRACTICE PROFILE BASE IS LIKELY
SOMETIME TOMORROW.

IN CONCLUSION, THEN, THERE IS EVERY INDICATION THAT THE VOLUNTARY
SYSTEM OF MEDICAL EDUCATION AND HEALTH CARE DELIVERY WILL EVENTUALLY SOLVE
OUR HEALTH CARE PROBLEMS. THE ONLY REAL DANGER SEEMS TO BE THAT OUR FEDERAL
GOVERNMENT, INSTEAD OF LENDING NECESSARY ECONOMIC ASSISTANCE TO A VOLUNTARY
ENDEAVOR, MIGHT IMPOSE UPON US NARROW PATTERNS OF PRACTICE AND SUCH FINANCIAL
RESTRICTIONS AS TO MAKE LASTING SOLUTIONS IMPOSSIBLE OR PERHAPS CREATE A
STANDARDIZED TYPE OF MEDICAL CARE OF QUESTIONABLE QUALITY. OUR HOPE WOULD
BE THAT THE ULTIMATE WISDOM OF THOSE GIVEN THE RESPONSIBILITY FOR SUCH
DECISIONS WILL BE MANIFESTED IN THE DEMOCRATIC PRINCIPLES OF A FREE SOCIETY.
BUT -- MEDICAL SCHOOLS AND COMMUNITY PHYSICIANS MUST ALSO GIVE MORE THAN
LIP SERVICE TO A UNIFIED EFFORT. THE ANSWER LIES IN A TRUE ALLIANCE WITH
THE COMMON PURPOSE OF PROVIDING WELL TRAINED PHYSICIANS FOR OUR NEWLY
DEVELOPED TYPE OF MEDICAL CARE WHICH HAS BEEN CREATED BY SCIENTIFIC ACHIEVE-
MENT. THERE SHOULD BE A FULL REALIZATION THAT THE ART IS AS IMPORTANT AS
THE SCIENCE IN OUR RELATIONSHIP WITH PATIENTS. AND, FINALLY, WE MUST REALIZE
THAT PRIMARY, SECONDARY, AND TERTIARY CARE ARE HERE TO STAY. MEDICAL SCHOOLS
IN THE UNITED STATES HAVE DEVELOPED THE FINEST TERTIARY CARE IN THE WORLD.
THEY NOW HAVE AN OBLIGATION, WITH COMMUNITY INVOLVEMENT, TO PLACE EQUAL EMPHASIS
ON SECONDARY AND PRIMARY CARE. I FIRMLY BELIEVE MEDICAL EDUCATION WILL MEET
THIS CHALLENGE.
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A confirmed family physician whose belief in general practice has influenced an impressive number of medical students to become general practitioners was chosen the Academy's president-elect last month in Boston. Dr. George E. Burket, Jr., Kingman, Kan., will become the AAFP's 20th president next year in Dallas. His influence on the education of medical students has been achieved by his 16 years of active service as a preceptor in medicine for the University of Kansas. He has also served the cause of medical education as chairman of the school's advisory committee to postgraduate school.

Dr. Burket was elected to the Academy's Board of Directors in Chicago in 1963 and last year in San Francisco was chosen chairman. He has served on the Commission on Education and a reference committee on education (1963). An Academy member since 1949, the new president-elect has been active on both state and national levels. He has been both an alternate delegate and delegate, as well as a member of the Committee on Insurance. He has served the Kansas chapter as its president (1954), as chairman of its hospital committee and as a member of the board of directors for four years. Dr. Burket is the immediate past president of the Kansas Medical Society, which he also served as vice president, secretary and member of the executive committee. In addition, he is a past president of the Kingman County Medical Society.

Early this year, Dr. Burket was invited to serve as a special consultant to the Health Communications Branch of the Public Health Service's Division of Community Health Services. He also has been a consultant to the USPHS on postgraduate medical education. On the state level, he is a member of the Kansas State Board of Health and a past member of the Governor's Advisory Committee on Medical Care of the Aged. A past president of the staff of Kingman Memorial Hospital, he is a member of the board of trustees of the Mid-West Research Foundation. His civic affiliations include past membership on the Kingman Board of Education (for 12 years), the Kansas State Chamber of Commerce, the Lions Club and the Midian Shrine. He is a past senior warden in the Episcopal Church.

Dr. Burket was born December 10, 1912 in Kingman to Dr. George E. and Jessie Talbert Burket. He attended Wichita State University in 1930-33 and received his medical degree from the University of Kansas in 1937. He served his internship and residency at the Santa Barbara (California) General Hospital in 1937-39. In 1955-56 he was a graduate assistant in surgery at Massachusetts General Hospital, Boston. Dr. Burket's wife, Mary Elizabeth (Sue), is a graduate of the University of California. They have three children: George III, 24, a graduate of the University of Kansas; Carol Sue, 21, a senior at Stanford University, and Christine, 18, a sophomore at the University of Kansas.
Education, New Director’s Forte

IN THE WORDS of a delegate seconding the nomination of Dr. George E. Burket, Jr. as a candidate for the AAGP Board of Directors, “He’s a man who has shown he practices what he preaches. If we had more members like him, who actually have done something about the shortage of general practitioners, we wouldn’t have a problem.”

Dr. Burket, of Kingman, Kan., who won election to the Board in Chicago, is a firm believer in general practice. Not content with giving lip service, Dr. Burket demonstrates his interest by actively serving as a preceptor in medicine for the University of Kansas School of Medicine. He has influenced an impressive number of medical students to enter general practice since he accepted the preceptor role in 1949.

A good portion of Dr. Burket’s professional career has been concerned with medical education. This made him a logical choice for an appointment in June to the Academy’s Commission on Education. He is chairman of the Post-Graduate Education Advisory Committee to the University of Kansas School of Medicine, in addition to his preceptor work. This year he was a member of the AAGP Reference Committee on Education.

Dr. Burket has been an Academy member since 1949, and has been active on both state and national levels. He has served the Kansas Chapter as its president (1954), as well as chairman of the Hospital Committee and member of the Board of Directors for four years.

The Kingman native has been both an alternate delegate and delegate to the AAGP. He has been a member of the Committee on Insurance for eight years.

The new Board member is first vice presi-

dent of the Kansas Medical Society. He has been its secretary for five years and a member of its Executive Committee for six years.

Dr. Burket is a member of the Governor of Kansas’ Advisory Commission on Medical Care, and also serves his state as a member of the Kansas State Board of Health. Other memberships include the AMA and the American Association of Railway Surgeons.

The chief of staff of Kingman’s Memorial Hospital was born in Kingman December 10, 1912 to Dr. George E. and Jessie Talbert Burket.

He received his medical degree from the University of Kansas School of Medicine in 1937, and served his internship and residency in Santa Barbara, Calif. in 1937-39. In 1955-56 he was a graduate assistant in surgery at Harvard Medical School, Boston.

Dr. Burket is a member of the Episcopal Church and has been senior warden for two years.

Civic affiliations include the Kingman Board of Education (for 12 years), Lions Club, Masonic Lodge, York Rite, Midian Shrine and Order of Jesters - with golf, fishing and hunting rounding out this busy physician’s schedule.

Dr. Burket and his wife, Sue Wallace Burket, have three children, George III, 21, a senior at University of Kansas; Carol Sue, 18, a freshman at Stanford University; and Christine, 15, a junior at Kingman High School.
People

Wilcox formula for success includes honesty, truthfulness

By JUDITH ZACCARIA

Gene Wilcox has a simple formula for success: Be honest and truthful and always be on time.

“Always be a little early,” said the soon-to-be nonagenarian. Wilcox will celebrate his 90th birthday Aug. 6.

One reason he has been successful, according to his wife, Sally, is that “he always opens his mail the day it comes. That makes a big difference.”

The Wilcoxes will be celebrating Gene’s birthday with a reception from 2 to 4 p.m. Sunday, Aug. 10, at Grace Episcopal Church. Friends and relatives are invited. Your presence is the only gift Gene desires.

Wilcox was born Aug. 6, 1907, in St. Paul. At Southwestern College he studied English and history on a football scholarship, but he wasn’t sure what he wanted to do when he graduated.

“I liked coaching and playing with kids,” he said, so after he graduated, he went for a job interview at a little school “over east.” He met with the board of education, and after talking for a while, they asked him what he wanted for a salary.

“I have no idea,” Wilcox said he told them. “Things were real tough at that time.” They offered him $65 a month, and he said, “I’ll be seein’ ya,” wished them luck and went on his way.

A friend got him a job working for Curtis Publishing selling magazines in Oklahoma. They would go into a town, meet with the ladies in the church organizations and show them how they could make $1 on every subscription sold.

“They’d sit back and watch the ladies do the selling,” Wilcox said. He received a commission, “over $100 every two weeks ... I was making more money than the president of the school board.”

After a year, he decided to look for another job. He had married his first wife, Katherine Louise Frankenfeld, on June 6, 1934, and he wanted to settle down and not be on the road so much.

It was the heart of the Depression and the Dust Bowl, and jobs were still very scarce. He got a job as a case worker for the welfare department in Sumner County. “It wasn’t driving all over the country, and you could stay home. You had a foundation to build on,” Wilcox said.

He stayed there three years and then became head of the Butler County Welfare Department for three years, from 1937 to 1940.

It was a challenge trying to find work and assistance for the many unemployed people. The Works Progress Administration and especially the Civilian Conservation Corps put young men to work.

“We gathered up the young men, got them to go to camps. It was one of the best things that ever happened to them,” Wilcox said. “They earned $25 a month, sent $20 home and got to keep $5, and that was all some of those families had to live on.

“If you’ve never been in (an economic depression), you don’t realize what problems they had trying to bring food to their families.”

The three years as head of the Butler County Welfare Department were even more difficult than his time in Sumner County. “That’s when I got my ulcers,” Wilcox said. He faced real life and death decisions, “deciding what this person, that person should receive, making decisions like that on families. I was not even 30 years old yet. People can’t realize what those years were unless they lived through them.”

He worked for two years with the United States Employment Service; and then “just fell into” his job as executive secretary of the Cowley and Butler County medical societies. Wilcox learned his job “by experiment and feel.”

He set up meetings, got speakers, took minutes and kept a record of the doctors’ medical education hours for recertification.
While those tasks were not unusual, one of his tasks was.
At that time the Cowley County Medical Society was furnishing medical care for the county's indigent people, Wilcox said. The care was administered by physicians in each community. The medical society wanted a program that would equalize the physicians' responsibilities toward the poor.

Wilcox set up what he believes was the first "health maintenance organization" in the country in 1942. He organized the Cowley County doctors so the burdens of serving the indigent were shared among them. He also worked with hospitals, drugstores and physicians to establish fees for services and medications. The county paid a fee to the society for each person served.

"I got the job (as executive secretary) on July 25, and I had to have the program set up six days later, for Aug. 1. We did it," Wilcox said.

A year and a half later he set up the same kind of program in Butler County.

In July 1950 he became executive secretary of the Kansas Academy of Family Physicians, a post he held for 35 years. Wilcox spent a lot of time recruiting physicians for the society. He organized meetings and arranged for speakers and locations and did the academy's public relations work. He also organized its annual conventions.

When the academy began, about 100 physicians belonged to it; 35 years later, when Wilcox retired, there were about 1,100 members.

In 1997, Wilcox continues to be executive secretary for the Cowley County Medical Society.


On Dec. 22, 1973, Wilcox married Sally (Dutton) Jarrott, a freelance writer who was for 15 years the writer and editor of The Jayhawk Family Physician, the bimonthly journal of the Kansas Academy of Family Physicians.

She, too, has three children: John Bennett Jarrott, Jr., Sally Sue (Jarrott) Stratmoen and Linda Lee Jarrott.

"We were good friends before we married. That makes the best marriages," Sally Wilcox said. "Besides, I saw how (Gene) treated Louise. I knew he would be a good husband."

Gene Wilcox believes the key to a successful marriage lies in always being honest. "Treat your wife as you would want her to treat you," he said.

Wilcox has served as a member of the vestry and as a chalice carrier for Grace Episcopal Church and was on the board of directors of the Winfield Child Care Center for many years. He is still a member of the board of directors of Canterbury Village Apartments.

He also coached the Eagles, a Little League ball team, for 16 years.

Wilcox is a 52-year member of Masonic Blue Lodge 110 and a member of the Queen City Chapter of the Order of Eastern Star and Wichita Consistory, Scottish Rite.
Plan Cooperative Program with WSU

Dr. D. Cramer Reed has been named dean of Wichita State University’s new College of Health-Related Professions and associate dean of the University of Kansas Medical Center. The appointment was effective April 1.

The college was established by the legislature in response to a joint study by WSU and the KU Medical Center. The study recommended the establishment of such a college because of the severe manpower shortage in all health fields. The potential for program development with the excellent hospitals in Wichita, and the needs of the large rural and urban population in the region.

Tentative plans outlined by the study call for programs in physical therapy, occupational therapy, medical technology and dietetics and nutrition. Existing programs in health professions area at WSU include nursing, medical technology and dental hygiene.

in describing Dr. Reed’s responsibilities for the Medical Center, Dr. George A. Wall, Jr., dean and provost said, “He will represent the Medical Center in Wichita, and assist in the development of cooperative educational relationships with respect to private hospitals in Wichita. He will assist me and the KU academic departments in planning for any undergraduate medical relationships which may involve Wichita hospitals. Dr. Reed will also have similar responsibilities with regard to the development of short-term courses and other post-doctoral programs in medical education, which could conceivably serve the interest of the local medical fraternity and hospitals.”

Dr. Reed is a Wichita surgeon. He is relinquishing his private practice in urology. He began practice in Wichita in 1947, following graduation from WSU, and completion of his M.D. degree at Washington University in St. Louis. He served on the Wichita University Board of Regents during its period as a municipal school. He has since chaired and served on the subsequent WSU Board of Trustees.

“I decided to accept this position because I am tremendously enthusiastic about the future of health-related professions,” Dr. Reed explained. “It is through people in these fields that the slack caused by the shortage of doctors in face of the increasing population will be taken up. Another factor that affected my decision was the challenge of a second career in my life—particularly a career combining medicine with education.”

Reed and his wife Gene have two children, Kit and Kim.

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Stephens to Head WSU Family Practice Unit

The Wichita State University clinical branch of the University of Kansas School of Medicine has appointed its first faculty member.

Dr. G. Gayle Stephens, founder and former family practice residency director at Wesley Medical Center, has been named chairman of the Department of Family Practice for the WSU branch.

In an April, 1972 announcement it was said Dr. Stephens would leave Wesley for a new medical school at Texas Technological University, Lubbock. Wesley sources said Friday that appointment did not materialize and Stephens remained in Wichita. New codirectors for the residency program be created have since been named there.

He will also hold a joint appointment as health education professor in the WSU College of Health Related Professions and

Reed said Stephens' appointment will permit early development of a curriculum to introduce students to the principles of health care delivery by the primary physician.

The branch will admit its first 18 students next summer from KU and have 112 students by fall 1976 for the final two years of clinical medical education.

Dr. Stephens said he would like to develop a program in which students would get a portion of their training in cities and rural areas outside Wichita. He has practiced in Wichita since graduation from Northwestern University, Evanston, Ill., in 1952.

He was named head of the Wesley family practice program in 1967 and in 1971 was appointed assistant clinical professor of family practice at the KU Medical Center.

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Few Schools Insist On Family Practice

Following is the third in a series of six articles on the doctor-shortage dilemma and related problems.

By JANE FLOERCHINGER
Staff Writer

A self-professed commitment to family practice by university officials has not exempted Kansas schools from strong criticism.

The Wichita State University Branch of the University of Kansas School of Medicine has even been charged with failing to live up to its potential for creating a new emphasis in medicine.

“We have the opportunity in Wichita to develop a new kind of medical center,” says Dr. Victor Verhees, co-director of Wesley Medical Center's family practice program.

“Unfortunately, WSU is requiring students to take all specialties except family practice.”

NEXT: Physicians Aggravate Problem

Responds Dr. Cramer Reed, dean of the branch: family practice as a specialty still lacks credibility.

“It would be suicide for a new school to be designated a family practice school.”

A major problem with family practice, adds Dr. Joe Dominic, is that it has failed to define its role.

The result, he said, is that general practitioners are threatened and ask “what does this guy do that I don’t do?” and specialists resent the encroachment in areas they already handle.

Only eight of the 114 medical schools in the country require family practice study, Reed adds, pointing out that WSU is attempting to make its family practice clerkship so attractive students will want to take it.

Dr. Gayle Stephens, originator and former director of Wesley’s program and chairman of WSU’s department of family practice until last summer, says:

“The way I see the branch developing is in a very traditional imitation of the University of Kansas Medical Center. It is going to be more like KU than different in the sense that it is going to fragment the education of students into the various disciplines — so many weeks of obstetrics, so many weeks of pediatrics.”

Moreover, he continued, the students will be training in the hospitals with specialists as role models — exactly the pattern that has led to the present surplus of big-city specialists and shortage of primary care physicians in small communities.

“The State of Kansas cannot justify spending the amount of money and effort it will spend in Wichita to increase the number of medical school graduates by 30 or 50 a year if they produce the same choice of doctors who choose to live in the same places. The state is not going to be better off,” he said.

Dominic says that as long as residency programs are conducted in metropolitan areas and in conjunction with major medical centers, the new doctors are going to have limited interest in practicing in remote rural areas.

To try and solve this problem, both KU and the branch have developed programs to expose post graduate students to outlying communities.

KU’s graduate program began a year and a half ago with development of a

(Turn to Page 8A, Col. 1)
Continued February 12, 1974

Medical Schools Hear From Critics

★ From Page 1

three-month surgery rotation at Garden City, where participants are taught by community physicians attached to the KU faculty.

A similar program in pediatrics has been started in Topeka and plans are to establish others, including in family practice, in all sections of the state, according to Dr. William O. Rieke, vice chancellor for health affairs at KU.

"We are trying to expose them to communities in Kansas during the second and third year of residency training when they are nearly ready to go out on their own," he said.

The resident's family accompanies him, living in housing provided by the community, because, as it was expressed, "if you can't interest the wife, there is no chance you can win the doctor."

Similarly, in Wichita the hospitals offering graduate residencies have been encouraged, with state funding, to establish rotations.

Wesley's family practice program has done so in four communities - Phillipsburg, Coffeyville and Minniesota, and Dr. James Donnell, director of family practice at St. Joseph Hospital and Rehabilitation Center, indicated it hopes to do so this year. (St. Joseph's outreach efforts also will include flying lessons so doctors who do practice in outlying areas will have greater mobility, Donnell said.)

So far, it is too soon to tell whether the idea has merit — or whether three months exposure is potent enough to have the desired effect. None of those who have had the experience have graduated and selected where they will practice. Similar proctorships for undergraduate students have existed for some years but results are difficult to determine because so many years intervene before they set up a practice.

Ostensibly, the students like the experience. "The only one who was required to participate," Rieke said, "was the first one to Great Bend and we had to kick him out there. But now, Topeka is already booked through September, 1974."

And though not in a good position to criticize, Dr. Robert Haskey, who is currently in rotation at Garden City, said both he and his colleagues have found it valuable.

"The word I've gotten and among the residents at KU is that they actually look forward to the placement out here," he said. "They have only good words about it."

Some Wichita hospital administrators and family practice educators have been less than enthusiastic.

The hospitals have not liked the idea of losing the residents' services during the time he is out — though they are reimbursed for his salary during that time. Training is the emphasis, but residents still provide considerable service.

All involved have expressed concern that the quality of the placements be excellent.

If the word goes out to potential applicants that the rotation experience in Kansas residencies is bad, they say, not only they, but the whole state will be the loser.
Med School Tug
New vs. Old

Following is the last of three articles examining the struggle to mesh the Wichita State University Medical Branch of the University of Kansas School of Medicine with Wichita's private medical community.

By JANE FLOERCHINGER
and FRANK GAROFALO
Staff Writers

Dr. Victor Voorhees is in a unique position to understand the struggle between tradition and innovation.

And that philosophical struggle, he believes, is at the heart of affiliation negotiations under way between Wichita's medical community and the Wichita State University Branch of the University of Kansas School of Medicine.

Voorhees is co-director of Wesley Medical Center's family practice program, one of the first established in the country, and has bucked tradition to gain acceptance for the new medical specialty.

Voorhees' concern about affiliation is that the innovative quality of Wichita's community-oriented medical education programs will be smothered under the weight of the university's more rigid system.

"All of the fears," he said, "revolve around the idea that we would like to see the school and medical education be something different from what it traditionally has been and better speak to needs for medical care in the state.

"We're afraid if there is too much interference by the mother institution (KU), this will not be realized. We're afraid there will be too much 'we've always done it this way.'"

"We ought to have the opportunity to try something different and see if it works," Voorhees maintains.

More specifically, Voorhees continued, the physicians who have developed Wichita's residency programs have invested them with ideals and principles they consider valuable.

If they were to lose control of their programs to the university, those ideals and principles might not be perpetuated.

"Cramer's task," Voorhees said, referring to Dr. Robert Reed, vice president for health education at WSU, "is to find a way to assure us our offspring will be continued.

Donald Conroy, associate administrator at St. Francis Hospital, which has been involved in medical education six years, elaborated on some differences between the traditional medical education approach and that of private hospitals and physicians.

Medical schools, he said, have been self-contained organizations, usually with their own hospital and a closed medical staff and controlled patient population.

"If a man controls pediatrics in a medical school, he controls everything, the staff, beds, he may hire and fire nurses, he controls the residents and also the students when they rotate through. In a medical school things are much more subject to regimentation," he said.

By contrast, he said, in a private hospital there may be a dozen pediatricians, each of whom practices independently. They are organized and coordinate their efforts, but each has a voice and the chief physician may be rotated regularly.

It is a much more democratic process and this kind of freedom is deeply ingrained in physicians, he said.

"When you get married to a medical school and the medical school faculty comes along with its different background and philosophy, you're in the middle of the town and gown syndrome."

Conroy said about 25 per cent of the physicians at St. Francis had not been in favor of involvement with the WSU branch at the outset, making it clear the relationship would have to be developed in stages.

There has been little difficulty in areas where there were no existing residency programs, as psychiatry and pediatrics, and most are very pleased the branch is now providing leadership to get programs started in these fields, he said.

However, in areas where there are strong programs, as general surgery, internal medicine, obstetrics, there is more opportunity for friction to develop.

There is a prestige factor, he said.

"Take the man who has devoted his time and energy and talents to making a good program, say in orthopedics, and he has not received a dime in return. He's proud of that program.

"Then the university comes in and says, 'Charlie, you've done a good job, but we're going to take over and do a better one.'"
Med School Tug New
vs. Old Continued
March 16, 1975
Also, Conroy said, it is not unheard of for a university man to come in and start telling the community doctor he's been doing something all wrong.
The question is, he said, "Does the resident or his training chief have to have unswerving loyalty to the university to do a good job teaching undergraduate students? We don't think so."
Conroy said he felt a great deal has been accomplished in the past 2½ years and added, "I'm optimistic that in another few years we will be over the hurdles, but if we get arbitrary with these five men, we can only hurt ourselves."
While support for the branch by Wichita physicians has been good — there are about 100 heavily involved, most of them without reimbursement — it has not been as much as hoped for, said Dr. Archie Dykes, KU chancellor.
In fact, some have begun withdrawing, not a "mass exodus," Conroy said, but enough to raise concern.
Said Dr. Ronald Linhardt, recently resigned director of medical education at Wesley Medical Center: "Cramer's looking for more troops to keep it (the branch) from falling apart, which it could in a year if they keep withdrawing."
Why are they withdrawing? Time and money are key reasons, Linhardt said.
When they volunteered, many probably thought they would have enough time available to accept the additional teaching responsibilities, but now are finding that not necessarily true, he said.
Those responsibilities might mean as much as an hour a day for the doctor, which is time not spent with patients, introducing an economic factor, and may represent a drain on his energies.
Many doctors put in 12 to 16 hour days and that extra hour is one that he will not have to shop with his wife or play with his children, Linhardt said.
Some have found it not as rewarding to teach medical students as its residents, he continued.
"They are two different things. The time you (the doctor) spends with residents tends to be to your own advantage. Much of it involves patients and you're reading and talking about information you can use.
"You have to gear down for the medical students, like talking to the PTA, and it's just not as much fun. There are few patients and more chalk and slides."

For some, the students can represent a threat. "Their fund of knowledge is so great . . . it can be a challenge to respond to their questions." Linhardt said.
Some doctors have been less than eager about the branch because of fear it will increase the number of doctors in the community and dilute the "patient load."
This may eventually happen, but it is certainly no immediate threat, Linhardt said.
"If this community had an influx of 100 new docs, there would be a clamor to take medical students. Since we can't advertise, that would be a means of being visible. But there are plenty of patients in Wichita and not enough doctors, so we don't need the visibility," he said.
Economics, as so frequently, is the common denominator in relations between the university and the medical community.
It's important to the residency programs. As Voorhees said, "In the back of everybody's mind is that they may not get the money (stipends from the state) if they don't affiliate."
It's important to the hospitals. Already the question has been raised, Conroy said, whether the cost of medical education should be borne by the sick patient paying his bill.
And, he added, the day may come when hospitals, faced with ever increasing costs, will find it difficult to justify an investment in medical education programs and will have to look elsewhere.
Reflecting on the situation, Linhardt said, "Physicians in the hospitals feel they don't need the branch and KU. They need us. We really feel like they ought to be nice to us."
"This is an imposition on the way we live and work — only we wanted to do it. The students incur increased costs per patient per day, so the hospitals pushed for stipends," he recounted.
"But did no one realize back then that there would be strings?"
Of course, they realized, Linhardt said.
"What dummy thinks they're going to get $130,000 and not have any strings? But now that it's happening they're saying, 'let's get a little bit of whoa up.'"
Reed Asks to Leave Med Branch Position

By JANE FLOERCHINGER
Staff Writer

Dr. D. Cramer Reed has submitted a letter requesting that he not be reappointed as vice chancellor of the University of Kansas School of Medicine-Wichita as of July 1, sources said Thursday.

Reed was unavailable for comment Thursday, as were Dr. David Waxman, head of the medical school in Kansas City, and KU Chancellor Archie Dykes.

Sources said the decision came as a result of differing opinions over operations of the branch. A recent point of contention was the naming of a new director of the branch's outreach program. The director determines where in the state the branch's outreach efforts are to be directed.

The level of financial support from the state is a major area of contention also, according to sources, as cuts in budget requests, by the Legislature, are causing hardships.

"THERE IS continued erosion of the decision-making process, plus a lack of teachers, research and financial support," one source said.

In Kansas City, there is a state hospital for the students, but in Wichita students work in community hospitals. Wichita allows the students to use the hospitals, but is not sufficiently reimbursed to run a quality medical education program, according to one source.

Reed’s decision not to seek reappointment is the latest problem for the KU School of Medicine's Wichita branch. Dean Richard Walsh recently resigned, and budget cuts have caused hardships.

He received his bachelor’s degree from WSU in 1937 and his doctor of medicine at St. Louis University School of Medicine in 1941. He received his master’s degree in urology from the University of Pennsylvania Graduate School of Medicine in 1957, and was engaged in private practice in urology in Wichita from 1955 to 1970.

Reed was preparing to retire at the time the branch was being conceived, and he took responsibility for establishing undergraduate medical education in Wichita.

The branch came into being as a combined entity with WSU. A year ago, the branch separated from WSU, moving from Fairmount Towers, adjacent to the campus, to new quarters at E.B. Allen Memorial Hospital.
KU Medical Branch Is Here to Stay, Dykes Says

By JANE FLORECHINGER
Staff Writer

In an effort to calm roiled waters around the Wichita medical school branch, Kansas University Chancellor Archie Dykes met last week with school and community groups.

The direct message he wanted to convey: The KU-medical branch is in Wichita to stay.

A more subtle message also came through. With Dr. Cramer Reed's resignation as vice chancellor, the branch will be controlled from Dykes' office in Lawrence.

No effort was made to retain Reed, and there are no plans to fill his position, at least in the near future. Dykes told the Eagle in an interview Dr. Richard Walsh, who resigned recently as dean of the branch, has agreed to stay on in that position, Dykes said.

Still unspecified are the reasons for the sudden resignation last week of Reed, who for eight years has led the branch through some intricate political thickets.

"Frustration" was the word most often repeated in an interview Tuesday with Reed, Dykes and Dr. David Waxman, executive vice-chancellor for the medical school. Waxman will be Dykes' main contact with the Wichita branch.

Reed spoke of the frustrations he felt from a lack of clear direction.

"There are no manuals to follow in developing schools like this," he said. He has sought but has been unable to obtain guidance from superiors, he said.

Dykes blamed the lack of direction on legislators: "It's frustrating to not know whether you're pleasing them or not until something is done."

Dykes and Reed have been hoping an interim study committee will establish ground rules for the branch to give it continuity of direction and financial support from one legislative period to the next.

With no manual to follow, Reed innovated. Sometimes that caused him and Dykes trouble with the Legislature.

For example, Reed initiated a program in Harper, Kan., to give small-town experience to medical students and students in allied health fields. Continuing education for doctors and nurses was offered in several counties. There was even a computer hookup with the branch.

When legislators learned of the Harper project, they complained to Dykes that it had not been authorized. A legislative committee since has endorsed the project as a model and it has been written into the law. But the problem continues.

The legislature this year refused to fund an outreach project run on a shoestring by the branch for about a year. Dr. Vernon James and an interdisciplinary team have been traveling the state periodically to conduct follow-up clinics for handicapped children and high-risk babies born at Wesley Medical Center's perinatal unit.

That project has not been authorized either.

"We really need," Reed said, "to have the opportunity to explain, hopefully to a legislative person, what it is we're trying to do, because perceptions have been confusing. There have been some who thought we were a school to train family practitioners."

The Wichita branch is oriented to primary care and trains doctors for family practice, but that requires specialists in various disciplines, Reed said.

"You must have the assemblage it takes to have a full curriculum in all these disciplines, because that is what family practice really is," Reed said.

For some time, that wasn't understood, and it caused budget frustrations.

Dykes said that the legislature two years ago eliminated funds for a psychiatry program at the branch.

"Obviously, you can't train family-care physicians without giving them psychiatry," Dykes said. "But every time Cramer has proposed psychiatry residents in Wichita, there has been a cry that you're going to specialize."

Some money for psychiatry since has been replaced in the budget.

"Finally, that one single issue is understood, but it's symptomatic of a whole series of problems we've had," Dykes said.

(See REED, SC, Col.3)
Reed: Branch Lacks Direction

From Page 1C

KU chancellor is calling the shots but head of med branch won't play the game

DYKES

And Reed has had problems at his own school. Lack of desired financial support for educational and research activities has caused discontent among faculty. Research is considered vital to a good medical school and many teachers came to Wichita with the understanding that they would be able to do investigative work along with their teaching.

Urging from some faculty to upgrade the status of the branch and increase its financial support was partly responsible for Reed's resigning last year as vice-president for health education at Wichita State University.

Difficulties in finding a permanent home have done nothing to improve morale.

"When I talked with the faculty (last week)," Waxman said, "one of their concerns was that they didn't have their own place. They expressed it in such a way that I can understand it, although someone else might say it couldn't be. They said, 'You know, we expect someday we'd wake up and the school had moved and here we are.'"

Until about a year ago, the branch was in Fairmount Towers, a dormitory adjacent to the WSU campus. It was to have moved to a building under construction on the campus until the split with WSU occurred.

The school moved to E.B. Allen Memorial Hospital, expecting to stay there some years, but that no longer appears feasible.

"One legislator said to Cramer when he was in Topeka recently for a hearing, 'You have to have a place to put your shingle out, a place that is going to be permanent.'"

"You have to have the opportunity to plan," Waxman said, "to know how much space you've got and to project for the next year and he (Reed) hasn't been able to do it. He has been, I think, more or less, you'd have to say, on a shoestring. That's not the proper way to approach education."

Now Dykes is counting on the interim study committee to address the problem.

"We're talking about a substantial sum of money either in long-term commitment on a lease, purchase of a building or even construction of a facility," he said.

Waxman, who is new in his position said that Reed "might have been my boss." Reed was offered the position at Kansas City and declined.

Dykes said Reed was invited to the community meetings that Dykes and Waxman were conducting, but declined. Reed said he was not invited.

Dykes said it was his policy to accept resignations without protest and therefore he had not tried to change Reed's mind.

However, he did change Walsh's mind about continuing as dean.

Dykes and Waxman increasingly have been calling the shots at the branch. A recent incident apparently went too far.

Dr. Larry Miller resigned as chairman of the branch's family practice department, leaving the immediate question of who would run the preceptorship program placing students with doctors around the state.

Reed recommended that his director of outreach assume the responsibility. Waxman assigned the job to someone else.

Reed says he won't play the game that way.
The Cramer Reed Affair

Let there be no doubt about the fact that Dr. Cramer Reed’s resignation as vice chancellor of the University of Kansas School of Medicine-Wichita leaves a gap in Wichita and in Kansas that will be painfully difficult to fill.

Dr. Reed has become one of the nation’s most respected and influential spokesmen for medical education, not only by virtue of his having built a major medical institution from scratch but by dint of his own devotion to the pursuit of excellence — and his refusal to accept anything less.

It is a mark of the good work he has done here that the Wichita branch of the KU medical school probably will survive his departure. But survival is not enough; replacing the present first-rate institution with a second-rate one would be tantamount to destroying the whole medical school structure for which Dr. Reed and a few others worked so long and so hard.

Everyone concerned, from KU Chancellor Archie Dykes and legislative purse-holders on down, says this isn’t the intention. Their actions will speak louder than their words in the months to come.

There was widespread suspicion that Dr. Reed started getting the administrative shaft when the Board of Regents removed him — rather, voted that he “resign” — from the position of vice president for health education at Wichita State University last year. We accepted the regents’ word at the time that the move was purely an administrative one.

Now, with the apparent decision not to replace Dr. Reed — and the resulting shift of control from Wichita to Kansas City — we are left to wonder if the motives for separating Dr. Reed from WSU were so pure after all.

The possibility of the Wichita facility’s downgrading is exacerbated by the KU administration’s willingness to let a legislative interim committee decide what the local school’s role should be. That should be the function of the educators themselves, who should then be willing to fight for what they see to be the school’s legitimate mission.

Chancellor Dykes assured several members of our staff in a meeting this week that KU’s commitment to a Wichita branch of the medical school is “unquestioned.”

That was good to hear. But it takes more than commitment to an undefined ideal to provide the quality of medical training that Kansans have a right to expect — whether the facilities for such training are in Wichita, Kansas City, Lawrence or elsewhere.

We will be watching future developments with great interest.
Kortge Resigns as Head Of Health Systems Agency

Dean Kortge, president of the Health Systems Agency of Southeast Kansas, announced Tuesday that he has resigned to accept a similar position in Eugene, Ore.

Kortge also said he has resigned as special projects director at the University of Kansas Medical School in Wichita, effective Sept. 1.

He will leave Wichita Aug. 20 to become associate director of the Western Health Systems Agency in Eugene.

"Both my wife and I are from Oregon, and we think this is the thing to do," Kortge told HSSEK directors at a board meeting Tuesday.

However, in response to questions, Kortge said later Tuesday that he would not have resigned if Cramer Reed was still at the University of Kansas Medical School in Wichita.

Reed, former vice chancellor of the medical school, resigned in May amid reports of disagreement over the direction of the branch. Last week, he became senior vice president for medical-professional development at Wesley Medical Center in Wichita.

Kortge said: "We started at the same time when the school first started in 1973, and we had a close bond and relationship. That and the new administration and change in philosophy made it possible for me to leave."

Kortge has been president of HSSEK since April. He has been a member of the board of directors since the agency was founded in 1975.
STATE LEGISLATORS DISCUSS MEDICAL EDUCATION IN KANSAS

They will make recommendations before next year's session

Legislators Discuss New College, Wichita's KU Med School Branch

By GORDON ATCHESON
Staff Writer

The role of the University of Kansas Medical School branch at Wichita and the creation of an osteopathic college here were the major items before state legislators Monday as they began studying medical education in Kansas.

KU Chancellor Archie Dykes told the Special Committee on Medical Education that the school's Wichita branch is entering a "critical time" during which decisions must be made about its financing, size and permanent location.

Rep. Fred Weaver, D-Baxter Springs, chairman of the joint Senate-House committee, agreed with Dykes that location of the branch is perhaps the most important question.

"We can't get along without the Wichita branch," Weaver said. "But, we need to secure a permanent place for it... We will look very hard at that issue."

THE FACILITY, serving 70 undergraduate medical students with an annual budget of $4 million, has been housed in E.B. Allen Memorial Hospital for the past year. Previously, it was in Fairmount Towers on the Wichita State University campus.

"There is a need to develop some long-term plan," KU executive secretary Richard Von Ende told the committee, which met at E.B. Allen Memorial Hospital. "Presently, operating on a year-to-year basis leaves some uncertainty."

Dykes suggested the committee might want to define the precise role and ultimate size of the branch before tackling the question of finding a permanent home.

The committee will prepare recommendations on the Wichita facility and the feasibility of an osteopathic hospital, among other topics, prior to next year's legislative session.

THE LEGISLATIVE panel did not rule out E.B. Allen Memorial Hospital as a possible site for the Wichita school, if a multi-year lease could be agreed upon.

During the afternoon session, the committee met at Osteopathic Hospital to begin review of a proposal for an osteopathic college to be operated in conjunction with the hospital and WSU.
Continued The Wichita Eagle
Tuesday, June 27, 1978

The possibility of an osteopathic medical school was raised late last year by state Sen. Larry Rogers, D-Wamego.

There are 12 such colleges in the country — five of them founded in the past five years, according to research materials presented to the committee members. None of the schools is in Kansas, although one is in Kansas City, Mo.

ACCORDING TO THE research material, 223 osteopathic physicians practice in Kansas.

Dr. Carlton Syler, director of medical education at Osteopathic Hospital, said the facility could not immediately accommodate a full-scale teaching program.

The hospital has eight interns and one resident who are instructed by the facility’s 27-member full-time staff on a voluntary basis.

If a college were started, full-time, paid teaching staff members would have to be hired, Syler told the committee.

"TIMING IS the question," he added. "If you said build a school, I don’t think we are ready. It would have to be done gradually."

Syler agreed with Weaver’s assessment that the push for an osteopathic college is coming primarily from the public rather than the osteopathic profession.

Weaver said many people view such a college as one way to meet the shortage of physicians in rural Kansas because the vast majority of osteopathic doctors go into general practice.

"We are just studying the potential of such a college," Weaver said. "I think we are a little apprehensive about it."

STATE SEN. MICHAEL Johnston, D-Parsons, suggested that an osteopathic college here, coupled with similar efforts in other states and recent expansion of the KU medical school classes, might create "a glut of physicians."
Donnell: Medical Branch Losing ‘Wichita Flavor’

By CRAIG STOCK
Staff Writer

City Commissioner James Donnell said Thursday that recent departures of two administrators from the Wichita branch of the University of Kansas School of Medicine will diminish the school’s “Wichita flavor.” Although Donnell said he did not know the details of the resignations of Dean Kortge and Cramer Reed, he said their departures “herald a new era of KU control of the WSU branch of the KU medical school.”

Donnell, a physician, was a supporter of a separate medical school in Wichita, but the Wichita branch was begun as a joint project.

Reed was vice chancellor of the Wichita branch before resigning July 1.

Kortge has resigned, effective Sept. 1, as special projects director at the Wichita branch.

REED LED THE WAY in developing both WSU’s College of Health-Related Professions and KU’s medical school branch at WSU. Complications resulting from his working for both universities led to his resignation from WSU last summer.

His more recent resignation from KU reportedly came as a result of differences of opinions about operation of the branch between Reed and KU Chancellor Archie Dykes.

“There ought to be some investigative reporting — that seems to be the ‘in thing’ these days — about the departure of Dean Kortge and Cramer Reed from the medical school,” Donnell said.

After Dykes made a visit to Wichita to explain the situation this spring, the Eagle ran a lengthy article explaining that, while the KU medical branch would remain in Wichita, it would be controlled from Dykes’ office in Lawrence.

In recent months, the Wichita emphasis in the medical school branch has lessened. The medical school was physically separated from the WSU campus and moved to E.B. Allen Memorial Hospital.
Wichita Medical Leader Retires
Cramer Reed Made Presence Felt for Almost 50 Years

By Dianna Sinovic
Staff Writer

During the North High convocation of 1933, a handwriting analyst predicted that Cramer Reed, then senior class president, would become a "marvelous engineer."

She couldn't have been more wrong. Reed, who turns 71 in July, has spent his entire career in medicine. From a successful urology practice to posts at Wichita State University, the University of Kansas School of Medicine-Wichita, and finally to Wesley Medical Center, Reed has never stepped outside the medical realm.

That service came to an end Friday upon Reed's retirement after almost a half century as a doctor.

