LINNEA CAPPS

Dr. Fitzhugh Mullan,
interviewer

Mullan: We're at Harlem Hospital, and it's the 24th of June, 1996. Dr. Capps was good enough to break away from briefing the new class of interns to chat with me. We got to go to lunch, which included excellent curry, compliments, I guess, not of the interns, but making that at home. Anyway, what I'd like to do it is start back with your background, talk a little bit about where you come from and how you first got interested in medicine.

Capps: I was born in Wichita, Kansas, and spent all of my childhood in Kansas and Iowa and Missouri, and I really didn't think about being in medicine until I was in college. I was always interested in science and, actually, for a while, when I was in junior high school, I thought about being a nurse, but I didn't think about being a doctor in those days.

Mullan: What was your date of birth?

Capps: 1950. I was very interested in biology and chemistry, and when I first went to college I thought I wanted to be a research chemist, but I decided, after I really couldn't deal with calculus and all of that stuff, that I didn't want to do research chemistry, and it was sort of at that point that I

decided I wanted to think about going into medicine, but it really wasn't until I was in college.

Mullan: What had your family done?

Capps: There's no doctors in my family. My father is a retired air traffic controller, and my mother was an English teacher. I was always encouraged to be well educated and do well in school and all that stuff, but nobody in the family is into medicine.

Mullan: So when did the decision come?

Capps: I guess when I was a sophomore in college, I kind of switched gears and took more biology courses and more stuff geared towards going to medical school.

Mullan: And where were you in college?

Capps: I went to college in Kansas State, Kansas State University in Manhattan, Kansas.

Mullan: So having decided to go into medicine, at that point, as you pointed out, there were less women going into medicine. Were you supported or were you in any way countered by anybody in the family or school or elsewhere in particular, one way or the other?

Capps: I was definitely supported by my family. Medical school was a little difficult because there were only about 10 percent women in my class.

Mullan: Where were you?

Capps: At the University of Missouri at Columbia. The vast majority of people in the class were white men from rural Missouri who wanted to go back to rural Missouri and live in that environment and be the town doctor. It was pretty politically conservative, and there wasn't much sympathy for feminism and the Equal Rights Amendment and things like that. So that was sort of difficult.

Mullan: And how was medical school in general? Did you like it?

Capps: After the first year, I would say I did. The first year was difficult partly because of all the problems. I was stuck in a lab group with a bunch of basically male-chauvinist-pig men. But by the second year I had sort of found a little cadre of people who thought more like I did, and that was also when things that were more apparently useful for somebody who wanted to take care of patients-- [Telephone interruption. Tape recorder turned off.]

I was basically saying that I think that was when I began to see courses appear that seemed to be more useful than gross anatomy. It was a very traditional medical school where the

first year was just anatomy and physiology and biochemistry. I began to like it more later. There was absolutely no contact with patients during the first year and a half.

Mullan: Which year was that?

Capps: That was '73 to '77. I graduated from medical school in '77.

Mullan: And did you find faculty members or house officers or others who sort of stimulated the other side of you, other than the academic side, mentors?

Capps: Not many. There was one. The dean of students at the University of Missouri was actually fairly supportive, although just by virtue of his position and how big the school was, it wasn't like I had much personal contact with him. Actually, there were some other things that were sort of in the opposite direction which, when I think about it, make me surprised that I ended up in medicine and in a place like Harlem Hospital. I have no idea how it ended up this way, but when I did my rotation as a junior medical student in medicine, it was at the V.A. Hospital. For some reason, four of the ten women in the class were all on the same rotation as medical students. The interns and residents and attendings were all men, and it was horrible because they all clearly looked at us as not worthy of careers in medicine or of staying at the University of Missouri.

In fact, I was explicitly told when I was counseled on how to apply for a residency that I probably wasn't tough enough to be in the Department of Medicine at the University of Missouri. [Laughter] So, yeah, there really weren't that many, and there were extremely few women faculty. So I guess most of my support actually came from other medical students, because there was sort of a small group of more politically progressive medical students that hung around together.

Mullan: Men and women?

Capps: Most of the women in the class and a handful of men.

