The Medical Education and Career of Dr. James Bryan, II
Also Known As: Evolution of the General Medicine Division at UNC School of Medicine

By Dr. James Bryan, II (edited for clarity posthumously by Dr. Darren DeWalt)

The UNC School of Medicine was able to resume granting the MD degree after Memorial Hospital was opened I952 (clinical training and granting of the MD had been discontinued after the Flexner Report). Dean Reece Berryhill, of the Basic Sciences Medical School, had led the effort to have the MD program restored. The extreme shortage of medical care and shortage of physicians was illustrated by the failure rate for the selective service system when preparing for WW II. North Carolina had very high rates of "4F" draftees who were too ill to serve in the military. The political will of the state to support a teaching hospital at Chapel Hill was mobilized through the "Good Health Movement" and progressive community and medical leaders. Two other medical schools, Duke in Durham, and Bowman Gray in Winston Salem, were granting degrees and a few Black North Carolinians attended Meharry Medical School in Nashville, TN. Arguments were made to place the teaching hospital in Charlotte, but having it in Chapel Hill with the greater University, and its established dental, nursing, public Health and pharmacy schools prevailed. When the hospital opened, the faculty was largely recruited from northern schools, some having NC roots and many having served in WW II. (Note: in a segregated society, the hospital had the motto "Built by and for the People of North Carolina.") Medicine reflected the increasing move toward science and specialization. Penicillin became available, tuberculosis waned.

Some of the hospital policies reflected that world. The anxiety of the community physicians that they would lose their patients to the specialists was offset by the rule "no continuing primary care, referred patients only to go back to their own physicians." (This of course ignored the facts of poverty, chronic complicated medical issues, or lack of access to a physician.) Many rural areas

lacked hospitals despite the Federal Hill Burton Program of the 1940's, which provided funds for hospital construction, contingent on treating all residents. The National Institutes of Health was just starting its support of medical research, and the explosion of drug and treatment options triggered by the needs of WWII gave expanded opportunities to cure as well as care, the main emphasis of the teaching hospitals. NIH and other monies flowed to research. DNA was deciphered.

I was enrolled in the University of Pennsylvania School of medicine, as a 20 y.o. old Presbyterian Missionary/Minister's son who got to Bessemer, AL after leaving Japan in 1941 on the cusp of the war. My mother's beloved father had a solo medical practice in Columbia, SC, and died shortly after the influenza epidemic. I attended Davidson College in NC (a Presbyterian School) with a ministerial son's discount. The biology professor Dr. W.O. Puckett had prepared pre-med students who had excelled, therefore his recommendation gained admission for me to the University of Pennsylvania medical school with 4 others of the class. We joined 120 others from all over the country, 5 women, one Black medical student, and many other students (and faculty) from the South.

I joined a wonderful mix of students, many Jewish with immersion in an urban setting with so much medical history and access to ethnicities, poverty, art, music, and culture. The boys from the south joined the Phi Chi medical fraternity with many Davidsonians (the fraternity being supported by Penn). It also provided an opportunity to gain food support by waiting tables or washing pots (I became boarding house manager my 3rd yr.). The fraternity also enabled paid participation in human research projects of the professors, oftentimes money before subject safety in those days before IRB's.

We marched through the standard basic science curriculum lockstep, sometimes alphabetically. I gained lifetime friends through the alphabet, Paul Brucker, leader in Family Medicine, and founding head of that Department at Jefferson Medical College, where he later became President; Bill Bradford, a fellow Davidsonian who trained in OB at the Hospital of University of Pennsylvania (HUP) with later fellowship at Memorial-Sloan Kettering in NYC. Bill went back to Charlotte to the Bradford Clinic and led care for women in that City. There were introductions to patients as the clinicians would present and discuss a patient for the students on Saturday mornings. (This was wildly popular as we were all trying

to understand what doctors did). The large painting of the Agnew Clinic by Thomas Eakins, with Professor Agnew performing surgery in a 19th century amphitheater, hung at the entry to the Library. This and many other stories around the first medical school in America, provided much history. There was also an elective, chosen by about half of the class, where seven of us would meet every other week with a physician from the department of medicine, a senior nurse, and a social worker to discuss a patient. Each of us was given a patient with a chronic problem. Mine was an 18 y.o. with sickle cell anemia who lived in public housing with his family; I visited at his home and went with him to clinic. These small group meetings illustrated the bio/psycho/social nature of medicine and medical care. This was championed at medical schools like Western Reserve who also gave opportunity for students to follow patients over time and gain a broader view of medicine. This experience clearly affected my definitions of medicine and medical care.