Described by a colleague as "an outgoing, congenial, friendly man," Reed is highly respected and liked within the medical community, chiefly because of several important medical programs in which he has had a hand.

He was the first dean of WSU's College of Health Professions. He helped organize the Wichita branch of KU's medical school, and was its vice chancellor before he left. He helped develop Health Strategies, Wesley's health promotion program. When he retired, he was president of Health Strategies and a senior vice president at Wesley.

"He's been a major influence in this city as a specialist and as an educator," said William Reals, dean of the medical school, who has been a neighbor of Reed's for 25 years.

Said Clark Ahlberg, former WSU president: "Not very many people have had as many distinguished careers, as an administrator and a practitioner. He's a one of a kind."

The competitive health-care market in Wichita has caused hospitals, including Wesley, to make dramatic changes in operations in recent months. Wesley, which became a for-profit hospital a year ago, has "laid off workers and reassigned some management staff to cut administrative costs. Reed, however, discounts the impact of the changes on his decision to leave.

HE SAYS only, "You don't really need those kinds of excuses when you're 71."

Reed said he knew from the age of 10 that he would be a doctor, although he almost changed his mind once. Reed, interviewed in his Wesley office, pointed to an old black-and-white photograph, shot in the mid-30s, of the first police cadet class in Wichita. Reed is there, second from the right.

He worked as a police officer in Wichita during his first few years of college and briefly toyed with the idea of police work as a career.

"I spent most of my time with the vice squad, where I learned a lot," he said, grinning. But he considered how disappointed his parents would be if he didn't become a doctor and plunged ahead into medicine.

He earned his medical degree from Washington University in St. Louis and then served as an Air Force flight surgeon in World War II. He later earned a master's in urology at the University of Pennsylvania and completed a fellowship in pediatric urology at the University of Virginia.

REED JOINED the Wichita Urology Group in the mid-1950s and practiced until 1971, when he was named the first dean of WSU's new College of Health-Related Professions, later renamed the College of Health Professions.

Shortly after he took the WSU post, Reed helped develop a branch of the KU Medical School in Wichita and was appointed part-time vice chancellor. "He really was the founder of the school," said Reals.

At first, the medical school was housed in a small building on the WSU campus and was affiliated with both WSU and KU. It was difficult to balance his jobs as both dean and vice chancellor, he said. When the medical school split from WSU, Reed went with it, although the move angered some at Wichita State who felt that Reed was abandoning them.
Cramer Reed, who retired Friday, stands in the cardiac rehabilitation unit at Health Strategies. He helped develop the health promotion program at Wesley Medical Center.

“My perception was, the medical school was just getting students. I needed to devote my time to the medical school,” he said.

Then, in 1978, with the medical school going well, he accepted an offer from Wesley to be a senior vice president. It was a chance to do something he said he’d long thought about — to help change people’s lifestyles to help prevent disease.

“WHERE BETTER to deal with this than the hospital?” he said.

He worked with Jerry Kerschen, vice president of Health Strategies, to develop the idea. The first wellness programs, in 1980, were limited to Wesley employees. But Health Strategies has been expanded to the community, including those with disabilities or injuries. He’s now looking toward promoting fitness in the geriatric community, he said. Kerschen will succeed Reed.

Reed’s personal lifestyle reflects his concerns for fitness and health. He plays handball at least three days a week, walks and jogs a little and watches his weight. His only shortcoming seems to be too few hours of sleep a night, the stamp of a full-fledged workaholic. “Going to bed seems so awfully dull,” he said.

He and Geney, his wife of 45 years, enjoy adventure trips including river rafting and backpacking. A group of doctors has arranged for a hot-air balloon trip for the couple as a retirement present. “I’m utterly delighted by the prospect,” Reed said.

Their daughter, Kit, lives in Honolulu with her husband and children. Their son, Kim, works in the communications department at Wesley.

Reed’s not saying what he plans to do now, except that he is considering several opportunities. He would not say whether those opportunities are health-related.

“I really ought to go home and just relax,” he said.
AN INTERVIEW WITH ROBERT BROWN, M.D.
EXECUTIVE DIRECTOR, SALINA HEALTH EDUCATION FOUNDATION
JANUARY, 1998

**Kellerman:** Dr. Brown, we are interested in the origins of the Smoky Hill Family Practice Residency and your work before you arrived in Salina. Start with a little bit of your background, where you grew up and where you went to school.

**Brown:** I grew up in Atwood, a little town in northwest Kansas. My father ran a grocery store there, and he and my grandfather leased quite a bit of farm land south of town. My first job was, at about age 12, going out every summer and driving a tractor, which I would do from sunup to sundown. I drove one tractor and granddad drove the other. I did that and school and not much else until I went to K-State after graduating from high school in Atwood.

I went to K-State on a lark. Three weeks before we were supposed to matriculate, a friend of mine asked, “Why don’t we go to K-State?” I didn’t have a dime. But we went. I think tuition was $55. My father said that he would try to send $10 a week. He couldn’t do it, but he got close.

I went to school at K-State for a year, but that was the year of Pearl Harbor . . . 1941. Rather than be drafted, I joined the Enlisted Reserve Corps. Then, I transferred out to the University of Colorado which was closer to home. I didn’t like ROTC at K-State anyway! So I went to Boulder and I got in two quarters before I was called up in the Enlisted Reserves for Army pilot training in 1942. I graduated from pilot training in March of 1944 in the U.S. Army Air Corps. I spent a couple of years on Attu in Alaska flying P-38’s and was discharged in 1945. I went back to Atwood and returned to the University of Colorado and graduated from there in 1949.

Then I went to KU Medical School. Colorado University was in the WICHE program. I’m not sure of those initials, but it was a consortium of Utah, Colorado, Montana, North and South Dakota, Montana, Idaho, Arizona, and New Mexico. Only Utah and Colorado had medical schools, so they admitted a quota from the other states. If you came from a state with a medical school, they did not expect you to apply in Colorado. That’s one reason why I went to KU Medical School.

I graduated in the class of 1955. We had about 105 students. It was a pretty routine class except we had two groups of students. One group of students had gone to the military and the other hadn’t. There was a six or seven-year differential in age between those 60 or so non-veterans and the 40 or so veterans, so there were two societies within the class. There were only seven or eight females. We were the last class that had the first year on the Lawrence campus. We took gross anatomy, neuroanatomy and physiology in Lawrence. We took the last three years at the medical center in Kansas City.

Franklin Murphy, the Dean (vice chancellor, provost) of the medical school, was a very popular state medical leader. He was acutely aware of the doctor distribution problems in Kansas, and the impending shortage of medical services. He had made a promise to the communities of Kansas that if they would build a hospital, the medical school would put a doctor in it. Because of the availability of federal funds, there were a lot of 20-to-30 bed hospitals built in the state. It was a challenge.
for the University to try and supply physicians for them. Even at this early date, medical manpower was an issue in Kansas.

I stayed on at KU after graduation and took a residency in internal medicine and endocrinology, and then went to the Kansas City VA as a staff physician in internal medicine. I was soon Chief of the Medical Service (240 beds) and soon tired of being so overextended.

So, the upshot was, in 1964, that I went back to KU in the Department of Medicine and Section of Endocrinology with Dr. Bob Bolinger. It was a good deal for me because he was one of the brightest people around KU and one of the hardest workers, too. We had several interesting activities going, and were shortly joined by Dr. Barbara Lukert, then Joe Meek, M.D., and within two-three years later, Joe Kyner, M.D. So we went from a section with one person to five in fairly short order and we were all very busy.

During that time, the curriculum for medical education at KU was an integrated program of teaching. The basic science professors assisted the clinical physicians on the hospital wards. The Department of Pathology, for example, with Dr. Robert Stoll and some of the brightest faculty anywhere, participated in clinical teaching on the wards. So did pharmacology and biochemistry, and so on. The junior clerkships in pediatrics, medicine and surgery were the hub of the exciting and the crucial part of medical school undergraduate education. We had three general medical wards with about 20 beds each. Dr. Mahlon Delp and Dr. Max Allen each had a service and a rotating group (of mainly me!) ran the third one. All medical students rotated on those general medical wards during their junior year, six weeks at KU and six weeks at the VA.

The Medicine Department was not strongly subspecialty oriented in any discipline. That’s not to say we didn’t have subspecialists. They were just not a predominant part of the third year teaching program. For example, Medicine had a very good section of Cardiology. We had an Oncology Service and a Hematology Service with six or eight beds. The Chest Service had eight or ten beds and also a TB Ward. So all the subspecialties had a few beds. But the hub of patient traffic was the General Medicine services. In their senior year, the students were assigned to the subspecialty services.

The clinical faculty at KU were very much aware of the fact that things were changing out in the state. We had several ways of maintaining a liaison with doctors in Kansas. One of the major ways was through the Circuit Course, a four-day trip, twice a year in a Plymouth with rusted-out floorboards. Teams of four faculty went to four different towns in the western end and four different towns in the eastern end of the state. These doctors put on each course with lectures or demonstrations.

The turn-out was excellent. We’d meet 20-30 “GPs” and others who would come and participate. They paid attention and asked good questions. It was a social and educational teaching event. It identified the University as a personal part of the practicing physician’s medical community. The local physicians got to know some doctors of the University and realized they were there to help. It was good public relations.

It was also a way of getting patients into KU. I went on the Circuit Course three or four times and when I’d get back to KU, I’d find out two or three patients had been referred to me from some doctor somewhere in the State of Kansas. That was good public relations! It kept the doctors in Kansas thinking that KU was a concerned part of the environment. It made us aware of the medical manpower shortage of the state because of all of the doctors that we dealt with out in the state.

Logistically, however, the Circuit Course was a problem and it petered out and was abandoned years ago. Another liaison was through CME at KU, and a third was physician-to-physician contact through patient referrals.

The local doctors (GP’s had four years of medical school and one year’s internship) had very substantial practices, especially after Medicare came along, but they were not terribly well-trained and not uniformly maintained in regards to continuing medical education. As the GP’s retired, they weren’t often replaced.
There were no physicians being trained that were going out to replace the small town doctor.

There was talk about some kind of new doctor trained in internal medicine and pediatrics. We had one member of my class, Dr. David Shivel, who spent two years divided among orthopedics, obstetrics, medicine, and pediatrics. He went to Great Bend and is still practicing, but he was the only one in that type of program.

We were going along internally at KU with growing turmoil because, through the years, the Department of Medicine had traditionally trained general internists. But increasing pressure was developing to train more subspecialists. The subspecialists wanted beds in the hospital under their control. All the new medical subspecialists wanted beds and they wanted them at the expense, of course, of the general internists. So there was unrest.

There were those people known to be identified and satisfied with the way things were, and there were those who were advocating a change to subspecialization and downsizing general medicine services. These movements were taking place in the late 1960’s along with outside advocacy for a new breed of cat - the “family physician.”

Then out of the blue came a program called the “Regional Medical Program.” It was part of President Lyndon Johnson’s Great Society, along with the Peace Corps, Comprehensive Health Planning (CHP), Regional Medical Programs, and all kinds of programs here at home.

The Regional Medical Program was created through Dr. Mike DeBakey in Houston, Texas. DeBakey was one of the world’s premiere cardiac surgeons. Apparently Johnson asked DeBakey what he thought they ought to do to improve medical care. DeBakey said they ought to regionalize it. What he meant was that all the patients were to be shipped into regional center hospitals and taken care of by a handful of specialists.

They sent the idea to Congress and got a lot of money appropriated, but the concepts to accomplish anything were vague at best, and Washington relied on the boondocks for “innovation.”

Federal money, however, was available. Bureaucrats from Washington solicited medical schools to submit grant applications with “projects.” KU and The University of Missouri were two of the preferred first groups in the program. They were some people at KU that knew as early as late 1966 that this was coming down the pike and that there would be quite a bit of money available.

I was approached to develop a project in Great Bend. It included many educational activities and promise of residency training, so, in addition to what I was doing at KU, I started going to Great Bend two-to-three days every week or two to set up some educational activities for the area.

I didn’t know a lot about Great Bend, but Chuck Lewis, who was head of the Department of Community Medicine at KU, had been out there for some reason and got the idea that it would be a good regional center.

Great Bend had just built a new circular hospital, sort of an engineer’s model, and moved into it from an old hospital. They had gone from bare essentials to having new equipment and all kinds of stuff that only a handful of people knew how to use, so we set up a library, nursing education, physician conferences and other educational efforts.

Someone had the thought that somewhere down the line we would have residents rotate there. I hired a local librarian, a nurse, a couple of secretaries and a neurologist. Dr. Lauren Welch was the neurologist, and he helped out a couple of years before moving to Wichita. However, he recruited a neurologist, Dr. Jim Wiggs, who liked Great Bend and practiced neurology there until he retired.

At one time we thought we might recruit a cardiologist and an oncologist for the potential rotation of the residents. We never did get a resident or student rotation, partly because Chuck Lewis left and went to UCLA, and partly because I didn’t think they had enough medical manpower to support a resident training program. Also, KU wanted me to be the director of the RPM, so I took over the whole program at KU, and had to give up Great Bend. Dr. Jim Wiggs continued it locally. It
continued to have some educational components.

I learned from that experience. I didn’t think Great Bend had the medical personnel to handle a full-fledged continuous residency program. They had about 24 physicians. Eight of them were useless in an educational venture. Four or five were hostile.

We were left with a fairly small number of physicians who would have a lot of work to do and who would have to control the adverse things that would happen within the hospital with a residency program. They would have to face some indifferent doctors and an insecure administration.

As I look back on the RMP days in the state of Kansas, there were only a small group of state hospitals who were equipped to handle a family practice residency program from the manpower point of view: Hutchinson, Garden City, Salina, Topeka and Lawrence.

In the 1970’s, RMP’s national management had a bad time of it. When Nixon got elected, they promptly cut Great Society programs out of the budget. The amount of money budgeted for the RMP in 1970 was zero.

Some RMP coordinators actually sued the government. They had good lawyers and kept some of the money coming. Overall, it brought in quite a bit of money for KU, $10-12 million, which was good.

We had a core group of staff people because we had so many things going on. We had RMP regional offices that covered the whole state. We had an agreement with the Comprehensive Health Planning group, which was never written down, but they had little money for staff and we did, so we designated some staff people to help accomplish their tasks.

It was very beneficial in terms of the state because they could show that Comprehensive Health Planning in Kansas was alive and well. Our purpose was to cover the state as well as generate some basic services and projects.

But by 1970, we weren’t pushing projects much because we had no idea if the RMP was going to have money or not. We did have this core group of staff who were experts in computers, statistics, evaluation, and sociology. We were learning a lot about the “Health Care Delivery System.”

These people weren’t a permanent part of the University. They were RMP staff. We decided to do a medical manpower study because it was apparent that things were not well regarding production of primary care physicians, but no one had quantified the problem, so our staff, under Dr. Dale Taliaferro, performed a manpower study. It confirmed the need for expansion of the capacity to train family practice physicians. During these RMP years, (1968-1973) I was learning a lot about the health care delivery problems in the state, which were rapidly beginning to focus on physician manpower.

The best person in the state in the family practice movement was Gayle Stephens far and away. He was a good leader and respected nationally. There were few people to lead the family practice movement who had any type of training in academics whatsoever. Ned Burket, who was as nice a guy as he could be and a great public speaker, was telling people all over the United States that we needed to do something about future medical manpower.

A fellow in Missouri, Dr. Jack Colwill, was one of the few academic family practice people in the country. They were beginning pretty strongly to develop this concept of “Family Practice,” though nobody knew for sure what to call it, let alone what it was. The bottom line was that something had to be developed to replace the GP’s.

But how are you going to do it and where are you going to do it? KU realized it had to do something about family practice because the issue wasn’t going to go away. So, they cobbled together a program and, indeed, some family practice doctors were produced and some students entered the program. And, of course, this increased the interest in medical school for family practice.

But there weren’t near enough academic GPs or family docs in the world. That created some problems. You are asking somebody at KU, like the Department of Medicine chairman, who had come up through the academic ranks doing research, teaching, writing a book,
lecturing, attending numerous committee meetings, who got to be a professor to vote on a promotion committee to appoint to professorship somebody whose only demonstrated skill was in patient care? No, they wouldn’t do it!

And it wasn’t just the clinicians. The Chair of the Department of Nursing wasn’t going to do it either! Nor pharmacology or pathology. So who are you going to acquire as chairman of Family Practice to lead the movement? You don’t have anybody. But you can try to make one.

And that is, of course, where Dr. Jack Walker comes in. He had already been identified in 1966 or 1967 as an acceptable person already on board to be chairman of the Department of Family Practice.

The main thing needed in a chairman of a Department of Family Practice was that he had to be skilled in taking care of people, dealing with people, and be an inspirational leader. If he had no other skills whatsoever, he would have been a good chairman because the students were clinically oriented and didn’t want to do research, didn’t care what was going on in the laboratory. Those students wanted to rotate around in a series of disciplines and learn enough to go out and do what is called family practice. For that they were in desperate need of a preceptor, a teacher, a leader, who was skilled and who could hold his own with both students and aristocrats in the school.

Well, KU didn’t have that. Jack Walker was a nice fellow and an able administrator, but it was obvious that the hub of state family practice activity was not going to be KU, no matter what. KU wasn’t going to be a real attraction in terms of students interested in family medicine.

In the mean time, things were really buzzing down in Wichita. We (KU internists) had been going to Wichita for years trying to help Wichita get its base line up in internal medicine. They always had a little trouble between hospitals about who was going to be the leader in internal medicine. What they did was place the administration of the program in Dr. Givens’ shop at the VA. The programs were improving. Incidentally, through these activities, I got to know some people who were working with family practice programs in Wichita.

The Wesley program had an old building across the street from the Wesley hospital. Vic Vorhees and Stan Mosier were known to me. I had known them as students.

St. Joseph didn’t want to have anything to do with KU. They were set up so the residents were essentially in charge of the whole program. I had nothing to do with St. Joseph until later on when we agreed to set up the first year of the Smoky Hill program there.

Bob Riederer was at St. Joseph by then. I got to know Riederer well because Smoky Hill’s first year was at St. Joseph. Even then, the residents pretty much ran that program.

On at least one occasion, Smoky Hill had a candidate selected to match but was vetoed by St. Joseph. We honored their veto. The resident applicants to Smoky Hill had to be forewarned that they could be rejected by the St. Joseph program. Other than that, our Smoky Hill residents had it pretty good; got along pretty well.

Nothing much was happening on the generalist front at KU. The RMP was winding down. Then KU got a new chairman of the Department of Medicine, Dr. Clifford Gurney, who was actually a generalist and was in the line of succession of general internists who had control of the program. But he got constant static from the specialists and, after a couple of years, he decided that life was too short and he returned to Chicago.

Then a big change occurred when they brought in a subspecialist to be chairman of the Department of Internal Medicine. They brought in Dr. Norton Greenberger, a gastroenterologist, and KU was transformed to a subspecialty training center for internal medicine: cardiology, gastroenterology, hematology, pulmonary, etc.

Meanwhile, the RMP Kansas Manpower study was completed and it was right on line with what we all suspected in terms of general medical manpower in the state of Kansas. At the rate the rural practitioners were retiring, there were enormous gaps in the state where
no one was going to be able to get medical care. Some people who read that study got a little upset because it said exactly what was true. KU wasn’t effectively doing anything about it. In fact, they hadn’t even established the branch down in Wichita.

The Legislature was upset with the University. They decided that the vice chancellor had too much power and that the medical school was too independent of the Legislature, and that’s about when Archie Dykes came on as chancellor.

A lot of political pressure was developing to establish a branch in Wichita. The professional people in Wichita wanted a branch and they wanted state grant money to develop it. There was increasing political pressure to get doctors into rural areas.

Then I got into a kind of strange experience. As part of the Regional Medical Program, I had what was called a Regional Advisory Council. It was composed of 16 people from all over the State. They were fairly influential people and periodically approved all KRMP activities. The Council had a Northwest Kansas vacancy, so I went out to Phillipsburg one day and I talked to Huck Boyd, who was the publisher of the Phillipsburg paper and ran a printing business there.

Huck was very influential. He was especially interested in any activity in Northwest Kansas. He was said to be responsible for Bob Dole getting reelected over Dr. Bill Roy.

I asked Huck if he would serve on the Regional Advisory Council. He was real pleasant about it and agreed. Some months later, one Saturday I got a notice that there was going to be a Sunday morning breakfast in Topeka. I didn’t know what was going on, but I kind of got the message from whoever gave it to me that it would be nice if I could be there.

Everybody who was anybody in the state of Kansas in the business world was there, plus Archie Dykes and some of the department chairs and administrators from KU. Huck Boyd was sitting right next to Dykes, and Huck got up to give a speech. He told the medical school people that they weren’t doing anything right and he was tired of it and they ought to be doing something to produce doctors for the state of Kansas.

The speech was totally blunt as far as Archie Dykes was concerned. For him, this meeting was just a disaster because KU had just been criticized in a crowd of 40-to-50 very influential people in the state of Kansas.

Well, several things happened right away. An agreement was drawn up to establish a branch in Wichita. That meant there would be an official University of Kansas office administered in Wichita. I don’t think Archie ever got over that meeting. He thought I had arranged it, but in fact Mr. Boyd never ever said a word about it to me, before or after.

To get back to the Wichita branch, it was established. Up until this time, Dr. Cramer Reed was trying to get some things going down in Wichita with family practice, nursing and so on. If you listened to him, you would think Cramer was talking for the University of Kansas, but he didn’t have anything to do with the University of Kansas. He was really a member of the faculty at Wichita State University and had his offices there. That was pretty awkward because there wasn’t anybody at the University of Kansas that was going to give Wichita State any of KU’s money to run anything. So the Wichita branch needed the formal affiliation with KU to claim a legitimate base of operations and receive funds.

Family practice was Wichita’s leader and they were booming. The nurse practitioner program was on going. Dr. Reed did a lot of things for Wichita. People liked listening to anything he had to say. He pointed out the fact that KU had quite a few things that potentially could go on in Wichita, including student education, residency programs and nursing education.

We always tried, as I indicated before, to support the Wichita internal medicine residency, so they could maintain accreditation. With a branch, then all those things could occur with local representation in a local office. There could be money flow to Wichita, and there could be some administrative coordination.

However, that didn’t mean everyone in Wichita was conducive to having the branch.
For example, the family practice residency at St. Joseph didn’t want to have anything to do with KU. They didn’t care whether a branch was established or not. They had been an independent program and they wanted an independent program.

On the other hand, Roy House, who was the administrator at Wesley and who really built the program from a small hospital to the giant it is now, was on my Regional Advisory Council. He was a good friend of mine and strongly supported family practice, and the same was true over at St. Francis. Wichita was, of course, the chief rival of the University.

The Wichita branch had Salina in its orbit, but they did not have Southwestern Kansas. Garden City and the rest of those towns didn’t want to have anything to do with anybody anyway. But they were “assigned” to KU, so there was sort of an arbitrary division in the state according to the two super powers of KU and Wichita.

Dr. Jack Walker even tried to get some residents out to Garden City for a while, but it didn’t amount to much. Things at KU had gone pretty much sour as far as training family doctors. There was no leadership. The faculty wasn’t going to bring anybody in and give them an academic position. Students were disenchanted with what they had. Family practice residents were setting up three years of monthly rotations wherever they could arrange it just like the osteopathic schools did. In the meantime, family practice programs at the other Kansas City hospitals were only marginal.

My observation from Kansas and other programs I visited, and from RMP contacts, was that the best family practice program was probably carried out in a hospital in which there were no competing residents or in which the competing residents were actually part of the “teaching faculty.” Otherwise, family practice could best be taught in a hospital where they were the sole residency. One of the things I learned from my experiences in Great Bend was that you certainly have to have a fair amount of medical talent available to sustain a program.

People in Wichita and at KU were looking at all kinds of different family practice programs. We went up to Mason City, Iowa, and back to the University of North Carolina. The Mason City, Iowa, program was one of the few one-and-two programs. This was an advantage to hospitals that didn’t have all that much medical teaching talent available. The first year of residency could be taught in an established program and the final phase in a community hospital.

That was pretty attractive to my way of thinking because in obstetrics, surgery and the emergency room, you really needed to have residents with a little bit of experience under their belts before they hit the community hospital. You didn’t know how much responsibility they were going to be given.

There is an issue of giving residents too much initial responsibility and getting into trouble; the wolves are right there to stomp on them. On the other hand, if they don’t have any experience, they’re going to disappoint their faculty because they won’t know what to do in any given situation. So the one-and-two concept seemed to be pretty good.

By 1975, Dr. Dykes was running the medical school. Only problem was, he didn’t know how to run a medical school and didn’t know how to run a hospital.

There is always a little controversy in a medical school. There are always things going on. It’s not a society in which one comes to work and has uniformly a pleasant day. There are always contentious problems.

Dr. Dykes was in charge of it and he appointed Dr. Dave Waxman to be his vice chancellor. The chancellor came down from Lawrence two or three days a week. Otherwise, Dr. Waxman was the chief administrative officer at KU.

Dave’s job was not to make decisions. He relayed whatever the problem was to Archie and Archie would tell him what to do. Then Dave would try to carry it out. Of course, that was very rough going because the medical staff and everybody else was on Dave’s tail all the time for something.

Anyway, the RMP was finished and was going out of business nationally. We had developed, with Dr. Reed, Dr. Jim Donnell
and some others in Wichita, a proposal for a one-and-two residency program in a community hospital in Salina. Dean Kortge had been up to Mason City and wrote the proposal and was assured that it would get state funding. The reason they chose Salina was that it was in Wichita’s orbit.

I got word from a guy outside of Kansas that he had heard that Dr. Dykes had told Dr. Greenberger that when the RMP went under, he didn’t want me to have anything to do with the Department of Medicine or KU. We were going in opposite directions because, among other things, the Department of Medicine was headed for subspecialization. The institution wasn’t doing what I was happy with, and I was not going back to the VA hospital.

I decided to leave. I could have stayed in Kansas City and gone into practice or I could have come out here with good friends or I could have done a lot of things.

Well, I wanted to see how this family practice thing would go in Salina. There was a void in that nobody at KU wanted anything to do with the program and there wasn’t even a Department of Family Practice down in Wichita. So I didn’t even have to ask anybody for the job! All I had to do was decide to move and come out and go to work!

So I advised my wife and hoped she would come along with me. We moved and I got started developing educational programs, writing grants, organizing, etc.

Later, the Kansas Academy of Family Physicians in 1991 published a paper which said essentially what we had said before. That gave considerable additional emphasis to the statewide medical community that something should be done that was going to be useful to primary care medicine. In time, there was a little bit of momentum through the Wichita programs to train more rural physicians.

But Wichita had minimal impact out in the state. All the residents they trained stayed in Wichita. They didn’t have any outreach program.

That was another stimulus for me to try to put a program in place which was going to do something for rural Kansas. I was as knowledgeable about all the factors that had to do with the way people practiced in rural areas as anybody. The key was to put a residency in a community like Salina and encourage residents who are pretty sure they want to do a rural practice. If you take even the most assured residents down to KU and let them near someone who is used to living in the suburbs, they are not going to go back to a rural practice. If they do, they won’t stay long.

So, I decided to come out here. Fortunately, my wife came along!

I didn’t come to a vacuum. I knew some people pretty well. Dr. Bob Weber and I worked together down in KU. I knew Dr. Wendell Nickell and Dr. Ramon Schmidt. They and others indicated they would like to try something like this. Actually, no opposition materialized.

We wrote a federal grant and got some money in addition to what the state was providing. In three years we had students recruited and were underway. Then we began to learn where the problems were. The volunteer faculty, of course, had never been through a family practice residency program. They went through every other kind of residency program but not family practice.

They are not very similar in many respects. The urologists, who spent all their time during residency training in the hospital, didn’t understand a family practice residency. They were terrfiically procedure oriented and knowledgeable about their own specialty and not too much else. They expected a family practice resident to like doing things the way they used to do it when they were residents.

It doesn’t work that way, as you know. In the first place, a family practice resident doesn’t have that much time. In the second place, they aren’t taking a urology residency. They’re taking a family practice residency. They’ve got other responsibilities. They don’t care much about what the latest articles are in the Journal of Urology. It isn’t going to affect their practices one bit.

It takes a while for both resident and faculty to realize that the resident is there to learn the nuts and bolts about what to do when you
have a patient with a urological problem, whether its something he can handle or if its something he has to refer. That’s all the resident is interested in. They’re not much interested in research, either.

For example, we had a volunteer faculty member who thought our residents ought to know as much about his specialty by the time they got through a month or two of his service as he does. That was impossible, because the volunteer faculty member admitted he knew more about medicine than anybody else in the world!

He gave a resident an obscure paper to read. The resident said “I’m not going to read that.” The volunteer faculty member got angry, grabbed his coat and left. He wouldn’t have anything to do with the residency at all after that. All had to do with the perceptions of the teacher and the perceptions of the student. They were different. That was difficult.

In addition, the GP was not a very good teacher of scientific medicine. They had never done any teaching. They spent one year (internship) learning the most essential part of how to do certain things. It wasn’t near enough time to get prepared to practice in today’s world. They had an inferiority complex about teaching and were intimidated.

They weren’t comfortable in the teacher/student environment. But we can turn it around and say they know people.

Well, they don’t know people. They know how to survive in the world of medicine as a doctor, but that doesn’t mean they know a lot about people. They know how to manage things to their advantage to survive. The actual psychology of why people do things, the family, the dynamics, they know that in kind of a rough way. But they don’t know anything like what the behavioral scientists contribute to family medicine.

I’ve got to hand it to the family practice leadership: they held onto a concept and built it into something which is important and unique. If they had sat on the edge vying for surgeries, they wouldn’t have thrived.

Early on, the family practice doctors in Salina didn’t teach much. They didn’t seem to be interested in what was going on until the residents got ready to finish their training. Then they started recruiting.

One of the things the program accomplished was satisfying the physician shortage in Salina, which was enviable. The same thing happened in Wichita. The residencies satisfied the local physician shortage.

The family doctors weren’t opposed to the program. They were always supportive. I think we are at the point now that they’re confident they would survive a confrontation of some sort. I’m pretty sure they are at the point of pitching in and helping with a problem if the program had one. If we ask some of the family docs to really get in there and help us, they’ll do it.

They have been pretty passive in the past, but I think the residency will become a higher priority. The surgical specialists, and I don’t know why, seem to enjoy teaching and they sometimes get some convenient labor from the residents. That’s a pretty good trade off.

As far as the hospital, I don’t think they initially knew what the residency was all about. But they pitched in and helped every way they could. They’ve been a very positive contributor.

I was pretty paranoid about who was going to interfere with this program when I came out here. There wasn’t any Department of Family Medicine at the Wichita branch. I didn’t have any trouble with the branch because they didn’t know what was going on anyway. KU didn’t have anything to offer.

The community newspaper was a total loss. They were worse than nothing for the first ten years and I’m not sure I trust them to be valuable now, although we seem to have one or two guys over there that we can relate to. Early on, they reported things incorrectly. They always treated this as an undergraduate training program, somewhat below medical students. The newspaper never seemed to acknowledge the fact that these were graduate doctors who were in post graduate training. They never seemed to understand that we were making a pretty positive contribution to the community.
**Kellerman:** How did the first year get set up at St. Joseph as opposed to Wesley?

**Brown:** You know, I don't know. I don’t know who suggested which hospital. I might have done it because I knew Jim Donnell over at St. Joseph and I just can't imagine who else could have done it. I felt back then that the residency program at St. Joseph was more independent than the other two. The residents could do more.

**Kellerman:** What about your relationship with the legislature?

**Brown:** Of course, Mike Hayden grew up in my hometown. I played football with his dad. His mother was two classes ahead of me in high school.

The Legislature never caused me any trouble. They didn’t then and they haven’t since. I had a good relationship with them. I knew Representative Clyde Hill from Yates Center. I spent a lot of time talking to him about health care problems in Kansas and what we thought could be solved. I think he educated a lot of his friends through me.

I never had trouble relating to people like that. I’ve always been very good at it. I’ve never had trouble with any of the people out here.

**Kellerman:** How about your relationship with the Department of Family and Community Medicine and the medical school in Wichita?

**Brown:** After Cramer dropped out of it, they hired Dr. Donatelle. I don’t know what they told Donatelle before they hired him. He had spent a lot of time up in North Dakota writing voluminously about family practice. He made pretty good money as a family doctor in Minnesota.

When he came to Kansas, I don’t think anybody really sat down and told him what he was supposed to do. He brought two young guys with him, both family doctors, and they made the rounds. St. Joseph kicked them out, which was predictable. He apparently took the young guys over there and said “I’m going to put them here and we’ll watch you boys and tell you what to do.”

Worst thing he could have done. You could have just waited for that kind of maneuver from KU. No one wanted to have anything to do with Dr. Donatelle except Wesley, so he dug in there. I don’t know what they told him.

He was about as welcome in Salina as he was at St. Joseph. I could have used a person to advise me, especially about what to do with the program directors.

The program directors here were lonesome boys. They had little experience. Tim Scanlan had a little bit, but not much. He was assistant director down at St. Francis. John Listerman had never been in a family practice program except for that one in North Kansas City. Lou Forester was very helpful and a very bright guy, but Lou didn’t know how to run a family practice program and he was ill often.

The program director position was key, but I don’t recall much help from anybody with regards to improving that situation. Donatelle came up here and demoralized the program directors. He talked Listerman into retiring. John Listerman was a heck of a nice guy. You couldn’t meet a nicer guy. He’s got his heart in the right place in terms of his work. He was a lieutenant in Viet Nam.

If you’re a program director, the residents and faculty have to be willing to do what you say even if they don’t like it. They have to have confidence that they’re going to get out of the program with something that is valuable.

You see, what I needed back in the early days was for the chairman down in Wichita to be Don Goering. I needed a guy that could come up here and talk to the program director and say, “What are you teaching and how are you teaching it, and how are you getting along with your other doctors?” Pass on to them some qualities of leadership which gave them confidence about what they are doing.

The program directors needed somebody to come up and pat them on the back and help. For example, how do you set up the resident’s schedule? The schedule in a family practice residency is so complicated. I don’t under-
stand it. But it has evolved into something that works very satisfactory. We’re into acute care, we’re into obstetrics without any serious problems, we’re into everything.

The schedule is a son-of-a-gun, but the residents understand it, and I guess it’s fair. They even get some time off to go moonlighting.

That’s what we needed back in those days. I tried to give the program directors total freedom. All I strove to do was generate patients for the residency and that was it. The program director was supposed to be running everything.

These programs are “inversions” of academic programs or what is usually promoted to get ahead. I mean, you go to medical school and you take a residency. You publish papers. You learn how to lecture. You learn to teach. You write a book. You get a job as an assistant professor and then they will promote you every two or three years until you get to be a professor. If you don’t, you stagnate or leave.

Well, that’s not the way it is in family practice. What family practice faculty know are the dynamics of patient care. They must be role models for the residents to emulate. It didn’t make much difference if you had done any research or not. It didn’t make any difference if you could teach or not as long as you could talk, because the residents can see what you are doing. Of course, most people who are good at patient care are pretty good talkers. We needed a leader with clinical experience who could relate to the residents.

**Kellerman:** Looking back, what are you most proud of about the program?

**Brown:** Oh, I think doing what we set out to do. It’s a program in a community hospital with a single discipline residency training program. Our recruiting and training systems are designed to maximize the probability that a resident’s going to practice in a rural area. That is all there is to it.

These programs don’t come cheap. I don’t know how to even discuss finances now compared to what they were not very long ago. It just costs so much money to do things, and the technology is something we never had before. I mean, how do you account for the resident’s access to a computer? The computer costs $3,000 and it is worth a million dollars if you turn it on.

**Kellerman:** Any regrets?

**Brown:** I didn’t like breaking my back in 1990 in a boating accident because it curtailed my exposure to patients. I always liked seeing patients and I had a lot of good patients. I had to give that up when I broke my back. About the time my back was getting better, I had a triple bypass. But I don’t have any regrets we haven’t talked about.

**Kellerman:** What about the needs of the state now?

**Brown:** For the foreseeable future, I think we are still producing a highly useful product. I don’t know what’s going to happen in Western Kansas under managed care. I can’t see that the need for family doctors is going to go away. It’s not like in Massachusetts where they have no family docs, only specialists.

I think Kansas is going to need all the family doctors we can train for the foreseeable future. We’ve trained a whole generation. But time goes by pretty fast. We’re fifteen years out, and some of those that we’ve trained are 45 years old. So they are also going to have to be replaced.

The biggest problem to maintaining a teaching program is the cost. I think regional hospitals like the Salina Regional Health Center wouldn’t be nearly as good without a teaching program. The cost is worth it.

I don’t think you are going to convince third party payers that having a program with residents questioning the attendings practice decisions is really “quality improvement.” Physicians who train residents must be open to questions about their patient care. The level of performance is always going to be higher with a housestaff than it is without it.

How can we convince them to fund medical education? I don’t know what’s going to
happen in terms of who is going to pay the bill.

Number-wise, family doctors are going to outnumber everybody else. They’re not going to make more money than some of the others, but I think they will do reasonably well.

I expected more argument and posturing with insurance companies over reimbursement than we have seen but we may not be anywhere near the crust of what’s going to happen. I think that payment is going to be a problem with some specialty groups. Also, lawyers are getting far too close to the bedside. They are intimidating to open discussion.

I have some problems with “residencies” that have just one resident. There needs to be a critical mass of learners. I think that works better in terms of learning.

In the first place, 12 residents learn far more from each other than they do from us. The third year residents, when they leave here, are knowledgeable about damn near everything and they learn a lot of that from each other.

Now that doesn’t mean you don’t need a faculty. Where you have one teacher and one student, there’s not a lot of information that can be exchanged. If the preceptor has bad habits, the resident will pick them up and carry them forward the rest of his life.

I’m not adverse at all to one-on-one experiences, but I think they ought to be fairly short term, and I suspect there ought to be some evaluation of the student when he comes back so you have some way to determine what he has learned. We shouldn’t rely on “it was a great experience” or “we did an emergency operation, and the patient lived.”

I think family practice is on the right track. What has happened in medicine is we are losing the general internist. Now we have a group of fairly narrow procedure-oriented specialists who really don’t care about the whole picture of any given patient. The fact is, they often don’t want to hear about all the patient’s problems.

Some of the proceduralists can make all the money they need by 10:00 in the morning. Then they don’t even want to go to the office to work, but they have to go round up more people to put a tube in.

Cardiology is a different kind of discipline from the rest of the medical subspecialities. They don’t create competitors for family practice. I don’t think the combination of general medicine and pediatrics is going to do it either. There may be a lot of those people produced, but I don’t think they are going to be very happy people.

Kellerman: Why is that?

Brown: They will be in cities, and med-peds is kind of a compromise. They’ll be incomplete; neither pediatrician nor internist.

What burns a pediatrician out is the first 2-1/2 hours of the day. He gets up, goes to the hospital and he’s got a group of really sick kids to see. He gets over to the office which is already full of a bunch of kids that have to have some type of attention. By 10:30 or 11:00 o’clock, he has already done two days work. Then he has a whole afternoon to see patients. Well, what are you going to do if you’re an internist and you have people 70 years old mixed in with all that? I mean, we’re not talking just about adolescents here. The pediatrician is going to see kids and babies.

I don’t think they can work like that. They will burn out and go back and take on some other specialty training or they’ll narrow it down to either pediatrics or medicine.

As far as the future of the general internist, I don’t know if it has one. I don’t know what the answer is to that. According to the data that I read, half of the people who are being graduated out of internal medicine residency programs are general internists.

I seriously doubt that data. If I were running an HMO that was paying the bills for medical care, I would be willing to pay a general internist as much money as I pay almost anybody else that worked for me if they have good judgment about patient care. When they see patients, they would almost always do so as a consultant either in the hospital or outpatient, or even in an administrative office.

I think they have a different perspective as far as diseases are concerned than almost any-
body. I think they have to have a hands-on approach in order to do that. You must get in there and put your hands on patients. They could be a special consultant for special cases at the community level.

Look at our general internists in Salina. We throw them a patient, a problem, and I don’t care how complicated it is or how many disciplines it overlaps, they will study it a little more and give us a pretty solid opinion about the problem. I think they usually go into a little more depth in the disease process than the family doctor.

As our doctors get older, they may get more depth but I think there is a real risk that they will get shallow. If you don’t see people with hyperthyroidism who are sick, and just see a textbook, you can hardly understand the disease and what it can do to people. General internists are supposed to have the outlook of what’s best for all. What should we do for this patient? Say we have a pancreas cancer; should we do a pancreatectomy? Well, no, it doesn’t do any good.

Slap the surgeon on the hand. Slap whoever’s hands need to be slapped. It takes somebody who has been around and is unbiased to do that. So if there is a future for the general internist, I think it is in that kind of environment.