Mullan: And how did you begin to shape your notion of what you wanted to do? First of all, what did you think you wanted to do in medicine on the way in? Do you have a notion of what kind of career you wanted, and then how did it change and develop?

Mullan: I think my notion was always that I wanted to do more general primary care medicine. I never wanted to be a subspecialist or a surgeon, and that didn't change. I didn't like surgery. I didn't like intensive care. I did sort of think I wanted to do family practice. However, given that I didn't want to stay at the University of Missouri and that I didn't really see myself in as a family doc in some rural Ozark community for a lot of social reasons, I guess, then I sort of

began to think I wanted to do my residency at a big urban public hospital.

I did a couple of electives during my third and fourth years, one in Lincoln in pediatrics, actually, and one at Cook County in medicine. So when I ended up sort of figuring out where I was going to apply to do my residency--I mean, basically, family practice really wasn't that easily available in those big urban locations in those days, and therefore I chose medicine.

Mullan: But your background is pretty un-urban?

Capps: Yeah.

Mullan: What lured you to the city?

Capps: Probably politics and feeling like I would have a difficult time dealing with having different political views from most of the people in a conservative rural community. I felt, in Columbia, Missouri, which was a pretty easy place to find at least a few other people with leftist politics, even there it felt like you were isolated into this group of ten people that wanted to protest the Vietnam War and stuff like that. So I thought, "Well, there'll be more people like me in New York or Chicago." I think that's it.

Mullan: Where did your political sense, or political instinct, come from?

Capps: I guess I have to say that it came from growing up during the era of the Vietnam War, because I come from a very conservative family. My parents were always Republicans, and that was all I knew growing up. I remember writing a little essay for civics class or something when I was in seventh or eighth grade in favor of [Barry] Goldwater for president in 1964. But that just completely turned around when I was in college. I met other people who were against what was happening in Vietnam, and I got into that whole protest movement, and gradually went from knowing nothing but the conservative politics of my family to becoming pacifist and then a socialist. I guess that's how it happened. I can't think of any other explanation.

Mullan: The choice in Missouri must have been difficult to the extent that you had political awareness. You were going to a campus that was surely politically conservative. Is that something you felt at the time or you thought it was more [unclear] at the time on the way in?

Capps: It was important, but I honestly didn't think seriously about going to medical school anyplace else, mainly because of the economics of it. I was a resident of Missouri, and it was so much cheaper to go there and more likely to be a place that I could get into. I really didn't seriously apply to very many private medical schools or looked in other parts of the country or anything. I just kind of assumed that that's where I'd go.

Mullan: So you had political leanings, you had urban leanings, which were somewhat tied together, and you had generalist leanings.

Capps: Right.

Mullan: You said you did both Lincoln and Cook County as electives. How did you focus in on your internship selection?

Capps: I actually only applied to Cook County and a bunch of places here in New York City, having already decided that I really wanted to live in one or the other place, and I kind of narrowed it down after interviewing to either wanting to be in social medicine at Montefior or coming here. And Harlem, mainly I was impressed by the person who was the director of medicine at the time, Gerald Thompson. He sort of ended up being, for many years, a major mentor of the sort that I had never had in medical school. So I think his powers of persuasion are what ended me up here.

Mullan: Were there others that you knew that came to Harlem at the time?

Capps: No. I didn't know anybody else here. In fact, I don't think anyone else from my medical school came to the Northeast. I was really the only person in medical school that even came to this region of the country, I think. I didn't know anybody.

Mullan: And what did folks at Missouri and what did folks in your family say about going to Harlem Hospital?

Capps: Well, my classmates had already decided that I was completely nuts, and that just confirmed their view. My family, again, they wanted me to do whatever I wanted to do, although my mother especially didn't want me to be far away and didn't want me particularly to work in Harlem. They learned gradually over the years that I would do that anyway, and they really couldn't say anything. So they accepted it fairly readily.

Mullan: When you say your classmates had already decided you were nuts, were there political activities or community activities that you'd been involved in in medical school in particular that caused that?

Capps: Yes. In those days, it was mostly political activities. It was the very end of the Vietnam War, and there were still some anti-war demonstrations. There was a time period where we set up a tiger cage in front of the Student Union once a week and somebody sat in it. We had demonstrations, you know, mostly anti-war, anti-militarism stuff against the B-1 bomber and some of the kinds of things that were going on in those days, so people did know about that. There were also some women's movement activities that were going on. People knew that I did that. Most of them, that was not their political opinion.