Clinical experiences occurred in various venues. I volunteered" in the ER at Old Pennsylvania Hospital (first hospital in the US) on the nights the welfare checks were distributed, and the interns instructed us in suturing wounds that followed the excess use of alcohol. In the second year, clinical correlations elective was held at Philadelphia General Hospital (PGH) in the Neuro-Psychiatry Auditorium, where various organic conditions were discussed such as tertiary syphilis, multiple sclerosis (very common in Philadelphia not in NC), effects of poliomyelitis, and various types of psychoses. Thorazine and its capacities were a newcomer. Going to that conference we would pass the PGH autopsy building where Dr. Wm Osler, a young Canadian Professor at the University of Pennsylvania did so many postmortems. He used them in his seminal book after becoming first professor of medicine at the new Johns Hopkins Medical School in Baltimore. My third year psychiatry clerkship was at the Trenton (NJ) hospital for the insane, where I stayed in the building that Dorothea Dix had an apartment at the end of her life. There I observed the use of Insulin shock therapy. More history: I observed electric shock therapy and one of the last pre-frontal lobotomies in the US done on one of the "criminally insane." Third year surgery clerkship included 6 weeks at the old Children's Hospital of the Univ. under the charismatic C. Everett Koop, later US Surgeon General. I was drawn to pediatrics because of summer lab work under Prof Lou Barness. I was later turned away from pediatrics after experience on the wards with many deaths from leukemia and cystic fibrosis. At that time, cystic fibrosis had a life expectancy of 7 years.

The options for becoming a competent physician seemed to narrow onto Internal Medicine, requiring internship and residency with an extra year of fellowship in a specialty of choice. (The specialty boards and colleges were just starting in the 1950's, the American College of Physicians in 1915.) Betsy and I married just before senior year, with her job as second grade teacher supporting our $80/mo apartment in a brownstone duplex 3 blocks from the hospital. Funds were limited so instead of looking elsewhere for this training, I signed a list, was interviewed for the rotating internship, and accepted at the HUP. Dr. Francis Wood, Professor of Medicine, invited me to become one of his residents (early in internship) and the experience continued. The pay was $500/year, but the attendings were outstanding. One of my patients as an intern was a fraternity brother at Davidson, referred to the HUP hematology group for treatment of Hodgkin's Disease. Though he died as I watched, the great care, diagnostics, and treatments given by the chief of hematology so impressed me, that I took my fellowship in that field. One of my fellow interns died of the influenza in 1957 one week after I had played him on the hospital squash court. He had not taken his vaccination for that lethal strain and I am reminded yearly as I remember Joe Schwartz. This fellowship with Dr. Jack Frost which ended in 1961 gave experience using the drugs then available for hematologic malignancies and doing research on the newly available Vinca alkaloid drugs. I also took care of much mononucleosis as I augmented income by covering the Penn. Student Health Service. Betsy and I enjoyed my fellow house staff and community around the Hospital. We were members of the Walnut Street Presbyterian Church while we lived near the Hospital, then joined the Ardmore Presbyterian, when we had the great opportunity to live rent free in the garage apartment of a "Main Line" home during the last three years in Philadelphia. During medical school, I would volunteer at the ARCH Street Mission Clinic on Sunday nights providing simple medical (and dental) care to the homeless and alcoholic men.