In practice, they are going to have a tough time because cardiology is going to take away a big chunk of patients. Gastroenterologists own the scopes, so it is going to be very difficult for general internists to maintain a quorum.

Pediatricians are similar to family physicians. I don’t know why it is, but if you look at the Blue Cross/Blue Shield administrators in Topeka, most of them are pediatricians.

They are good at it. I don’t know why that is, but it certainly is true in Kansas.

It’s hard to know who is going to make the decisions in regards to all the patients who have problems that are not clear cut, and there are a lot of people like that. You can see five people with the same diagnosis, and those five people are as different as duck eggs and chicken eggs. Just because they have the same diagnosis doesn’t mean they’re all the same.

There is going to be a lot of overlap, I think, between the good family doctors and the general internist, but I think the general internist, from a clinical point of view, is going to be somebody who has a good deal more depth in disease processes than the family doctor who just doesn’t have enough time. I don’t care what kind of computer you get. There is too much knowledge to assimilate and maintain and renew for the family doctor.

**Kellerman:** What about the idea of a primary care discipline?

**Brown:** I think if we get down to a payment system that will pay people to take care of well people, they really have primary care without a specific discipline. I see the ordinary family doctor not doing very many procedures unless they are in a rural area. In an urban area, let somebody else do it.

On the other hand, if you just do nothing but pass out “you are okay,” “there is nothing wrong with you,” or “there is something wrong with you, go see a consultant,” that’s not good either. You’ve got to have enough depth that you know you are important in terms of what’s going on.

That’s why nurses have always thought they ought to be doctors. They watch a doctor who does routine stuff that they can do, but they don’t have the total picture.

Turn it around and look at the paramedics running around, and if there is somebody laying on the ground that’s bruised and tossing around, they think they are God’s answer. Everybody gets ventilated and gets the whole nine yards of what they can do.

Well, that’s not right. Somebody has to say, “Well, did you ask anybody in the family whether they want this person resuscitated?” “Yeah, we did.” “Well, what did they say?” “They don’t want it.” “Then what are you doing?” It gets complicated real fast. I think there are discussions that doctors have to take part in and decisions doctors have to make.

**Kellerman:** Anything else you want to include
in your comments?

Brown: Family practice has an environment that's different from general internal medicine, different from pediatrics, different from every other discipline. It is different because we teach it differently to residents. It doesn't just happen. We teach it that way.

I'm very happy with how this program has turned out. We've trained more than 50 residents. We've had good residents. This program did what we set out to do. It has exceeded all expectations. I am proud of that. I have had a lot of help, and many, many people share in the success of this program.
"... our lives were filled with many humorous and sometimes very annoying events."
by JAN WILDMAN MILLER
BUSINESS MANAGER
SMOKY HILL FAMILY PRACTICE RESIDENCY
FEBRUARY 13, 1998

When I started employment with the Salina Health Education Foundation in May, 1980, all the startup work for the residency program had been completed, approved and the first class of residents was actually nearly finished with their first year at St. Joseph's in Wichita.

Smoky Hill Family Practice Residency Program began as a one-and-two type program so during the months of May, June and July of 1980, we were consumed with trying to get contractors to finish renovation of our ambulatory training site, i.e., fondly known as "the dorm" or "the longest trailer house in the world," as well as acquiring medical supplies, exam tables, office furniture, draperies, and hiring a staff of nurses and business office employees. Our target date for opening the clinic was July 1, 1980. We did not make it! Instead we set up "shop" in the emergency department at Asbury Hospital and started our first four second-year residents seeing patients there. It was actually August before we were able to open the doors on Claflin Street with Dr. Robert Brown as acting director, four residents and six employees.

In the early years of the program, because we were housed on the campus of a university, our lives were filled with many humorous and sometimes very annoying incidents. We had ceilings falling down because the students who lived on the second and third floors above us frequently overflowed their plumbing; community car washes in the parking lot during business hours; sunbathing coeds outside our exam room windows (this definitely presented a challenge in getting male residents to see patients!!); football playing; drug dealers selling their wares in the parking lot; lots of very loud music from upstairs and outside; students who set off the building's fire alarms as pranks and we even shared our lobby with the college students in the evenings (before the dorms were "officially" coed).

We also had bats in our belfry (so to speak). There were times when bats would get in the building at night when the janitors were emptying trash. One morning, our receptionist was in the employee break room and saw something fly by the door out of the corner of her eye. When she looked out into the hall, she saw a bat hanging on the exit door and promptly screamed and slammed the break room door and refused to come out until the bat had been captured. What ensued might have been called a Chinese fire drill, but the bat was eventually captured using a metal trash can and a piece of cardboard.

Dr. Brown functioned as the director and only faculty member with the exception of a few "visiting firemen" for the first two years of the program. During these first two years, one of the male residents suffered a heart attack on the eve of his wedding day while at the home of another male resident. He had virtually total amnesia for approximately six months following the heart attack and was not able to complete his third year with his class. He did start back with the program later but then suffered a fatal heart attack.
In 1982, we graduated our first class of three residents.
We hired our first family physician pro-
gram director in 1982, Dr. Timothy Scanlan.
Dr. Scanlan functioned as program director
until 1984, when he returned to Wichita. The
next program director hired was Dr. John
Listerman, who stayed with the program for
approximately 2 years. Following Dr.
Listerman, Dr. Daniel Dees, who had been
functioning as a faculty member, was named
acting director. In 1988, Dr. Rick Kellerman
was hired as program director and remained
with the program for the next 8 1/2 years. Dr.
Kellerman provided the first measure of stabili-
ty the residency program had experienced.
This, our tale of growing pains . . .
...convinced the rural model would work in Kansas."
by RICHARD R. BRUMMETT, M.D.
FORMER DIRECTOR, AMERICAN ACADEMY OF FAMILY PHYSICIANS
BOARD OF DIRECTORS, 1984-1987
OCTOBER, 1997

I do not exactly remember the years and dates; however, I do recall the beginning of the family practice residency at Wesley Medical Center in the early 70's. As I had interned there and as I was deeply involved in the family practice movement at that time, I welcomed the opportunity to become a "visiting fireman" at the residency. That entailed my flying my airplane from Neodesha, where I was practicing, on a monthly basis to be available in the model family practice unit. As best I can remember, I just sort of hung out there and waited for the residents to ask questions or to invite me to consult on their patients when they wished. I do remember that each afternoon between 4-5 p.m., we had a conference to sum up and discuss the more interesting cases of the day. I was provided a $50 stipend for my time and trouble.

I greatly admired Vic Vorhees, M.D., and Stan Mosier, M.D., for their direction of the program. I recall that the Wesley program was recognized as one of the best, if not the best residency in the country. I was also participating as a preceptor with the KU rural preceptorship program at that time. My very first student was Bob Haskins. Bob and my second student, Bob York, both wanted to get into the Wesley program. However, they were told that Wesley considered themselves to be a bit more eclectic, desiring to take students from outside the state. I lent my support, as did others, and they were accepted. Subsequently, they have proven themselves as physicians, leaders and teachers. They are both a credit to the program and I am very proud of them.

I remember an involvement at another point when the Salina program was being considered. There was a model in Iowa for rural affiliated programs. Drs. Ernie Chaney, Don Goering and myself were committed to developing more residency slots in Kansas and were convinced that the rural model would work in Kansas. We envisioned several such locations. On one occasion, we three went to Topeka to lobby the Speaker of the House to push funding through. He did so, but only the Salina program proved to be feasible. It has been gratifying to see the Salina program develop into a very popular option for the would-be family practice residents.
April 28, 1998

Victoria Neale, Ph.D., MPH, Editor
Family Medicine
Letters to the Editor Section
Wayne State University
Department of Family Medicine
4201 St. Antoine, Ste 4-JUHC
Detroit, MI 48201-2153

Dear Dr. Neale,

Enclosed is a revised letter to the Editor which we think will be of interest to the readers of Family Medicine.

Sincerely,

Rick Kellerman, M.D.
Professor and Chair

RDK/ks

Enclosure*

The “Special Series: Rural Residency Tracks” gave welcomed emphasis to an innovation in family practice education which attempts to meet a societal problem: the shortage of family physicians in rural areas. (1) We thought Family Medicine readers would be interested in the experience and outcome of a residency program which has a stated mission to train physicians for practice in rural areas of Kansas. The Smoky Hill Family Practice Residency Program in Salina, Kansas, received ACGME approval in 1978 as a “one-two” rural residency track. Salina is a community of 45,000 people which is 90 miles north of Wichita and 180 miles west of Kansas City. Early on, the program experienced many of the problems put forth in the special series: a skeptical affiliated university, funding problems, a small cadre of critical local physicians and medical student recruitment disappointments. The family practice center was housed in a converted small college dormitory and did not have running water in the examination rooms. The program continues to suffer from outdated federal graduate medical education funding formulas and regulations. Fortunately, the program had its supporters, including the Kansas state legislature, a larger cadre of supportive local physicians and the foresight and guile of the residency founder, Robert Brown, M.D.

In the late 1980s, after several years of not
filling residency positions through the National Resident Matching Program, it became apparent that if the program was to survive, it could not do so as a “one-two” track. Recruitment of students suffered from the additional move required after the PGY-1 year from Wichita, which had well-established residency programs, to Salina. In 1990, after receiving Family Practice RRC approval, the PGY-1 year was moved to Salina. Subsequently, support of the Salina Regional Health Center and a grant from the United Methodist Health Ministry Fund allowed the program to move to a new Family Practice Center which was specifically designed for residency training.

HRSA Title VII grants allowed the program to develop rural behavioral science, emergency medicine and procedural medicine curricula. The state legislature awarded Smoky Hill residents an increase in salary. The majority of the local medical staff rallied around the residency, recognizing its contributions to the local hospital, community and state. Over 50% of the patients seen in the Family Practice Center have either Medicaid or no insurance.

The program has filled all positions through the NRMP in each of the last five years. As of July 1998, a total of 55 residents will have completed their residency at Smoky Hill. Twenty-three practice in communities of less than 5,000 population, most in rural counties of Kansas. Another 10 practice in communities with populations of 5,000 to 17,000, and 12 practice in towns with populations between 17,000 and 45,000. Only three practice in what could be considered metropolitan areas. In 1996, the program was recognized as the “Outstanding Rural Health Program in America” by the National Rural Health Association.

The successful Smoky Hill experience confirms the process for developing a rural residency track put forth by Damos, et al. Although Smoky Hill was not integrated into an existing family practice but was set up as a free-standing entity, the site selection criteria of Damos still apply. Salina is 1.5 hours of travel time from its sponsoring affiliated medical school department in Wichita. The program experienced instability and medical student recruitment problems until a core group of full-service supportive full-time family physician faculty members were recruited. Having a local program director to navigate the medical-political waters is critical. The local hospital system is viable and supportive. As the local medical community has added additional subspecialists willing to teach family physicians, the program has offered more training opportunities in Salina. During the last three years, rotations in cardiology, intensive care and emergency medicine have expanded. A Marriage and Family Therapist committed to family practice education is a “value-added” and essential component of the resident’s training for rural practice.

Rural residency tracks must meet all criteria for ACGME accreditation. Because of the limited resources and relatively few subspecialty physician teachers in a rural community, program directors must be innovative and flexible. Smoky Hill has experimented with a block rotation dedicated to procedural skill development, flexible scheduling to take advantage of itinerant subspecialists conducting clinics in the area, out-of-town specialty rotations and hospital in-patient family practice services. These experiments have been variably successful and have been refined and modified as medical community resources have changed over 15 years.

Rosenthal notes that thirty percent of RTTs had unfilled positions in 1996. There are many reasons for this, including the inconvenience and cost of an extra move to the RTT, their oftentimes unstable and developmental nature, the lack of recruitment support from an indifferent or doubting medical school faculty and want of a resident cohort support structure. Another factor which is oftentimes overlooked is spousal employment opportunity. Many medical student spouses have well-paying professional jobs in urban environments. The RTT community may not offer as many opportunities for spousal employment or support. Moving school-age children is also a detriment to recruiting.

We agree with Norris that family practice
residency programs are an agent of positive social change. However, we are concerned that many rural communities, hospital administrators and physicians may perceive an RTT as an immediate or low-cost way to expand physician resources and provide care in underserved rural communities. They will be disappointed when they learn that residency education is, at best, a zero-sum budgetary proposition and that resident education and the administration of an RTT requires time and effort. One of the precepts of the Smoky Hill program is that the emphasis is on resident education. The care provided by residents to the underserved is a by-product of education.

We are concerned that wording of the Balanced Budget Act of 1997 may discourage the expansion of existing programs into rural areas. The interim final rule's section on "Hospitals with Residents prior to January 1, 1997, not located in Rural Areas, Section 413.86 (g) (6) (ii)" would preclude adding residents to an existing program unless a hospital decreased it's FTE's in other training programs. We believe exception language should be incorporated into the rule to encourage the development of RTT's.

Many medical students enter medical school interested in eventually practicing in rural areas. Unfortunately, the urban academic health center environment discourages their intent. The major reason that a large percentage of graduates from RTTs eventually do practice in rural areas is because the RTT offers a training environment that is supportive of residents who wish to practice in small town communities. Smoky Hill and other rural-focused programs collectively make a statement that "it is O.K." to practice in a small town.

Rick Kellerman M.D.
Chair, Department of Family and Community Medicine
University of Kansas School of Medicine - Wichita


Sincerely,
Charles Allred, M.D.
Program Director, Smoky Hill Family Practice Residency Program
Salina, KS
New Salina clinic may help cure shortage of rural doctors

By David Chartrand

SALINA, Kan. — Gary Peavler has known since his high school days in Topeka that he wanted to be a doctor. But he didn't consider the notion of practicing in a rural community. Now, at age 28, he's at least thinking about it.

"I never could see myself setting up a solo practice out in the middle of western Kansas. Now I think my mind's more open," says Peavler, a 1979 graduate of the University of Kansas School of Medicine.

Peavler and three other family-practice physicians are being wooed into Kansas' first rural-based residency program aimed at attracting doctors to understaffed areas.

The four doctors will arrive at the Smokey Hill Family Practice Clinic in Salina next week to complete the last two years of their three-year residencies.

State officials are gambling that the best way to lure a doctor to a small town is to train him in one.

Not only is the new clinic a first for Kansas, it's also unusual among physician-training programs nationwide. There are 4,500 residency programs in the country for doctors of all specialties and only 15 family-practice residencies similar to the Smokey Hill project, according to information supplied by the American Academy of Family Physicians in Kansas City.

Smokey Hill will be a family-practice clinic because, like most rural Kansas, Saline County is short of "primary care" doctors such as family practitioners and pediatricians.

"Most doctors tend to set up practice in or near the area where they did their residencies," says A.J. Yarmat, the medical center's associate outreach director.

"So we hope that the Salina residents (physicians) will be impressed enough with good life can be in a smaller town and make enough client contacts that they'll think seriously about staying."

Traditionally, the residency part of a medical school graduate's training lasts three years and often occurs at a hospital or medical center in a major urban area. For graduates of the medical center, the residency normally includes a stint of one or two months in a rural area.

By contrast, the pioneering Smokey Hill doctors will be spending most of their residency seeing rural clients. Those taking part in the program will spend only the first year of the three-year residency in an urban facility — in this case, St. Joseph's Hospital in Wichita. The last two years will be spent at the Salina clinic.

The project, launched four years ago with an appropriation from the Kansas Legislature, is a combined effort by the Family Practice Department at the medical school's Wichita branch, St. Joseph's Hospital and two Salina hospitals.

Four more residents will join Peavler and his three colleagues next year.

The clinic will operate like a regular family-practice clinic. Patients will regularly see the same doctor-resident and pay fees for services. The residents' work will be supervised by the Salina Health Education Foundation, which was formed three years ago by the local medical society to administer the clinic.

It was hard to recruit medical students for the Smokey Hill project, says Dr. Robert Brown, the clinic's executive director. "Most of the graduates are skeptical about going to a brand new program. But it's looking up now. We've got 33 inquiries for next year."

Peavler and the other Smokey Hill residents will finish their training about the same time that the first "graduates" emerge from the state's broader-scope physician recruitment experiment.

The Legislature two years ago agreed to pick up the medical school tuition for every year that a student agreed to later practice in Kansas. About 30 states, including Missouri, now have similar laws that allow officials to the scholarships to a student's commitment to practice in the state.

Currently, about 600 of the medical center's 650 students have entered the scholarship program, as have a small number of students at the Kansas City College of Osteopathic Medicine.

While those in the scholarship program are enticed by substantial monetary aid, the Salina program offers no unusual financial carrots to lure physician-residents. In fact, the immediate beneficiary is Salina. The project creates several jobs, and the city gets a new clinic.

Rather than financial incentives, Brown says, the Smokey Hill project simply offers a homey, small-town environment to young doctors who "already may be leaning toward a rural area. They're the ones more likely to stay."

"In a residency, you establish all kinds of lines of consultation with other doctors," says 36-year-old Ron Hunsinghake, another of the residents arriving at the clinic next week.

"You get to know all the specialists in town, you know who can do what and where you can refer patients. That kind of thing makes you think twice about leaving when you're done. I think it'll work..."
A WARM WELCOME

Four new family practice residents have begun their training here in Salina. The doctors are (pictured above, left to right), Ron Hunninghake, Karen Nonhof, Gary Peavler, and Bob Yoachim. Asbury Hospital is providing them with temporary facilities until the Smoky Hill Family Practice Clinic is completed this month, located on the first floor of Wilson Hall Conference Center of Kansas Wesleyan.

The residents have all completed their first year of family practice resident training at St. Joseph's Hospital in Wichita. The final two years will be completed here in Salina, with a two-fold program. The residents will see patients at the clinic during regular hours. They also will work with various physicians at both Salina hospitals in specific areas.

This arrangement is the culmination of three years of planning by the medical community, the hospitals and their Board of Directors, and the Salina Health Education Foundation. Dr. Robert Brown, temporary Program Director explained, "Teaching programs such as this are beneficial to the hospital and the community. The generous cooperation of the medical staff and hospitals has made this possible."

Salina is the only non-metropolitan city in Kansas to have a residency program. One of the benefits, according to Dr. Brown, is that physicians tend to practice in a setting similar to where the residency occurs.

In addition to operating the family practice residency program, the Salina Health Education Foundation is also involved in continuing education for the whole medical-surgical staff.

In order to sponsor this new program, Asbury Hospital has been recognized as a co-parent teaching hospital, along with St. John's Hospital, by the American Medical Association.

The advent of the residents constitutes another major step in Asbury Hospital's service to the community as a teaching hospital.
Proposal imperils center funds, KU doctor training program

By DALE GOTE
Kansas Correspondent
TOPEKA (HNS) — An $80,000 limit on state funds for the operation of the Smoky Hill Family Practice Center in Salina would be removed by proposed legislation endorsed Tuesday by a state legislative interim committee.

The proposal by the Special Committee on Ways and Means also places a greater share of the responsibility for the future of the Salina doctor training program with the University of Kansas School of Medicine.

Under the current statute, enacted in 1977, the state's contribution to the operating expenses of the Salina clinic is limited to $50,000. However, the family practice center — which is administered by the Salina Health Education Foundation — will run about $125,000 short of funds this fiscal year, according to Dr. Tim Scanlan, director of the family practice residency program. In addition, the program also expects to lose an additional $100,000 in federal funding next year, Dr. Scanlan said.

The program currently has six residents on staff who are completing their medical training, and another four in Wichita who will come to the Salina center during the next two years.

The legislature conceived the program in 1977 in response to concerns about a shortage of family physicians in Western Kansas. However, the legislature now has some concerns about a possible oversupply of doctors, according to Rep. Bill Bunten, R-Rossville, chairman of the interim committee.

A state program that provides scholarships to medical students in exchange for their serving in "doctor-poor" areas of the state after graduation is beginning to yield its first physicians, Bunten said. The legislature now needs to sit back and assess the state's need for additional physician training programs before considering any further expansions, he said.

With the scholarship program and residency training programs in mind, the legislative committee also recommended that KU be precluded from beginning any similar programs without specific legislative approval.

Although legislative concern about doctor shortages may be more subdued now than several years ago, the interim committee still is interested in seeing the fruits of the Salina program, Bunten said.

"We didn't consider terminating it because we haven't had any people coming out of it yet," he said. "We want to see if it does help put doctors in that area around Salina. We don't know that yet."

Bunten said he expects KU officials to continue to seek funding for the Salina program.

"My feeling is that the university will propose that it (the Salina program) continue for a while," he said. "If residents that serve in the program in the rural areas, then the program will be successful and we will want to continue it."

A key question still unanswered is whether the University of Kansas would be willing to seek the amount of money required by the program's current needs. The program would have no special status under the proposed legislation as it has had in the past, and it would have to compete with other KU medical school programs for its share of the school's budget.

In the past, the university didn't have to worry as much about funding levels for the program because the law limited the state's contribution to its operating fund to only $80,000. However, under the proposal endorsed by the committee Tuesday, the university would have to decide how much of the $200,000-plus financial needs of the center it would want to seek in its annual budget request to the legislature.
Salina Journal September 4, 1983

Smoky Hill Family Practice lures doctors to rural areas

By MARY JO PROCHAZKA
Staff Writer

On the first floor of a dormitory at the Kansas Wesleyan campus in Salina, Dr. Timothy Scanlan trains family physicians.

Sometimes, that means he tries to “undo” a little of what’s been instilled in medical schools.

Other times he works to dispel myths about the Smoky Hill Family Practice Center he directs — myths that the center closed for lack of money, that doctors there are only medical students and that family practice is synonymous with general practice.

Since July 1980, Salina has been home to Kansas’ only rural residency program for doctors who plan to specialize in family practice.

Scanlan is ending his first year as director of the residency program he believes serves a two-fold purpose.

“It provides medical care to the community while being an educational center,” he said.

For Kansas, the Smoky Hill program is unique, because it’s the only family practice residency program not located in a metropolitan area. The state’s four other programs are in Wichita and Kansas City.

“There was the feeling that if we trained young men and women in a community setting like Salina, there would be more of a tendency for them to settle in a smaller community,” Scanlan said.

One test of success would be whether graduates settled in rural areas, but with only four graduates, it’s too early to spot trends, Scanlan said.

Of Smoky Hill’s four graduates, one practices on an Indian reservation in Minnesota, one’s in Wichita, one’s in Arkansas City, and Dr. Ronald Hunninghake practices at Salina Family Physicians.

Hunninghake, a native of Seneca, attended one year of a residency program in Wichita but quit to wait for the Salina program to open.

Big-city residency programs emphasize training for specialists who’ll deal with rare, serious illnesses, Hunninghake said. In Salina, he dealt with problems similar to those he’ll confront during a career in family practice.

Family practice was approved as a specialty in 1969. Practitioners must complete two more years of residency training than required to become a general practitioner and must be recertified every six years by the American Board of Family Practice. Family physicians are trained in pediatrics, surgery, internal medicine, obstetrics and gynecology, psychiatry and community medicine.

Much of what distinguishes family practice has to do with philosophy and taking “a human approach” to medicine, Scanlan and Hunninghake said.

“The old orientation of general practice was oriented to episodic treatment: when somebody was sick, they went to the doctor,” Scanlan said.

“We take the best of that world and make it better. Medicine is medicine. We still teach them how to treat illness, but it’s the orientation with how we do that that makes the difference.”

“In family practice, we look at behavioral aspects of disease and illness and the role the patients themselves are playing in their own disease by their habits and attitudes,” Hunninghake said.

At Smoky Hill, emphasis is placed on wellness and preventive health care — topics Scanlan said are virtually ignored in medical schools.

Smoky Hill’s residency program is affiliated with the KU Medical School’s Department of Family Practice in Wichita. The three-year residency is limited to four students per class. Residents spend their first year in residency at St. Joseph Hospital, Wichita, and the last two years in Salina, where they train with local physicians.

Because Kansas licenses physicians after one year of post-medical school training, residents are licensed physicians when they move to Salina.

The program was placed under the auspices of the Kansas Board of Regents during last spring’s legislative session. It operates on a $720,000 budget, of which about 60 percent comes from state sources, about one-third from patient fees and the remainder from Salina’s two hospitals, Asbury and St. John’s.
"The program grew successfully..."
by DONALD J. GESSLER, M.D.
FOUNDING DIRECTOR
ST. FRANCIS FAMILY PRACTICE RESIDENCY
APRIL 28, 1997

I was first approached by the administration of St. Francis Hospital (later St. Francis Regional Medical Center and now Via Christi) sometime in the first half of 1974. They were asking at that time if I would be interested in starting and developing a family practice residency at St. Francis Hospital. As you know, there were viable, operating programs at both St. Joseph and Wesley at that time. I initially declined as my practice with V. Dean Schwartz, M.D., was just beginning to really succeed and I felt a debt to him not to leave. This was in spite of an interest on my part to somehow get involved in education.

Shortly after that, I had a discussion with Dick Hattrup, M.D., on a plane to Dallas where we were both going to take our boards in family medicine. Dick asked me about the program at St. Francis Hospital and seemed to have an answer to every concern I had. With that in mind, upon returning to Wichita I decided to talk to my partner.

I discovered that St. Francis Hospital had already asked for permission to talk to me, but that neither Dr. Schwartz nor the hospital had shared that in hopes that I would not be overly influenced in either direction. I agreed to accept the position and began working half-time preparing the applications and designing the program.

The residency opened on July 1, 1975, with two residents: Dave Robl and Tom Alderson.

The program grew successfully with a lot of support from the medical staff at St. Francis Hospital. In 1978, the chair's position at KUSM-W, Department of Family and Community Medicine became vacant and I was asked if I would look at accepting that role. The residency was still fairly new and I was not really interested in becoming a full-time employee of the state of Kansas; however, both I and the administration of St. Francis Hospital realized the importance of a viable Department of Family and Community Medicine at the school. Based on this, we reached a compromise in that I agreed to serve as acting chair on a half-time basis and to continue to be program director of the residency. This accommodation was with the clear understanding that I saw my role as two-fold: 1) keep the department operating and 2) find a permanent chairperson.

I saw the next Society of Teachers of Family Medicine meeting as an ideal opportunity to recruit a permanent chair. I had been given the name of Ed Donatelle, M.D., by someone (I don't remember who) and contacted him at the meeting. He told me he was not interested in moving (from Grand Forks, N. D.), but that he would meet me for breakfast, as he was always open to discussion.

We talked the next morning and his interest was piqued. I don't know whether the concept of developing a department that was new without a lot of history to bog it down and based in the community was the leading factor, or the fact that his wife, Marion, did want to leave where they were, overshadowed his decision.

Whichever, Ed agreed to come to Wichita and head the department. He asked me to stay on for a year as acting vice-chair because of the fact he was new to the city and did not know anyone. I agreed to do that and that is how I
came to become vice-chair after being a chair, the opposite of the career path you would anticipate.

I then continued as program director at St. Francis until I resigned in 1983 to pursue opportunities in the managed care field.
"We had to brainstorm, set policy and recruit, recruit, recruit."

by JO ANN B. HETRICK, R.N.
FORMER NURSE
ST. FRANCIS FAMILY PRACTICE RESIDENCY
AUGUST 25, 1997

Prior to merging of the two local Saints to become the Via Christi Health System, the St. Francis Family Practice program tallied thusly, six full-time faculty, one full-time pediatrician, a half-time behavioralist, and 27 residents. The following are a few personal memories of the birth of this program.

In the beginning, there was the director, Don Gessler, M.D., (who couldn’t direct full-time as he was temporary chairman of the medical school while a search was going on for the permanent chair). The St. Francis program started with two residents, Dave Robl and Tom Alderson, and soon acquired a part-time behavioralist, my spouse. I entered the picture in August, 1977.

During my recuperation from rheumatic fever (at the tender age of 33), my family practice doctor (the director) suggested I pursue a less stressful line of nursing. Prior to that time, my nursing background was exclusively in critical care. In his recruitment of my nursing skills, Don expressed great enthusiasm and excitement about this program and the positive impact the new specialty would have for the community. So, I signed on as a part-time staff nurse with a full-time hobby of nurturing and supporting this fledgling frontier of medicine.

With only one faculty doctor and two residents, my formative clinic time was spent finding my way, learning office procedures and practice, and interacting with patients. We had to brainstorm, set policy, and recruit, recruit, recruit.

In writing this retrospective, three formative memories come to mind which helped my transition from critical care to family medicine.

The first was Ed Donatelle’s remarks given at the dinner during his recruitment visit. He was so enthusiastic and positive about family medicine and a closing line about his patient being his friend really struck my heart. What a lovely idea. I encouraged my residents to look on their patients as friends.

I remember being at an Amelia Island Family Practice Conference, and hearing “let’s keep the family in Family Medicine.” Right on!

Lastly, our behavioralist (my beloved), kept exhorting the residents to treat the whole person, not just the presenting physical complaints. This was a refreshing perspective from my focus in critical care nursing.

An important part of residency life were the social functions. I volunteered, or was I drafted?, to become assistant cook, hostess, bottle washer. Before requiring a banquet-sized facility (the Olive Tree), there was the relatively humble and homey, J and J. Jan Gessler and yours truly planned, cooked, and presented several memorable (to us) occasions.

What fun meeting the residents, spouses, and families. Lots of grand friendships were formed there. In fact, when I was getting feedback from the Hetrick children regarding their memories, they both mentioned the super parties, picnics, etc., and the feeling of being a part of a larger family. Heather, in particular, remembers walking up to a resident, her friend, and asking Dr. Schultz, “Why does my skin do like this?”, and Adrienne exclaimed, “Ehler-Danlos Syndrome”: an accurate, on the spot diagnosis, and in Heather’s memory, the beginning of her contribution to several resident’s education. She would come to clinic.
for her well-kid check, and any resident hanging around was invited in for first-hand experience of ED.

My son, Mark, also has positive memories of his family practice family. A resident, fresh from his dermatology rotation, noted Mark's acne and suggested a successful course of treatment which did much for his self-esteem. He also remembers when he broke his ankle, the energetic involvement of three residents. Mark was impressed by the caring he felt from these people. It did much to alleviate his pain and trauma.

A couple of unusual forms of amusement came from the fertile mind of our residents. One was the graduation video from the Class of '81 entitled, "A day in the life of a family practice resident," which we filmed on a steamy Sunday a few days before graduation.

This film classic resides in the residency library, a must-see for Muppet fans as several of them had supporting roles in this video.

We had a classical theater buff in the Class of '83, Bruce Williams. His farewell presentation was to rewrite one of the Canterbury Tales. He cast it with several of his peers for our amusement and edification at the graduation dinner.

Although I no longer work at the Family Practice Center, the program continues to have a warm spot in my heart. I keep an eye out for the family practice residents when I encounter them in specialty clinic. I am grateful for my experience with the program. It was a grand time and a privilege to have been part of the residency.
Dr. Don Gessler asked me to teach behavioral science in the residency during its second year. I was delighted. We had two second year residents, David Robl and Tom Alderson. In my need to succeed and earn my keep, which was part-time, I scrambled for help from every family medicine journal I could find. I searched for a definition of my job. What were others doing? I can’t remember how Don defined my job. I expect it was as general as “psychological aspects of medical practice.”

Looking back on those early days, I was reluctant to ask Tom and Dave what they thought about our sessions. We met about two hours a week. I am sure I filled our sessions with intellectual psychosocial content.

I clung to two guidelines: to honor medicine as I highlighted psychosocial factors that might enhance the resident’s effectiveness; and relate treatment to family issues. Difficult patients and rough topics were fodder for discussion.

If I had it all to do over again, I would make rounds with the residents. I could observe and even participate in some aspects of care. Also, I would model an approach which addressed all relevant needs of both resident and patient. It seemed that residents felt that a psychologist might attempt to make them mini-psychotherapists. That was not our conscious goal. It was clear that new residents had their hands full attending to presenting complaints. They seemed most anxious about attending to physical concerns and, unspokenly, viewed anything else as extra or gravy for the patient.

I hope family medicine has grown to see that physicians can practice holistic medicine without having to become a social worker, psychologist, clergy, etc. I would have residents increase their sensitivity to three areas of patient functioning without attempting to “fix” them.

Today, I would model the benefit of opening a dialogue with patients about their thoughts, feelings, and intentions with respect to their illness. Of course, this would occur in the context of significant others in their lives (family, etc.).

In the early days, Dr. Gessler gave me freedom to use my skills as I saw fit. Family medicine had few guidelines beyond generalities, like asking the doctor to address the family and the patient’s body, mind, and emotions. I expect that time in the saddle, for most graduates of the residency, enabled them to appreciate how feelings such as fear, and conditions such as pride, shame, or ignorance play a key role in the doctor-patient partnership.
"It was a distinct honor..."
by JAMES M. DONNELL, M.D.
FORMER DIRECTOR
ST. JOSEPH FAMILY PRACTICE RESIDENCY PROGRAM
OCTOBER 1997

It was a distinct honor for me to help develop the St. Joseph Family Practice Residency Program. My own departure from a very busy private practice was abrupt, but cushioned to a large degree because my patients became the first customers for the residency program. Initially, there were curriculum debates among Dr. Purinton, Dr. Purves, and myself about the best designs for training that would follow the AMA guidelines.

Fortunately, the rules allowed some flexibility and experimentation, since teaching some primary care subjects was new.

My personal goals for the program were as follows:

1. To recruit the best graduates from a variety of medical schools. In-breeding seemed to me to be detrimental to education quality.

2. To find the best possible teachers in the community for the residents.

3. To avoid hazing, skut work, rote learning, required humility, and meaningless activity. All seemed educational plagues.

4. To reward good work, insist upon excellence, and to diversify learning experiences for the group.

5. To generate enough funds from seeing patients (nearly every patient paid something-often just fifty cents). The funds were directed toward resident enrichment.

Our first resident was Dr. Antonio Osio, who had just completed an internship at St. Joseph's. He had already had training in many medical areas in Colombia, his home. He was especially well trained in obstetrics.

This was really useful for us all since Ob teaching from the community physicians was, at times, sporadic. He had the disadvantage of testing the water for me and those who succeeded him. His good nature and positive outlook were always present for us to draw upon.

Dr. Joachim Schnelle was the next resident to begin and finish the program. He tolerated the painful climb up the learning ladder with only a little less cheer than Dr. Osio did. A good sense of humor helped, and he has one.

Our first group of several residents was made up of especially good students. They were well adjusted, had marvelous wives, and wished to further develop the program. They and subsequent resident classes worked hard, played hard, and had good times. We grew from one resident, Dr. Osio, to 24 residents during a short period of time.

In addition to doing our work well, we had picnics, went boating, had parties, learned to fly airplanes, made presentations, participated in local politics, volunteered for charity work after the Guatemala earthquake, manned an outreach clinic in Howard, Kansas, hunted, fished, and saw patients.

The St. Joseph Family Practice building housed offices where residents saw patients; learned office management; were involved in personnel acquisition and training; and learned how to make a living practicing their skills.

The St. Joseph Family Practice Residency Program became a part of the KU Medical
School-Wichita in 1975. Prior to that time, there was a national survey of sites for possible new medical schools. Wichita was listed as a possible site.

Shortly after that, I proposed publicly that Wichita build and develop its own medical school. Within the week, community businesses and individuals volunteered $7,000,000 to that end. The following week, the University of Kansas School of Medicine in Kansas City brushed off old plans to develop a branch of KUMC in Wichita. There was need for this from their point of view because Kansas City, Missouri, had expanded medical facilities which left KUMC with a local population only marginally able to supply adequate patient numbers for some kinds of training.

Wichita hospitals agreed readily to accept medical students in return for budgetary support from the State of Kansas. St. Joseph's joined the other hospitals to teach medical students in addition to interns and residents; thus losing uniqueness from any other residency program in the United States.

Early residents in the St. Joseph program were spectacularly good physicians. They risked all to come to a new, unique family practice program; a program whose only mission was to teach residents in family practice and to care for patients. They made the program one of the very best in the country. The success of their program had little to do with structure, state funding, or formally hired teachers; rather, it was successful because bright, knowledge-seeking doctors were shown how to work hard and practice medicine while seeking excellence.

All of the teachers deserve mention, but outstanding were Dr. Jack Mosely, Dr. Les Cobb, Dr. Richard Hattrup, Dr. Lew Purinton, Dr. Charles Jenney, Dr. Herbert Goldberg, Dr. Larry Sifford, Dr. Paul Murphy, Dr. Ed Fitzgerald, Dr. David Kirk, Dr. Fred Wolfe, Dr. Ward Madison, Dr. Richard Morrison, Dr. Louis Morgan and Dr. Rex Lee. Many others helped us pioneer. I hope they will forgive me for omissions.

Community teachers gave unstintingly of their time. The primary reward for these doctors was the inner gratification all teachers must hope to find.
"... the family practice movement encouraged us."
by LEW W. PURINTON, M.D.
FORMER DIRECTOR OF MEDICAL EDUCATION
ST. JOSEPH MEDICAL CENTER
NOVEMBER 1997

St. Joseph Medical Center's involvement in the family practice residency movement evolved because of the desire of its administration to develop a residency in family practice for the education of young physicians. Not only was the origin of the residency a true desire for education, but, perhaps on the selfish side, there was a desire to develop a better image for the hospital and to entice graduates of the program to remain on the staff and practice at the hospital.

The hospital had an approved rotating internship, but recruiting was an endless problem with limited success. St. Joseph's only other involvement in postgraduate medical education was the pathology residency founded and directed by Dr. William J. Reals.

Shortly after my arrival in Wichita in July of 1957, I settled on developing an internal medicine practice at St. Joseph. Since I was new in town, just out of residency and with plenty of free time on my hands, I was invited to take on the part-time position of director of medical education by our chief executive officer, Mother Mary Anne McNamara and her assistant chief operating officer, Mr. Joseph Heeb.

Dr. Robert Purves, a local general surgeon and a loyal St. Joseph physician, was very much interested in medical education. Dr. Purves, Dr. Reals and myself took on the task of developing meaningful postgraduate medical education for the hospital.

Our efforts at recruiting for the rotating internship were, in general, a disaster. There were too many competing programs in the nation and the attraction for a private hospital with no supporting residencies was just too much to overcome. In the 60's, we were approved for a general practice residency program. Nationally, this was a dead issue and we never recruited a single graduate to the program.

By the mid 60's, general practice was being replaced by the new emerging concept of family practice. Its appeal was based on several factors, including a three-year residency with emphasis on prevention, broad general care, and the ability to care for most patients without referral to specialists, and a new image for the generalist.

Internal medicine had no interest in training physicians for general medical care and devoted their energies to specialty training, thus leaving a real need and void in general medical care. Family practice, the new kid on the block, filled the void and took off.

Kansans like Dr. George (Ned) Burkett of Kingman played a vital role in this national move and was helpful as a consultant to St. Joseph for developing a family practice residency.

This was a huge revolution that would result in many changes in the way medical care was to be delivered in the United States. Those of us at St. Joseph realized the changes that were to come. With our strong base of general practice physicians and the hospital's reputation as a friendly, family-oriented institution, the family practice movement encouraged us.

Early on, Dr. Purves and myself prepared an application to the Residency Review Committee for Family Practice requesting approval for a three-year residency in family practice.

Our letter of approval arrived June 15,
1970, and we were in business. At the time of our approval, there were six other new programs given Provisional Approval. This made a total of 45 approved programs.

One of our foreign graduates in the internship program, Dr. Antonio Oslo, became our first family practice resident on January 1, 1971, as he moved from the rotating internship. We were approved for four recruits each year. In July of 1974, there were 18 American graduates in the program. This launched what was to become a very successful and highly sought after program.

Dr. James M. Donnell was appointed program director in July of 1971. Dr. Richard Hattrup became his assistant. Due to a philosophical difference in ownership and management between Drs. Donnell and Hattrup and the hospital’s administration, both eventually resigned.

After their resignation, we were in a real bind. I was asked to become the interim director. This lasted for about nine months, until Dr. Larry Miller was hired as the new program director.

A major shift in the program came by aligning with the University of Kansas School of Medicine-Wichita in the early 80’s, whereby residents and teachers became University residents and faculty. This was not an easy sell, but at the time was necessary for the future security of the program.
“Could I fit into this scene?”
by MARY MADDING
FORMER RESIDENCY COORDINATOR
ST. JOSEPH FAMILY PRACTICE RESIDENCY
MARCH 1998

1970

The idea of having a family practice residency at St. Joseph Hospital and Rehabilitation Center began with Robert K. Purves, M.D., a general surgeon on staff. This followed the disappointment of not being able to have an internal medicine residency. The residency archives contain a letter dated June 15, 1970, from Thomas W. Johnson, M.D., Field Secretary, Division of Education of the American Academy of General Practice congratulating Dr. Purves on the approval of the family practice residency. At that time, there were 44 approved graduate training programs in family practice in the United States and St. Joseph was listed as #18. Dr. Purves was assisted in the residency planning by Lew W. Purinton, M.D., Director of Medical Education (internal medicine), William Reals, M.D., (pathology), and family practice physicians, Victor North, M.D. and Doris North, M.D.