In fact, at the little graduation party that the senior class had, they read the names of everybody in the class, where they were going and what they were doing, and then there was some little funny quote, and they said that I was going to be going to New York to work at Harlem Hospital and I was going to request to sit on the left wing of the airplane. So that was sort of where they placed me.

Mullan: What was it like going to Harlem?

Capps: It was very different, although I felt actually more accepted as a doctor than I had at the University of Missouri, because, again, there were so few women in the medical school at the University of Missouri that you were always just assumed to be a nurse trailing along with the doctors if it was mostly men and one or two women. So in some ways I didn't feel terribly out of place. In those days, as well, the house staff was almost all American-trained and was kind of an ethnic mixture. It was maybe two-thirds African-American and one-third white and a few other. There was a substantial number of people of both races who had come here for specifically sociopolitical reasons. There were a number of people that saw the world in the same way I did, in a way that there hadn't been.

Mullan: You were aware of that coming in?

Capps: Yeah, I think I was, partly because it was so clear to me when I interviewed, that the whole political consciousness around health care and around health care in poor urban communities and stuff like that was here in the Office of the Director, and also because I met some of the house staff who were here, and I had a little bit of a feel for what people were going to be like.

Mullan: We're talking about the expectations and reception here at Harlem when you came. As you did your internship, talking now for the moment socially, politically, and medically, was it what you expected?

Capps: Yes. There were a substantial number of people in my group of interns who had come here for some of the same reasons I had, and a fair number of those people are still around here. There are people who are attending physicians here but work in one of the neighborhood health centers around here, or people who have gone into private practice in this neighborhood or nearby and still significantly, at least part of the time, serve this community.

Mullan: That kind of culture of politics and service which existed here then, mid- to late seventies, does not exist here today?

Capps: Not in the same way, partly because of the trends that have affected everybody, but especially urban public hospitals.

Fewer people who go to American medical schools are here as house officers. So that whole culture of politically aware and progressive interns and residents is not the same anymore because most of the interns and residents are not from the United States.

Mullan: What happened? I'm jumping ahead in the story because this is such an important point. Why has that come to pass? There were several factors, I suppose.

Capps: Yes. It's a number, and I don't know how many of these are provable and how many of them are various people's speculation, but part of it, at least in New York and to some extent in other places, has been the change in the way that house staff working hours are looked at in terms of number of people on call and all that. So there's been a huge expansion in the number of house staff positions available. At the same time there was a period of time which is, I think, probably reversing itself a little bit now, because people now see that the jobs are back in primary care again, but there was a time when primary care specialties were much less attractive to people. I guess also with the change in politics, there were fewer people going into medical school who were going into medical school with the same kinds of ideas of service to the community and whatever that those of us who were sort of children of the anti-Vietnam War movement had. All those things together sort of made it so that fewer and fewer people who were graduates of American medical schools and who were interested in coming to an urban public

hospital because of political reasons, that whole source of people dried up.

Mullan: When did that happen?

Capps: Here it happened in the mid-eighties. I don't know exactly, because I wasn't directly involved in house staff recruiting or in teaching house staff in those days, but there were a couple of years right in that time period where this program at Harlem went from being almost entirely American medical graduates to being the vast majority foreign graduates. And since the mid- to late eighties, that's the way it's been.

Mullan: And what had it been before the mid-seventies? Had it always had admission of U.S. grads?

Capps: Yes. There's a long complicated history of the residency program here that was first connected with Bellevue and then connected with Columbia University. But ever since the Columbia University affiliation, which dates back--I'm not even sure how long but I think thirty years--until the mid-eighties, there was a house staff that was mostly graduates of American medical schools.

Mullan: And mostly African-American?

Capps: That I don't know. Actually, I think it was mostly African-American, at least from the early seventies. It may have been less, though, before that just because there were fewer African-Americans who were in medical school. I'm not sure about that.

Mullan: Going back to pick up your story, you interned, you found a community that's more simpatico than what you had in Columbia. How was it medically?