The end of the fellowship meant that it was time to fulfill my obligation to the US government for two years of service, which I had deferred since the Selective Service (Draft) was reinstituted for the Korean War. One of my fellow residents with Dr. Wood, Dr. Phillip Brachman, had been sent by the CDC (then Communicable Disease Center), to finish his residency. He was a career member of the US Public Health Service (USPHS) and part of the Epidemic Intelligence Service (EIS) (telling stories of imported Anthrax incoming from goat hair from

Pakistan, etc.). He asked "why don't you come to the EIS to do your two years instead of doing army physicals?" He helped me apply and get accepted for July 1961, and this experience opened up a new understanding of medicine. After retirement Brachman helped found the School of Public Health at Emory University.

I was assigned to the poliomyelitis surveillance unit. The CDC had gained fame in 1954 when the FDA-approved Salk vaccine received mass distribution, and a production problem by one of the manufacturers led to vaccine induced paralysis--"The Cutter Incident". The EIS illuminated the issue, the problem was solved, and there was only slight delay in vaccinating school children. During the following years the incidence of paralytic polio plummeted by 90%. The polio job in 1961 was to track poliomyelitis cases in the country, as reported by the state health departments, monitor the presence of the three polioviruses causing paralysis recovered from various monitoring systems, and to intervene if an epidemic occurred by using the Sabin live virus vaccine. Tested "safe" in the USSR, this live virus propagated in the gut of recipients and blocked paralytogenic strains of the virus. The crash course in epidemiology headed by Dr. Alexander Langmuir provided enough reading time so that we EIS officers could become expert in the disease we were responsible for. Betsy remembers my interview on the radio within 2 weeks as an "expert." (I had not cared for a polio case though grew up in the pre vaccine era, with classmates experiencing and being paralyzed). Dr. Langmuir's Chief of Staff was Dr. D.A. Henderson, who later headed the successful smallpox eradication effort by the World Health Organization, then became Dean of the School of Public Health at Johns Hopkins.

My second trip to work on an epidemic sent me to Newberry, SC giving me an insight into social organization, disparities, and first appreciation of systemic racism. The South Carolina department of health asked the CDC (States hated to ask for help) to come, bring the Sabin and deal with a Polio outbreak. Whether I was chosen because of my Southern background, ability to turn on the accent, or that my grandfather had been a physician in Columbia is unknown, however all helped. The 23 paralytic cases were in "Negro" ("separate but equal") elementary school children to whom the Salk vaccine (available 6 years) had not been distributed. This epidemic write-up led to being invited to speak at the American Medical Association clinical meeting that fall. Other epidemics followed: we were sent with Sabin vaccine to the Trust Territory (Marshall Islands). We found that

the US, which had “trusteeship” after WWII, had not distributed Salk vaccine after it was available “because there had never been polio.” This caused 200 paralyses and 12 deaths among 13,000 people exposed to the virus which had caused the epidemic in Texas the previous winter. A great adventure illustrating movement of diseases.

By 1962, Sabin vaccine was approved for general use. Reports started coming documenting that family members of children receiving the vaccine sometimes became ill, and there were occasionally paralyses. I was dispatched by Dr. Langmuir all over the US to “work up” the clinical aspects, obtain any samples showing a shift in the “benign” vaccine virus, looking for another “Cutter” incident. In the Spring of 1963, Surgeon General Luther Terry called together an advisory committee to see whether Sabin Vaccine (with all its promise of eliminating polio should be withdrawn. (I met with Dr. Sabin to go over the cases the week before the meeting, so that he could defend his vaccine, and met with the committee (Langmuir, Sabin, Enders, FDA, etc.).) Dr. Terry was to make the decision, and I went to lunch with him for two days as he escaped the egos being exhibited. Several years later as Dean at Temple School of Medicine he offered me a position. Terry wisely chose to continue Sabin use, and polio was eliminated from the Western Hemisphere in the 1980s.

As polio abated (I was the last chief of that unit as we changed the name to CNS Virus Surveillance), D.A. Henderson sent me out to deal with other epidemics such as the Salmonella Derby outbreak in Hospitals on the East Coast. Several patients and staff were affected, with some dying. While at the CDC, several of us worked as volunteers at the Atlanta public hospital (Grady) so I had an Emory appointment. Living 2 blocks away in our first home I also worked in the Emory Student Health Service. I took advantage of my CDC lab contacts to try to discover the cause for Mononucleosis. This illness was obviously viral, so I spent ’63-64 running specimens to CDC while attending on Grady wards (seeing a resident run hospital). My professor of virology at Penn, working with the Epstein-Barr virus from the Burkett Tumor in African children stumbled onto the cause when one of his laboratory workers exhibited Mono. My efforts with mono virus discovery failed.