By August, 1972, there were seven residents. As of January, 1997, there were 26 residents.

1975

Mary Nichols, secretary to Dr. Purinton, director of medical education, asked me to consider the position of department secretary for the residency. Since I knew nothing about the program, I decided to take a tour of the premises. I entered through the front lobby, which was already filled to capacity with afternoon patients. I followed the hall south and turned the corner and found a large room that obviously served as a multi-purpose room - “breakroom” and patient exam room! (Coffee and doughnuts were on the east side of the room and an exam table with a privacy curtain was several feet away!). Continuing my hallway tour, I next ran into the clinic lab - literally! It was in the hall! The tech had an armchair for the patient and a small table for lab supplies. If a patient fainted, the hallway floor was the only “resting place” available.

As I turned the corner, heading back to the lobby, I passed the famous autoclave room, medical records and business office areas. My first impressions were all mixed up. Could I fit into this scene? Everyone seemed so young - I was 44 years old with visibly gray hair. I had also heard that Drs. Donnell and Hattrup were resigning from their positions due to a difference in management and hospital administrative philosophies. Who would be hired as the new program director? I needed time to think this through - so I waited awhile before deciding to take the job.

Meanwhile, the first graduating class
completed its training. Class members were: Steven Bruner, M.D., Reginald Goodwin, M.D., Wayne Morton, M.D., Thomas Simpson, M.D., Steven Thomsen, M.D., and John Tipton, M.D. (Their “claim to fame” can be read at the end of this history.)

1976

Upon completion of the new 400-bed hospital located on the east campus in 1976, the administration, medical staff and medical education offices moved from the first floor of Building A on the west campus to the third floor of the new hospital.

Mother Mary Anne McNamara was a very capable CEO and showed great support of the residency, the residents and their families. She took time to meet and hold each baby born to a resident family.

Dr. Purinton, as the director of medical education, assumed the position of interim director following the resignation of Drs. Donnell and Hattrup. I accepted the position of department secretary in May.

Lawrence Miller, M.D., and Kenneth Evans, M.D., were later hired as director and associate director. Dr. Miller was unable to be on site for six months, and so Dr. Purinton and Dr. Evans shared responsibilities in running the residency. Dr. Evans worked around the clock seven days a week, responding to resident needs at the clinic and to in-house patient care. His loyalty to the residents and program will be remembered by all that worked with him.

The “multi-purpose” room was remodeled into a library. A small 5’x6’ office was added adjacent to the library. This would be my first office at the family practice center. For the first six months, I spent nearly half of my day at the medical education office learning my responsibilities as well as providing office coverage for Mary Nichols when she needed to be away from the office. Dr. Purinton and I “corresponded” with each other through transcription tapes. He was a very thorough person who made this arrangement work easily and well. He was a very kind person to work with.

Precepting faculty at the family practice center included family practice physicians Drs. Victor and Doris North, and Dr. Floyd B. Grillot. In addition, rotation chiefs came to the clinic to assist residents with patients related to their particular specialty.

Graduates this year were: Donald Bosken, M.D., Ronald Davis, M.D., Roland Duncan, M.D., Dennis Ela, M.D., Ronald Hay, M.D., Thomas Norris, M.D. and Carroll Verhague, M.D.

1977

Meetings continued planning for a residency program located in Salina that would be named the Smoky Hill Family Practice Residency Program. The residents would spend their first year at our site and then complete their second and third years in Salina.

Colby, Kansas, was selected for our outreach rotation. Colby physicians provided a house and Dr. Don Bailey, an orthopedist who worked with the program, bought a new washer and dryer for the home.

Colby did not prove to be a popular rotation principally because of its distance from Wichita and the inconvenience this placed on residents with children.

In 1977, additional remodeling of the clinic included deleting patient rooms to accommodate a small laboratory, resident room changes to provide a room for the program director, and moving my office to the front hall area adjacent to the lobby and program director’s office. My office was also across from the restroom, and a glass wall was installed to protect me from patients getting sick over my desk, etc. What a gift that wall was!

Dr. Whitney Vin Zant joined the St. Joseph Hospital staff and offered a rotation in general surgery to the residents. Dr. Jerry Streit was his first resident. Over the years, Dr. Vin Zant became a close friend of the residents.

Graduates were: Rodney Barnes, M.D., David Cooper, M.D., Jan Garwood, M.D., Samuel Kevan, M.D., Keith Mackenzie, M.D., Steven Mosier, M.D., James Omel, M.D., Antonio Osio, M.D., Roger Simons, M.D., and Daniel Ward, M.D.
1978

Full accreditation of the program was received from the Association of Graduate Medical Education offices.

Doris Butler, M.D., was the first female resident of the program. She also had the first baby born to a female resident. She kept pace right up to delivery time and following delivery. I don’t think she was in the hospital more than six hours.

Graduates were: James Braden, M.D., Doris Butler, M.D., Thomas Hays, M.D., Julie Reser, M.D., Robert Stader, M.D., and J. Mack Worthington, M.D.

1979

As the affiliation with the medical school developed, the first impact of some of the changes inherent in developing that relationship emerged. It was a time when faculty and residents felt unsure about how this relationship would affect the residency. Most everyone involved in making the major decisions fell heir to criticism. As the years passed, our relationship with KUSM-W proved beneficial to faculty and our program.

July 1, we welcomed the first Smoky Hill Family Practice residents to our facility. They were: Robin Mitchell, M.D., Gary Peavler, M.D., and Robert Yoachim, M.D. Our residents and faculty warmly welcomed these residents.

Dr. Miller and Dr. Evans decided to resign, and Robert E. Riederer, M.D., a KU graduate on the faculty of the family practice residency of the University of Nebraska, in Omaha, Nebraska, was hired. Without the assistance of associate faculty, he, too, found himself working many hours each day covering in-house patients of the residents, clinic patients and precepting responsibilities.

This was a difficult time for the residency because of the lack of faculty. Through the dedicated efforts of Dr. Riederer, the residents and the hospital administration, the program continued to move forward.

Graduates were: Steven Barker, M.D., Christopher Herndon, M.D., Craig Moore, M.D., Richard Rajewski, M.D. and John Ronck, M.D.

1980

R. Bruce Woods, Ph.D., joined the faculty to develop the behavioral science component of the residency. This year also brought the option of two outreach locations: Colby or Wellington with Drs. Anderson and Weigand.

On June 30, we waved goodbye to Drs. Mitchell, Peavler and Yoachim who left Wichita to go to Salina to begin their second year of training. Arthur Schlyer, M.D., was the only incoming Smoky Hill resident for the 1980-81 year.

Graduates were: Dan Criswell, M.D., Lary Hill, M.D., Michael Mosier, M.D., Gary Settje, M.D. and Jerome Streit, M.D.

1981

Jerome (Jerry) G. Streit, M.D., graduated from the residency and joined the faculty as associate director to work with Dr. Riederer.

His transition from resident to faculty was an overnight experience. He assumed the responsibilities of that position with great dedication and loyalty to the residents and care of their patients. No one will ever want to count the consecutive hours/days/weeks that he worked for several years. Vacation time was not an option.

Graduates were: John R. Eplee, M.D., Jed Holmes, M.D., Gary Johnson, M.D., Edward Lind III, M.D., Robert Markwell, M.D., Jeffrey Martin, M.D., J. Michael Patton, M.D. and Ronald M. Phillips, M.D.

1982

In June, 1982, Deborah G. Haynes, M.D., graduated from the program and joined Dr. Streit as a second associate director. She was a wonderful addition to the teaching staff and shared in the long hours of work.

Graduates for 1982: Stanton L. Barker, M.D., Paul Callaway, M.D., Michael Dunlap, M.D., Deborah G. Haynes, M.D., Guy Kline, M.D., Diane Klingman, M.D. and Lynn Shaffer, M.D.

1983

Adrian Walling, M.D., joined the faculty. His expertise in Ob/Gyn was a positive addition to the program. This was also the year
that we received our first PC. His interest in the computer helped us develop the first programs that were used in the residency and clinic.

Graduates were: T. Kim Arganbright, M.D., Michael Flaherty, M.D., Roberto Garcia, M.D., Gary Lawrence, M.D., Larry Lewis, M.D. and Douglas Phipps, M.D.

1984

Ernie J. Chaney, M.D., assumed the position of program director, having just completed his term as president of the American Academy of Family Physicians. Dr. Riederer assumed the newly created position of senior associate of geriatric education.

A major remodeling of the Family Practice Center was undertaken during this year. It included the addition of five faculty offices along the west side of the building, a room for behavioral science faculty, a full basement that would include a breakroom, a conference room and a large area used at that time for storage of medical records. The lobby and business office area were also redesigned. The nurse's station and laboratory were completely redone. Offices for patient education and the head nurse were added along with space for two staff secretaries. It was a major improvement for all of us.

On Nov. 6th, Dr. Chaney hosted the dedication festivities for the completed clinic remodel. Dr. Purves and his family were in attendance. Although Dr. Purves was in declining health, he was able to have a tour of the clinic and then see the clinic named the Robert K. Purves, M.D., Family Practice Center.

This was the first year the residency received funding towards geriatric training. Family practice residencies were alerted to the need for this educational component. The Family Practice Center had a large number of elderly patients, and under the direction of Dr. Riederer, residents received more specific teaching in geriatrics.

Graduates were: Randall J. Brown, M.D., Joe Davison, M.D., Edward Hett, M.D., Todd Miller, M.D., Barbara (Bell) Potts, M.D., Christopher Rodgers, M.D. and John Ryan, M.D.

1985

Dr. Riederer retired. Gerald Van Es, M.D., joined the faculty. Unfortunately, he found it necessary to return to Iowa and left the program in August. Dr. Haynes also resigned to enter into private practice with alumnus, Diane Klingman, M.D. Dr. Haynes' contributions to the residency through leadership and loyalty to the program as a resident and faculty member will not be forgotten.

Graduates were: Joe Barnes, M.D., J. Randy Henwood, M.D., James F. Hesse, M.D., Stephen Lemons, M.D., David Niederee, M.D., and Timothy Pauly, M.D.

1986

Our faculty now consisted of Drs. Chaney, Streit, Walling and Woods. Robert J. Haskins, M.D., joined the faculty in March. His recent private practice (real world) experience was helpful as the program continued to develop.

Graduates were: Mark S. Hall, M.D., Michael Jones, M.D., Marlin Locke, M.D., Elaine Mader, M.D. (later to be Mrs. J. Mark Osborn), J. Clark Osborn, M.D., David Richman, M.D., and Terry Rivers, M.D.

1987

We added three new faculty: John G. Bradley, M.D., Kenneth M. Wakefield, M.D. and Merrill F. Raber, Ph.D. Dr. Bradley became involved in providing additional lectures and rotation opportunities along with research projects. Dr. Wakefield assumed responsibilities for the geriatric component. Dr. Raber joined Dr. Woods in behavioral science education.

At this time, Edward Donatelle, M.D., held the position of chairman of the Department of Family Medicine. He was very instrumental in the development of the Department of Family and Community Medicine at KUSM-W and needs to be remembered for those efforts.

Graduates were: Carl Fugate, M.D., Randall Goering, M.D., J. Mark Osborn, M.D., Lora Siegle, M.D., Michael Skoch, M.D., Dennis Spratt, M.D., and Rick Tague, M.D.

1988

John N. Dorsch, M.D., was the next addition to our faculty. He came to us from private
practice in Hays, and was an alumnus of the Wesley program. Over the years, he developed close friendships with many of the residents. (I think Dr. Dorsch taught as much through telephone calls from residents and alumni to his home as he did during the clinic day.)

We now had a Geriatric Institute under the direction of Dr. Wakefield. It was housed in offices on the east side of Clifton. We acquired a geriatric social worker and nurse to assist in this new venture. The Institute moved to the medical building at Hillside and Grand Avenues. Before the month-long rotation in geriatrics was based at the family practice center.

Verlin Janzen, M.D., spent hours developing a computer program to record each resident's procedures. This was used until 1995.

Graduates were: W. Thomas Ashburn, M.D., David Buller, M.D., Bain C. Cate, M.D., Joel Hornung, M.D., Verlin Janzen, M.D., Alan Lyne, M.D., and Richard Watson, M.D.

1989

July 1989, was the last year that we had Smoky Hill residents. They were Regan Ganoung, D.O., and Marian Nelson, M.D. Salina had made significant growth in the physician population to adequately provide for teaching residents for the entire three-year program.

Faculty changes included Dr. Haskins leaving our program and joining the Department of Family and Community Medicine at KUSM-W. However, he continued as a preceptor in the residency.

The Family Practice Center was now too small to house the business office and medical records area; resident rooms were overcrowded; the library was used for precepting, recruitment efforts and . . . parties; the basement storage area would need to be shared with the medical transcriptionist staff. There were "rumors" of plans for a new clinic to be built on the site of the School of Nursing.

Graduates were: Michael Carnahan, M.D., Mark Crump, M.D., Rick Friesen, M.D., Terry Horton, M.D., Diane Nightingale, M.D., Craig Shumard, M.D., and David Stamy, M.D.

1990

Following the resignation of Dr. Haskins, Mickey C. Myrick, M.D., who had been in practice with Dr. Dorsch in Hays, was hired.

Once again, we were fortunate to have attracted another faculty member with the medical experience and teaching skills of Dr. Myrick. He immediately became involved in presenting conferences to teach procedural skills in cardiology, obstetrics, endoscopy, treadmill, etc.

Graduates were: Calvin Beck, M.D., J. David Dye, M.D., Jeffrey Hoffsmmer, M.D., J.M. Huser, M.D., Luke Lemke, M.D., Thomas Stewart, M.D. and Christopher Wright, M.D.

1991

Lary M. Hill, M.D., a graduate of the program who had been in practice in Great Bend, Kansas, joined the faculty. He, too, brought the experience of the "real world" of medicine to the residency and has continued to be a faithful member of the faculty. We now had eight full-time faculty.

Graduates were: Brian Basham, M.D., Cynthia Nash (Brazell), M.D., Melanie Greenwood, M.D., Michael Havekost, M.D., Michael McGinnis, M.D., James McGouran, M.D., Sarah (Jantzen) Peters, M.D. and Timothy Peters, M.D.

1992

There were no major changes within the residency, but always faculty worked at the on-going efforts of refining the program, improving on rotations, the evaluation process, and teaching the many changes in insurances.

Graduates were: Kris Kimpe, M.D., Bradley King, M.D., David Kortje, M.D., Dan Lichty, M.D., Ashley Register, M.D., Daniel Schowengerdt, M.D., Todd Stephens, M.D. and Timothy Talbert, M.D.

1993

When Donald S. Seery, M.D., entered our residency, I don't think he thought he would some day be a member of the faculty, but that is indeed what happened in July when he graduated from our program.

Graduates were: Diana Crook, M.D.,
Harold Huff, M.D., Scott Kardatzke, M.D.,
David Lehr, M.D., Mark Murphy, M.D.,
Michael Parra, M.D., Donald Seery, M.D.,
Robert Sweet, M.D. and John West, M.D.

1994

Dr. Chaney decided to retire from the residency in September, having directed the program for 11 years. He brought to us a commitment to family practice, an interest in the KAFP and AAFP that led many graduates to hold offices and support both organizations. Under his leadership, the program grew in resident numbers and the educational experience was enhanced, providing the residency with qualities that annually attracted medical students who were interested in a family practice residency training program. We did very well in filling our slots in the NRMP. Dr. Chaney and his colleagues were some of the first physicians to be board certified as family practice physicians.

Dr. Chaney, as program director, faced major challenges as rules and regs changed within the hospital staff/organization. He continued to argue the importance of having family practice residents trained in specific surgery and Ob/Gyn procedures so that on graduation, these physicians would have skills they needed to use in a rural practice setting.

Dr. Jerry Streit assumed the position of program director, Sept. 1st.

Graduates were: David Bohlender, M.D.,
Michael Bohlm, M.D., Peter DeWitt, M.D.,
Kathryn Hayes, M.D., Brian Johnson, M.D.,
Robert Miller, M.D., Scott Samuelson, M.D.,
Marla Ullom-Minnich, M.D. and Ray Woodmansee, M.D.

1995

Discussions of a merger of St. Joseph Medical Center and St. Francis Regional Medical Center became the #1 focus of everyone. The new name of the combined hospitals would be the Via Christi Regional Medical Center. Loyalty to the St. Joseph Medical Center site and the residency brought some major reactions to the “unknowns” that come with mergers of this size.

Graduates were: Douglas Anderson, M.D.,
Kelly Christensen, M.D., John Evans, M.D.,
David Hoeft, M.D., Leslie Koelliker, M.D.,
Marie Forred, M.D., James Prescott, M.D. and Mark Rucker, M.D.

1996

John Dorsch, M.D., decided to resign from the residency and join the Department of Family and Community Medicine at the KUSM-W. However, he did continue to precept in our clinic, making this decision easier for us to accept.

Dr. Jerry Streit, M.D., resigned as program director effective, April 30, 1996. Dr. Mickey Myrick, M.D., accepted the position of program director, effective May 4, 1996.

Graduates were: Richard Carter, M.D.,
Maurice Duggins, M.D., Rhonda Forren, M.D.,
Byron Garibaldi, M.D., Michael Jackson, M.D.,
Wanda McMichael, M.D., Ann Trausch, M.D.,
Paul Ullom-Minnich, M.D. and Michael Wilson, M.D.

1997

The faculty now numbered six. The merger of the two residency programs was a reality and meetings were being held to accomplish this so that the new program could be approved in time for recruitment activities. We achieved that goal through the dedication of everyone involved.

We also knew that the Family Practice Center needed to be remodeled to accommodate changes in the business office, precepting area, and changes in the program itself. Having received approval from hospital administration, efforts began immediately to address the family practice center remodel with the anticipation that all would be accomplished in 1998.

This was also the year I would have my big 65th birthday, and I decided it was a good time to retire.

Graduates were: Rachael Barr, M.D.,
Edward Discose, M.D., Gregory Greer, M.D.,
Michael Grimes, M.D., Mark Hilger, M.D.,
Joseph Luinstra, M.D. and James Ratzlaff, M.D.
1998
April 1, I finally retired.

MEMORIES
When I accepted this position, I really had little knowledge of what a “Family Practice” doctor was. As I worked with the faculty and residents, it became very clear to me that these were very special people. They had creative minds, were highly intelligent, and were “doers.” They also were men and women who enjoyed the challenges of ministering to the medical needs of people of all ages - and in some cases, entire families. It was not uncommon to see children run down the Family Practice Center halls to their “doctor-friend.” The nursing staff had that same trait - happiest working in a family practice setting. They, too, were special friends of our patients.

The attendings who worked with the residents often became very good friends with them. I always marveled at the loyalty of these physicians who added the training of family practice residents to their busy practices. Many who started as early as 1976 were still affiliated with resident teaching in 1998. That’s commitment!

Class of 1975 - “The Wall”
The most famous incident in the history of the program was the removal of the wall in the autoclave room in 1975. With remodeling of the clinic, this wall prevented everyone from walking through the autoclave room to the opposite side of the clinic. Walking around the outside of the clinic was both time-consuming and awkward for doctors and patients. So one night, the residents and spouses came to the clinic with saws, vacuums and flashlights with the intention of taking the wall down. And they did!

The door-sized piece of magenta-colored wall was taken home by Dr. Tom Simpson. Mother Mary Anne McNamara, CEO, ultimately learned of the “destruction,” and residents were fined $500. Now it became a valuable piece for more than one reason! It was crated and followed Dr. Simpson and his family through his stint in the Navy and finally found its “resting place” at his home in Sterling, Kansas.

Twelve years later, (1987), Dr. Ward Madison, pathologist and friend of the program, called to ask if I knew where the wall was. I tracked it down, and together he and I put together a framed piece of the wall. We worked with Mrs. Tom Simpson to get Dr. Tom to be in attendance at the graduation activities that year. Dr. Madison presented him (as a representative of his class) with the framed wall, and then Dr. Tom officially presented it to the residency, where it has since hung on the wall.

A story entitled “And the Wall Came Tumblin’ Down” (referenced to Joshua) in verse was written by Dr. Madison. It is attached to the back of the framed “wall.” We remember with sorrow Dr. Madison’s death, Jan. 29, 1989.

A Special Birth
Dr. Rod Barnes not only delivered a set of twins - but they were Siamese twins.

We Learned to Fly
Residents were also moonlighting many hours, which allowed those interested in learning to fly to afford lessons and/or buy a plane.

I recall one resident whose wife decided she wanted to learn to fly also, and on a “cross country” training trip home from Texas, he (in his plane) heard her call “May Day” from her plane. She landed in a field of high grasses and (fortunately) came to a stop just at the edge of a ravine. We were relieved when we knew that both had taken off safely from the field and had returned to Wichita.

Our residents were creative and fun-loving and flew up the east coast and filled the plane with fresh seafood - and not just one time! I’ll not question if that was all that “we” did on those trips!

We’re Proud - Mead Johnson Awardees
1976 - Rick Rajewski, M.D.
1981 - Deborah Haynes, M.D.
1984 - Stephen Lemons, M.D.
1985 - Terry Rivers, M.D.
1986 - Carl Fugate, M.D. and Michael Skoch, M.D.
1987 - Bain C. Cate, M.D. and Richard Watson, M.D.
1990 - Melanie Greenwood, M.D. and Michael Havekost, M.D.
1992 - Donald Seery, M.D.
1993 - Marla Ullom-Minnich, M.D.

Recruitment Weekend Comes Home
In the earliest days of residency recruitment, Drs. Purves and Purinton put on a big party in Texas to attract medical students to the opportunities of the St. Joseph residency. During the evening, one student came by and commented on the “wonderful party” and then asked them if they had any idea who was sponsoring it. From then on, recruitment activities took place in Wichita. For many years, these were held in the Wichita Club with its beautiful view of the city and attendance ran as high as 170 people. Support such as this by attending staff impressed interviewing candidates and helped us in our recruiting efforts. Thanks to Dr. Michael Brown, we were able to use the Wichita Country Club for our most recent celebrations.

First Year Resident Surgery Awards
Dr. Whitney Vin Zant incorporated something special to invite-back weekend when he started the tradition of handing out awards to first-year residents. The award (always clever) recognized a specific incident that took place on their rotation with him. It was the highlight of the morning session.

Nursing Staff
The nursing staff of the Family Practice Center contributed so much to the success of our program. Head nurses were: Diane Stearns Chenoweth, R.N., Evelyn Parker, R.N., Ellen Charleston, R.N., Margaret Reinert, R.N. and Marilyn Wasinger, R.N. This limited list indicates the loyalty of their service to the program.

Catherine Baxter, R.N., was nurse to the faculty and so good. She also kept the nurses station and lobby abloom with flowers from her garden.

Patient education began with Colleen Crawford, R.N., and Joan Fox, R.N. They made a significant contribution to the teaching of the residents.

Lab Staff: Our lab was under the direction of Sharon Marcotte all the years that I worked at the clinic. She not only ran the tests, but also took time to teach interested residents - often sharing her microscopes with them. Those who worked along with her were also very important in working with the residents.

Weddings and Babies
We had quite a number of marriages and babies born to the residents over the years. The faculty, nursing staff and business office staff made it a priority to attend many of these. We considered ourselves to be a family and supported each other in these family events.

Sorrows
We remember the families of Gary Peavler, M.D., (Smoky Hill resident), Jim Braden, M.D., Tom Hays, M.D., and Robert E. Riederer, M.D.

Special Clinic Celebrations
There was always a reason for celebrating in the clinic. Dr. Riederer started the tradition of a St. Patrick’s Day noon luncheon by providing all of the food. It took several days to rid the clinic of the odors of corned beef and cabbage, but we came back for more - year after year. It was still celebrated in 1997.

The annual Christmas party with residents and family practice center personnel was also a special occasion. The white elephant exchange that followed the luncheon provided many laughs. I’ll not mention those gifts that were the “best” or who was “lucky” enough to get them. Some “gifts” returned each year to find a new owner.
Hello/Farewell Time

June was a month of mixed emotions as we bade farewell to the third-year graduating class and welcomed the incoming first-year class. Once again, all employees made an effort to come to these parties. It was common for alumni who were in town for a class reunion to join with us. For many years, these parties were held at the Mulvane property owned by St. Joseph. We had skeet shooting, swimming, fishing and eating! Around 1993, heavy spring rains and flooding of the Mulvane properties finally forced us to find a new site for our party - Eberly Farms. Now we could do line dancing!

Resident Meetings

What can I say?! Usually great times - even when emotions ran rampant.

Bikers by the Dozen

Bruce Woods was a biker. He developed recruitment bike trips to visit hospitals in Kansas that were looking for family practice physicians to join their staff. The bikers (residents and spouses) wore shirts advertising their affiliation with St. Joseph and were entertained by members of the hospital staff and community businesses. Over time, this biking adventure grew away from the recruitment aspect into a three day R&R trip to Frisco, Colorado. Graduates and their families were also invited to attend. These “celebrations” will long be remembered by the participants. In coming years, I am sure some of these bikers will continue to ride together.

White Coats and Birthday Cake

Dr. Alan Wedel and the residents decided to have a surprise birthday party for Dr. Riederer’s 70th birthday. It would be held in the loft at The Grape restaurant on North Rock Road. Knowing how upset Dr. R. got when residents didn’t wear their white coats, all of the residents donned their white coats and crammed into the corner of the loft. When he arrived for what he thought was to be a cozy lunch, he was greeted by a roar from the residents all dressed in their “whites.” He was totally surprised - and delighted.

Famous PGY-1 Movies

Annually, the first-year residents made their own movie which highlighted “special observations” noted by them during their first year of training. No one was overlooked in these roasts. For many years, Dr. Ward Madison was involved in the editing and splicing, etc., and kept the content in line. Most of them were harmless, although funny. Now and then, there would be a message or two that was “to the point.” Tapes have been made and distributed to the classes, so we know that across the country there will be times remembered for all of them.

Some of the First Family Practice Doctors

When I first came to the program, there were not many boarded family practice physicians. Many of them were involved in running residency programs. Some ultimately took positions in the American Academy of Family Practice and the American Board of Family Physicians. Recall with me the names of Drs. Ned Burkett, Robert Graham, Dan Ostergaard, Nicholas Pisacano, Robert Rakel, Gayle Stephens, Thomas Stern, and Jack Walker, to name a few. I appreciated the opportunities I had to attend the Residency Assistance Program meetings in Kansas City where I continued to learn about family medicine/residencies and also meet some of the aforementioned physicians with whom I have often talked on the phone.

Special Recognition

I would like to recognize the following physicians who over the years worked with residents and who were also very kind and helpful to me in my job responsibilities. Many are still attending our residents.

Allergy Dr. James Loeffler
Cardiology Dr. Lawrence Sifford,
Dr. William Scott,
Dr. Charles Beck
Colorectal Surgery Dr. Jace Hyder
Emergency Medicine  Dr. A. J. Reed,  
Dr. Alberto Carro  

ENT  Dr. George Randall, et. al.  

Family Practice  Drs. Victor and  
Doris North,  
Dr. Richard Morrison,  
Dr. Floyd Grillot,  
Dr. Terry Poling  

Gastroenterology  Dr. Francisco Rausa  

General Surgery  Dr. Robert Purves,  
Dr. Charles Jenney,  
Dr. Whitney Vin Zant  

Internal Medicine  Dr. Lew Purinton,  
Dr. David Kirk,  
Dr. Glen Hastings  

Neonatology  Dr. Jiggs Nelson,  
Dr. Howard Whiteside  

Nephrology  Dr. Howard Day,  
Dr. Timothy Smith  

Neurology  Dr. Dilawer Abbas  

Ob/Gyn  Dr. Cornelius Sullivan,  
Dr. Verne Mueller  

Ob/Gyn  Dr. Michael Brown,  
Dr. Patty Wyatt-Harris  

Orthopedic Surgery  Dr. Donald Bailey,  
Dr. Ronald Eyster  

Pathology  Dr. William Reals,  
Dr. Ward Madison,  
Dr. James Farley  

Pediatrics  Dr. Herbert Goldberg  

Plastic Surgery  Dr. John H. Rempel  

Podiatry  Dr. Frank Galbraith  

Radiology  Dr. E. J. Fitzgerald,  
Dr. Paul Murphy,  

Dr. H. D. Clifton,  
Dr. Gust Nelson,  
Dr. G.E. Cook,  
Dr. Eric Kater  

Rehab Medicine  Dr. Albert Siegel,  
Dr. Jane Drazek  

Urology  Dr. James Burpee,  
Dr. W. Smith  

Thanks For The Memories  
Throughout my years with the residency, I  
have had the privilege of working with many  
fine physicians. I truly enjoyed them and  
learned much from them. I probably am  
biased, but I will always view the family  
practice physicians as special because of the  
wide range of knowledge they are required to  
maintain in order to care for all ages of people.  
Residents supported me whenever I  
needed their help. Spouses became friends  
and also helped me. I recall one surprise when  
I was given luggage from the residents to use  
on my trip to Norway to meet my family; I will  
always appreciate the care given to members of  
my families during serious illnesses and their  
support of my masters degree completed in  
1993. Although I could have claimed them as  
“my” daughters or sons, I really respected  
them as physicians. I have always been proud  
of all of their accomplishments—their  
scholastic achievements, their bravery in  
attempting new skills and procedures, and the  
contributions they have continued to make to  
medicine after entering private practice.  
Thanks to everyone at KUSM-W who over  
the years worked with me, especially Beverly J.  
Coover and Bill Kimble.  

A Parting of the Ways  
I anticipated the usual morning coffee  
farewell with everyone in the clinic. When this  
party was over, I returned to my desk to  
complete work I had saved to do this last day  
on the job. To my great surprise, there were  
other plans that had been made for me. To all  
who planned the party and worked to make
my last day so special - THANK YOU. Thanks for memories of many years of fun - I loved the “occasional” chaos, the crises, the political “whatevers” - lots of good times.
As far as I can remember, the program started in 1971, when I was accepted as the first resident in the program. The hospital administrators at that time were:

CEO: Mother Mary Anne McNamara
Administrator: Joe Heeb
Director of Medical Education: Lew W. Purinton, M.D. Robert K. Purves, M.D. was in surgery and shared some of the duties with Dr. Purinton.
Director of Family Practice Residency: Dr. James Donnell.

Members of the staff that come to mind:
Pediatrics: Drs. Herb Goldberg, Bill McGuire, Katherine Pennington and Mary Blood.
A bunch of the general practitioners did Ob/Gyn.
Orthopedics: Drs. Eugene Kauffman, Duane Murphy and Don Bailey.
Dermatology: Dr. Blaylock.
ENT: Drs. Richard Cummings and Joseph Budetti.
Family Practice: Drs. Jim Donnell, Rex Lee, McKerracher, Moyer, L. Morgan, James Morgan and N. Morgan, Floyd Grillot, John Aunins, B. Barker, John Weninger, Terry Poling.
Pathology: Drs. William Reals, Goering and W. Madison.
Radiology: Drs. Fitzgerald, P. Murphy and David Clifton.
Urology: Drs. Tony Miles and Raul Brito (the best teachers I ever had and I am NOT talking medicine here).

I came from Colombia, South America, Dec. 27, 1970, and started my internship, soon to be first year of residency on January 1, 1971. The family practice clinic was a third the size that it is today though exactly in the same spot. The new hospital was not yet built.

I came to the states to take a one-year rotating internship, since I was already accepted at Menninger’s for a five-year residency in psychiatry and they demanded a year of rotating internship. I wrote to 52 hospitals in the USA, most of them in the central USA, because I was bound and determined to get here and learn English in one year. After 27 years, I’m still determined to learn English!

I never wrote to St. Joseph Hospital, but somehow the letter I wrote to St. Francis was given to Dr. Lew Purinton and he answered me, telling me about the beauties of St. Joseph and Wichita and offering me $350.00 if I did an internship here. That was an offer I could not refuse!

On my first day, I realized I did not speak a nanogram of English, or at least not understandable, and also realized that the English in Kansas was as clear as Russian in Colombia.
I also discovered that there were no American interns at St. Joseph. There were three Koreans, two Egyptians, and one Argentinean with the name of Russinovich and another Colombian. There were two female pathology residents, one from India and one Afro-American. She's still around. Her name is Gloria Sanders.

The Thursday noon conference meetings were funny because no one understood each other.

Shifts were 36 hours on and 12 hours off IF the attending let you off. Most attendings were nice, though most of the surgeons kept us working during the 12 hours off.

I started my internship on Ob/Gyn, since that was my trained specialty in Colombia. The labor rooms, postpartum and delivery rooms were on the third floor of the old hospital building. The Otis Elevators were the most modern at the time but still took three minutes to open, three minutes to go from first to third floor, and another three minutes to open to let you out. Running the stairs was always faster, exciting and tolerable at 168 pounds, my weight when I first arrived here.

The Doctor On-Call Rooms were two rooms next to each other with one shower, two toilets and seven beds altogether.

The busiest doctor in Ob was Dr. Halpin though he WAS NOT a member of the teaching panel due to internal politics. He recognized my knowledge in Ob and we got along fine and I delivered a bunch of his patients and assisted on a bunch of C-sections with him.

My second rotation was surgery. I never knew that surgeons were “prima donnas” until I did my rotation in surgery. Some of them treated the nuns, the nurses, and the assistants poorly, threw instruments around and yelled. I was not impressed. One surgeon yelled at me because I was not retracting like a “man.” I told him (in Spanish, of course) to call his mother to help him. I never assisted him again.

The most gentle and cleanest surgeon at that time was Dr. Hartley. He is still around as a plastic surgeon. He was a great gentleman with everyone.

The busiest surgeon was Dr. Purves. Dr. Larry VinZant was a special individual. First, he was a magnificent surgeon. Second, he also did orthopedic, ENT, plastic and reconstructive, and neurosurgery. He was very amiable, invited me to his home just two blocks from the hospital and showed me the picture of his twins who were in college and hoping to become physicians.

Pediatrics was probably the nicest of the rotations. The pediatricians were very nice, very relaxed. Children were nice and easy to take care of and parents were very attentive and followed instructions. The nurses were happy and we had the chance to rotate through the attending's offices.

The busiest of the rotations was internal medicine. Dr. Purinton, Kirk and their newly arrived practice associate, Dr. Frederick Wolfe, moved an immense amount of patients through. We were responsible for all the H & Ps, getting all results ready on the chart and tracking down x-rays to be available for review with them. It was like in the military. We started at 7 a.m. in CCU, then to the floors and then reviewed x-rays. A typical day followed with anywhere from five-to-25 admissions. All three attendings were very good.

Dr. Wolfe diagnosed my gout. I spent eight hours in his office. He did four arthrocentesis on my right knee until he could see (and show to me) the uric acid crystal he needed to make the diagnosis.

During the early months of my internship, Dr. James Donnell talked to me several times and even took me out for dinner. Everyone was so nice to me that I was overwhelmed and sorry I would have to leave soon. But Jim Donnell explained to me about a new specialty for doctors just like general medicine, but instead of opening your office after internship, you went through three years of training. I could not see the difference clearly but I was very ignorant in the American Way. I was not very concerned since I did not have any debts.

The hospital paid for my apartment, meals were free in the hospital and I had few expenses since my time off was spent sleeping.
I agreed to go into the family practice program, wrote to Menninger's and told them I had changed my mind and by the time I finished my internship, I was already a second-year resident!

Dr. Joachim Schnelle got here to start July 1, 1971, and a little later, maybe September or October, Dr. Dick Morrison arrived from Kansas City, where he was training in Ob/Gyn as a third-year resident.

All so suddenly, a six-month-old family practice program had residents in the first, second and third years.

I went to Kansas City and took my licensure exam on Jan. 7, 1972, and started moonlighting on Feb. 1, 1972, in the E.R. under the directorship of Dr. A. J. Reed for $4 an hour. By July, 1972, I was so good, Dr. Reed gave me a 20% increase in my salary.

In April, 1972, in the Western Kansas town of Spearville, near a school called St. Mary of the Plains in Dodge City, the doctor who lived and worked there all of his life was ready to go on a long overdue vacation (12 years in the making). He was found dead while loading the trunk of his car.

This matter is mentioned here for you to understand how the first outreach program in Mid-America developed. In that little town of Spearville were a bunch of sisters of St. Joseph, who owned and operated St. Mary of the Plains College and happened to be the owners of St. Joseph Hospital. They were very close to the CEO, Mother Mary Anne McNamara, who was, as you can guess by her name, an Irish-impressive, decisive, feet-on-the-ground, never-intimidated-by-anyone woman. She called Dr. Donnell and told him, “We need to send Osio to Spearville and he needs to be there no later than tomorrow.” And so, Outreach was launched for the family practice program.

Of course, it was not perfect. There was no other doctor there. There was a surgeon who came from Dodge City twice a week and did “major” surgeries. The deceased doctor had done tonsils, adenoids and deliveries.

Imagine, if you will, a doctor from Colombia planted suddenly in the Wild West. For the first three days, I saw about six patients. The second night, the wife of a prominent, rich farmer went into labor and they brought her to the hospital for delivery. Then they realized that her doctor had died. I happened to be there and the secretary, assistant, nurse and part-time anesthetist of the previous doctor told the couple to have the expectant mother checked before driving to Dodge City to which they agreed.

She was dilated fully and once she was placed in delivery position, being a multipara, no one could stop her from pushing. The baby came out very easily, with his right hand extended toward me as if to say, “Thank you.” I said, “You are welcome” and also welcome was a second baby that nobody expected! I just caught them. No episiotomy, no tears. The placentas dropped by themselves and the postpartum was smooth as silk.

The next day, by 7 p.m., I had seen 50 patients. It continued like that with no interruptions for the following four weeks. Routine returned to town and I assisted the surgeons who came to perform gallbladders, appendixes, tonsils, etc. I was invited to eat in more homes and restaurants and places, not only for dinner, but also for breakfasts and lunches, than I ever had in my whole life.

Patients paid $4 for doctor visits and $2 for office services - 98 percent cash, 1.9 percent insurance; nobody ever talked about the other 0.1 percent. I suppose it was charity. I continued to receive checks for up to six months after I returned to Wichita.

No one knew what to do with all that money, until Dr. Donnell came up with a wonderful idea: “Keep it,” he said, and that was it!

In December, 1971, the family practice program and clinic were formally established in a ceremony presided over by Governor Docking.

The second year of residency was nice. The program started to grow steadily. Dr. Donnell became the Wichita City Mayor and that increased the residents’ loads, but the excellent support from the ancillary departments was always present. Some of us saw patients in the A.M. and some in the P.M. Each one of us developed our own practices.
The call schedule became easier, every third day and every third weekend. Moonlighting in the E.R. also became easier: two days on and one day off, two weekends on and one off.

The Mayor of Wichita, Dr. Donnell, made a deal with Cessna or Beechcraft and they offered free flying and instruction lessons to the residents of the program. Many took advantage of the program, among them Dr. Schnelle. Many residents were licensed and certified through this program in preparation for their future assignments in the "outreach" program.

There was a primitive ambulance service in Wichita which was trying to become something. It was Lanternman Services and the owner, along with Dr. Reed, was trying to develop a good service in Wichita. They teamed with St. Joseph Hospital and the Mayor pestered Governor Docking to appoint a Task Force to develop an ambulance transfer program not only in Wichita but in Kansas.

Somehow I got selected as a Task Force representative and for three years, twice a year, I went to Topeka to discuss everything from how many lights should be on the top of an ambulance to how many hours of training the EMT's should have.

In Wichita, the EMT's first started with 12 hours of training, then 40, then 82, then 120. I do not know how many hours they require today. The E.R. doctors used to ride in the ambulances with the EMT's to give them training. From the EMT's we discovered 1001 places to eat delicious and greasy foods in Wichita, to which I account 100 of the extra pounds I have put on since then. I learned a great deal in this new type of "outreach," the second outreach program I participated in!

We started to see a lot of rape victims in the E.R. and because of the frequency of the trauma, Dr. Donnell, the Mayor, called a meeting attended by Dr. Donnell, Wichita Police Department Lt. LaMunyon, myself and a lady from social services. We developed what was known as the Wichita Area Rape Center Task Force and, with the cooperation of the St. Joseph E.R., established one of the first programs in the country. I still have the Certificate of Merit given to me by the Justice Department.

During the early part of my third year of residency, St. Joseph Hospital and A.J. Reed developed a system that, at the time, was named Minor Emergency Centers. During the developmental process, the E.R., staffed by four full time doctors, suddenly lost two doctors. Dr. Ferrell went to law school and Dr. Howell decided to move to Montana. I was asked by Dr. Reed to become a full time E.R. physician and Mother Mary Anne gave me her personal guarantee that I would be able to return to the family practice program and finish my residency within the next five years. We shook hands (in those times we never signed contracts) and I became a full time E.R. physician.

The first group of full-time, first-year residents were Drs. Mary Goodwin, Steve Bruner, Tom Simpson and Tom Norris. They started July 1, 1972.

During the second and the third year of residency, we had to rotate each year through two months of the standard rotations (medicine, surgery, Ob/Gyn, pediatrics) and the other months each year were for specialty electives. I did mine in dermatology (two months), ENT (two months), orthopedics (two months), surgery (two months), oncology (two months), and of course, E.R. (two months).

I graduated from the program on April 30, 1977.

I suffered a massive CVA on May 13, 1977. That tells you what residency training at St. Joseph was!

Records I established:
• The first resident in the program.
• The first "outreach" participant in the program.
• The longest lasting resident in the program: started 1971, graduated 1977.
• The only resident to suffer a cerebrovascular accident upon completion of the program . . . and survive!
"... the residents were a proud, intelligent, hardworking and well-trained group."
by LARRY R. ANDERSON, M.D.
BOARD OF DIRECTORS, AMERICAN BOARD OF FAMILY PRACTICE
FORMER DIRECTOR, AMERICAN ACADEMY OF FAMILY PHYSICIANS
BOARD OF DIRECTORS, 1992-1995
MARCH 17, 1997

Joel T. Weigand, M.D., and I established the Sumner County Family Care Center in Wellington, Kansas, in July, 1976. As practice was slow, we started working in the emergency room at St. Joseph Hospital on a regular daily basis in the fall of 1976. For various reasons, the St. Joseph Family Practice Residency Program lost its entire faculty that fall. Lew Purinton, M.D., director of medical education at St. Joseph Hospital, then became the interim director for the residency program. As two of the few available residency-trained, board certified family physicians, Joel and I were then recruited for the daily role of teaching ambulatory family medicine in the St. Joseph Outpatient Residency Clinic.

We continued in that capacity for about 10 years. As our practice grew, we were forced to reduce the time spent in the ambulatory clinic and eventually we discontinued on-site teaching in the residency. During our last few years of teaching, the residents used our practice site as their rural rotation. This rotation continued for several years and I am not sure exactly what year it was discontinued.

Kenneth Evans, M.D., joined the St. Joseph residency faculty staff as a full-time associate director in early 1977. It was not too long after that when Larry Miller, M.D., arrived as director. During our time as faculty, Dr. Riederer replaced Dr. Larry Miller and Dr. Ken Evans moved to private practice in Shattuck, Oklahoma. Jerry Streit, M.D., completed his residency training at St. Joseph and became full-time faculty. Lary Hill, M.D., a St. Joseph resident, returned to full-time faculty work after several years of private practice in Great Bend. During these additions, Joel and I discontinued our faculty positions at the residency.

During some of those years, the St. Joseph Family Practice residency had additional first-year resident slots for those family practice residents matching with the Smoky Hill Residency for their second and third years in Salina, Kansas.

During all my years at St. Joseph, I think the primary memory would be that the residents were a proud, intelligent, hardworking, and well-trained group of physicians. This group was unwilling to accept negative comments about family medicine from anyone.

They were openly proud of their choice regarding family medicine and St. Joseph Hospital as their site of residency training.

It was well understood that an association with KUMC might have some political, financial, and academic advantages for family practice residencies. Even so, the residents in the late 70's and early 80's felt little need to embrace the University of Kansas Medical Center - Kansas City or Wichita. This was partially because residents were frequently from "out-of-state," but mainly, I think, because the medical students coming from KUSM were not positively impressed with KUSM's treatment of family physicians.

Managed care became an issue in the mid 80's. It would be interesting to contemplate where primary care and family medicine would be now if it had not been for the "managed" approach to health care. If
fee-for-service medicine had continued its dominance, it is most likely that primary care residencies would still be fighting for residents and their residents would be fighting even harder for privileges.

In the last 25 years, Wichita residencies have produced a large number of family physicians who have become leaders in academic and clinical family practice positions across the country. I am confident that Wichita and affiliated training programs will continue to be a strong foundation for family medicine throughout this country, building on the early work of family practice pioneers such as Ned Burket, Gayle Stephens, Don Goering, Ernie Chaney, Richard Brummett and others.
“...the Legend of the Wall was born...”
by TOM SIMPSON, M.D.
FORMER RESIDENT, ST. JOSEPH FAMILY PRACTICE RESIDENCY
PAST PRESIDENT, KANSAS ACADEMY OF FAMILY PHYSICIANS
JUNE 1, 1997

During my turn as chief resident of the St. Joseph Family Practice Residency in 1975, the Legend of the Wall was born. It is a great story. It is a true story. It is also a story that tells a lot about the nature of the residency program in those early years. It has been told over and over in dark rooms and at banquets. It has probably been embellished upon to various degrees. I don’t know that it has ever been recorded. Here goes:

Our office in those days at 1131 S. Clifton was getting crowded as the first third-year class built their office practices. Space was at a premium. We felt the need to develop an in-office lab so that every urine and throat swab didn’t have to be taken to the hospital lab with the mandatory hour wait for a result.

The only space available to put the lab was the crossing hall between the long east and west corridors that were lined with exam rooms. It fit quite nicely and there was still room to get through from one hall to the other.

One day, we came to work to find the hospital maintenance department hard at work closing off the west end of the hallway with a wall. They were at work for several days studding in the wall, dry-walling it and then painting it to match the office decor.

Apparently, it had been decided by the “hospital” that a laboratory facility in a hallway was not appropriate; it had to be in an enclosed space, a room. “It was a Medicare rule,” we were told.

We were angry. Worse than angry; we were furious. The change meant walking to one end or the other of the office each time you needed to get from one hall to the other. Not only that, this was our practice! This was our office! No one asked us about the wall! The wall had to go!

In those days, the residents worked hard and we played hard, too. The next weekend, the fortitude to take down the wall was provided by 6-carbon beverages at a backyard picnic at Carroll Verhage’s house. Carroll is the one I pulled off the bottom of Dr. Chuck Jenny’s swimming pool with a pulse of 15 and apneic and my associates resuscitated on the pool deck - but that’s another story.

Anyway, we had had a good time eating, drinking, playing volleyball, telling war stories from the C.C.U. or the E.R. and giving Charlotte Hays a hard time about being due with their first baby and not being able to participate in the activities.

As the evening wore on, a plan was formulated. We would go home to collect the needed tools and meet back at the office at 1 a.m. We all had keys to the office so getting in was no problem.

This was no ordinary demolition job. The dry wall was carefully cut apart with a cast saw and bagged up in trash sacks. The studs gave way to hammers and crow-bars. All the lab equipment was carefully covered with plastic to keep it clean. The girls very carefully vacuumed up all the plaster dust and even washed down the walls and counters so as not to leave a mess.

The studs and the bags of wall board were loaded into my station wagon and Steve Thomsen’s Suburban and taken to the dumpster behind the appliance store at Harry and Oliver. Always did wonder what those folks
must have thought when they took their trash out on Monday.

Perhaps foreseeing the significance of our actions, I took several pieces of the wall home with me that night. I hauled them to New Hampshire where we left St. Joseph for my tour with the U.S. Navy and then brought them back to Sterling when we moved to establish a private practice in 1978. Several years later at a residency graduation banquet, it was my pleasure to present a piece of the wall to Dr. Ward Madison, a now deceased pathologist who was Chief of Staff of the hospital at the time and was one of the residency’s great supporters in those days. I understand he had it framed and hung back in the residency office.

Later that night, I was called back to the hospital to deliver a beautiful, healthy baby boy for Tom and Charlotte Hays. Guess all Charlotte needed to go into labor that night was a glass of what she thought was orange juice at the picnic.

Dr. Tom was killed in a plane accident several years ago. The community lost a tremendous family physician and the world a wonderful spirit with Tom’s death. I was able to muster a quiet smile through tear-stained cheeks when I saw Andrew escort his mother into the church for the funeral of Tom and his two sons who were killed with their dad.

Monday morning brought great confusion and excitement. Someone had broken into the office over the weekend and vandalized the office. They had taken out the wall on the west side of the lab. How was such a thing possible?

The Wichita Police Department was called to investigate and found the resident’s fingerprints in the lab and on the adjacent wall surfaces. What did they expect? We worked there.

There was a steady stream of hospital administrators and medical staff through the office, inspecting the damage. Many thought it was kind of funny, but the company line was that this was a very serious matter and that criminal charges might be filed.

Tuesday morning found me in Mother Mary Anne’s office “on the carpet.” She was holding the residents personally responsible for this action. We would receive a bill from the hospital for the damages.

Wednesday morning found a coffee can on Dr. Joe Fitzgerald and Dr. Paul Murphy’s desk labeled “Resident’s Relief Fund.” Drs. Fitzgerald and Murphy, as the senior radiologists, were tremendously supportive of the young residents and their rebellious, bold spirits. Dr. Fitzgerald gave me the coffee can the next week. It was full of tens and twenties that had been collected from the entire medical staff. The residents seemed to have united the hospital’s medical staff around our cause.

The can had almost $800 in it, which was more than enough to cover the hospital’s bill for something over $600. I dutifully took the can in and set it on Mother Mary Anne’s desk. I had the feeling that she was a little angry over the medical staff covering the resident’s folly, but I suspect that she also knew how good it was for the hospital to have a strong residency program and to have the medical staff behind the program. She later gave the money back to us and we used it to purchase speakers and a receiver for the office’s first background music system.

I honestly don’t remember whether the wall was rebuilt or the doorway simply reconstructed. I guess it doesn’t really matter. We had affirmed our ownership of the residency. The office was ours to manage and operate. The patients were our patients; the practice was our group practice. We knew we had the support of our mentors and teachers and the hospital’s medical staff.

Each of us carried away from St. Joseph many wonderful memories. We all remember certain patients, certain nights in the E.R., certain cases in the O.R. or the delivery room. We will always remember rounds with our favorite attendings. We hold dear our comrades who we trained with for those three years. But none of the memories top “The Legend of the Wall.”
"... it was a superb place to learn to practice family medicine."
by THOMAS E. NORRIS, M.D.
FORMER RESIDENT
ST. JOSEPH FAMILY PRACTICE RESIDENCY
MAY 27, 1997

My first visit to Wichita was in the summer of 1972 as a fourth-year medical student at the University of Texas Medical Branch in Galveston. I was returning from doing a summer clinical clerkship in cardiology and family medicine at the U.S. Naval Hospital in Bremerton, Washington.

During that time period, the rigid coordination of interviews at residency sites, which we now take for granted, simply did not exist.

If a third or fourth-year student wanted to interview at a family medicine residency site (remember they were all less than two years old), the student simply called the residency and arranged for an interview.

With that in mind, having heard many positive comments about the training programs in Wichita, and having read much written material by Gayle Stephens, M.D., I decided to interview at the two programs in Wichita.

Upon arriving in Wichita in August of 1972, I first went to Wesley Medical Center for an interview. I had had an opportunity to talk with Dr. Stephens on the phone and I found that he did not plan to be at Wesley during the three years that I would be a resident. Indeed, Gayle had decided to move to Alabama to accept a position in their Department of Family Medicine.

At that point, both residents and faculty at Wesley were quite concerned over the impending loss of their residency director. This led me to decide not to rank Wesley highly among my potential choices. Gayle did suggest to me, however, that I should visit the new family medicine residency program at St. Joseph’s Hospital. With that in mind, I called Jim Donnell, M.D., the new residency director at St. Joseph’s program and arranged an interview. St. Joseph’s had just started training its first class of family practice residents. For many years prior to 1972, St. Joseph’s had had a rotating internship. Many of the “slots” in the internship classes were unfilled. For this reason, St. Joseph’s was not used to having high quality, enthusiastic, energetic, U.S. trained first-year residents.

The new first-year residents from St. Joseph’s first class of residents, whom I met in August, 1972, had been there for about a month. Among this class of residents were some excellent physicians, including Steve Bruner, M.D., Steve Thompson, M.D., Wayne Morton, M.D. and several others. At that point in time, there was one faculty member, the residency director, Jim Donnell, M.D.

I was quite impressed by the genuine acceptance of the new residency program by the medical staff at St. Joseph’s. Furthermore, I was extremely impressed by the opportunity to participate in the development of the curriculum and to tailor it to one’s own vision of future practice needs.

Finally, the attitude of the hospital toward becoming a “major player” in medical education in the Midwest was refreshing. With these strong positive attributes in mind, and with a sense that I would probably fit in well with the residents a year ahead of me, I left Wichita with plans to rank the St. Joseph’s program as my first choice when the match list was due.

The senior year of medical school at Galveston went rapidly. We turned in our match lists in February and I was pleased to
find, later in the spring of 1973, that I had been selected for the residency program at St. Joseph’s Hospital and Rehabilitation Center in Wichita, Kansas. At that point, the relationship between the University of Kansas and the residencies in Wichita had not been completely developed.

My wife, Sandy, and I moved to Wichita in June of 1973 after graduation from the University of Texas Medical Branch.

Since my class was the second full class that had entered the family medicine residency program, there was not an R3 class to provide senior leadership. I recall that, even for the first-year residents, we had two half-days per week of time in the Model Family Practice Center.

The Model Family Practice Center was located behind the hospital on Clifton Street and had been completed just prior to our arrival. The first year went very smoothly. With only 12 residents in the hospital, and with a very high occupancy rate, the residents were allowed to accept as much responsibility as they felt comfortable with.

This created a remarkably positive teaching environment. Call was much more frequent than is common today. I recall many periods during my first year when I was on call in the hospital every other night. My major recollection of the first year is that when our residency class wanted to do something, be it a clinical rotation or involvement in a hospital committee, we were almost never told “no.”

Late in the first year of residency, we began developing a satellite rural clinic in the small town of Elk City, Kansas. Dr. Donnell had served as plant physician for Cessna Aircraft and he arranged to have a family practice resident (and usually a faculty member) flown to Elk City to do a “rural” clinic several afternoons a week. This was a fantastic experience and one that I participated in throughout my residency program. It gave me the opportunity to learn to fly, and it also created a true love of rural medicine which persists to this day.

I discovered during my second year of residency that I really enjoyed doing endoscopic procedures. Fiberoptic endoscopes had recently come to Wichita and were being used by several of the surgeons at St. Joseph’s. During my residency, I was able to learn to perform upper GI endoscopy and bronchoscopy. These are skills that I have been able to participate in and teach for the last 25 years.

The residents in our class truly valued the time spent in the Family Medicine Center, and found it to be very successful. Another member of the faculty, Dr. Hattrup, was added during that year. At the beginning of my third year, a third faculty member, Kenneth Evans, M.D., joined the faculty. During this time period, Dr. Donnell was serving as Mayor of Wichita. I recall that he was heavily involved in setting up a sister city between Wichita and a community in France. This led to a significant amount of travel and frequent absences from our residency program.

Dr. Donnell’s strong guiding philosophy of family medicine, placing the patient first and foremost, did a lot to set the tone for the residency. Additionally, Jim’s approach to the residents as members of his own family created a sense of warmth and security that taught me important lessons about running an office.

During the third year of my residency, I had an opportunity to do electives with many private practicing specialists in various disciplines in Wichita. My clear recollection is of the immense interest and enthusiasm for teaching exhibited by these physicians.

I truly feel that the quality of education offered to those first classes of residents in Wichita was superb. Much of the credit for this should be given to the voluntary specialty faculty serving the residents. Among outstanding members of this group were Dr. Purves, our faculty member in general surgery; Drs. Purinton and Kirk, our faculty members in internal medicine; and Dr. Goldberg, our faculty member in pediatrics. Additionally, Dr. Mueller provided strong instruction in obstetrics, and we also had excellent role models in psychiatry.

During the start of the third year of my residency, the famous “wall” episode took place at the Family Medicine Residency Center at St. Joseph’s. A decision had been made to
add a nurse practitioner to the staff of clinicians in the residency program. Based on this decision, office space was needed. The hall system in the clinic was that of a figure eight, with exam rooms around the outside and support facilities around the inside. Someone came up with the idea that a good location for the nurse practitioner’s office would be in the middle portion of the eight. This necessitated closing off the hallway across the middle to create an office. For this reason, a wall was built across one end of the hallway, and this elongated office served our nurse practitioner.

Unfortunately, it resulted in a major increase in steps for the residents who now had a racetrack rather than a figure eight to deal with. With this in mind, a group of, to this day unnamed, mysterious individuals used a cast saw and rubber gloves to remove the wall one evening after a resident party. The identity of these individuals is still shrouded in mystery (and hopefully will forever remain so).

Another highlight of the third year of residency was the opportunity to spend some time in Guatemala. The Diocese and the Order that sponsored St. Joseph’s also had a missionary clinic in a small town in the mountains of Guatemala. There was a major earthquake in the spring of 1976 in this area. The clinic was damaged and several of the personnel were killed. Because of this, several residents, myself included, had the opportunity to go to Guatemala and to work in the clinic. This gave us the chance to witness Third World medicine and to utilize our primary care skills under some difficult, but seriously needed, circumstances.

Upon completion of residency in the summer of 1976, I entered the military. Like many of my contemporaries, I had a “Berry” plan deferred service obligation. Viet Nam had been under way at the beginning of my residency, and the draft was very much a reality for us. Thus, my next two years were spent at the Naval Regional Medical Center in Long Beach, Calif.

My general recollection of three years at St. Joseph’s, during the second through fourth years of its existence as a family medicine resi-
"... everyone went into the hospital together as they were all so scared."

by KATHY BRUNER
WIFE OF FORMER RESIDENT STEVE BRUNER, M.D.
ST. JOSEPH FAMILY PRACTICE RESIDENCY
FEBRUARY 1998

I am writing to you on behalf of Steve Bruner, M.D. He commented that there were a lot of memories that you probably really would not like included — like the time the residents took out a wall with a cast saw in the Family Practice Clinic, got into trouble from Sister Mary Anne and sold "pieces of the wall" to the attendings to pay the bill Sister assessed for damages.

... Or the unanticipated Siamese (conjoined) twins that were delivered vaginally by an intern (Dr. Barnes) and a second or third year resident (Dr. Simpson). The Wesley folks tried to steal the babies for their Level III nursery, but Dr. Hattrup stood guard and wouldn’t let them in the nursery. Later, a high powered team flew in from Boston Children’s Hospital to separate them and they shared no organs - just skin! Months later the indigent father kidnapped one of the babies from the hospital just before social services took them away for placement. He and the baby were gone for over a year.

... Or how the very first night of the very first residency class, the residents (Dr. Bruner, Dr. Morton, Dr. Thomsen and Dr. Goodwin) and their wives all came to our house for dinner. Dr. Thomsen’s beeper went off and everyone went into the hospital together as they were all so scared.

... Or how Dr. Morton took the Infamil from the drug rep for his new baby despite the fact that his wife was nursing, and made ice cream out of it for a party. When we wouldn’t eat it, he gave it to his hunting dog. For the first week of residency or so, he talked so much about Betsy, we thought that was his three-week-old baby, but the baby’s name was Barbara. Betsy was his German Shorthair!

The families of the residents cannot thank the attendings and their families enough for their support during those intense residency years. The annual Christmas parties at Jim and Elizabeth Donnell’s home was a highlight for all of the St. Joseph Hospital residents. Our children are the ages now that their kids were then, and I don’t know how they managed to make time for all of us.

Dr. Donnell was mayor during that time and tried to instill in the residents a sense of community commitment. He took Steve along for the visit of presidential candidate George McGovern on the last stop of his campaign. Dr. Donnell and Steve had to tromp across a muddy field to reach the platform. A national newswoman interviewed Steve and observing his muddy whites, asked if he was a "veterinary" doctor.

The Donnell’s were kind enough to share their cabin and boat at Beaver Lake and we really appreciated it. Our weekends there were often the only breaks we got from all the new responsibility. They only asked that we replace the beer in the refrigerator and the gas in the boat. We were happy to comply.

Dr. Paul Murphy was a good and true gentleman. He seemed to know more about the breadth of medicine than any doctor Steve had ever met. He was the first physician we knew who kept a file of medical journal articles. He could go to that file on any question the residents would come up with. He knew his specialty of radiology and everyone else’s and was also fun to be around. Steve keeps a similar file to this day.

Dr. A. J. Reed was the Milo Minderbinder
(see *Catch 22*) of St. Joseph’s. He knew more about the business of medicine than anybody else.

Dr. Schnelle introduced the residents to high grade stereos.

Dr. Chuck and Lucia Jenny let us all “house sit” for them when they were out of town. It always seemed to rain, but we used the pool anyway. Dr. Jenny introduced the residents to Chivas Regal, and loaned us a book, *The Underground Gourmet Guide to New Orleans*, which started us on an intense romance with that city. Our waistlines will never recover!

Dr. Robert Purves was the most courteous surgeon Steve had ever scrubbed with. The first time Steve scrubbed with him, he adjusted an instrument to give better operative exposure, and Dr. Purves said, “Thank you.” Steve says he almost fainted dead away with surprise. When discussing c-sections as a surgical procedure, Dr. Purves said, “doesn’t take much of a surgeon to find an eight pound tumor.” Dr. Purves used to say a great day consisted of an easy gallbladder and a round of 18. He was a true professional, a great teacher, a gentleman and is sorely missed.

Our residency mates were bright and fun to be around. We had a memorable scavenger hunt, that Dr. Tom and Linda Simpson organized, that began with the rhyming clues frozen in ice cubes! Dr. Tom and Sandy Norris were the wine sophisticates of the group, despite an early experiment with grapefruit wine that was less than successful.

For years our residency group kept a round robin letter going from Kansas to Missouri, to Montana to California and we would all write about our experiences, our concerns, and our children. When that big manila folder arrived in the mail, we dropped everything to touch base with our old friends. Now we e-mail.

Most of us are with our original spouses and some of us are even proud grandparents. We cherish those special years of residency. It was an intense three years and we thank the named and unnamed for their support and encouragement.
"... it is obvious that the only truly primary care physicians in the State of Kansas are family physicians."

by ERNIE J. CHANEY, MD

PAST DIRECTOR, ST. JOSEPH FAMILY PRACTICE RESIDENCY
PAST CHAIR, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE
PAST PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS
PAST PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION
AUGUST 1997

In thinking about the history of family practice education in Wichita, I am taken back to the establishment of the Wichita campus. My medical school education was at the University of Kansas School of Medicine in Kansas City and my referrals for limited specialty consultations were generally to that institution in the 60's and 70's. However, the Board of Regents decided that a medical school branch in Wichita was a consideration.

I am not sure that I really was too much in favor of that. Due to great foresight by many individuals, the school came about and my next recollection about the medical school was my involvement with the Wesley Family Practice Residency.

The co-directors of the Wesley residency had elected to establish a rural rotation and chose Minneola and Belleville as the two rotation sites. My partner, Herb Doubek, and I would fly our plane to Wichita the first Monday of each month and one of us would precept there for half a day.

We later established a two-month rural rotation. A resident and his family would come to Belleville to practice with us. The most difficult thing about that arrangement was finding living facilities for the resident and family. A community of 3,000 does not often have apartments available, but due to our practice and our interest, and the interest of the city of Belleville, we were able to find apartments where residents were housed.

At the time, the RRC required the residents return to their "mother house" once every four weeks. Inevitably it seemed that during the time the resident was gone, we would have patients that were extremely interesting. One of our first residents was Ken Wright, who happened to be with us at the same time that my partner fractured his atlas. It was indeed an experience for Ken (as well as myself) to have me busy practicing with a senior resident. I believe the Wesley rural rotation in Belleville continued until just recently.

My first connection with the St. Joseph Family Practice Residency was at the time I was president of the American Academy of Family Physicians. Dr. Deborah Haynes was the Mead-Johnson Award winner and I was invited to make the presentation and give a talk at her graduation exercises from St. Joseph.

In 1981, I was approached by the chairman of the department, Ed Donatelle, M.D., to come to Wichita to direct the St. Joseph Family Practice Residency. I remember telling Ed that I thought that was a very nice compliment for me, but that I was quite happy in my practice in Belleville and enjoyed the community, the practice and my partnership.

However, those who know Dr. Donatelle remember his bulldog tendencies and he kept asking me and asking me to consider coming down to look at the residency.

Finally, I told Margie we would go to Wellington where our family lived and passed through Wichita and I would visit with Dr. Donatelle and get him off my back. I did have
the opportunity to visit with him and Dean Bill Reals and the residents at St. Joseph Medical Center. When we left Wichita, I told Margie that it certainly was an interesting opportunity and that while I did not think I was interested, I thought we might want to have more thorough discussions with the individuals involved.

We later returned and had an interview with Lew Purinton, who was vice president of medical education at St. Joseph Medical Center and with Mother Mary Anne McNamara, who was the CEO. After considerable meditation, prayer and contemplation, I decided to make one final visit to St. Joseph.

During that visit, I visited with Mother Mary Anne. I told her that I was interested, but that I would not come unless I could be assured that some of the surgical privileges, which I had worked so hard to obtain in Belleville, would be allowed at St. Joseph Medical Center. This particularly involved Ob/Gyn surgery, hysterectomies and C-sections. Mother Mary Anne told me that, of course, these privileges were the decision of the medical staff. However, if that was the only thing holding me up, that I should get ready to pack because she had “Executive Override.”

Mother Mary Anne did not need to exercise that right because the privileges were granted and I took over the leadership of the residency.

At that time, the faculty included the retiring program director, Bob Riederer, Jerry Streit, Debbie Haynes and recently hired Adrian Walling. The majority of my efforts in the first two years was the recruitment of adequate faculty with the knowledge that Dr. Riederer would soon retire completely. Later on, Debbie Haynes decided to go into private practice and Adrian Walling entered the HMO business. Consequently, recruitment of an active and knowledgeable faculty was important and we were able to do that by recruiting individuals such as John Bradley, who now is the program director in Decatur, Illinois; John Dorsch, Ken Wakefield, Don Seery, Lary Hill; and Mickey Myrick.

The residency at St. Joseph Medical Center, I believe, developed into one of the top ones in the country. Originally, we would supply the education and experience for first-year residents who had matched at the Smoky Hill residency in Salina. This was a problem at Smoky Hill because of the transition the students had to make from their medical school to Wichita and then move to Salina. After much work, we were able to change that so that the Smoky Hill residency was all three years in Salina.

I was program director of the St. Joseph program for about 12 years. In 1994, it was time for me to relinquish that position, so I retired. I spent several months in south Texas, where I have two sons and four grandchildren. However, in early 1996, I received several calls while I was in the Rio Grande Valley from Dean Meek and other individuals requesting that I come back to Wichita, out of retirement and help as chairman of the department until a permanent chair could be located.

It was with some trepidation that I accepted that call. I must say in retrospect, it was one of the most enjoyable times that I spent in academic medicine. The department re-examined itself, set new goals and I believe made significant advancements.

Historically, I can also tell you that I served on the search committee for the original chairman of the Department of Family Practice at the University of Kansas School of Medicine - North Campus in Kansas City. I believe Don Goering may have been on that committee with Dr. Max Allen and me. I can remember flying my plane several times to Kansas City for meetings and interviewing with potential chairmen.

I can distinctly remember one evening after a dinner meeting at Dr. Max Allen’s house to discuss candidates. I left the Kansas City airport downtown and lost my generator in the plane and had to land without radio communications or lights. I also very distinctly remember several meetings where I flew to pick up Don Goering and he and Margie and I would fly to the university to visit with medical students about the potential and advantages of family medicine.
In regards to the earlier days of precepting when we were in private practice in Belleville and had residents, initially the Wesley residency paid a very modest sum to help with the expenses that occurred, such as utilities, phone, rent, etc. My recollection was that it amounted to about $1,000 a month. We also had a very small reimbursement for travel from Belleville to Wichita, when we precepted at the residencies. It seems to me that as the medical school became more established, and with the transfer of administration from Wesley Hospital to the university, those reimbursements disappeared. I think that is unfortunate and I believe it is something that should be looked at very carefully in the future. It would seem that perhaps some of the PCPE money might go towards preceptor reimbursement.

Our own rough calculations of our cost of having residents in a private practice were as follows. It took about 20 percent extra time if we had a medical student in attendance, since one had to go slower and do more teaching and explaining. In the case of third-year residents, it probably took an additional 10 percent of time.

While residents were soon to be in practice, their clinical skills and operating room skills still needed to be observed and verified. It was our impression that we were there to teach, so teaching did take some time. It is true that in those days, we were able to recap some of our lost time by charging insurance companies for assistance during surgery. On occasion, the residents were able to handle emergency room calls.

Belleville, Kansas, would not have Dr. Robert Holt, a prominent family physician there today, if it were not for his experience on rural rotation during his residency at Wesley.

The University of Kansas School of Medicine at Wichita is a unique institution of higher learning. Because of its location, the ability of its faculty (which tend to be mostly volunteer) and the dedication of the full-time faculty at 1010 N. Kansas, our training can produce family physicians who are equipped to treat 90-to-95 percent of the illnesses that are presented to them. This is extremely important for the proper care of individuals residing in a rural state such as Kansas.

Although the term “Primary Care” has received a great deal of emphasis, it is obvious that the only truly primary care physicians in the State of Kansas are family physicians. The general internists, general pediatricians or Ob/Gyns cannot survive in towns like Plainville, Belleville, Smith Center, Fredonia, etc. The only individual who is trying to serve those communities in a cost-effective and truly quality medical service is the well-trained, well-rounded family physician.

It seems quite obvious to me that individuals have to be trained in an institution which understands family medicine, which is free of the turf issues regarding operating suites, delivery room suites and coronary care units. Tertiary care centers are seldom able to provide this, whereas community hospitals have a different and realistic perspective.
"... to introduce residents to the day-to-day practice of medicine in rural America."
THE RURAL ROTATION: A ST. JOSEPH LEGACY
by MERRILL RABER, Ph.D.
JANUARY 1998

In 1978, the St. Joseph Family Practice Residency Program began a one-month rotation with an established group of practicing family physicians in rural Colby, Kansas. There, a two-bedroom house and utilities were purchased for the residents' comfort and convenience. Depending on the resident's wishes, meals were furnished at the hospital or could be prepared at the house.

The main goal of this program was to introduce residents to the day-to-day practice of medicine in rural America. Additionally, it gave the resident an opportunity to participate in the business aspects of running a practice, experience the personal side of life of a rural physician and experience the community-related aspects of health aside from medicine. If the resident was married, the spouse was encouraged to become acquainted with the community and its professional activities.

It was noted that while the rural practitioner may see voluminous numbers of patients, relatively few result in hospital care or referral to specialists, or present with dramatic diagnostic challenges. Rather, most rural physicians have an established patient population. For the resident to receive the kind of experience and training necessary, it was important to see numerous patients and be available for patient care, as much as possible.

As a result, the rural rotation included emergency room call every third night with physician back-up for consultation if needed. If hospitalization was necessary, the resident was responsible for the admission of the patient and assumed primary responsibility for the patient's care, using the patient's personal physician for consultation. If the patient had no personal physician, the resident could involve the physician of his/her choice in the care of the patient. Daily rounds began at 8 a.m., and the resident was responsible for consulting with the attending physicians about the patient's case on a daily basis. The residents were responsible for writing the admission history and physical, all orders and progress notes and the discharge summary.

The resident began office hours at the same time as the other physicians. Office hours generally were from 10 a.m. until noon, and from 1:30 to 5 in the afternoon. This was a daily routine which was intended to model the practicing physician's schedule as closely as possible. The resident was expected to participate in surgery, if requested. Additionally, the resident was encouraged to participate in as many procedures as possible.

Various specialists were located in Colby and, contingent upon the resident's interests, one morning each week could be scheduled for special study, depending on the case load and the types of cases that were being seen. It was assumed that residents should have the opportunity to expand their experience as much as possible within their range of interest. It was felt that a collaborative arrangement with sub-specialists would enhance the practice of family medicine, provide a teaching opportunity and build relationships with subspecialists.

With regard to weekend call, the resident was on-call Friday night, Saturday and Sunday every other weekend. This included office hours on Saturday morning until 1 p.m. Again, this was intended to provide the opportunity for seeing as wide a range of patients as possible to enhance the experience of the resident.
In addition, the resident was required to attend several meetings on a monthly basis that related to the business management of the practice. Monthly hospital staff meetings made it possible for the resident to be exposed to the problems and difficulties encountered by physicians in a small, rural community, and the running and operation of the hospital.

Extracurricular activities with physicians involved relating to community health service agencies, emergency medical services, EMT training and other meetings that could be attended at the discretion of the resident. At the invitation of the physicians in the community, residents would attend different service club meetings such as Rotary and Lions.

The Colby rural rotation site was eventually discontinued. Colby’s distance from Wichita put a strain on resident’s families. In 1980, an alternate rural rotation site was developed in Wellington, Kansas. The objectives of the Wellington site were essentially the same. As in Colby, it was a required one-month rotation occurring in the second year of the residency program. The rotation was under the supervision of two board-certified family physicians, Joel Weigand, M.D. and Larry Anderson, M.D. These two physicians had a busy office and hospital practice with an active interest in Ob/Gyn and surgery. The rotation gave the residents an appreciation of the advantages, disadvantages, and satisfactions of delivering primary care in a rural area. They received an educational experience in office management and were involved in community activities during the rotation.

The Wellington site was discontinued due to difficulties arranging adequate on-going housing. Some felt Wellington was geographically too close to Wichita.

In 1987, a third rural rotation site was developed at Arkansas City, Kansas. In Arkansas City, an intentional attempt was made to leave the experience reasonably “non-structured” so that each resident could tailor it to his or her own needs and desires. The plan was to make the rotation an educational and enjoyable rotation and, hopefully, one of the highlights of the residency training.

During this one-month rotation, the resident works with all of the doctors of the Arkansas City Clinic but has one physician assigned as the primary preceptor. The resident’s call schedule for nights and weekends as well as his/her afternoon off is generally the same as the primary preceptor’s. The preceptor is the physician primarily responsible for providing consultation to the resident whenever needed during the month. It is understood, however, that residents can seek consultation from any of the physicians when needed.

The resident spends his/her mornings at the hospital rounding, and afternoons are spent in the clinic. The resident works up and manages the primary preceptor’s hospitalized in-patients and any other selected in-patients of other physicians he/she is interested in following. The resident is encouraged to keep his/her hospital census at a reasonable level, in most cases around six or seven patients.

Optional activities such as researching patient problems and scrubbing in surgery on cases of special interest can be arranged with permission of the primary preceptor. Residents also follow the primary preceptor’s Ob patients and participate in their deliveries.

On weekends, the resident’s responsibilities are similar to those of the other clinic’s physicians. Residents are required to spend one weekend on call and one free weekend in Arkansas City to allow exposure to non-medical aspects of community life. During remaining weekends, residents are allowed to return to Wichita to be with their families.

Residents are provided with a furnished house that is suitable for families. Kitchen utensils, appliances, a TV, baby crib, bedding, and towels are all provided. Residents and their families are expected to take good care of the housing accommodations and be responsible for day-to-day cleaning and maintenance of the residence. The residents have the option of eating meals at the hospital cafeteria free of charge, although eating and cooking utensils are available at the resident’s house.

The Arkansas City rural rotation site has been the site of choice for the last 11 years. A variety
of evaluations by various faculty members visiting with residents and preceptors suggest overwhelmingly enthusiastic support for this particular site.

In 1991, the residency experienced more pressure to train rural physicians and recognized more legislative support for training physicians in rural areas.

In 1992, the rural rotation was deliberately included in the vision/mission statements and goals of the St. Joseph Family Practice Residency Program. It was part of the vision that the family practice residency would attract top residents and “all would stay in Kansas.”

In 1993, an action step was noted “to develop and promote the rural rotation and rural preceptorship.” Thus, the rural rotation legacy became part of the fabric of the teaching curriculum for residents who participated in the St. Joseph Family Practice Program.

The goals and objectives of the rural rotation in 1992 noted that residents should be aware of the interplay between the patient, their family, work, relaxation, and local community. The rural family physician is often called upon to provide various community medical needs including service as coroner, school physician, public health officer, athletic team physician, etc. It was also noted that a rural family physician serves not only as a healer but also as a counselor, advisor, friend and patient advocate. Rural family physicians also serve as community leaders whose opinions about community affairs are respected and frequently sought-after.

Residents are urged to learn that the uniqueness of family practice is the process by which rural physicians make decisions and solve health care problems. Residents must learn new factual information and skills, be aware of new attitudes and values, and must learn to integrate these educational components into the decision-making and problem-solving processes of rural practice.

The following are identified as goals for the Arkansas City rural rotation:

1. Attitude
   - to become familiar with the concepts of comprehensive, holistic care in dealing with extended families
   - to identify methods of providing continuity of care to extended families
   - to identify those responsibilities, such as leadership, education and community involvement that are unique to the practice of medicine in the rural community

2. Knowledge
   - to identify the patterns of consultation and referral that are unique to the community
   - to integrate and adapt skills learned in other rotations to be applicable in a particular practice setting

3. Methods/Strategies
   - to experience clinic days with regularly-assigned patients
   - to be assigned to a primary preceptor but interact with physicians throughout the community
   - to have the responsibility, with consultation from the preceptor, for management of the patient in ambulatory and in-patient settings
   - to be responsible for initial evaluation of patients in the hospital, including rounding
   - to follow up on the primary physician’s obstetrical patients and participate in deliveries
   - to be responsible for in-patient care, including performing history and physicals, differential diagnosis, and formulating treatment plans
   - to act as first assistant on surgeries with a preceptor
   - to spend two of four weekends in Arkansas City on-call, and the other for exposure to rural community life
• to spend at least one-half day per week in consultation with the clinic manager
• to become involved in as many of the community activities as is feasible

In January, 1992, the program director applauded and expressed appreciation for the activity and work of the rural rotation faculty, noting that all of the evaluations had been excellent. In turn, the Arkansas City clinic physicians were appreciative of the residents’ activity and felt that all were benefiting from the association. The Arkansas City hospital administrator and nurses expressed their pleasure with the residents who came there and felt they were an asset to the hospital.

In reviewing evaluations by the residents of the rural rotation in Arkansas City, it is clear that, in terms of structure, time-efficiency, clinical teaching, communication, development of procedural and diagnostic skills, and patient management, the residents uniformly give high marks to their experience there.

In summary, the family practice curriculum has been enriched by the now 20-year history of having rural rotation sites for educational experiences. The exposure to a rural community in Kansas has enhanced the potential for more residents to stay in the State of Kansas as they become more acquainted with various practice options throughout the state.
There is a glaring need for training programs in general hospitals for general practitioners who wish to increase their surgical abilities and subsequently their surgical privileges. One active, working plan by which general practitioners are gaining increased surgical privileges is in operation at the Wichita-St. Joseph Hospital, Wichita, Kan. Details of this plan are described in the latter half of this article.

Generally speaking, medical societies, hospitals and medical staffs in most areas make available some training facilities and programs. However, such programs represent only a mere beginning toward providing the general practitioner with an opportunity to increase his skill and knowledge. Any program dedicated to maintaining high standards of medical care must include provisions for training in all branches of the healing arts.

It is unrealistic to wave the banner of specialized surgical care and insist that "only board certified surgeons shall do surgery." In small communities and rural areas, with excellent hospital facilities already available, the family doctor is the only available surgeon. It is futile to discuss surgical residencies, board certification, pathologic audits and hospital surgical privileges under such circumstances. If the patient needs surgery, the family doctor operates. There is no practicable alternative. The active staff's evaluation of the general practitioner's abilities and integrity is the only logical standard. It therefore becomes the duty of all general hospital staffs to provide the facilities and methods through which their members may advance in skill and training - and by so doing, increase their surgical privileges.

Problem Is Geographic

The general practitioner, as the family's medical counselor, must have a thorough, up-to-date knowledge of medicine, surgery and their subdivisions. It is a rare family doctor who is not called upon first in an emergency, be it medical, surgical, obstetric or traumatic. He must be prepared to evaluate major complications in all fields. The problem is not one of training family doctors to step in and substitute...
for board certified specialists. It is rather one of geography, population factors, hospital facilities and local customs. Every family doctor who wants to do surgery should be allowed to handle surgical cases within the limitations imposed by his training, experience and demonstrated ability. More important, he should have an opportunity to increase his privileges by learning and demonstrating abilities in advanced procedures.

Many established general practitioners have had two or more years' service as military surgeons, during which they have assisted men of excellent training, and have also been allowed to perform basic surgical procedures themselves. In many instances, they have shown ability for competently handling major surgery and its attendant complications. To steadfastly and arbitrarily deny these men privileges is an unfortunate waste of training and ability. It is likewise wrong not to provide these men opportunities for further surgical training.

The Academy has repeatedly underlined the importance of residency training for general practitioners. It currently favors a two-year residency, with the first year devoted to medicine and the second year devoted to surgery or surgery and obstetrics. The Academy does not contend, however, that the general practitioner who plans to do surgery should be required to complete a four- or five-year surgical residency. In addition to being unduly burdensome and time-consuming, such a requirement would place disproportionate emphasis on surgery. Although a two-year residency is ideal, it is only part of a training program and does not provide for the physician who has already established a private practice.