As my CDC time was ending, I did not have a decision for the future. My younger brother Ned, who had come to Penn Med from Princeton, also came to

Atlanta in 1961 to do an internship at Grady Hospital. He then decided to do his residency in Internal Medicine at Memorial Hospital in Chapel Hill. In thinking about the future, I looked at options as varied as staying on at Emory for a PhD and joining the hematology group, going back to Penn Med at HUP (too much commute), entering practice (offers from Laredo, Texas, where I had dealt with an epidemic but quickly eliminated by Betsy), and a visit to the hematology group in Winston Salem, where the chief encouraged an academic trail. We visited Ned at Chapel Hill and he introduced me to Dr. T. Franklin Williams, who had come in the first wave of faculty in 1952 to open the hospital with founding Professor of Medicine Dr. Charles Burnett. Dr. Williams was part of the young professors interested in metabolism, but as a diabetologist was also active in the Preventive Medicine Department. The Preventive Medicine Department was headed by Dr. Wm. Flemming, a Syphilis investigator, but also a teacher in the UNC Medicine Basic Science School responsible for teaching Epidemiology and Public Health. His department held adjunct faculty involved in teaching Human Ecology a varied 1st year course with lectures by an anthropologist from Duke, a social worker, philosopher, ethicist, and lawyer. All had appointments. Dr. Kerr White, from Canada, came as an educator attached to Medicine, and organized and got funding for "The Comprehensive Medical Clinic" to which all new patients referred to the department were sent. All senior medical students (67) took 6 week rotations, meeting each morning to have an hour on a medical topic, meeting and working up their patient and being precepted at the end of the morning by a faculty or volunteer community (Burlington, Siler City, Durham) internist. We would go over labs and other studies that had been obtained, arrange consults with specialists (psychiatry and social work in clinic), and communicate with the referring source.

Before visiting Chapel Hill, in 1963, I had taken the youth group from the Emory Presbyterian Church to meet M.L. King, Jr. who was visiting his father's church (Ebenezer Baptist) as part of his civil rights work. My father had led this type of effort in Alabama, and my exposure to Grady Hospital confirmed the racial inequities. Dr. Franklin Williams (a North Carolinian and young faculty at UNC) was active in desegregation efforts in Chapel Hill in 1963. As we met, this mutual interest, as well as my interest in remaining academic, ed to the offer to come to UNC. I was to take over the responsibility of the Comprehensive Clinic work (Dr. Kerr White had moved to the Univ. Of VA in Community Medicine) and to precept the senior resident in the Walk in/urgent care clinic (next door to the

“Comprehensive”). I would also join faculty in the hematology clinic, take in-patient attending tours, and gain an MPH in Epidemiology at the UNC School of Public Health. This arrangement, with a salary less than CDC and Emory was formalized by meeting with Dean Berryhill and a short meeting with Dr. Burnett, who was ill in his home with his Crohn’s disease. All of these arrangements worked out, and I started my 50 happy years at UNC in July 1964. Only a handshake. Never a paper contract in 50 yrs.

As the Bryan’s arrived, the need to picket for equal public access for the races was removed by the Federal Equal Access Laws, and the “Great Society” programs started. Segregated beds ended at Memorial Hospital, and the hospital was air conditioned. (Air conditioning came because a State Senator’s wife suffered as a patient.) We had paper records, non- automated labs, the policy that all referred patients should be returned to their referrer, and “separate race” attitudes persisted.

UNC’s student population had grown remarkably following WWII and the return of the Veterans. Health affairs schools included medicine, nursing, pharmacy, dental, and public health. This enterprise located on “Pill Hill” on the South Campus. It was adjacent to the biology, botany, and geology departments. The new McNider Hall contained the dean’s office, and the departments of physiology, anatomy, microbiology, and pathology. Pathology was headed by the dynamic young leader in coagulation research, Dr. Kenneth Brinkhouse, who already was attracting patients with hemophilia to the hospital for his research group and clinicians. Another leading clinical effort was in metabolism, where Chairman Burnett had made his mark with the milk alkali syndrome caused by the treatment for peptic ulcer. There was an associated renal interest. (The “artificial kidney” had been introduced in WWII and used for the acute treatment of kidney failure due to hemorrhagic fever in the Korean War.) Dr. Louis Welt was recruited from Yale to lead nephrology, bringing his research assistant Gloria Nassif who married Bill Blythe. Dr. Blythe inherited Dr. Welt’s role as head of nephrology when Welt left UNC as second Chair of Medicine and returned to Yale.

The Blythe family immediately became our friends, and Bill found us our home for many years in the historic part of the town. We went to “the” Presbyterian Church our first Sunday and quickly became involved. We were sent out with our family to start a new congregation to be led by Rev. Buie Sewell.

Sewell had come for this purpose from an unwelcoming situation in Alabama where he was working on desegregation. The new church took the name "Church of Reconciliation" with a chief purpose of reconciling the races. Binkley Baptist, with similar purpose, had been founded two years before. an exciting and busy time. The work at the med school, hospital, school of public health and the clinics was consuming, but the contacts and relationships in the small med school community were so glorious, supportive, cooperative, and good. Mrs. Norma Berryhill welcomed and greeted the young faculty (largely not Carolinians) to the small village, and the number of medical students was small enough to develop close relationships - precious.

The hospital and reestablished 4-year school was created because of deficient medical care in NC which was revealed by WWII. The nature of medical school, patient care, and funding changed markedly as new therapies and technologies arose. The comprehensive clinic fee was $10 to include lab and x-ray. Care for the poor was donated as costs were covered by the legislature. As I arrived in 1964 the last iron lung was put in the closet, and there was no intensive care. Closed chest resuscitation had just been introduced. As a hematologist, I addressed Hodgkin's Disease, lymphomas, and leukemias using new drugs with some success. Our patients had to come early to get their non-automated blood count (the MD did the platelet count by hand).

Dean Berryhill retired in 1964 to be replaced by Dr. Isaac Taylor. Berryhill returned from sabbatical to establish a division in the Dean's office called the Division of Education and Research in Community Medical Care to help fulfill the purpose of the school. Joining him were several young clinicians who had been residents or chief residents in medicine. These included Dr. Robert Huntley who had practiced in Warrenton, NC and returned to residency. He later headed Community Medicine at Georgetown, Dr. Carl Lyle, Dr. Glenn Pickard, and Dr. Lawrence Cutchen. Various "Great Society" fundings allowed involvement in the Appalachian Regional Medical Program, and ultimately Area Health Education Centers, and the Orange County Community Health Service, a predecessor to the current Piedmont Health. Many clinicians (especially those with co-appointments in Preventive Medicine) participated, including myself.

Our interest in seeing that timely care was available led to the changes in the clinic and medical student education. We created an ambulatory continuing care clinic for non-specialty patients, and to follow their hospital discharges from

the local community. The family nurse practitioner program started with Glenn Pickard, his wife Fay (Chief nurse at NCMH), and her contacts in the nursing school. The students organized the Student Health Action Committee (SHAC, the first student run free clinic in the nation), involving students from all of the health affairs schools at UNC. This free/volunteer clinic at first involved Duke med students and served as a free source of care both in Chapel Hill and Durham. It is still active as a free clinic in Carrboro.

There was politically mandated insertion of a Department of Family Medicine into the school, with its faculty leaders recruited from England. There was establishment of the air transport for the medical faculty (under Carl Lyle) to support the AHEC system under Glenn Wilson. The Department of Preventive Medicine became Social Medicine. Internal medicine clinicians joined to fill this work: Dr. Robert Lawrence, Dr. Sam Putnam, and later Dr. John Noble and Dr. Axalla Hoole joined clinical work and teaching. Many premier internists have joined the division over the years.