Academy Supports Program

Adhering to basic Academy objectives, a physician's surgical training should not terminate with a residency. No physician can ever complete his medical education, for there is too much to learn and too much daily progress in the fields of diagnosis and therapy. Keeping up is half the battle. For these reasons, the Academy attaches great importance to in-hospital surgical training and welcomes and supports programs designed to provide this training.

For physicians whose training did not include the recommended two-year residency, such programs are most important. It is equally important for a physician who, having completed a general practice residency, wants to supplement his training and ultimately become qualified for increased surgical privileges.

Such a program has been established at the Wichita-St. Joseph Hospital, Wichita, Kan., through the cooperative efforts of the general practice section of the staff, the surgical committee, and the hospital executive committee. As pointed out by the Academy's Commission on Hospitals, any program must be adapted to local conditions, and modifications and improvements are certainly in order. It is hoped that this program may serve as a guide to others in planning in-hospital surgical training opportunities.

In no manner do we wish to imply that such a program should constitute the only manner in which a member can qualify for advancement. A year of post-graduate training in surgery is highly desirable for any general practitioner who wishes to include surgery in his practice, but this should not be mandatory.

Minor Surgery Requirements

For minor surgical privileges, a physician must have been in active practice for one year and shall have done a minimum of 25 minor operations under supervision. A formal request is presented by a letter accompanied by a list of cases with chart numbers and names of surgeons who have supervised the applicant's work. The surgical committee takes one of three actions and notifies the candidate in writing of (a) approval for minor surgery (b) probationary approval with specific recommendations, or (c) refusal of privileges with the committee's recommendations. Upon successful attainment of minor surgery qualifications, a physician may
proceed to higher categories.
Minor procedures include:
* Dilatation and curettage with cautery of the cervix.
* Tonsillectomy and adenoidectomy.
* Simple fractures.
* Nabothian cyst.
* Ganglion of the wrist.
* Small hemangiomas, superficial lymph nodes and superficial tumors.
* Biopsies of the cervix and superficial lesions.
* Removal of superficial foreign body.

**Group II Privileges**

This category includes (1) major surgery with restrictions (limited surgical privileges), and (2) probationary major surgery.

To qualify, the physician must complete 100 major procedures arising from his own practice. No one procedure may constitute more than 30 per cent of the total, and the candidate should work with two or more consultants so that a number of surgeons may become acquainted with his abilities.

**First 50 Cases:** The first 50 of these cases are to be handled by a Group I surgeon, with the candidate acting in the capacity of assistant to the consultant. The referring doctor’s fee shall be for diagnosis and work-up only.

**Second 50 Cases:** The second 50 cases are to be handled by the candidate with a Group I surgeon acting in the capacity of consultant and assistant. The fee of the Group I surgeon covers only consultation and assistance.

In each case, the consulting (Group I) surgeon is asked to examine the patient prior to surgery and to submit a written consultation report. In elective procedures, the consulting surgeon is asked to see the patient at his office prior to entering the hospital. The candidate is responsible for outlining the arrangement to the patient and for specifying who will perform the operation and who will assist. The patient is also told that he will receive separate statements. In all cases it is recommended that the total fee should not exceed the usual single fee charged for the procedure.

**Surgical Committee Must Approve**

When requesting privileges, either minor or advanced, the applicant submits a list of his cases to the surgical committee, indicating patient’s name, hospital number, consultant’s name, diagnosis and disposition. The charts of all cases used should be reviewed by the applicant before they are turned in to the surgical committee, to be sure that (a) a postoperative note is attached giving the name of the procedure, surgeon and first assistant, fluids given, drains, packs and any other general information that is pertinent to that particular operation; (b) progress notes are complete with summary on dismissal from hospital; and (c) the signing-out diagnosis is justified either by the pathologic or clinical findings.

The surgical committee examines the charts submitted by the applicant, obtains opinions of the consulting surgeons as to the candidate’s fitness for advancement, gives favorable consideration to all post-graduate work completed by the candidate, and may request the candidate to appear before the committee prepared to discuss any case submitted, including pathology, anatomy, diagnosis, treatment, possible complications, etc. The surgical committee may approve the applicant for probationary major surgery or reject the application and make positive recommendations. If probationary major surgical privileges are approved, the physician remains on probation and has neither limited nor unlimited privileges until staff members have observed a sufficient number of cases to warrant promotion.

As previously indicated, this plan is one in which general practitioners have gained, and are gaining, increased surgical privileges. It is far from perfect and has many inherent defects, but at least it is a beginning. The staff at the Wichita-St. Joseph Hospital, and especially the surgical committee, are literally feeling their way in this new attempt to increase surgical privileges for the general practitioner who demonstrates the knowledge, ability and integrity to competently care for his patients.
AN INTERVIEW WITH GERHART TONN, M.D.
PAST CHIEF OF MEDICAL STAFF
WESLEY MEDICAL CENTER
JULY 11, 1997

Kellerman: Tell me where you are from, where you grew up and where you went to medical school.

Tonn: I was born in a little town called Haven, Kansas, which is about 40 miles northwest of Wichita. We always thought that Wichita and Hutchinson were suburbs. It was quite a big town when I was born, with a population of about 450.

As time went on, we received national recognition because at one time the high school had a football team with a front line that averaged 230 lbs. In those days, the line usually averaged about 150 lbs.

Oil wells had been drilled north of town and our team had some boys from the oil field families that had not finished high school, and so were a year behind. They were big fellows, like their dads—most of them had to be big to work on those old wells.

One year we played 12 games and we were never scored on. The lowest score was run up against the second team in the state, East High — it was 60-0. The highest was 256-0, which is in the Guinness Book of World Records.

I have newspaper clippings of those times. We made an average of a touchdown a minute. It was 1927 and I was in the seventh grade.

Three people in that backfield eventually went to college and became first and second team All Americans. One of them ended up as editor of the Kansas City Star sports section and one became a vice president of Kroegers.

My mother was a German immigrant. She was born and reared in a town called Kreischa am Baden which is near the Schwarzwald (Black Forest). There were eight brothers and sisters.

The oldest son was conceived after the prince of the land raped my grandmother. To pay for his son’s crime, the Kaiser agreed to pay for the education of all of my mother’s siblings. The boy was raised by the man who married my grandmother along with their seven youngsters. Most of them eventually came over to this country, and because of the outbreak of World War I, they were able to stay.

My grandmother’s sister was known as Tante Hulda Hoeme. You may have heard of the Hoeme plows which were produced by this farming family near Pratt, Kansas. Tante Hulda died young in life. She was 104. An interesting note: there was an area of about a 10 miles radius from the Hoeme home where the local Indian tribes would come. They wouldn’t bother each other, even the ones they hated, because they had come to visit the lady medicine woman. In 1900-1910, many were healed, and they all remembered her.

And how were they healed? They were healed with moldy salt pork and moldy bread packed into their wounds, tightly wrapped, and redressed frequently. This treatment worked on most wounds that she treated. Of course, she was “using” penicillin. This was a concept that I had as a youth, and I also admired our family doctor.

I was born an asthmatic, which meant that I was only given about 45 years to live. Asthma, of course, belongs to a class of autoimmune diseases. I always believed that if I was going to be sick, I better find out what
was causing it. I followed the family doctor around, and I tried to get good grades.

Our family moved to California for a year, then returned to Haven, where I attended the Lutheran parochial school. When I was a senior, there were two of us vying for the top grade. A lady that I still admire very much was working to try to outdo me in grade points and darned if she didn’t. Her four year average was 94.4 and mine was 94.2.

During that same time period, my mother’s closest friend, Tante Marie, became like my second mother. After “Tante Ree’s” fourth pregnancy, she developed multiple abscesses over her body, breasts and neck, that finally spread even to her scalp. The bombardment of toxins from the strep and staphylococcus that invaded her system finally killed her.

I sat next to her for more than 12 hours weeping, and I swore I was going to find the cause of her death. The only way I could accomplish this was to go to medical school. I was 14 years old. Everybody said I would never make it, it costs a lot of money, etc. But I was determined.

When I got out of high school, there was no money. I asked around and finally got a job, and at the end of the first year I had $36.96. I found out that the KU band paid $10 if you went a week early for practice. That’s how much I needed to pay for my room, so off I went—and they accepted me. I don’t know why. I don’t play very well, but I was a “sliver sucker”, and played clarinet in what became one of the most prominent marching bands in the nation.

That gave me a start, but I still didn’t have an income and it cost $36.18 for my fees. I figured that I would go around and see what people would pay to have their windows washed. I could buy a little vinegar and some rags and I could make a business of it, and I did.

It wasn’t long and I had a good-sized clientele—I charged 25 cents an hour. I started gathering some of the students who needed work and we organized a window washing company. Then I charged 30 cents an hour. I kept a nickel and let my “employees” have 25 cents, and I went around and got the business.

We did pretty well. At the end of the first semester, I came out about $40 ahead. That’s how things got started.

When I was junior, I got a job at the student hospital as a custodian, and from then on it was easy pickins. When I got out of med school, I had $120 clear and didn’t owe anybody.

I had worked one summer at Sunflower Ordnance at $1.50 an hour to start, seven days a week, with double over-time. In four weeks I was drawing double that, and in two more weeks I was promoted to expediter of the fourth area and was drawing more still, and I socked it all away.

I have ankylosing spondylitis, called Marie-Strumpell disease, an inherited condition which I developed at age 12. World War II was imminent, and when the Army examined me, they just looked down the upper end and looked up the lower end and it was black so they said “you’re in.” I had one semester of free schooling in my senior year of medical school, courtesy of the Army.

Overall, things went well. My wife was working so we got along fine, but my parents were not doing too well. My father had lost one eye in an accident and because of this, my wife and I decided to come to Wichita to Wesley Hospital to establish an internship. They had had a few interns, one at a time, but they didn’t have an internship program.

Kellerman: What year was this? Were you the first internship class?

Tenn: Dr. Plowman was there a year ahead of us. I started medical school in 1940. Because of the Army’s accelerated program that eliminated the vacation between our junior and senior year, we graduated on the 31st of January, and our internship started Feb. 1, 1944.

Unfortunately, individuals with ankylosing spondylitis often develop other problems, one of which is iridocyclitis. I’ve had 27 episodes, but recently have been able to control the condition with steroids. This was a devastating illness that put me in bed for two weeks before I could begin my internship.
During that time, when the other interns would come over to visit, we organized a program of night lectures with a dinner meeting each night. If you weren’t on duty, you would gather in the dining room. (The food wasn’t very good, but they did the best they could. We had two ladies, Mildred and Margaret Schwartzendruber, who were the cooks. They brought us things that we weren’t supposed to have, like wiener and bacon and tomato sandwiches. That was strictly against the hospital rules.) At each meal, one of the interns, a surgeon, or an orthopedist would come and lecture to us for an hour.

On Friday nights, Dr. Frost, the radiologist, would come in and give us a view of the week’s X-rays with diagnoses. This was quite exciting.

At that time, we did not work eight-hour days. Our days were 24 hours long, and you were on duty the entire time. If you were needed, you went and there was no question.

If you shirked your duty, they gave you the front door. The pay was tremendous. We got $50 a month, a room and our board, and our whites were washed for us.

We had organized it so we worked two at a time. In some instances, we would be on a special service. For example, we each did a three-month surgical rotation, part of which was orthopedic. Then we added an extra month for thoracic surgery, because they were beginning to do open chest work for the first time. I’d seen the fifth open chest surgery ever, performed by Dr. Graham in St. Louis, who was the originator of this technique.

While observing the procedure, I sat next to Dr. Adriani, an anesthesiologist from Louisiana State University, and became acquainted with him.

I admired these people for diving into a chest with the poor instrumentation available, and for daring to do all the things they had to do to make chest operations viable. Now it seems so routine. We had to learn as we went along.

During our internship we were on our own, and we could do anything that we felt qualified to do, as long as we could back it up. We were supervised by one of the staff men. If there was ever a question in our minds about doing something, we had to check with him. In this way we learned very rapidly what you could do, what you couldn’t do, what was good medical care, what was poor medical care, how to talk with patients, how to stimulate patients, how to relax patients, and so on. Of course, we only had nine months, because we were in the service. We had received our second lieutenant’s commission when we graduated, and at the end of the internship, we had to have our physicals prior to entering the service.

To get back to one of my orneriness, when I was intern, I was very much upset by the anesthesia used during childbirth. I loved obstetrics, but I could not stand twilight sleep. We frequently had to perform artificial respiration for hours on some babies before they could get rid of the morphine and scopolamine, and I felt it was a terrible thing.

I learned that two Swedish researchers had used a drug that is now being handled by Abbott called pentathol sodium. Some doctors on the East Coast found that if one gram of pentathol sodium for 50 lbs. of body weight was given rectally, it gave a very slow and sleepy induction, and didn’t harm the baby.

The mothers remained partially awake, and if they needed a little more anesthesia, a whiff or two of ether would take care of it. The combination produced a fine anesthetic.

I carried out the protocol with materials furnished by Abbott and permission from Dr. Maxwell and Dr. Clark, who were obstetricians, to use it on their patients. After testing 100 patients, the results were promising, so I wrote a paper on it, which was published.

Soon, the anesthesiologists at the medical school in Tulsa called me and said they wanted me to present my findings to the Southern Medical Convention. They were in the process of writing the anesthesia board exams. I consented to go, and I asked my intern, Dr. Ernie Crow, later to become a great internist, if he would like to ride with me. At that time, instead of having sleeper seats, we could book straight seats, and we could both go on the
same ticket. We headed to Cincinnati on a long train ride. First, we rode the MoPac, and the B&O, and when we arrived at our hotel, why, we were in the big city.

After we registered, my intern went to the internal medicine meetings, while I proceeded upstairs to the Hall of Mirrors to sign in. Two hours later, I was to present my paper. I was introduced to Dr. Adriani, Dr. Drips, Dr. Baker, and other doctors appointed to the Board of Anesthesia. They were sitting on the front row. I asked how many people would be there and was told about 200. I thought that was fine and I could handle that. I was a cocky little fool, but I always have been.

The presentation just before mine was given by a tall, dark and handsome Southern gentleman named Ray Parmalee. Dr. Parmalee gave his treatise on saddle block anesthesia for Ob. His instructor, Dr. Adriani, was impressed. Then I gave my paper, which was really just a collection of observations. I wasn't trying to prove anything, but I felt that I had found a way to eliminate twilight sleep. My wife delivered under it and she thought it was great.

Following my presentation, I asked if there were any questions, and immediately Dr. Adriani said, "you know that isn't an anesthetic." I said, "Sure, I know that. I'm not talking about an anesthetic. I'm talking about relaxation during anesthesia and I used a sedative that belongs to the Phenobarbital group. You know that better than I do. I wasn't even thinking about using it as an anesthetic. I was using it for relaxation in obstetrics because I don't like twilight sleep." All five Board members stood up and applauded, and said they thought I was on the right track.

As I looked around the Hall, it seemed like there were a lot more than 200 people. I was told later that there were 1,180 people from 15 countries that had come in to hear this paper. Believe me, I have read through it many times, but I never have written another. The one thing I accomplished was that we never saw twilight sleep in Wichita, Kansas, again.

Let's return to the problems that we had in family practice. The family practice residency seemed to go so smoothly that we were not in too much of a hurry to really get organized. Some wanted to organize it like a surgical residency or a residency in internal medicine, but I disagreed. We had quite a few arguments. But then I was Chief of Staff, it did carry a bit of weight. Usually it came down to just talking things over and reaching conclusions.

By 1948-49, the young doctors were getting a well-rounded program. Now, I don't remember exactly what the program entailed, but if an intern decided to stay for a residency, we planned a longer service in surgery that was focused on what they would need in practice. For example, in orthopedics, they had to be able to set a Colle's fracture. We eventually worked out the program, but these things always come slowly because you never know what you want right away.

In internal medicine, we had to think about what things are most dangerous and require immediate care. We thought of heart attacks and strokes and conditions with which the residents didn't have much experience.

What do you do with a heart attack victim? Refer them to a cardiologist. Patients with strokes are sent to a neurologist, while other conditions will be referred to other specialists. If your practice is located out in the sticks, you cannot do this because the travel time can be dangerous to the patient's health.

We formulated the training so the family doctor could give good supportive care, if nothing else. Performing diagnostic studies and having the proper drugs available meant that these doctors could treat people as well as anyone in the business. In this way, they could handle 95 percent of the emergencies that came up.

I believed that we ought to have a threeyear residency, like the internists. This didn't go over well because it was felt that the need for family physicians out in the state was so great they couldn't spare an extra year. During 1950, I kept talking to the Board of Education, and they agreed with me, but it never quite seemed to happen. We couldn't get the young doctors interested in spending three years, so we went along.

On Jan. 1, 1953, I got my orders to re-apply
for military duty, providing that I could practice more than one hour a day. I had received some school funds from the Army, and my arthritis and asthma were under control, so, I went out to the air base to receive my commission as a captain in the Army. Soon I left for a month's training at Fort Sam Houston in San Antonio, then on to Ft. Leavenworth to become a gynecologist.

Mr. Roy House became an administrator at Wesley and was supportive of a residency in family practice. Jack Tiller was director of the general practice residency program. Cayle Stephens took over in 1967 and developed a solid family practice residency at Wesley. This has been one of the top programs in the country. It was a general practice residency until 1967 when it was reorganized to become a family practice residency.

One problem that was still bothering me in family medicine was that we weren't talking about research. Doctors by observation find out things. They see things happening; they know that certain things produce certain results, and if these observations aren't tested and proven scientifically, they're ignored and we miss some great plums of life. So, I was thinking about a research organization.

Back in 1949, I had gotten together with Dr. Bert Stoffer, Dr. Trefese, who was an internist, Dr. Jim Hibberd, a very close friend, a neurosurgeon, and Dr. Ernie Crow, and we had organized what we called the Wichita Foundation of Medical Research. Our first speaker was the man who formulated the NASA program in Houston. We met in the Lassen Hotel and had about 250 people in attendance. The Wichita Foundation of Medical Research was later adopted by Wesley and became WMRI, or Wesley Medical Research Institutes, of which I am an emeritus member of the Executive Committee.

The war in Europe was hot in 1944 and we knew what was coming up. There was going to be a big drive and we were going to be caught up in it and would probably be out in the field. We would have to go in for some specialized training.

At the end of my internship, I was ordered to go to Salina. As I walked in to the examination area, a big, tall man walked behind me. He was a full colonel, and he tapped me on the shoulder and said he wanted to see me. I said "Yes, sir." Then he walked by me and looked at the group and examined some of them. When he came back to me, he told me to jump on the table. I told him I could crawl up there. "All right," he said, "You crawl up." So I got up on the table.

Then he told me jump off. I told him there isn't a power in heaven and hell that could make me jump off this table. I knew what would happen, because with my condition, the pain in the pelvis from jumping was terrible.

The colonel ordered X-rays. When he saw them, he asked me how in the world did I expect to get into the service with Marie Strumpell arthritis? The disease was just beginning to fuse my pelvis. At present, I have five vertebrae and the pelvis fused solid, but I eventually learned how to stop the progress of the disease. But that's another story.

The colonel told me that they were going to assign me into an active reserve unit, a concept just created by Congress. If there was an immediate need for a doctor on active duty, I would be called. Otherwise, I would not get any active duty. There were to be about 50-100 people in this organization nationwide. It would be reflected on my commission that I was in the reserves, but I would not get paid.

I accepted the ruling and returned to Wichita heart broken because I wanted to be in the service like everybody else. I thought, "Gee, I could work in the hospital." The work wouldn't be too difficult and I always did work in hospitals and enjoyed it, and I could help the Army. Nope, they wouldn't have it.

When you are on active duty, you might be sent right to the front, and you have no business being there with your back. So I accepted it, and was basically out of the service.

When I returned to Wesley, I talked to the radiologist. He suggested that because of my arthritis, I would not be able to travel easily, so why not set up a residency for me here in radiology. He would pay me $200 a month and I would do the fluoros for two weeks and then
treat for one week. He offered to teach me and help me prepare for the boards, believing—correctly—that I could then use my expertise to establish a career. We accomplished his plan and I had 18 months of residency as a radiologist.

There were so many other needs, because so many doctors were involved in the war effort, that he gave me permission to make night and Sunday calls. One Sunday, I made 32 house calls. This helped my income, because—my gosh!—I got $3 a house call.

During that time I began to see a need for training people. This was my big concern. Young doctors were graduating and starting practice, and the state didn’t even require an internship. You’d get out of medical school and go straight to work. Some doctors in Western Kansas had done that, and really weren’t prepared to carry out the job.

This had been bothering me for quite a while. I was seriously concerned about it, so I began to investigate some possibilities. I asked two young men if they would come in for an extra year of training. They were going into general medicine, not to the Army, and they wanted a year extra.

And that’s how the first general practice residency started. It was the middle of June, 1946. They seemed to thrive, and made good progress. The next year, we added another resident. Subsequently, I found out that this was the first general practice residency in the United States.

Kellerman: I just wanted to make sure I have it correctly: they did one year of internship plus the one year extra of residency? And did you have a residency director? Did you set that up? Was there someone else that set it up? Do you remember some of those first inter's names?

Tonn: I don’t always remember the names. I know we had a Dr. Baker, and Dr. Hidaka, who was Japanese. Hidaka went into my office later on for further training, and I directed that since I was the head of the Education Committee. At that time, Dr. Gil Kendrick joined me on the Education Committee and we realized that we needed a library. I was appointed to be the director. At the inception, we all contributed our magazines and extra books, and found a room in the hospital we could use. It was quite an aid to education, and we got a lot of cooperation from the other physicians.

Kellerman: Did you participate in the origins of the KAFP and AAFP?

Tonn: Realize that this situation was something that began as a need for a number of people. It was recognized first as an attitude, then eventually as something that might actually be accomplished.

There was a lack of medical care that the Western Kansas and Southeastern Kansas people felt that others were able to get, and they weren’t. This, of course, raised some doubt whether we were dealing with the patient care situation adequately.

There was a nucleus of about 75 general practitioners from all over the state. We formed a committee, of which I was a member, with Dr. Bruce Meeker, Dr. Clyde Miller, a Dr. Young from Kansas City, Kansas, and I can’t remember all of them. There were seven or eight of us, and we’d meet about every other month in Emporia in the Broadview Hotel.

Over a period of months, we formulated the “Kansas Plan,” finally decided the only way to accomplish our goal was to organize something nationally. Dr. Miller had been in practice a long time and knew quite a few doctors from national meetings, so he helped organize a meeting in 1947 in Cincinnati. I didn’t attend because I was in Cincinnati the year before, and I’ll go back and explain that. The outcome of the meeting was the formation of The American Academy of General Practice in the United States.

Then came the hard work. We had all kinds of ideas, and we would throw those away and make new suggestions. It became quite a challenge, and we served as the driving force because we kept the pressure on. Then Dr. Murphy became dean of the medical school.
and he gave us a lot of help.

I attended the second meeting in St. Louis in 1948 in Keel Auditorium. We had a wonderful meeting. The lectures were great, and we had 2,240 people there — about 80% of the membership. What is the membership now? Close to 100,000? This thing has grown tremendously. We worked hard, year-by-year, going to national meetings, publicizing our goals, and gathering support.

We were finally accepted as the 22nd specialty. In 1968, we became the American Academy of Family Physicians in Dallas, Texas. Our first president was Dr. Ned Burket, and our first physician of the year was Dr. Bob Boyer of Kingman.

When I applied for medical school, the head of Ob/Gyn, a professor with whom I was never on friendly terms, promised me he would not let me in. There are no doctors in my background; there was, in his estimation, no medical promise in me at all, and so he wouldn’t let me in.

It turned out that the dean of the medical school married my wife’s best friend, and when I approached him with this, he said, “Gerhart, that’s not right - I’m the Dean here,” and he got me in; 95th place out of a group of 95.

When I reached my senior year, this same professor of Ob/Gyn, had announced that those who had A’s didn’t have to take the orals, and he listed the names. Mine was not among them. So I went up to take my orals.

The Ob/Gyn professor stomped into the room and scowled. He said, “What in the blankety-blank, so-and-so are you doing here?” I said my name wasn’t on the list, and you demanded that those not on the list report for their exam. “Well, you beat me twice. If you can answer this question, you get an A. Give me the four steps of the density of the cervix.” It was easy to do, so I gave him the answer. Then he said, “Damn it, you got an A, now get the heck out of here!”

Later, when I was at Wesley, it happened that our group of 75 doctors was worried because the surgeons were trying to take over the hospital. One evening, this was in 1949, when the vote came up for Chief of Staff (which was like a dictatorship at that time), I was selected. This was a tremendous responsibility for a 34-year-old, when nobody under 70 had ever been in the position before. But I was given an opportunity, and with the people available working with me, we got a lot done.

At Wesley Hospital, we’ve always felt that we had a tie to the University of Kansas School of Medicine. They have given us some help, but they have also been a little political at times, fearing that we were tromping on their toes. With that preamble, I want to talk about some of the things we tried. Our obstetrics staff, Dr. Maxwell, Dr. Clark, Dr. West, and Dr. Cowles, was interested in having a KU first-year Ob resident come down and spend a year with us, then go back up to Kansas City and complete his second and third year of residency there. The head of Ob/Gyn thought that might be a good idea, but he didn’t think we were qualified to do it, so Dr. Maxwell, who was one of his former residents in obstetrics and got his training in Kansas City, worked out a plan that would meet the national needs of the Ob/Gyn boards in Wichita. He invited the head of Ob/Gyn down. He was escorted through the Ob department and spent his time criticizing everything. He said, “That won’t work for you. You can’t do that.” He said, “Let me talk to your Chief of Staff and I’ll explain to him.” Well, Dr. Maxwell brought him in. It just happened that I was doing my desk work at 4 p.m. when he stepped in. I said, “Hi, how are you?” “Tom, are you the Chief of Staff? My God, this world is coming apart.” He was furious that anybody would even introduce me as Chief of Staff.

Dr. Maxwell said, “This is the finest Chief of Staff we’ve ever had. He is active; he works on things and we get things done. What more can you ask?” The head of Ob/Gyn said, “To hell with this program,” and walked out.

We still believed that if we could come to an agreement with the University of Kansas. We could use some of our material to train some students in Wichita. We were considering transferring a few from the junior and senior classes of medical school to give them
instruction in Wichita because the classes were overwhelmed at KU — they had gotten up to 200 students, and it was actually more than they could handle.

We offered to provide training at Wichita State, which was Wichita University then, but there was a lot of politics involved. The family practice program that we wanted to establish in Wichita was controlled at that time by a lady named Kassebaum. She was married to Dr. Kassebaum’s son from El Dorado, who is a psychiatrist, and she was a school teacher. I can’t remember her first name. Another young man who was very political was also involved, but he didn’t support our goals. I was to head the committee, but our meetings got nowhere.

Finally, Wichita University became a state school and was organized as Wichita State University. This gave us an “out.” Dr. Cramer Reed, who was a graduate of Wichita, thought that we ought to have a medical school in Wichita. After much discussion, we finally determined that we would be a branch of the University of Kansas School of Medicine and, of course, that was the proper way to go.

The Department of Family Practice was disorganized and having problems, so I asked some of my patients, two of whom were senators and three of whom were members of the House, to come down and see about coordination and recommendations from the Legislature down. We had a dinner meeting at Crestview County Club during which the legislators confirmed that the University of Kansas School of Medicine would establish a branch at Wichita State University, and would not involve other schools. This was a big step.

I asked my friend Ned Burket to come by and advise on the selection of a chairman for the Family Practice Department. He told me about a very devout Catholic man in North Dakota and said he had a lot of feeling for him. He is an honest man and has done a fine job every place he’s been. Ned didn’t think we could get him, but thought we should try. The man was Dr. Ed Donatelle.

Now Dr. Ed, being a very devout Catholic, would not have much to do with a devout Lutheran like me. But I had on my committee another devout Catholic, and I suggested that he talk to Dr. Ed about setting up a program like Wesley’s at St. Francis, then help build up St. Francis, and maybe we could get him here this way. It was difficult at first, but finally he consented to come down and give the graduation speech for the residency program at St. Francis.

While he was in Wichita, it was suggested that Dr. Ed come over to talk to this old hard-head at Wesley to see if something could be worked out. I tried to play the hard-head and, of course, I fell in love with Ed and he kind of liked me, too. It turned out that we were both gardeners and loved flowers, and I knew about the application of nitrogen and how it is transferred to plant cells—he was excited about that. He finally accepted our invitation, and that’s actually how the family practice program got its first big boost in Wichita.

It got to the point where Dr. and Mrs. Donatelle and my wife and I always went to the national meetings together. We talked about the politics of our organization, and when Dr. Ed made a presentation, all points of view were represented. Eventually, we felt that the family practice program in Wichita, Kansas, was solid, and I guess it must have been because at Wesley the second year of Dr. Ed’s tenure, we had 81 applications for eight places.

I had some definite feelings about the practice of medicine, and felt that doctors should work together to solve problems. In 1947, two of my medical school classmates returned from the service and on September 15th of that year, we opened our practice. Dr. C.C. Parmalee was a surgeon, and had been in the Navy for three years. Dr. H. Lee Barry, a personal friend, was an internist. We shared a philosophy of patient care, and basically they both practiced family medicine. They joined the Academy, and so we became the Hillside Medical Office.

After I returned from military service, we had some differences, and went our separate ways. Dr. Barry then went down to Winfield and Dr. Parmalee set up an office of his own.

In the late 1940’s and early 1950’s, the biggest medical problem was polio. We would see patient after patient, all claiming that they
had polio. The diagnostic method we used was spinal taps, and we did a number of them. The family doctor could carry out this procedure and make a diagnosis.

As the level of knowledge and expertise increased, family doctors began to take over more and more of the general work of medicine. This was quite a blow to the internists, pediatricians, and others, so we began to get a little ruffling of the feathers. I don’t think that will ever stop, because I don’t think one specialty can work without treading on another.

The Hillside Medical Office has continued to grow. We’ve trained many young people. We take students for one month to teach them family practice and what they can get out of it. They see patients with us in the office; they go with us to deliver babies; they make house calls with us.

The western part of the state is now well supplied with good family doctors but there will always be areas for improvement. I think probably as long as the Hillside Medical Office can remain stable, and if you can continue to encourage them to teach, they will serve you well.

Of the first 20 presidents of the national American Academy of Family Physicians, five were graduates of the University of Kansas. When we held our national conventions, they called me “the bartender.” If someone from Kansas was running for the board or running for president, I did the bartending. In Las Vegas one night, a friend of mine and I mixed 1,100 drinks for our members and guests.

That same convention elected Dr. Chaney as its president. Dr. Chaney has been very active in the organization. He eventually came to Wichita and headed the program at St. Joseph, developing it into a residency just for family physicians. In fact, St. Joseph’s was known as a family physician hospital for years.

St. Francis’s program has also been pretty solid. They have had their ups and downs, but so has Wesley, primarily because it takes a lot of money to run programs where the young doctor is making over $2,000 a month.

It will always be a problem because the money’s always going to be short.

The more government gets into it, the more of a problem we’re going to have. Our greatest political need is to get government out of medicine. When I was in medical school, it was possible to have what I call “compassion without foolishness.” This was a great tool to reach patients, and helped to establish a doctor-patient relationship. The main thing that has been taken out of medicine is that the doctor-patient relationship is gone.

Let me tell you a story that defies belief. I have adequate proof, but I don’t care about proving it. I want to tell it to you about a doctor-patient relationship and how it relates to a spiritual life.

I was called early one morning just after I returned from the service (in 1955) to see a woman who lived in the northwest corner of town. Her daughter had been my patient and she told me that her mother’s doctor wouldn’t see her anymore because she was terminal, and she needed a physician. Well, having just been discharged from the service I had some time, so I drove out.

She was a horrible looking human. She must have had some 250-to-300 masses the size of pecans over her abdomen and chest. They were very irregular and hard as rocks. She’d had a breast removed and these were all metastatic carcinoma of the breast. Scirrhus carcinoma, one of the worst kinds. She hadn’t been able to ingest a bite of food for two days. I said she was going to the hospital, and she readily agreed.

Something very unusual happened when she got to her room. I had to go down and see another patient and when I finished, I decided I’d better go up and write orders. I went back and a good friend of mine, who was a nurse, went back with me.

My patient was lying back and they were trying to feed her some broth. I had given some orders for pain medications, so she had no pain. She whispered, “Dr. would you have a prayer with me?” Well, being quite scientifically oriented, back in the days when prayer wasn’t looked upon as it is now, I hesitated. The nurse said, “Well of course we will.” So I worked out something and said a little prayer,
asking that she have a restful evening and hoping that she could eat a little better in the morning. I closed with the hope that if there were any chance of her getting well that it would be granted to her at that time.

I looked at the nurse and she looked at me, and she said, “That was wonderful.” We walked out of the room and wrote the orders.

At 5 a.m. the next morning I went back to make rounds and I went to see my patient, this time accompanied by a different nurse. The woman was sitting on the side of the bed and on the table was a bowl of oatmeal which she was eating slowly—an impossible thing for her to do just hours before.

I couldn’t believe it. Nobody else could believe it. The nurse said it happened suddenly during the night.

We talked for awhile and she said, “Now doctor, you’re a praying fool and I want you to say another prayer for me.” Well, I was trapped, but prayed again, and by the next day, she was sitting up eating chicken. The following day, she sat in a chair, and slowly she regained her strength. Her tumors seemed to be smaller and she was feeling a great deal better, so I sent her home. The lady died at age 93, one year before I quit practice (in 1988).

Now this is not easy to explain, because suddenly for no reason whatsoever, she became immune to all the cancer and it just healed up.

After the first partnership was dissolved, I became partners with Dr. Clell Flowers and Dr. Walter Reazin. Dr. Reazin was on the board at Wesley and we worked together closely. He had been my resident and was a brilliant young man. He did a good job with his patients and they all seemed to love him. But he did not like to teach. So he did a lot of the extra work and I did more teaching.

Several years later we built a new office facility and added Dr. Conrad Osborne. He was brought into the organization and did a masterful job with his patients. I felt that he never shirked patient care. He was strict about his own behavior, had a great deal of teaching ability, and was well thought of by his patients. I was proud to have him as an associate.
"I date the official beginning of the Wesley residency on July 1, 1967...

by GAYLE STEPHENS, M.D.

FOUNDING DIRECTOR, WESLEY FAMILY PRACTICE RESIDENCY
PAST PRESIDENT, SOCIETY OF TEACHERS OF FAMILY MEDICINE
MARCH 17, 1997

The Bare Facts
I date the official beginning of the Wesley residency on July 1, 1967, when I became the first, full-time, paid director and moved part of my practice (about 400 families) from West 13th Street into the Wesley environment as the nucleus for a model family practice teaching unit, as recommended in the Willard Report, my blueprint for the new program.

Wesley was remodeling a house on Pine Street for my office, but it was not ready until September, so I practiced out of the emergency rooms. Wesley hired two of my employees from West 13th to run the practice: Kay Myrtle and Rowena Burroughs.

The first resident was Conrad Osborne, who was a rotating intern at Wesley since July 1, 1967, and declared his intention to join me about Oct. 1st. Jay Cranston came on as a second-year resident in July, 1968, from the Lancaster Hospital in Pennsylvania. Victor Vorhees came on March 11, 1968, as a first-year resident.

At this time there was no separate accreditation for family practice. With approval of the AMA Council on Medical Education, we were using the accreditation of Wesley's general practice residency, which had been in existence for several years and was directed by Jack Tiller. Jack agreed to retire from that position (a very important and generous decision), but there was a year of overlap when we had both general practice and family practice residents. As I remember, the general practice residents were Morgan, McCoy and Otto Kaak; the former two finished their program June 30, 1968, and Kaak transferred into a residency in psychiatry at the same time, despite my efforts to recruit him. He became a first-rate child psychiatrist.

I regard Wesley's residency to be the first operational family practice program in a community hospital in the U.S., although similar transformations of general practice residencies were occurring elsewhere. The first straight family medicine internship was begun in Miami, Florida, by Lynn Carmichael in 1965. Eugene Farley was beginning a family practice program at Highland Hospital in Rochester, N.Y. (affiliated with the University of Rochester School of Medicine); and Roger Lienke was doing the same at the University of Oklahoma. There also were some two-year family practice residencies in Canada.

There were 15 new-style residencies in various stages of development that were listed in the official application to authorize The American Board of Family Practice, which was approved in February, 1969. We all were betting on the outcome, especially the residents, that family practice would be approved as the 19th primary specialty board.

Why at Wesley?
The climate of support for family practice at Wesley in the late 1960's was propitious but by no means unanimous. I credit the chief administrator, Roy C. House, for making the difference. He went to bat for us with the Board of Trustees and the medical staff. He and I had been in conversation throughout 1966 about a possible role for me as a Wesley employee. I had been in practice in Wichita for 12 years and served in various appointive and
elected offices, including membership on the executive committee of the medical staff. Roy was interested in beefing up Wesley’s services to outpatients, and I was at a nodal point in my career, deciding whether to renew my office lease for ten years, build a new office on the west side, or take a year’s training in psychosomatic medicine at Menninger’s. I was not unhappy in my practice, but felt that the time was ripe to consider alternatives.

The crucial event for me occurred in the fall of 1966 when I read a copy of the Willard Report, which described a plan for a new type of family practice residency. This appealed to my latent interest in medical education and gave Roy and me something definite to talk about. I have to admit that I was not aware of the politics within the AAGP about board certification, but I knew that general practice was in trouble, and I got inspired to think that something could be done about it locally.

The deal that Roy and I finally cut was naively outrageous in retrospect. Wesley would employ me as director of Medical Outpatient Services, a nebulous title under which I would form a corporation of medical staff physicians to cover the emergency department, direct a new-style family practice residency and administer (vaguely) the teaching clinics in the hospital.

I still don’t know what possessed me to believe that I could do that. The plan had to be sold to the trustees and the medical staff, no small task in itself. The trustees had to agree to pay for the residency, and the medical staff had to agree that I could conduct a medical practice within the hospital setting and that we could siphon off the undesignated patients from the E.R. for the teaching programs.

To shorten a long story, the result was the formation of Emergency Services, P.A. and ultimately Family Physicians, P.A.

The Players
Not for one minute do I imply that family practice at Wesley was a one-man show. The medical staff made it happen educationally. There was strong support from the Section on General Practice: Gerhart Tonn, Clyde Miller, Jack Phipps, Walter Reazin, Jack Tiller, and others. We also received strong support from the specialists: Ernie Crow and his group, Jiggs Nelson, Gil Kendrick, C.P. McCoy, Larry VinZant, John Kiser, and Gene Kaufman. I will get into trouble by omitting important names.

One crucial development was in psychiatry, where Garry Porter wrote and obtained the first grant from the NIMH to train family physicians. We had the best training in psychiatry for family practice residents in the nation, in my opinion.

There were non-physicians at Wesley who undertook major commitments to teaching. Bob Eades (Chaplain), Virginia Stucky (Nutrition), Marlin Reissig (MSW), the medical librarian, and the nursing faculty.

We also got a lot of help from the AAGP, especially Ned Burket and the Committee on Education.

Looking back, our plans were audacious and some of them unachievable, but it was exciting to try.
"... it was 'blue sky times'...
by GARRY L. PORTER, M.D.
PSYCHIATRIST, FORMER FACULTY, WESLEY FAMILY PRACTICE RESIDENCY
APRIL 3, 1997

In 1967, I was discharged from the United States Navy Medical Corps, moved to Wichita and took the position of director/medical director at the (very small) Sedgwick County Mental Health Clinic. At that time there were six (counting secretaries) employees. Today, there is somewhere around 350 to 400 employees at COMCARE (the Sedgwick County Department of Mental Health).

Anyway, I had been in town only a short while when I was visited by this rather wild looking fellow named Gayle Stephens, M.D., who indicated he was planning to start a thing called a "family practice residency." (As I recall, it was one of the first few in the United States). He had big ideas and minimal resources. At the time we had minimal resources at the Mental Health Department, but were applying for funds under the Comprehensive Community Mental Health Center's Act (this was passed by JFK in 1963).

Having said this about both Gayle’s and my "problems" at that time, it was really "blue sky times" (e.g., with family practice and community mental health beginning within just a few years of each other.) He was experiencing resistance from within organized "general practice" who, I think, saw this as an implied threat and criticism.

There was no night or weekend on-call coverage available (I was the only M.D. at the Mental Health Center at the time... there are now five of us). Gayle had no money for "psychological medicine education." We made a deal. I would provide, between four to six hours a week of time to the, then, Wesley Family Practice Residency and his "guys" would provide "first call" for emergency night and weekend coverage... as well as see people that came to the E.R. in whatever stage of psychological disorganization.

A letter of understanding was struck and off we went. We weren't always sure where, and had to construct curriculum for, and interact with, resident physicians en route.