Problems to be faced by the clinicians over the following years intermingled with the organization and payment for medical care. Available treatments for heart disease, hypertension, diabetes, cancer, psychoses, tuberculosis, and hemophilia rapidly progressed. Hemophilia patients' vulnerability to the AIDS epidemic led to the elimination of Gravely Sanitorium, a new cancer center, and establishment of hospice in NC. Referral of "difficult" patients for care at the hospital and medical school increased.

I was asked to act as chief of a new Division of General Medicine, but after 6 weekly meetings in the Dean's office with Vice Dean Wm Cromartie, and having a migraine headache each of those evenings, I asked to have Bob Lawrence replace me.

In the 60's, a Canadian physician organized the Center for Health Statistics. Cecil Sheps had a great influence in the movement toward clinical epidemiology, and this effort attracted many young internists to join the work, especially as the Robert Wood Johnson Clinical Scholars Program came. Initially, the Clinical Scholars Program was headed by Dr. David McKay. Robert and Suzanne Fletcher took over the newly named Division of General Medicine and Clinical Epidemiology. Medicare and Medicaid money funded the clinics. Paper records

were slowly being replaced by electronic (UNC benefitted from the Web CIS electronics introduced by the Fletchers). Unfortunately, the idea that patient needs could be reduced to problems (Dr. Lawrence Weed and the problem oriented medial record (Univ. of Vermont)), and that reimbursements in hospitals and clinics could be controlled by problem-based coding, led to a movement away from hospitals as healing places. Clinicians were left organizing home health services as well as working in patient rehabilitation.

Medical education became a huge enterprise. Medical school classes doubled in size and changed character, as minority students were championed, and women were admitted to ultimately make up over 50% of the class. The teaching formerly done in the first two years by Preventive Medicine was now the responsibility of the new Social Medicine Department. (I led the Introduction to Clinical Medicine course in the first year, and Axalla Hoole, the second year Physical Diagnosis.) The Robert Wood Johnson program brought many wonderful Clinicians interested in Epidemiology (getting an MPH). These included Dr. Ed Wagner, Dr. Sheldon Retchin, and also Dr. Tim Carey, who became head of the Division of General Medicine and Clinic Epidemiology after the Fletchers left and would move on to become Director of the now named Cecil Sheps Center for Health Services Research, and would be my physician. Also as the number of internists/teachers increased (first in the Spencer Love Clinic then in the Ambulatory Care Center), they learned their way through “managed care” and “prior approval”. The hospital replaced social workers with “discharge planners” to optimize Medicare reimbursement based on DRGs (Diagnosis Related Groups). It became more difficult to organize continuing care for the clinic patients and for the residents to appreciate relational medicine.

Out of General Medicine grew hospice, work in the new retirement centers in Chapel Hill, the “hospitalist” program, geriatrics, and the palliative care program. The Division worked on several important areas: domestic violence, the opiate crisis, and the AIDS epidemic. Precepting the medicine residents in their clinics and the Urgent Care Clinic was ongoing as “primary care” emerged.

Geriatrics became a specialty following efforts in the 1980’s instituted by Dr. Harry Phillips from the School of Public Health. Dr. Mark Williams took over the geriatrics program. (Dr. Mark Williams trained under my mentor, Dr. T Franklin Williams, who was a national leader in Geriatric Medicine in Rochester,

NY.) Geriatrics became a separate division under Dr. Jan Busby-Whitehead. All of this growth and evolution was aided and supported by the Deans. Chris Fordham, an associate dean when I arrived asked me to be a “class advisor”, and my beloved Betsy arranged receptions, suppers, etc. for “our” classes. When Fordham became Dean, he arranged a Dean’s Office car on Monday. The Dean took house calls, visited nursing homes, etc. with students. This continued through the following deans, especially Dean Bondurant.

I retired from UNC Medical School after 50 years, as the Epic electronic medical record became mandatory. To continue my association with medicine I worked with the American College of Physicians, and was a homeless shelter clinic volunteer. I worked with the Medical Foundation to help fund an in-patient facility for UNC Hospice. (Hospice funding became available under Medicare in the 1980’s.) My patients contributed mightily, and it was a good valedictory.