Most of the residents during that first ten years were "game" to go along with Gayle’s predilection to include a heavy dose of psychological medicine (NOT psychiatry) input into the program, although there were varying degrees of enthusiasm. As I recall, the AAFP recommended 10 percent of teaching time be devoted to psychological education. As time went on, we modified the offering. As you might guess, there was a tremendous amount of competition for resident training time from the various sub-specialties and specialties of medicine.

Our initial curriculum included two to three hours (as I recall it) of "class time." The "backbone" was the Balint book, The Doctor, His Patient, and the Illness, which Gayle used heavily and which I bought into completely. It basically talks about how to refine the "prescription of the doctor as a drug," and emphasizes how important personality and counter transferential feelings and image, etc., are, and how they help patients lead better physical and mental lives. So, one thing that was fairly easy to do was that for a number of weeks we went chapter by chapter over the Balint book with the first year residents.

Second- and third-year residents were generally lumped into more clinically oriented efforts such as diagnosis and treatment issues.

One session, for at least a good part of the
time I was involved, was kind of an ongoing case conference in which people brought “problem cases” to discuss. As the trust levels waxed and waned, some of these dealt nicely with (depending upon the trust level amongst and with the group) counter-transferential and transferential feelings. At other times and with other groups, it was more superficial.

To add a little spice or froth to the program, we frequently had (remember, this is the late 60’s and early 70’s now) such things as black/white encounter groups in which people from the community were brought in. We used some “sensitivity and encounter tapes” and we even had couples groups in which various counselors from the community assisted. Residents and their spouses participated in an attempt to understand a wide range of marital issues and dysfunctions.

My residency had been at Menninger’s Topeka and I’m sure that (which is now dubbed the “prescientific” time of psychiatry) a good deal of psychodynamic theory was given to the family practice residents. They were, frankly, encouraged, if they had an interest, to try short-term psychotherapy.

Supervision time in the medical clinic was made available to deal with their patients there rather than having them come to the psychiatric office. One-on-one supervision was made available to residents who had an interest (and amazingly enough, some did) in short-term counseling and brief psychotherapy techniques.

This is probably rambling and too much, but my involvement went on for at least 10 years and perhaps a little longer. Shortly after Gayle left, a “sea of change” occurred; “the new broom” swept clean. I think it probably was time for a change as the program matured. I was a bit burned after 10 years, as well.

I summarized my experience in the program in a paper, “Ten Years of Teaching Psychological Medicine in a Family Practice Residency,” and participated in a panel at the American Psychiatric Association annual meeting in New Orleans in 1979.

I continue to see some of the men and women who were residents during this time.

Many have become leaders in family practice around the community. I was very happy to participate in what was a unique beginning of a marvelous direction change in medicine.

Don’t let physicians forget what their most important prescription is!
by VICTOR J. VORHEES, M.D.
FORMER RESIDENT AND DIRECTOR
WESLEY FAMILY PRACTICE RESIDENCY PROGRAM
MAY 20, 1997

I came to Wesley Medical Center to interview for the residency with three other classmates, Dick Roark, Phil Mohler and Stan Mosier. We all wound up at Wesley, eventually. We were interested by the higher salary at St. Joseph, but I did not apply anywhere else.

That was primarily because of Gayle Stephens, M.D., whom I had known since he was a teenager and when I was a grade school kid. I was quite certain I wanted to go to Wesley Medical Center.

I arrived on March 11 or 12, 1968. Having skipped my summer vacation between junior and sophomore years, I finished medical school early. Con Osborne, M.D., was the only other family practice resident there, having shifted from a rotating internship a few months earlier. There were a couple of GP residents, who welcomed me, showed me around, helped me out and were great guys. Jack Tiller, M.D., director of the GP residency, was also very kind to me. My experiences with him are another whole story.

In July, Dick Roark, M.D., came as a first-year resident, and Jay Cranston, M.D., as a second-year. Shortly thereafter, Myron Hultgren, M.D., transferred from the rotating internship to FP. At that point, with five residents, we were the largest FP residency in the nation, I understand. Another “rotator,” Verne Smith, M.D., later joined the fold.

The most remarkable thing about the residency then was its malleability and flexibility (synonyms for lack of organization, I suppose). If we encountered a teacher we liked, and he/she was willing to have us, we signed on for a rotation. There were general guidelines, of course, but we were really feeling our way along.

There was a total of about 12 house officers, all told, at Wesley Medical Center, and we were closely knit. There were a couple of pathology residents, a few general surgery, orthopedic residents rotating from St. Francis, general practice, some internal medicine residents and no Ob/Gyn.

There were “clinics” in medicine, pediatrics, Ob/Gyn and surgery. Family practice and general practice residents had pediatrics and Ob/Gyn to ourselves. We had an “office” in a remodeled house across from the hospital on Pine Street. The main floor had two exam rooms, minor surgery, reception area, filing/business area and a small lab. Upstairs were Gayle’s office and a conference room. The hospital provided the employees.

First-year residents had “office hours” two half-days per week and saw patients “in continuity.” Second-year residents had three half-days per week, and ultimately, third year would have four half-days per week. We also followed patients in the Wesley Clinic, and often, if we liked them, transferred them to “our own practice” in the family practice residency.

Continuity was the name of the game in our rotations, as well. We jealously followed any patient with whom we were involved, checking out only for very special events to the Officer of the Day. No one thought of not being available for any change in status of a hospitalized patient, or missing a call from a “private” patient of our own. It sometimes made for long hours, but it was invaluable in
terms of seeing the evolution of illnesses. I also think it made for much better care than shift work coverage.

Most of the teaching physicians welcomed us. We did take time from their days every day, but we also did H & P’s, discharge summaries, and came in during the night to handle problems, which they appreciated. One thing that did cause some trouble with some was our dual loyalty and our absence to go to our office hours and conferences. One prominent (non-FF) teacher once said, “If I want the resident assigned to me to be present to watch me clean my nails, he had better be available.” I recall this because his attitude was the exception rather than the rule.

However, as the critical mass of physicians in Wichita was exceeded, and as other residencies began to arise and flourish, political problems mushroomed, and there was a continual hassle with getting understanding and cooperation from other residencies when we were only theirs, body and soul, part-time. I understand it is better now than then, but the politics were sometimes fierce.

Early on, there was an emphasis on the psychosocial aspects of patient care. We had conferences with the social worker, Marlin Reissig, during the first year. There also developed early on, perhaps late ’68 or early ’69, a Doctor-Patient Relationship Conference. Gayle and Chaplain Bob Eades patterned it after the verbatim conferences Bob used with his Clinical Pastoral Education students. It was very difficult work for both residents and teachers.

After being in it for three years (later it was only required in the first year), I soon became involved as a co-instructor with Bob, as did Stan Mosier.

I think we had more complaints from residents about the Doctor-Patient Relationship Conference than any other aspect of the program, but I also have had more graduates tell me that it was more valuable than any other aspect of the residency.

Garry Porter, thanks to a grant, was involved in 1970-1972 with a curriculum in psychiatry for family practice residents. We had lectures, reading and “fish bowl” interviews with a one-way mirror, critiqued afterwards by fellow residents and Garry. This worked fairly well, but I believe the grant money dried up and it was dropped.

These psychiatry conferences, DPR conferences, weekly director’s conference and office hours caused much conflict with other residencies and their directors, but I consider them absolutely invaluable in my training. I think they, and the “real” office atmosphere, were chief differences from general practice residencies.

I recall one day when we were assembled for our psychiatry conference with Garry. Before we began, the door opened and a woman came in, seated herself, looked around the table and said, “Good morning, gentlemen. I am paranoid schizophrenic” She then proceeded to discuss the topic, rather erudite, with Garry interacting from time to time. We wondered who she was, and I decided she must be an actor hired to play the role.

Finally, after 30-to-40 minutes, Garry indicated “that is enough,” but she did not want to stop. He firmly stopped her, and escorted her out. She was a patient of his and had done the whole thing on her own, without his knowledge. Probably one of the best conferences we had.

Early on, it became clear that the residency (and the specialty?) appealed to people with a desire to be helpers. A large majority of applicants, and of those accepted, had been in teaching, social work, ministry or had contemplated seriously some other helping profession before choosing medicine.

Shortly before graduating early in March, 1971, I was allowed to take boards, and so was a Charter Diplomate. I immediately went into a teaching role, “supervising” some of my classmates from my position of three months seniority. That was not always comfortable for me. Con Osborne, Gayle Stephens and I, in 1970, formed Family Physicians, P.A., borrowing $40,000 from the Small Business Administration. That outfit formed the basis of the practice for as long as I was involved.

I am not able to detail all of Gayle’s
achancements, but insist that his role is more than
key, not only to the development of family practice
at Wesley Medical Center, but of the specialty, in
general. He was truly an explorer, shed much of
his own blood for us in political fights, provided a
role model par excellence, and shaped other
programs by example. His role is not to be
downplayed or overlooked.

In 1970, Gayle negotiated a move into the
county hospital, with a wing being remodeled into
an office for us. This expanded our practices, gave
us additional distinct identity and worked fairly
well. We stayed there until 1976, when FPPA
bought half a floor, and WMC the other half, in the
new Medical Towers Building.

We refused to join the other residencies in the
basement area, and persisted in seeing a broad mix
of all social and economic classes of patients. We
did, however, plan it so that when or if we split the
sheets, we could close and lock two doors and
continue with the lab, business office, record
storage and adequate exam rooms on the half
owned by FPPA.

When Stan Mosier graduated, he joined FPPA.
Conrad left to join Hillside Medical Group. In
1972, Gayle decided to leave to be dean of a
medical school, and Stan and I agreed to stay on
for six months as co-directors. Neither of us was
willing to report to the other, nor to be the top dog.
It worked well for us, and while the committee
searched, we struggled to learn how to run the
outfit. Seven and one-half years later, we quit the
struggle. It was something I am very glad to have
done, but did not know the weight of the cross
until after we had laid it down.

So far as I can ascertain, Con Osborne was the
first family practice resident in the country, and I
the second, although a program in Florida started
in July, 1967 or 1968. Also, so far as I can find, Stan
Mosier and I were the first directors of a family
practice residency who were family practice
residency trained.

Then, the KUSM-W began to be a reality, and
the “standardization” procedures began. The
residency was under pressure to be state “run,”
with all that means. I firmly believed, and have
not been convinced otherwise, that this would lead
from a position of superiority (evidenced by how
many people visited WMC to see how we did it
before starting their own programs) to a state of
mediocrity. Vorhees’ first law is that STANDARD-
IZATION ALWAYS LEADS TO MEDIOCRITY. I
think the university’s oversight was inevitable, and
I admire those who are able to live with the
bureaucracy. My temperament simply cannot
handle it.

In 1979, I was having PVC’s intermittently. I
would stop caffeine and get some improvement,
but they persisted; they became runs of bigeminy.
Finally, I said “OK, body, I hear you.” Stan and I
quit as residency directors December 31, 1979; like
a switch the PVC’s were turned off and have
stayed off since, with rare exceptions of one or two
isolated palpitations with heavy stress.

I will not go into my views as to the outlook
for family practice. I have been disappointed in
the way things have developed, but do not know
whether my dreams were practical, nor do I know
how it will look to those coming behind. I do
know I am glad to have been there, to have
experienced the birth pangs and the joy of
delivery. It was an opportunity I would not trade.

One of the things I cherish is the knowledge
that there are a significant number of Wesley
Medical Center family practice residency
graduates who are carrying forward the banner of
family practice education. It gives me vicarious
pride and a sense of eternal life. Continue the
fight; keep the faith.
"...114 residents..."

THE MINOLEA, KANSAS RURAL ROTATION OF THE 
WESLEY FAMILY PRACTICE RESIDENCY 
by CHARLES G. STEPHENS, M.D. 
MARCH 27, 1997

I first got personally involved in the Wesley Family Practice Residency in the fall of 1972 by submitting a proposal to Drs. Vic Vorhees and Stan Mosier to place a family practice resident in Ashland, Kansas and Minneola, Kansas. Ashland was without a physician at that time and I agreed to supervise a resident in Ashland and in Minneola. An attorney and a hospital board member from Ashland, the Minneola Hospital Administrator and I traveled to Wichita and met with Dr. Cramer Reed, Dr. Stan Mosier and Dr. Vic Vorhees and made the proposal. I do not believe that Kansas University was involved so much at the time in the operation of the residency, but Dr. Cramer Reed was dean of the new medical school. It took Kansas University a while to “take over” the program.

The people in Wichita were not interested in putting a resident in Ashland since they didn’t have a physician to supervise the resident. However, the relationship did begin and culminated in a rural rotation at Minneola. Either at the same time or shortly thereafter, a similar set-up was developed with Drs. Chaney and Doubek at Belleville, Kansas.

The first resident at Minneola was Dr. Ray Cook in July and August of 1973. Dr. Larry Eidt was next, and he served three months of September, October and November, 1973.

For the first few years, family practice residents came intermittently and served a two-month rotation. Later, Dr. Dave Holden initiated a program of continuous residents here at Minneola. Dr. Donatelle seized the opportunity and wrested $2,500.00 a month from the Minneola District Hospital and me for this voluntary educational experience. This was a burden and was discontinued after a few years.

We provided a good educational opportunity for the residents at Minneola. This has been a busy practice, and the residents seemed well equipped and well trained and able to jump right in and put their head knowledge to work in practical medical care. The residents were given greater responsibility than they had in Wichita. I spent at least eight to ten hours a day working side-by-side and closely with the residents, supervising them from either near or far, depending on the emotional makeup of the resident and their amount of medical know-how. I think this proved to be a very good experience for most all of the residents.

I have witnessed a change in medical education. A few years ago, the residency and the nature of the residents seemed to change.

There is less emphasis on taking care of sick people. Many residents don’t seem to desire the ability to take care of real sick patients.

It seems to me that over the past few years, residents have been trained to be a “Doc-in-a-Box,” and what really bothers me is that many of the residents seem willing to be a “Doc-in-a-Box.” This may serve the needs of many of the larger companies that hire doctors to work eight to twelve hours a day, but that image of a physician is an anathema to me.

I have seen a change in the number of female residents. This may be due to the great influence of feminism on our culture. I may have also changed, but I don’t admit that.

Ladies such as Alma Morgan, Peggy Roberts,
Carol Johnson, Susan Jones, Debbie Beeson, Kim Hartwell, Mila Means, Jana Nisley, Donna Logan, Francie Clark, Cherie McClendon, Betty Troutman and Teresa Johnson were excellent and complete physicians. Many of these ladies were absolutely great as people and physicians. Dr. Susan Jones is probably the best resident to have rotated through Mineola. A total of 114 residents have rotated in Mineola since 1973.

Recently, the rural rotation has been changed to a one-month period. I am not happy with that. At a time when the medical school is trying to provide education for medical students in smaller communities (i.e., out of the major medical setting), the premier family practice residency in the state is reducing that emphasis. Limiting the resident to a one-month rotation with many of the super specialists seems appropriate. But providing only one month with a busy family practitioner seems to be the wrong emphasis.

My hopes for family practice residents would be to train them to take care of the seriously ill patients in the hospital as well as equipping them to practice good outpatient medicine.

The residents need to have time with excellent physicians who are also good teachers. The Wesley residents used to spend time with Dr. Linda Francisco and her hospitalized patients. They all seemed to be quite ill, and she gave the residents good experience and training in managing fluids and electrolytes and altering medication dosages with the renal compromised patient. Learning how to manage her patients gave the residents great confidence in being able to take on other sick patients.

When I was an intern back eons ago, I knew when Dr. Crow was going to set foot in the hospital, be it morning or evening. I knew when he had certain procedures scheduled. I knew when Dr. Crumpacker or Dr. Larry VanZant was going to be in the hospital. I knew when Dr. H.O. Anderson was going to set a fracture. I knew which nurses and clerks had the information that I wanted, and I made sure I was in the communication flow and part of the grapevine for whatever department I was rotating through at the time.

It seemed to me that all residents knew that, but of late, many of them have lost this ability. They don’t know how to be with an established physician nor make the cognitive connection that “I can learn from that person.” This has been a significant change in the residents.

I would like to make some suggestions. Family practitioners ought to be endoscopists. I was taught to cystoscope men and women when I was a junior and senior med student.

It seems to me that fiberoptics have made endoscopy much easier. My family practice partners do EGD’s and colonoscopies here. I think all family practice residencies ought to hire the sub-specialists to teach their residents to do cystoscopies, bronchoscopies, EGD’s and colonoscopies. The family practitioner may not choose to do all of these during one’s medical practice, but all of these procedures lend themselves well to family practice.

No doubt one of the greatest things one could do for our country is to get everyone to stop smoking. That would certainly save billions of dollars and improve the health of the nation. That accomplishment alone would maintain the health of the nation on a different level and prevent more illnesses than any other behavioral change since teaching people to defecate in the proper place.
"Residents were always very serious at the beginning . . ."
by ROBERT E. BOYER, M.D.
PAST PRESIDENT, KANSAS ACADEMY OF FAMILY PHYSICIANS
AAFP DOCTOR OF THE YEAR, 1977
AUGUST 18, 1997

After medical school, I did a rotating internship at Wesley Medical Center in
Wichita. This was usual and customary at the
time. Family practice residencies were not
available.

The year I finished my internship was
1963. As was also the custom at the time, I
was drafted into the Army and spent two
years in Fairbanks, Alaska. During the last
year, I began to look for places to practice,
having already decided that I wanted to be
a rural family doctor not too isolated from
larger cities.

I had decided to look for practice sites in
Wyoming, Colorado, Arizona, New Mexico
and Kansas. I corresponded with many
physicians in those states, including Drs. Ned
Burket and Sam Zweifel in Kingman, Kansas.
My brother lived in Kingman and my father
was born in Kingman, so I had emotional ties
to this small community just 35 miles west
of Wichita.

When I left the Army, I spent four months
traveling the Midwest and West, finally
deciding to join Ned and Sam in Kingman.
This was in the fall of 1965.

The three of us had a great practice and
relationship. I learned lots of medicine from
Ned and Sam. Ned Burket, M.D., was presi-
dent of the AAFP and a past president of the
KAFP. Sam Zweifel, M.D., was also a past
president of the KAFP. For a short time after I
was president of the KAFP, Kingman, Kansas,
had had the most presidents of the KAFP . . .
more than Wichita or Kansas City.

Everything changed in 1960 when Sam
decided to leave Kingman and join the State
Department, where he remained until his
retirement to Phoenix. Ned and I practiced
together until 1971 when Ned decided to also
leave Kingman to join the faculty at the
University of Kansas School of Medicine in
Kansas City where he taught residents in
family medicine. I then practiced by myself
for two years.

This hectic time was tempered by two
things: Eileen Hawkins, a nurse in our office,
left to join the first nurse practitioner class at
KUMC and to subsequently return to Kingman
where we practiced as a team for over 25 years;
and Ned promised to use his influence at
KUMC to include Kingman and myself in the
rural rotation for family practice residents.

Ned kept his promise. Dan Fahrenholz,
M.D., was the first of about 20 physicians to
"rotate" through Kingman. Dan's brother,
Randy, who was a resident at Wesley, also did
his rotation in Kingman and both returned to
join me in practice until we all left Kingman
within 1 1/2 years of each other in 1993. We
built a new clinic, practiced good medicine,
trained residents and became good friends.

During this period, we leased a two-bed-
room apartment for the residents, which was
one of the nicest apartments in town. The clin-
ic furnished it and provided all the supplies.
In those days, the doctors and the hospital
were quite separated and the hospital did not
help us in any way. We had residents from KU
and Wesley and also had occasional medical
students, nurse practitioner students and even
got involved in a rural rotation for nurse
practitioner students from Boston. All in all,
we probably participated in training about 20
residents, 10 medical students and 25 nurse practitioner students. We still correspond with some of them and always received the feedback that we had provided an excellent teaching site.

We always thought that having fun was important in the practice of medicine and teaching students was a good format for some of that. When a resident arrived, we started them right off seeing patients on Monday morning. Residents were always very serious at the beginning, with their long white coats, name tags and pockets full of manuals.

We tried to initiate them to our practice by scheduling their first patient as a fake. We had a former nurse named Connie who ran a flower shop and whenever we had a resident coming, we would notify her. She would say, "Put me down. I will be there at 9:00."

The resident would enter the room and say something like, "Well, what kind of problem are you having?" She would reply, "Every time my husband and I have sex, my eyes water." We had rehearsed a number of chief complaints and had finally settled on that one because we thought it was unique.

Of course, all the rest of the clinic staff and doctors were listening outside with our stethoscopes pressed to the door. It wasn't the "solution" to the problem which interested us, although we had a number of very memorable ones, but our lottery was based on what the resident's next question was going to be. It was a time of laughs and a way to put the resident at ease, even though, perhaps, not immediately.

We continued to have residents until the early 1980's. At that time, the chair of the Department of Family and Community Medicine called and told us that we would have to pay for the residents since the residency programs were losing money when the residents were on rural rotation. Dan, Randy and I felt this was decidedly wrong, and, after a brief discussion between ourselves and the hospital, we elected not to "buy" residents for what we considered to be a valuable teaching experience. Our teaching site abruptly ended and has not resumed. The Kingman Clinic continues to have occasional medical students and nurse practitioner students.

Dan left our practice to join the faculty at Northern Colorado Family Practice Residency in Greeley, Colo., where he continues his fine teaching. Randy left to be the director of drug and alcohol rehabilitation at St. Joseph Hospital, and I left to work part-time in the Department of Rural Health Education and Services at the medical school. I look back on our teaching time with good feelings and memories and know that we did, in fact, provide a valuable service to medicine in helping prepare residents for rural practice.
"... I had to first go to the cafeteria..."
by RON BROWN, M.D.
FORMER RESIDENT AND FACULTY
WESLEY FAMILY PRACTICE RESIDENCY PROGRAM
SEPTEMBER 1997

I recall the “old pro,” Dr. Lou Forster (he had been a resident for three months) gently breaking the news to me that I was on-call as hospital OD for the entire Wesley hospital my first day as a house officer, July 1, 1973. The hospital usually ran a census of 600-to-700. At that time, there was no “code team.” The first-year residents from family practice and medicine were “it.”

That first night, I settled into bed in the call room on 5 Medical Pavilion (now 5 Women’s Hospital), but had trouble closing my eyes. I could get anywhere in the hospital from the cafeteria at the intersection of the main halls on first floor, so to get around the hospital I had to first go to the cafeteria and get oriented!

During that eventful evening, Dr. Ray Cook was on OB call and invited me to participate in a delivery. I thus settled into residency life with a bang. Before long “codes,” “sundowners” and other various and assorted nocturnal medical problems became commonplace, like eating your lunch during dissection of your cadaver in medical school.

My rural rotation in Mineola with Dr. Charles Stephens was a thoroughly enjoyable experience and a great opportunity to develop an accurate self-assessment of one’s knowledge base and clinical skills. The community was terrific, and Marcia and I felt welcomed and truly a part of the community during our stay.

I was the second family practice resident to do a special family practice OB elective. Dr. Ken Wiant conceived the idea and preceded me by a month. As the only resident on that particular “service,” I was on-call for 30 days straight, covering the deliveries of all of the family physicians who were delivering at that time. There were quite a few, including Dr. Bill Osoba, Dr. Con Osborne, Dr. Val Brown, Dr. R.L. Brown, etc. All together, I believe there were approximately 16-18 family physicians that I covered.

During that month, I averaged between 30-to-40 deliveries, which meant basically that I had somebody in labor almost continuously for the entire month. During that time, I also had my routine residency office hours and practice, as well. It was an interesting month and a good month.

This rotation subsequently transitioned into a month with Dr. Gordon Cowles and Dr. Manis Edwards and subsequently has become the situation of the FPOD covering the family physician’s Ob’s who deliver at Wesley.

I recall the first-year Doctor-Patient Relationship conference with Bob Eades, hospital chaplain, as probably one of the most significant and meaningful learning experiences of my residency.

During my third month of residency, I was on a pulmonary rotation with Dr. Spann and Dr. Drevets. After about the third or fourth day, Marcia and I purchased an extra-long cord for our home telephone so that at night I could move it from the hallway to the floor next to the bed and not have to get out of bed to answer the phone. There were so many beeps, I literally listened to blood gasses in my sleep. I can remember trying to take a bath on a Saturday and talking on the phone in the bathtub.

During my residency years, KU was graduating at odd, off-cycle times, and we had a
funny mixture of resident longevity. Dr. Bill Browning and I were the only two that were precisely at the same point in residency. Dr. Bill Ciskey started six months before us. Several others, including Dr. Rich Krebs, Dr. David Graham, Dr. Paul Williamson, Dr. Bob Haskins, and Dr. Dennis Biggs, were six months behind us due to KU’s unique graduation schedule.

I have secondhand knowledge of a story that Myron Hultgren told about Gayle Stephens. Apparently, in the very early years of the residency, Dr. Stephens had a lady in labor and she was progressing slowly. He felt she was OP and had all the family practice residents paged to come to the birth rooms. They evidently arrived and he gave an impromptu lecture/discussion on OP presentations and rotation. He then applied the Kielland forceps and rotated the baby . . . and promptly delivered it OP!

As part of our second and third year Doctor-Patient Relationship conference experience, we were assigned to a community psychiatrist and actually went to their office and had an hour-long session to discuss anything we wanted to, including pharmacology of the drugs and individual patient problems and management. I was assigned to Dr. Stuart Richardson who had an office in a large house on Douglas. His actual office was a huge room that was probably two of the bedrooms combined into one. There was a large, soft, comfortable cushioned chair in front of, and some distance from, his desk. During my month of covering the family physicians in the community who delivered (and being on-call continuously), I presented myself for the weekly encounter. I can remember beginning to discuss the ongoing saga of one particular patient and, the next thing I knew, I awakened with a start, and had been asleep for essentially the whole hour. Dr. Richardson was calmly reading a magazine and waiting for me to wake up. In his true psychiatric mode, he took no offense at my impromptu siesta.

During one of our occasional family practice noon lectures, one of our colleagues had an embarrassing moment. We were in a small classroom off one of the Medical Pavilion floors and a particularly boring presenter was droning on and on. At one point, he invited comments from the audience and Dr. Ken Wiant responded. As the presenter turned his back to us and began writing on the blackboard with a prolonged answer, Ken fell asleep. Unfortunately, he was sitting on the front row, and the rest of us were at least two rows of chairs behind him and could not reach him, tap him, kick him, or otherwise arouse him short of throwing a fork or knife at him.

The presenter eventually turned back around to ask for additional information. He did not handle the situation as smoothly as Dr. Richardson.

I remember the fountain wedding present (a girl holding a duck with water coming out of its mouth) that Wayne Stine purchased to give Dr. Stan and Kathy Mosier. It was not the Southwestern Indian art piece Stan had expected.

Post residency, I stayed on the residency staff, initially joining Dr. Stan Mosier, Dr. Victor Vorhees, and Dr. Gary Coleman in practice and supervision of the residents. After one year, Dr. Coleman moved to Abilene with Dr. Dennis Biggs and Dr. Steve Schwarting to form a three-person group. Dr. Paul Davis returned from his educational pay-back practice in Oklahoma to replace Dr. Coleman. After another year, Dr. Davis left and went into private practice and Dr. Terry Stryker (now Merrifield) replaced him.

As residency faculty, I recall that Dr. Randy Nichols had at least half of his Ob’s present at three in the morning . . . complete and delivering.

Dr. Vorhees professed the “Three Great Laws of Ashcraft”:
1. All bleeding eventually stops.
2. If you focus on your bowels long enough, your brain will turn to *!@#.
3. You can’t polish a t*.

During Grand Rounds, it was not uncommon for a resident to call out one of the Three Great Laws of Ashcraft when it was time to list the differential diagnosis.

Vic also made a famous self-assessment
that lack of knowledge never kept him from having an opinion!

At this point, I have probably rambled enough but would add that I was present with Randy Nichols, Jeff Steinbauer and Rick Kellerman for the bedside story of the gravelly jet . . . !
"I learned to respect the stories that people had to tell . . ."
by BETH ALEXANDER, M.D.
FORMER WESLEY FAMILY PRACTICE RESIDENT
SEPTEMBER 1997

I've included a few pictures of the Wesley Family Practice Residency Christmas party (1978). Pete Dalum is playing Vic Vorhees (VJV) with boots, Jeff Steinbauer is Santa, Ron Hunninghake is Stan Mosier and Randy Stewart is Ron Brown. Carol Johnson and I were elves in tights. (Thank goodness there are no pictures!)

Some of my more vivid memories of early times with the residency have to do with rounds with VJV, Terry Stryker, Mark Vin Zant, Mark Spence, Dave Miller and myself, with VJV reaching down into his boot to check his beeper, mock paranoid musings about the carpet and floor cleaners as we rounded (the "zamboni" was after us) and the famous phrase: "WAFM," which VJV would offer as the explanation for all things that didn't seem to have an answer.

Then there were those summer picnics at the VJV farm, everyone with new babies or ones in the hatcher, lots of food, pony rides, tractor rides and volleyball. Square dances every fall with a caller and everyone participating . . . Kay Myrtle organized all of it, as I remember. Christmas caroling with Ron Brown and his wife leading the troops down the halls of Wesley . . .

Perhaps, however, what I appreciate most about this program, were the wonderful models of patient care from Terry, Ron, Stan and VJV, that still guide who I am in the care of my own patients. I learned what it was to listen well, to listen "between the lines," to notice more than what was obvious, to consider the meaning of what patients told me, to consider the family members who were not in the room as part of the picture. I learned to respect the stories that people had to tell as the most important information I would learn, including that from texts. And we all learned the importance of continuity with patients and families, something that seems lost in many training programs today.

There were times when I wish to flee to the rural settings, to try to regain that ideal that was imprinted on us as "the standard" during our training years. It seems much easier to attain when there are not integrated systems, multiple specialists fighting over territory, insurance-plans-of-the-month to deal with, Dan Roberts (rest his soul) conflicted over whether family docs should do obstetrics, or whether family practice residents should grow beards. But then, perhaps, what we learned from our teachers does continue to get translated in important ways. When we sit in rooms listening to patients, they tell us about ourselves as healers.
Wesley Medical Center has a long and rich history in medical education, especially education in general practice and family practice, later developing residency training programs in many other specialty disciplines. In 1922, Wesley received its first “extern” from the Kansas University Medical Center, and developed its own “internship” shortly after that.

Sometime prior to 1951, Wesley was providing a one-year internship specifically in “general practice.” In about 1959, the course work was extended to two years as a general practice residency. Dr. Jack Tiller was the training director of the general practice residency.

In 1966, G. Gayle Stephens, M.D., worked with Roy C. House, the Wesley Chief Administrative Officer, to establish the Wesley Family Practice Residency Program. Dr. Stephens was serving as president of the medical staff. The Wesley Emergency Room was the “sore toe” of the hospital at that time; Wesley was having difficulty staffing the Emergency Room, and was using primarily interns. Stephens and House made a deal that Stephens would work on the emergency room problem if House would fund a family practice residency. Thus, both the Wesley Family Practice Residency Program and Emergency Services, P.A. were born. Dr. Stephens established the residency program’s practice from his own private panel of patients, creating a “model family practice office” for family practice education.

In 1967, while the specialty of family practice was being created in this country, Wesley began training the first family practice resident, Conrad C. Osborne, M.D., under the direction of Gayle Stephens. Dr. Stephens was later to become president of the Society of Teachers of Family Medicine and the nation saw the Wesley model accepted as the national standard for family practice graduate education.

In 1972, Dr. Stephens left Wesley Medical Center to become dean of the School of Primary Care of the University of Alabama at Huntsville, Alabama, and later chairman of the Department of Family Practice at the University of Alabama in Birmingham. He is currently retired and much revered as one of the philosophers and fathers of family practice.

The residency was first housed in a small white frame house across the street from the E.B. Allen County Hospital, which is now KUSM-Wichita. The program was so successful that it soon moved to a larger white frame house on Murdock Street across from the Wesley Murdock parking garage. In 1976, the program moved to newly built quarters in the Medical Arts Towers at 3243 E. Murdock, with satellite offices in northeast Wichita and later KUSM-Wichita. In August, 1991, the residency program moved to its current office at 3340 E. Central.

Dr. Stephens was replaced by co-directors Dr. Stanley Mosier and Dr. Victor Vorhees, both 1971 graduates of the Wesley program. Drs. Mosier and Vorhees at that time became the first residency trained family physicians in the country to direct a family practice residency program. Drs. Mosier and Vorhees left in 1980 to enter private practice.

In 1980, the residency program came under the administration of the Department of Family and Community Medicine at the University of
Kansas School of Medicine at Wichita. The residency faculty hold faculty appointments at the medical school and also participate in teaching undergraduate students during their family practice clerkships.

Residents have been associated with WCGME (Wichita Council for Graduate Medical Education) since 1989. WCGME coordinates the salaries and benefits for Wichita residents.

In 1980, David M. Holden, M.D., became director of the program. Dr. Holden had been involved in full time family practice education since 1974 in North Dakota, Wyoming and Michigan. Holden left Wesley in 1983 to become chairman of Family Practice at the State University of New York at Buffalo. He currently serves as chairman of the Residency Review Committee for Family Practice. R. Alan Sather, M.D., was residency director in 1984 and 1985 coming from a teaching position in Alabama. He later returned to Birmingham to direct an HMO in that city. Thomas P. Houston, M.D., was residency director from 1986 to 1990. He came from Rome, Georgia, where he served as an assistant program director. He left Wesley, moving to Chicago, to become director of Preventive Health for the American Medical Association. Carol A. Johnson, M.D., was recruited to become program director in 1990, after serving as acting director on two previous occasions.

Wesley Family Practice residency has many firsts:

- It was one of the first four family practice residency programs in the nation and in the world.
- It had the first graduate of a family practice residency in 1970.
- It was the first residency program to be established in a community hospital.
- It was the first program to have a family physician as director and the first to have residency trained board certified family physicians as directors.
- It was the first to develop a Behavioral Sciences program and institute Doctor-Patient Relationship (DPR) Conferences and Balint sessions.
- It was the first to provide and require a rural rotation experience.
- It was the first to incorporate community medicine and Practice Management into the curriculum.

Although it does not fit in a “first” category, 100% of Wesley’s graduates since the program’s inception in 1967 have passed the American Board of Family Practice certifying examination on the first try! The program has maintained full accreditation from the ACGME RRC throughout its history.

The program is proud of its history, and especially proud of its graduates, who provide outstanding health care to families. There are now 186 graduates of the Wesley Family Practice Program. Most practice in rural Kansas and the Midwest. Others are in urban, suburban, academic, and missionary settings.

The mission of the Wesley Family Practice Residency Program is:

- to provide excellence in the education of family physicians.
- to promote health and provide compassionate, comprehensive patient care.
- to advance the discipline of family medicine by increasing its fund of knowledge and furthering its unique philosophy.

Current Faculty:
Program Director: Carol Johnson, M.D.
Associate Director: Scott Moser, M.D.,
(leaving August 1, 1998, to KUSM-W)

Physician Faculty:
Mary Kay “Katie” Mroz, M.D.
Mary C. Boyce, M.D.
Mitchell C. Wolfe, M.D.
Linda Goodson, D.O.
Ruth M. Weber, M.D.,
(joining September 15, 1998)

Part-time faculty:
Mark Romereim, M.D.
Other Faculty: Mary Beth Cupp-Criss, L.S.C.S.W., M.Ed. Director of Behavioral Sciences
Kay Bachus, M.S.N., A.R.N.P., Nurse Educator
Sudha Elangovan, M.D.
and Douglas Woolley, M.D.
(also see patients at Wesley Family Practice)

We also greatly appreciate our many volunteer faculty in family medicine and other specialties who contribute their time and talents to our program in both the hospital and the family practice center . . . and the residents who teach us as much as we teach them.

Previous Department Chairs:
Ernie Chaney, M.D. (Interim 1996)
Don Gessler, M.D. (Part-time Chair)
Billy Gardner, M.D. (1973-1975)
Gayle Stephens, M.D. (1972-1973)
Wesley Medical Center Officials:
Chief Executive Officer: Carl Fitch
Former CEOs:
Roy House, Jack Davis,
Jim Biltz, Jim Kelly,
Kevin Gross

Former Senior Vice Presidents for Medical Staff Affairs:
Gil Kendrick, M.D.
and
Walt Reazin, M.D.

Chief Operating Officer: Niels Vernegaard

Line Officer for Family Practice Education:
Cramer Reed, M.D.

Director of Medical Education:
Cindy Peterson

Former Director of Medical Education:
Bill Kimble and Ron Linhardt, M.D.

We hope the strength of our heritage and the support of our hospital, medical school and community will ensure our future endeavors to continue to educate outstanding family physicians in the tradition of the Wesley Family Practice Residency.
"... the most important educational contribution to medicine in the last half of the twentieth century."
by JOHN FREY, M.D.
PRESIDENT, SOCIETY OF TEACHERS OF FAMILY MEDICINE, 1998
MAY 1998

As one of the seminal institutions in founding the academic discipline of family medicine, Wesley Medical Center recognized the community as well as the hospital as the appropriate place for education in family practice. While the general practice residencies which existed pre-family practice served a useful purpose, the new family practice programs were distinguished by the movement of graduate education into model family practice centers which served as beacons for education and patient care. Family practice centers challenged the prevailing belief that graduate medical education could only take place in hospitals — a challenge that the intervening 30 years has supported as all other academic disciplines, from anesthesia to pediatrics, have moved out of hospitals into the community.

Gayle Stephens, whose influence grew from Wichita to encompass all of family medicine education, created the residency program at Wesley. His leadership nationally has made many of us feel that Wichita was a wellspring of thought and training in our discipline. The Flexner report in 1911 created hospital based education and the family practice specialty movement formally took education into the community. The model family practice center represents the most important educational contribution to medicine in the last half of the twentieth century.
THE FAMILY PRACTICE RESIDENCY AT
WESLEY MEDICAL CENTER, WICHITA, KANSAS

(A presentation to the State Officers Convention
of the American Academy of General Practice
Kansas City, Mo. April 20, 1968

G. Gayle Stephens, M.D.

It is an honor for me to have this opportunity of formally presenting the
developing Family Practice Residency at Wesley Medical Center to the State Officers
of this Academy. It was one year ago in January that I made the basic decision to
become involved in this aspect of medical education. During this year I have had many
private conversations and communications with various Academy officers and I feel that
I have had the enthusiastic encouragement of such men as Ned Burket, Si Grant, R^2 Hannas
and others, but today is the first exposure of my plans to a formally constituted body
of the Academy. In some ways I have the kind of anxiety about this presentation that
I used to have on examination day in medical school, for in a deep sense I am really
trying to pass your inspection. Quite honestly, your reaction to these plans will be
an important influence on their fulfillment, for I have tried in a self-conscious way
to plan this residency according to my best understanding of the ideas and ideals of this
Academy. I have sought the advice and counsel of many people but I must admit to a
certain sense of loneliness and vulnerability during the past year. A great deal has
been said and written recently about Family Medicine and Family Practice but when it comes actually to putting a program on paper there are very few places one can go for help. So I must bear responsibility for the degree to which these plans do or do not meet the best expectations of men like yourselves who have been involved for many years with the task of maintaining General Practice as a viable option in American Medicine.

In the interest of the economy of time I shall make certain assumptions and set certain limitations to the formal presentation which is to be concluded within 20 minutes. If I am mistaken in these assumptions it may become apparent in the question-answer period which follows.

The first assumption is that I do not have to justify the development of this program to this group. I assume your familiarity with the various studies and reports of the recent past which in monotonous consensus, describe and document the medical needs in contemporary society and the failure of our medical education system to meet those needs.

In this regard I shall abjure the polemics surrounding such terms as "comprehensive care", "Family Medicine", "Family Practice", "Primary Physician", and the like.
I shall avoid the sterile dispute over jurisdiction in the field of comprehensive care.

I simply note in passing that, if internists and/or pediatricians are destined to be
the future purveyors of such care, they must become different internists and pediatricians
than are now evident. The mere logistics are baffling. As difficult as it seems to meet
the primary health needs of society with a dwindling supply of general practitioners who
still constitute 24% of U.S. Physicians, it will be infinitely more difficult to do so
with the 13% who are internists or the 5% who are pediatricians.

With the ground thus cleared I proceed to a description of the Wesley Program.

As indicated the over-arching goal is to implement the ideas set forth in "The
Report of the Ad Hoc Committee on Education for Family Practice" and as elaborated in
two publications by this Academy, 1. "The Core Content of Family Medicine" and 2. "Graduate
Training for Family Practice". My understanding of the content and meaning of these
statements includes the following conclusions which have guided me in the kind of program
I have planned.

1. The Family Physician of the future is to be no "triage" officer, or some
kind of "sub-M.D." functionary. He is to be a fully qualified senior-
 partner on the health care team ready to take his place beside other medical
specialists. There is nothing in the publications mentioned which conceives
the family physician as simply a "sorter" or referral source, either unconcerned
with, or incompetent for, definitive health care. I think it is important to lay this image to rest. I recognize and am sympathetic with the efforts being made to train various categories of ancillary personnel who can perform many functions formerly reserved for physicians, but I wish it to be clear that my conception of the Family Physician is not either that of a low-grade professional or a high grade technician, or a combination of the two. He is to be a technically competent autonomous professional — and more!

2. There is to be inculcated into the teaching and practice of the Family Physician an effort to take seriously the concept of "the whole man". This term is often abused and has become a shibboleth for a wide variety of people, some of whom make strange bedfellows. (I've even heard a widely known faith-healer inject large doses of "whole man" rhetoric into his public pronouncements.) Be that as it may, the intent of this Academy to recognize and emphasize the human and social dimensions of health care has broad implications. For one thing it implies our willingness to become involved with our patients in new ways and puts us squarely on the side of those forces and issues which work for personal, in contrast to merely individual values. More deserves to be said on this point — perhaps at another time.
3. The Family Practitioner of the future must be exposed during his education to a model family practice. This is new—and important! If continuity and comprehensiveness are desired values they must be learned by design rather than chance. There are some things, perhaps the most important things, that can be learned only within the context of a continuing relationship. It is one thing to make a medical decision and quite another to live with that decision. The night time phone call may help one decide whether Darvon is as good an analgesic as codeine. The effect of one's explanation and reassurance about a functional symptom can only be measured by time. What this means I think is an attempt to recapture some of the values of the preceptor—preceptee relationship, which have been largely missing from medical education since the Flexner Report in 1910. The abuses and inadequacies of an educational system built primarily on a preceptor—preceptee relationship are well known but this does not mean that the relationship has no virtues, and I see the Family Practice Office as a place to learn and develop those virtues of wisdom, honesty and judgment.

4. The Family Practice Office does not provide the entire educational experience. There are many aspects of patient care that can be learned best on hospitalized patients. This may seem too obvious to mention but I do not see the future
Family Physician giving up his interest in and competence for hospital medicine. It seems to me however that his hospital educational experience should be primarily procedure oriented. Obstetrical deliveries, acute coronary care, intensive care, resuscitation and surgery are bona fide reasons for in-patient experience.

5. There must be some formalized effort to teach psychiatry as it applies to Family Practice. This relates to item two about "the whole man". There must be some effort to understand an appropriate model for psychiatric care. In my opinion this model will not be psychoanalytically oriented therapeutically but may include psychoanalytic formulations along with large doses of neurophysiology, behaviorism, phenomenology and existentialism in an eclectic theoretical mix for understanding human behavior.

The kinds of psychologic problems with which Family Practice will be most concerned can be classed as "problems of living" and will include marriage conflicts, child rearing, psychosomatic conditions and geriatric problems.

6. Built into the educational experience of the resident should be the opportunity and necessity for becoming reflective about himself. If it is true that the
physician himself is often the therapeutic agent of greatest consequence, it becomes imperative that he learn his assets, liabilities, foibles and idiosyncrasies. He must learn to apply himself to the patient's needs with the same discretion he uses to titrate the dose of digitalis. The mere acquisition of "subject matter" which becomes obsolete with discouraging speed is not sufficient. The Family Physician must learn attitudes that equip him par excellence to deal with people - patients, their relatives, employees and other professionals. He must have some grasp of the human situation and see himself as inextricably involved in the dilemmas and paradoxes of existence.

His skills should be those that are not eroded by the passage of time. He should know how to organize - time, records, people and money. He should be able to communicate clearly by writing and speaking. He should be able to read.

The foregoing six statements represent my interpretation of the uniqueness of the Family Physician and differentiates him in his educational experience from any other group of physicians that I know. It is apparent that the physician who qualifies on these points is indeed a special kind of person with unique attitudes, character traits
and skills. He is no resurrection or dusting off of a stereotype appropriate to a
previous social situation. The "horse and buggy" doctor had many admirable traits but
he could not survive the erosions of urbanization and technical progress. Hopefully
this new physician can preserve the virtues of his predecessor while overcoming his
liabilities.

ORGANIZATION AND METHOD

These educational goals will be sought within the context of Wesley Medical
Center, a private, church-related community general hospital with 550 adult beds
located in a metropolitan area of 350,000 people in south central Kansas.

There is a long tradition of educational concern at Wesley that expresses
itself in sixteen organized programs currently in existence there.

Medical education at Wesley is controlled by an appointed committee of the
Medical Staff. There are paid directors of Medical education, Surgical education and
Family Practice education. There are volunteer teaching chiefs in all major specialties
who organize the efforts of medical staff members who choose to commit themselves to the
responsibilities of teaching.

Primary responsibility for the Family Practice Program is vested in a full
time director who as part of his duties operates the Family Practice Office in facilities
provided by the hospital where approximately 500 families representing a cross section
of the community are now receiving their medical care.

The Family Practice faculty will consist of physicians, specialists and general
practitioners, two hospital chaplains, two medical social workers and a nutritionist.

The educational philosophy underlying the program is that education involves
controlled experience. In this context the crucial experience is that of patient care.

The patient is to be encountered in the office, hospital, nursing home, his home,
the community and by telephone. He is to be observed, interviewed, examined and treated
- all with appropriate supervision and reflectiveness.

The general scheme of scheduling the resident's time can be seen on the
accompanying charts. There are three major areas of activity, in-patient care,
out-patient care including the Family Practice Office, and conferences. The percentage
of time allotted to each major area is 65%, 25% and 10% respectively, with some
variation from the first to the third years. In terms of four major specialties the
required amount of time and percentage of the total is as follows:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Time</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>11 months</td>
<td>30%</td>
</tr>
<tr>
<td>Surgery</td>
<td>5 months</td>
<td>14%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>4 months</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4 months</td>
<td>11%</td>
</tr>
</tbody>
</table>
These figures are not especially meaningful since, in this program they do not accurately reflect the total experience of the resident. This is particularly true of Pediatrics which is predominately an office specialty. There is a 5 month elective in the third year and a 3 month rotation through specialty offices during the same year. These 8 months, plus one month in the Medical Center Emergency Room and 3 months as a locum tenens account for the remaining time.

Extra mural activities will include two hours weekly at the Sedgwick County Mental Health Clinic, two weeks of half days at the City - County Department of Community Health and eight field trips to local institutions.

In addition each resident will be expected to complete a clinically oriented research paper and to prepare one case report with review of literature during his three years.

Conferences are seen as an essential part of the residents experience and have been described separately along with bibliography.
CONCLUDING REMARKS

It is inevitable and desirable that trial and error will accompany the development of the new specialty, Family Practice. It is not so important that a program be "right" as that it be adaptable to the residents needs and that the idealism of human concern be given more than lip service.

If the impetus for this kind of program is from the unmet health needs in modern society and the discontinuities in medical education as asserted in the Millis Report, I do not see how we are in error in attempting to respond to those needs. If this program is inadequate either conceptually or practically, others will rise to take its place for I am convinced that we are on the threshold of a new era in the delivery of medical care to all the people. I am proud to be a part of an organization such as this Academy which is exercising national leadership in this revolutionary time.
PROSPECTUS FOR FAMILY PRACTICE RESIDENCY
Wesley Medical Center
Wichita, Kansas

PURPOSE:

Wesley Medical Center, through its Administration and Medical Staff proposes to establish a formal educational program for medical school graduates who wish to specialize in the practice of family medicine and comprehensive health care. The need for such a program has been amply documented by the findings of three major study commissions from whose reports the following quotations are taken.

"Every individual should have a personal physician who is the central point for integration and continuity of all medical and medically related services to his patient......Every hospital should have a service for the personal physician and each physician should have a staff appointment in one or more accredited hospitals." National Commission on Community Health, Folsom, Chm.

"There should be a specialty board, certification examinations and diplomate status for physicians highly qualified in comprehensive care." Citizens Commission on Graduate Medical Education, Millis, Chm.

"Recognition and status equivalent to other medical specialties should be given to family practice. The opportunity for specialty board certification is essential for those properly prepared for family practice. Certification should be primary and not secondary to some other specialty." Ad Hoc Committee on Education for Family Practice.

GENERAL DESCRIPTION:

This three year program will be based upon the Core Content of Family Medicine as published by the American Academy of General Practice and will aim at preparing the physician for examination and certification by the proposed Board of Family Practice.

Included in the curriculum is instruction in the following major categories of family practice.

1. Clinical Aspects
   A. Doctor-Patient Relationship
   B. Preventive Medicine
The educational goals will be implemented as part of the graduate medical education program of Wesley Medical Center, utilizing its human and material resources. These include its physical facilities which now provide for 550 adult beds and supporting services organized and managed by administrators who are progressive, far-sighted and committed to the idea of excellence in medical care. Also included is a medical staff long committed to medical education and providing a wide range of medical and surgical skills. Worthy of special note are the Departments of Laboratories and Radiology which have respectively five and eight full time board certified specialists. In addition there is a Department of Social Service with a fully qualified head. There are two full time Chaplains with an aggressive educational program directed towards local ministers and chaplain interns. There are schools of X-ray and Laboratory Technology, a diploma School of Nursing, Blood Bank Technology, Hospital Administration and Inhalation Therapy. Wesley is approved for internship, a one-year residency in surgery, a three-year residency in internal medicine, a two-year residency in General
Practice and a four-year residency in Pathology. Plans are well along to extend the surgical program to four years and to institute a complete residency in radiology. General control and supervision of all graduate medical programs is from the medical staff through its Medical Education Committee. There is a Director of Medical Education as well as a Director of Surgical Education employed by the Hospital.

Direct responsibility for the development and supervision of the proposed residency in Family Practice rests with the Director of Medical Out-patient Services who recently joined the hospital administrative staff after 12 years in general practice. He brings to the out-patient department a portion of his former private practice which will serve as a model for the residency. Faculty will be members of the medical staff, both specialists and general practitioners.

METHOD AND CURRICULUM:

There will be three major instructional areas, in-patient experience, out-patient experience and conferences. In-patient experience will include rotations through medicine, surgery, ob-gyn, pediatrics, laboratory, radiology, ENO and anesthesia. The emphasis will be on various aspects of medicine and pediatrics involving faculty members who are specialists and those who are general practitioners. Surgical in-patient experience will be concerned primarily with pre and post operative care, diagnosis and technics of procedures commonly done. Emphasis will be placed on ambulatory and minor surgery, especially as this relates to the sub-specialties of orthopedics, plastic surgery and urology. A resident may use his elective time to gain further competence in surgery, however if he anticipates that he will be required to do major surgery in his practice he will be encouraged to spend another year devoted entirely to surgery.

Out-patient experience is considered the sine qua non of the residency.
This will be centered in the family practice office where the resident will early be assigned a number of families for whose health care he will be responsible for the duration of his program. He will also acquire new patients and families as these are referred from the emergency room of the hospital. It is expected that the resident will be on 24 hour call to these families for telephone consultation, house calls, office visits during regular hours and hospitalization as needed. The resident will maintain his relationship to his patients through whatever consultation they require. Whenever possible, consultants will come to the family practice office for such consultation. This office will be staffed and equipped to provide for a wide variety of diagnostic and treatment services as can be done conveniently and safely on the ambulatory patient.

Further out-patient experience will be provided in the hospital emergency room and short preceptorships in specialty offices such as Allergy, Dermatology, Ophthalmology, Otolaryngology, Urology and Physical Therapy and Rehabilitation. A well child clinic sponsored by the local health department will also be available.

Finally, it is planned that the resident spend the final three months of his program as a locum tenens in a well established general practice.

The Conference schedule is the third and essential part of the curriculum. It is here that the resources of psychiatrists, social workers, chaplains, behavioral scientists and specially invited guests can contribute to the personal development as well as the fund of information of the resident. It is expected that the conferences will provide a framework in which the resident can become reflective about himself as a person and the kinds of personal relationships he habitually forms with patients. He will also develop sensitivity to the needs of society and the special responsibility that the medical profession bears to the public. He will have opportunity to become knowledgeable of agencies, both public and private, which contribute to the total health resources of the community.
The Conference program will include items relating to office organization and management, practice evaluation and legal and ethical relationships.

RESEARCH:

It is expected that each resident will assume a research project in some aspect of family and community health at the beginning of his residency to be completed in publishable form by the end of his third year. In addition he will do a review of literature on a subject of his choosing and a case report with literature review during the first two years.

SCHEDULE:

First Year:

1. Family Practice Office
   As early as possible in the first year the resident will spend three months of afternoons in the family practice office acquiring a patient load with which he shall maintain continuity throughout his three years. He will be available to these families on a 24-hour basis, making house calls as necessary, securing consultation as required and hospitalizing for indication. After the first three months he will spend three afternoons weekly in the office to serve his own patients.

2. First Three Months-Mornings:
   While the resident is acquiring his patient load in the family practice office in the afternoons, he will spend his mornings divided among the departments of Laboratories, Radiology and EXG. He will also take emergency room night call once every seven to ten days.

3. Remaining Nine Months:
   a. Medicine—Four months. Two months on General Practitioners services and two months on Internists services.
   b. Pediatrics—Two months. One month on Newborn service and one month on the acute pediatric ward.
   c. Obstetrics-Gynecology: Two months
   d. Anesthesia: One month

4. Conferences:
   a. Doctor-Patient Relationship I. Weekly
   This conference will involve physicians, psychiatrists, social workers, chaplains and the resident in a closely structured group situation focusing on the verbatim exchanges between the physician and the patient in an effort to elucidate the dynamics and meaning of the
interaction to both parties.

b. Family Medicine. Weekly
Subjects relating to family health problems such as periodic health examination, immunizations, sex education, family mental health, alcoholism, chronic illness and the like will be presented and discussed utilizing special speakers as much as possible.

c. Behavioral Science Reading Seminar. Biweekly
A series of books and articles dealing with sociology, social psychology, psychology, anthropology and philosophy as these relate to the care of families and the family's role in society will be reported and discussed.

d. Medicine-Religion Case Conference. Monthly
This is a well established conference attended by ministers and physicians to discuss behavioral and other problems in which both professions are involved. Community social agencies are often called on to participate in this conference. Residents will be expected to present relevant cases.

e. Medical and Surgical Grand Rounds. Weekly

f. Basic Science Noon Meeting. Weekly
This is also a well established conference covering such subjects as cardiovascular or renal physiology, acid base balance and immunology.

Second Year:

1. Family Practice Office
Regular office hours three afternoons weekly. Accept 24 hours for his own patients including in-patient care and consultation.

2. In-Patient Assignments
a. Medicine—Four Months.
b. Pediatrics—Two Months.
   Includes well child care, adolescent medicine and endocrinology.
c. Surgery—Four Months
   Divided into General Surgery, two months; Orthopedic—Plastic, one month, and Urology, one month.
d. Elective—Two Months

3. Conferences
   a. Doctor-Patient Relationship II
   b. Family Medicine
   c. Marriage counseling and group therapy.
d. Visiting lecturer in behavioral sciences, monthly
e. Medical and surgical grand rounds
f. Medicine-Religion Case Conference

4. Research
Continue research project started in first year and prepare a second review of literature on any subject or a case report.
Third Year:

1. Out-Patient Experience
   a. Family Practice Office, am's or pm's four half days weekly.
   b. Ambulatory Surgery, am's, one month
   c. Short Term Preceptorships in Specialists offices, half days, Total, three months. Includes allergy, dermatology, urology, ophthalmology, otolaryngology, physical therapy and rehabilitation and logopedics.

2. Elective Five Months
   Resident may choose any service or area in which he feels more training is needed. Every effort will be made to send him to any other medical center for such training if not available locally.

3. Locum Tenens
   Arrangements will be made for resident to serve three months in actual practice, perhaps relieving a general practitioner who may wish to come to the medical center for continuing education of his own. If the residency grows sufficiently it may be possible for us to assume year round responsibility for medical care of some nearby community now without a physician. Naming an office in the ghetto area of Wichita might be possible as an alternative.

4. Conferences
   a. Business and administrative aspects of office practice.
   b. Legal and ethical relationships and responsibilities
   c. Health and society
   d. Mental hygiene problems

5. Finish research paper and prepare for publication.
It has been more than a year since the first resident was accepted in The Family Practice Program, and almost six months since full operation with five residents began - time enough to evaluate the organization and effectiveness of the program.

Generally, I think there has been success in achieving certain stated educational goals. Residents have been meaningfully involved in the care of ambulatory patients in the Family Practice office. Each resident has an adequate case load of families. (Osborne 55; Vorhees 65; Roark 45; Cranston 42.) Specialists have been involved in in-patient teaching. Psychiatry has been included in the curriculum and coprofessionals have been involved in patient care. Conferences have been relevant and, on the whole, well attended.

Not unpredictably, problems have been identified and certain modifications seem in order. The chief problem has been trying to do too much. In-patient loads have been heavy, conference time has been over-scheduled and, inevitably, competition for time has developed. There has not been enough time for adequate reading and research. Not enough attention has been paid to the need for graduated experience in responsibility for patient care. The problem of supervised counseling and psychotherapy has not been solved.

Granting the validity of our original objectives, certain compromises seem in order and the following changes are proposed.

The first year should continue to be organized to qualify as a rotating 1 internship with 8 months of medicine. Four months of this time will be the standard intern rotation through medical panels and 3½ months will be a Family
Progress Report and Evaluation

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Elective consisting of the following:

1) Family Practice Office - 4 weeks (reduced from 3 months)
2) Emergency Room - 4 weeks (no change)
3) Cardiovascular Lab. - 2 weeks (changed from a.m.'s x 1 month)
4) City-County Department of Community Health - 2 weeks (changed from ½ day x 2 weeks)
5) Radiology - 1 week (reduced from a.m.'s x 1 month)
6) Laboratory - 1 week (reduced from 10 days)

The remaining time (four months) will be equally divided between OB-GYN and Pediatrics.

Each resident will attend the out-patient clinic one half day weekly when he is assigned to medicine (4 months), OB-GYN (2 months), and Pediatrics (2 months). He will spend one half day weekly in the Family Practice office for eight months.

There will be an average of 33 conferences per month including the standing teaching conferences. The conferences unique to this program will be held as follows:

a) Monday and Friday noons
b) Tuesday 5:30 p.m. - 6:30 p.m.
c) Thursday 1:00 p.m. - 2:00 p.m.

The second year will remain essentially the same with medicine 16 weeks, surgery 16 weeks, OB-GYN 8 weeks and Pediatrics 8 weeks. Two weeks will go for vacation and one week for a professional meeting of the residents choice.

Clinic time will be the same as the first year but the resident will spend 2 scheduled times per week in the Family Practice office.

The third year will provide for a 6 month elective, part or all of which may be spent extramurally. Twelve weeks will go to specialty preceptorships and twelve weeks to a locum tenens or a neighborhood health center.
There will be no clinic time unless the resident elects a clinical specialty that holds a clinic. Time in the Family Practice office will be two afternoons weekly when the resident is in town.

It is hoped that these modifications will strengthen the program and make it more sound administratively. I think it is important that flexibility be valued as we gain experience and hopefully wisdom.

G. Gayle Stephens, M.D.
Spring 1968

11 Planning
Internship
At Wesley

Wesley Medical Center has acquired 11 interns in the 17th National Intern Matching Program of the American Medical Association, according to Dr. W. C. Goodpasture, director of graduate and continuing education at Wesley.

Through this program, seniors in medical schools and teaching hospitals express their needs and preferences, which are then matched to those of the hospitals.

A total of 14,565 interns were requested this year by hospitals, but only 8,007 of these were filled. Wesley has a quota of 20 interns, and last year filled only eight.

Of the new interns, Victor J. Vorhees and William Calderwood from the University of Kansas School of Medicine already have started their training.

Joining Wesley July 1 will be John E. Wolfe, Richard D. Roark, Myron K. Hultgren, University of Kansas School of Medicine; Johnnie G. Hutka, Larry D. Mattson, Robert C. McDaniel, University of Texas; Chad L. Williams, University of Iowa; Gene L. Rogers, University of Arkansas; and Verne A. Smith, University of Oklahoma.
WESLEY RESIDENTS RECEIVE
3 OF 12 NATIONAL GRADUATE AWARDS

Dr. Hultgren  Dr. Cranston  Dr. Voorhees

Three first-year residents in the Family Practice Program at Wesley have been named winners of $1,200 scholarship awards by the American Academy of General Practice, announces Dr. G. Gayle Stephens, Director of the Family Practice program. Twelve of the Mead Johnson Awards for Graduate Training in General Practice were made nationally, with residents in the Wesley program receiving a fourth of the total awards presented.

The three are: Dr. Jay W. Cranston, Dr. Myron K. Hultgren, and Dr. Victor J. Voorhees. Dr. Cranston, a graduate of the University of Michigan School of Medicine, did cardiovascular research in Sweden, before starting his residency at Wesley. Dr. Hultgren is a 1968 graduate of the University of Kansas School of Medicine. Dr. Voorhees received his Master of Science degree from Oklahoma State University, was a high school and college science teacher for 6 years, then received his M.D. from the University of Kansas in 1968.
The Pulse Continued April 7, 1969

The Mead Johnson Awards are made annually by the American Academy of General Practice to 12 future general practitioners, who are taking their first year of training in approved graduate training programs.

At Wesley, the Family Practice program is now in its first year, and replaces the former General Practice program. The local program has a quota of five doctors, so three-fifths of those in the program were selected for the national awards.
It Might Work

County commissioners have given the board of County Hospital permission to talk to a group of Wichita doctors about leasing the hospital clinic as a family practice center.

The commissioners also have agreed to permit the board of trustees to begin negotiating for the replacement of the hospital's water heating and air conditioning systems.

Cost of the project is expected to be $250,000, financed through a one-mill levy.

This, and the fact that the county has also agreed to furnish maintenance and will receive only five per cent of the clinic's gross in return has caused some local consternation.

Although a case could be made for a larger county share of the gross, the arrangement can relieve the county of some expense without impairing the hospital's desirability as a mental health center, skilled nursing home, general hospital or whatever the county and the board of trustees decide to do with it.

In the first place, a clinic is in operation there now, and the county gets only a small subsidy from the state for each patient treated. Doctors who operate the clinic do not share their fees with the county now.

In the second place, it is only the clinic that is under consideration—not the whole hospital.

And the doctors who are negotiating with the county would be expected to supply their own nurses and aides and clerical personnel, and this would relieve the county of further expense.

There is a need for clinic services in the area surrounding County Hospital, and many who take advantage of it are without transportation.

Since it seems apparent that the county will continue to operate the hospital in one capacity or another, it seems wise to get some return on the clinic, even if it does not quite meet expenses.
County Agrees to Lease Doctors Out-Patient Clinic, Laboratory

By FRANK GAROFALO
Beacon Staff Writer

The Sedgwick County Commission agreed today to lease the County Hospital’s out-patient clinic, laboratory and X-ray equipment to a team of doctors who will operate the clinic as a family practice center.

After reviewing a contract drawn between the hospital’s board of trustees and Dr. G. Gayle Stephens, the commission voted unanimously to approve the lease.

The agreement with Dr. Stephens, director of medical family practice residency and out-patient services at Wesley Medical Center, and Drs. Conrad C. Osborne and Victor J. Vorhees, residents in family practice at Wesley, is for one year.

THE AGREEMENT calls for a graduated rental fee scale. The doctors will pay to the county five per cent of the collectable gross up to $50,000 and 7.5 per cent on the next $25,000. On gross collections over a total of $75,000 the county will receive 10 per cent.

This means the county could receive as much as $4,375 if the physicians collect up to $75,000. Earlier the physicians had proposed a flat five per cent on an estimated collectable gross of $30,000 for the year.

The physicians, according to the agreement, will take over the clinic the first day of the month following completion and acceptance of remodeling work at the clinic. This makes the opening of the clinic under the lease agreement indefinite since the board of trustees will have to determine exactly what remodeling must be done.

ACCORDING to the agreement, the county in addition to providing the required space and X-ray and laboratory facilities also will be responsible for providing utilities, except telephones, and janitorial service.

The county also will be responsible for financing the remodeling work which is to be agreed upon by the trustees and the physicians.

The lessees will be responsible for personnel, necessary furniture, management, collection of bills and keeping required medical records.

Dr. Stephens told the commissioners on Feb. 11 the family practice center would be open to all of the public on a pay-as-service basis. He said he would derive no salary from the clinic’s opera-

tion, but income for services will be used to pay salaries of the other physicians who work there.

DR. STEPHENS also said the clinic will be valuable as a training facility for physicians interested in specializing in family practice. He said this would be vital in keeping good, young physicians in the community working as family doctors.

It is believed by county officials the lease agreement will reduce the overall budget for operation of the county hospital and perhaps save the county some money.

The county has been maintaining operation of the clinic and also paying salaries of clerks and nurses working in the clinic. Several doctors now practice at the clinic on a fee-for-service basis.

These physicians get no money from the county and in turn the county gets no fees from them.

Practically all patients now treated at the clinic are cared for under the federal-state Medicaid program.

The lease agreement was urged upon the commissioners by the board of trustees, who are responsible for administration of the hospital, and numerous other medical and hospital administration experts in the community.
Dr. Stephens also said the clinic would be valuable as a training facility for physicians interested in specializing in family practice. He said this would be vital in keeping good, young physicians in the community working as family doctors.

Two of the commissioners, chairman Earl Rush and Tom Scott, expressed concern over the small percentage of money that would go to the county. Scott asked if the fee to the county could be re-evaluated with a little more revenue for the county. It would cost, he said, at least $200 a month for janitorial services. That alone would use up the total amount going to the county in one year.

Rush said he felt the agreement on the leasing fee should be on a graduated scale. "If it goes up, we (the county) will get a bigger hunk of the pie, and if it goes down, we get a smaller cut of the pie."

DR. STEPHENS assured the commissioners the fee is negotiable. However, he said "I think the county would be subsidizing the clinic the first year."

"I would be willing to renegotiate in 90 days if we see if it's making more than it has been estimated," Dr. Stephens assured the commissioners.

Frank Kessler, vice chairman of the board of trustees, said, in reference to the commissioners' concern over the financial arrangement, that the operation of the clinic by the doctors "will reduce the overall budget for operation of the county hospital and save Sedgwick County money."

KESSLER SAID this would occur because the county already is maintaining operation of the clinic and also paying salaries of clerks and nurses working in the clinic. Several doctors now practice at the clinic on a fee-for-service basis. The physicians get no money from the county, and in turn the county gets no fees from those doctors.

The request by the board of trustees for permission to negotiate was backed by top medical people in the community.

Dr. Ivan Rhodes, president of the Sedgwick County Medical Society, Francis Hesse, attorney for St. Francis Hospital, who spoke for the Wichita Hospital Council, and Roy House, administrator of Wesley Medical Center, appeared and threw their support behind the proposal.

Dr. Rhodes said the Medical Society's major concern is that the people of the Model Cities area have quality health care and this plan fits into the Model Cities health program.

Commissioner Elmer Peters made the motion to allow the board of trustees to negotiate with Dr. Stephens. He said he felt the monetary question was secondary to the "human need."

Scott seconded the motion, and after being assured the commission would give the final approval, the three commissioners voted to pass the motion.
Dr. J. Vorhees,
Co-director Wesley

Dr. Vorhees was born in Holyrood in 1936. He received his BS at McPherson College, his M.S. at the University of Oklahoma, and his M.D. at the University of Kansas. Following an internship at Wesley Medical Center in 1969, he served a family practice residency there and then became one of the Wesley family practice program's residency training directors in 1972.

Dr. Vorhees has a long history of teaching, having been on the teaching staffs of Lindsborg High School; Bethany College, Lindsborg; and the Kansas State University during the late 1950's and the 1960's. He became an assistant professor of Family and Community Medicine for KUMC in 1977.

An AAFP member, he became a Diplomate in 1971 and received his Fellowship in 1972. He is a member of the AMA, KMS and the Sedgwick County

According to his associates, Dr. Vorhees is "a born tinkerer," and in his spare time is interested in "anything outdoors," whether it's fishing, hunting, sailing, canoeing, or gardening.

The family has a farm where they keep three riding horses, namely a Tennessee Walking Horse, a pinto, and a half-Arabian, half-Welch pony.

They also have a garden and Dr. Vorhees' wife, Jean, makes a speciality of growing roses and other flowers. She lists homemaking as the most important of her activities, especially cooking. Music is another hobby.

The Vorhees have three children, Rod, 19; Beki, 16; and Jacqui, 13.

Stanley J. Mosier, M.D.,
Co-director, Wesley

Stanley J. Mosier, M.D., is also a Wesley Medical Center resident graduate, having served his family practice residency at the same time as Dr. Vorhees. He also became a staff physician for the program in 1971 and a co-director in 1972.

Dr. Mosier was born in Hoxie in 1942. He received his A.B. at the Kansas State University, Manhattan; and his M.D. at the University of Kansas in 1968. Following an internship at the University of New Mexico, Albuquerque, he served a family practice residency at Wesley Medical Center.

His professional experiences include being the co-director of the Wichita Methadone Maintenance from 1971-2, and the director of the program in 1972 to
Family Doctor on His Way Back

ALL three have directed some attention to rural medicine, but it's the very existence of the family practice specialty that rural doctors are finding so encouraging. That is because a typical specialist, say an orthopedic surgeon, would have very little to do in a town of around 1,000.

The boom aura surrounding family practice indicates a medical irony that would be amusing if it weren't so serious.

For several decades — from the end of World War II, one doctor said — the family doctor or general practitioner (GP) languished in the shadow of growing specialization. As the horizon of medical knowledge broadened, so did the conviction that no one person could possibly master the whole field — or even enough of it to adequately treat patients.

Ardent family physicians also like to point out that their practices had none of the glamour and few of the conveniences of the specialists. They weren't making widely hailed breakthroughs in research against dread disease. They also weren't making stupendous salaries and taking off three days a week.

By CAROL DUNLAP
Staff Writer

A new breed of medical zealots may ease the pinch on rural medicine in Kansas and other states within the next decade. They are called family doctors.

Kansas has two flourishing family practice residency programs, both in Wichita, and an educational component in the "new" specialty at the University of Kansas Medical Center, Kansas City.

...at right, Mrs. Sandy Goodwin and Joachin Schnelle of St. Joseph program...

ABOVE, WESLEY TEAM'S EUNEVA WHITE, DRS. KENDALL WRIGHT, S. J. MOIER, V. J. VORHUES

Staff Photos by Anthony Reed.
SO IT APPEARED the GP was going the way of the dodo and groat auk when a combination of circumstances flipped the downhill plunge into reverse.

Various authorities cite various reasons, but a couple crop up with almost unanimous frequency — especially among the Kansas doctors queried.

They all single out growing social awareness and consequent demand for "relevant" curricula among young medical students. Whether the fledgling doctors are called "service oriented" or "patient advocates," they seem, in the view of their mentors, to embody the kind of selfless idealism everyone thinks doctors ought to have.

THE OTHER FACTOR that seems to have had the most impact was imbalance between facilities and practitioners. Suddenly there were more hospitals than doctors to practice in them. The machinery of what some like to call "health care delivery systems" was gradually getting gummed up.

So the family doctor burst into prominence as the new savior of primary care. Dr. George E. Burket Jr., of Kingman, staunch believer in the program, probably defined the critical importance of family practice best:

"Family practice is a MUST. If it's not successful, we're just not going to have any rural doctors."

BURKET IS ONE who feels buildings have been stressed to the detriment of education and singled out what is known as the Murphy Plan as a contributing element in Kansas. "The Murphy Plan encouraged us to build hospitals with no thought to the education of the people to run the facilities," he said recently.

If that's the case, then there has been a distortion in the plan's goals since it was initiated in 1948. The plan, designed by a cross-section of state interests with concern for rural medicine in common, was named for Dr. Franklin D. Murphy, then dean of the KU medical school.

ORIGINALLY it had three aims — two of which were educational. Entitled the Kansas Rural Health Plan, it proposed to:

• Invest about $4 million in new buildings at the medical center and boosting the operating budget to allow expansion of classes. It also called for doubling the size of classes for nursing and medical technicians.

• Encourage small towns to build at least minimal facilities that could be leased or sold to doctors. The structures were to contain an office, reception room, diagnostic X-ray and clinical laboratories and examining rooms.

• Develop a traveling post graduate program to keep doctors up to date regardless of location. The courses were aimed at keeping doctors current without subjecting them to long absences from their offices.

The Legislature approved the plan and Gov. Frank Carlson signed it into law early in 1949.

BURKET SERVES on the American Medical Association (AMA) committee on residency review, which certifies programs like those in Kansas. Thus, he is in something of a personal dilemma.

The AMA standards, he said, are quite high and "we guard the quality of our programs very jealously." On the other hand, although he's cheered by the near-phenomenal growth in family practice residencies since 1969, he is convinced "we need facilities to train at least 5,000 residents a year — and we need them soon."

From an educational viewpoint, this urgency creates another problem.

DR. G. G. STEPHENS, ABOVE
...Dr. G. E. Burket, right...

DR. G. GAYLE STEPHENS is in charge of developing the family practice program for the KU medical branch at Wichita State University and is another devotee of the concept. He's been involved in family practice here since before it was a specialty.

In 1967 he took over outpatient services at Wesley Medical Center. The next year the program evolved a family practice residency — the third in the nation.

From his perspective as an educator, he points out that one obstacle the program faces in medical schools is personnel. "There's no reservoir of faculty for these programs," he said, "so for awhile we will have to siphon off some to teach others."

That will add to frustrations of men like Burket who foresees a 5 to 10 year lag before new family doctors begin to take up the slack. But Stephens insists it's necessary if solid quality training is to be available — especially on an expanding basis.

AGAIN FROM AN educator's view, Stephens thinks the model office concept embodied in hospital residencies "is one of the most profound pedagogic devices of many years" in terms of effectiveness. In fact, "office" is probably the best possible description for the Wichita residencies — one at Wesley and the other at St. Joseph Hospital.

In both instances the family practice unit is isolated from the parent hospital.
Waiting rooms are designed to look like waiting rooms and not hospital clinics.

Drs. Stanley Mosier and Victor J. Vorhees at Wesley and Dr. Jim Donnell at St. Joseph stressed the importance of this tactic and are in agreement on its intent — to get the residents used to the way they'll see most of their patients.

DONNELL SAID a study done on a national scale showed that only a tiny fraction of a doctor's patients are ever hospitalized, yet in traditional hospital programs residents seldom see patients any other way.

Although both programs stress a broad, solid medical education, both sets of directors are acutely aware of rural needs and have set up or are planning ways to expose their students to a rural practice.

Wesley has a rural rotation program. The residents spend a couple of months in a small town — either at a hospital or in a private office.

IT APPARENTLY has changed some attitudes. Vorhees said some of the men come back with a different or more realistic notion of rural practice. "They realize that they don't have to be alone and also that facilities and techniques are more sophisticated than they thought," he said.

At least as important as professional considerations, he said, is an accompanying discovery. When rural doctors practice in teams or small groups, "they can get away and take vacations, attend a professional meeting or just have the night off."

Donnell said his program is approaching the problem a different way. He feels it could have special benefits for the small towns that may never again have a resident physician.

THEY ARE WORKING out a method to place a highly skilled nurse in a town and have her do the initial screening, get case histories and make preliminary medical evaluations.

This material is fed into the program's computer system and becomes part of the clinic's files.

On a periodic basis, say once a week, a doctor flies to the town, takes residents' files and has office hours. Donnell said they even plan to throw in flying lessons for residents if the program gets established. He is, he said, quite excited by the possibilities.

Whatever the approach, men like Burket, who pleaded a futile case for so long, are at least getting some hope. As he said, "We have a lot of catching up to do."
$210,000 GRANT AWARDED TO WESLEY FAMILY PRACTICE PROGRAM

The first year's funding of a three-year program for enrichment of the Family Practice Residency at Wesley Medical Center was announced Sept. 1 by Congressman Garner E. Shriver.

Congressman Shriver said the three-year funding by the Bureau of Health, Manpower and Education in the Department of Health, Education and Welfare will amount to $210,000 with $70,000 obligated for the first year which is already underway.
The Pulse Continued September 11, 1972

With the Family Practice physician rated as the specialty in shortest supply, Executive Vice President Roy C. House was elated at the news. He said the grant assures the Wesley program of being able to move forward with an "enriched and strengthened emphasis."

The federal program is seeking to strengthen the established centers so as to increase the number of physicians trained in the practice of family medicine. Wesley's program has gained national recognition for its innovative curriculum which includes experiences in community health, small town medical practice and psychiatric training. The program at Wesley is the only one of the original 15 granted provisional approval, to attain and maintain full approval.

A Family Practice Clinic was established recently as part of Wesley's out-patient services. The clinic, which involves the Family Practice Residents, at present is conducted at 3232 E. Pine five afternoons a week.

Care provided by the residents is supervised by physicians practicing in Wichita and a number of physicians from outlying areas as far away as Atchison, Minneola, Kingman and Salina. They come in one-half day each month, providing increased opportunity for interaction and exchange of ideas between practicing physicians and house officers.

The Residency, which was started in 1968 with G. Gayle Stephens, M.D., as the director, is now directed jointly by Victor Vorhees, M.D., and Stanley Mosier, M.D. Under their leadership, the new family physicians are trained at various locations. These include, in addition to Wesley and the Pine Street clinic, the offices of private physicians, neighborhood health centers, and the Family Physicians Professional Association offices of Drs. Vorhees and Mosier at 1001 N. Minneapolis.

Shown in the photo on Page 1 are, from left, seated, Mr. House, Cong. Shriver, Dr. Mosier and Dr. Vorhees, and standing, James E. Lansdowne, II, Director of Development.
Receives $210,000 Grant

By CHARLES JACKSON
Beacon Staff Writer

Wesley Medical Center's nationally recognized Family Practice Residency has been awarded a $210,000 grant for enriching and enlarging the program, Rep. Garnet E. Shriver announced here today.

"The bureau of health, manpower education in the Department of Health, Education and Welfare (HEW) has notified me of the approval of a three-year grant to assist in the enrichment of the Family Residency program here at Wesley," Shriver told a news conference this morning in Wesley's Burton Auditorium.

He said $70,000 of the $210,000 grant will be available for the year under way.

THE PROGRAM, begun at Wesley as early as 1965 but not official until 1968, is a relatively new three-year postgraduate training program for physicians wanting to specialize in family medicine.

It was the fourth such program begun in the nation and the first developed in a community teaching hospital. Other such programs are part of a university medical center.

Shriver said HEW is seeking to strengthen the established centers to increase the number of physicians trained in the practice of family medicine.

WESLEY'S PROGRAM has gained national recognition for its innovative curriculum which includes experiences in community health, small town medical practice and psychiatric training.

The Wesley program is the only one of the original 15 granted provisional approval to attain and maintain full approval, according to Roy House, Wesley executive vice president.

A family practice clinic was established by Wesley recently as a part of the medical center's out-patient services. The clinic, at 3232 E. Pine, involves the 15 family practice residents and is open five afternoons a week.

Medical care provided by the residents is supervised by physicians practicing in Wichita and a number of physicians from areas as far away as Aitchoin, Minneola, Kingman and Salina.

THESE PHYSICIANS come to the clinic one-half day each month in an effort to provide increased opportunity for interaction and exchange of ideas between practicing physicians and house officers.

Of the 15 residents in the program, four are in their first year; four in their second and seven are third-year participants.

House said the first-year class will be enlarged to eight if financing can be developed. He added that the HEW grant will help improve the educational content of the program.

Dr. Stanley Mosier, who co-directs the program with Dr. Victor Vorhees, said it is planned to enlarge the program to 24 residents by 1975, with eight at each of the three levels.

SIX MEN GRADUATED from the program in June. The six other graduates from the program are in practice in the Wichita area, Mosier said.

The residency program was founded by Dr. G. Gayle Stephens who now works in the school of health related professions at Wichita State University.

The new family physicians are trained, in addition to Wesley and the Pine Street clinic, in the office of private physicians, neighborhood health centers and the Family Physicians Professional Association offices of Vorhees and Mosier at 1001 N. Minneapolis.

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Friday, September 1, 1972
Regents Back
Wesley Plan

The State Board of Regents on Friday endorsed a proposal that the University of Kansas School of Medicine-Wichita take over Wesley Medical Center's family practice residency program.

The plan, if approved by the Legislature, calls mainly for a shift in leadership of the program.

The program's 24 resident physicians would continue to train exclusively at Wesley, and patients would continue receiving their care in the hospital's family practice clinic in the Medical Arts Tower.

THE ADMINISTRATIVE takeover was sought by Wesley after the program's co-directors, Drs. Victor Vorhees and Stan Mosier, indicated plans to resign the positions, according to Jack Davis, the hospital's executive vice president.

Wesley's program, started in 1967, was the fourth family practice residency developed in the country and Vorhees and Mosier were among its first graduates. They took over the directorship in 1972.

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