Capps: I think it was good. I have no way to compare, because this and Columbia Presbyterian are the only hospitals that I've worked in. I have no idea what it would have been like if I had chosen to go to a private hospital or some other kind of place as a resident, but I certainly felt like I saw lots of patients, very sick patients, people with all kinds of different problems, in that by the end of the time I finished my internship here, I was sort of not afraid of anything. I think I learned medicine very well.

Mullan: The teaching was good?

Capps: Yes. There were several people, actually, who were my attendings when I was a resident that are still here, that are excellent clinicians and good teachers, and there were several other people who came for one or two months a year as voluntary attendings in those days, who were also extremely good teachers.

Mullan: So you decided to stay?

Capps: Yeah.

Mullan: And you went on through residency. Tell me a bit about that and also how the generalist/specialist tensions played out in those days, both in practice and on your attentions from what you wanted to do.

Capps: Well, I never had any questions that I might want to be a subspecialist. That never seriously entered my mind. Here, at least in those days, it wasn't assumed that that's what you would do if you were smart. I think actually that that may be something that might have been different if I had been a resident, for example, at Columbia, because I know there that, in those days anyway, they saw their mission as training subspecialists. It was only a few years later, but some of the residents up there used to tell me that the director of medicine would say that if you wanted to be a primary care doctor, it just meant that you would be a resident for the rest of your life, and there was no respect for wanting to go into primary care.

But that really wasn't true here. There was never any pressure to go into a subspecialty. Then the other thing that entered into all of that was I had a National Health Service Corps scholarship, and the other reason that I wanted to stay. I wanted to continue working in Harlem Hospital, and I was lucky enough that this network of neighborhood health centers was being

created just at the moment I was graduating from my residency, and they were National Health Service Corps sites, and so I paid back my time working in a place that I wanted to work anyway.

Mullan: Tell me about that. That was after three years, three years here?

Capps: Yes.

Mullan: And then tell me about the neighborhood health centers, the movement, and your experience.

Capps: There were at the time four fairly small--and they all still exist--small places that were created to be run by Harlem Hospital. I actually was again lucky enough because I knew that's what I wanted to do. People knew that I was applying to stay there to pay off my National Health Service Corps time so I was invited to be in on some of the planning of those, and they really were just opening and starting to see patients.

Mullan: These were satellite clinics?

Capps: Yeah. Three of them, actually, are in housing projects. A couple of them were created out of small spaces that were apartments that were kind of rearranged to be clinics. Over the five years that I worked in those places, I worked in several, and I was acting medical director for a while, but the one that I

started out in and the one that I spent the most time in was in the Drew-Hamilton Houses, which is a huge housing project over on 143rd and 8th Avenue. The clinic was in this little bitty place that was two two- or three-bedroom apartments that they didn't even do very much construction with. They just made bedrooms into an examining room. The entrance was around in the back of a building and on the ground floor. It was a couple of years before anybody knew we were there, so it took a while to get busy.

There were two internists and a pediatrician and a gynecologist that came part of the time. Actually, it was very nice. There was a wonderful nurse who sort of kept everything together, and the rest of the staff were nice people, and the pediatrician and I sort of became friends. In the non-busy times in the beginning where we were helping move in furniture and stuff, it was just fun.

Mullan: Was it a successful operation?

Capps: Ultimately, It was. It started very slowly, but both that site and one other one that's in another housing project have been expanded and renovated since those days. Several different organizational changes have happened. They eventually were joined with the neighborhood health center that was part of Sydenham Hospital, which is all that's left of Sydenham now that the hospital closed. And now yet another organizational change is in the process of happening, which is that they're all going

to become one organizational entity with the hospital out-patient services, and the in-patient services are going to become another organizational entity or something. But anyway, all four of them still exist and still see a substantial number of patients.

Mullan: Do you admit here?

Capps: Yes, although it's one of the problems that's never been worked out very well, to my satisfaction anyway, because we still have sort of a strictly ward attending setup for in-patients. Especially when I was younger and less sure of myself and all that, clinically, when I was working out there I always felt like a fifth wheel to come in and see my patients, because the house staff and the ward attendings were doing everything, and I would just be a social visitor and say "Hi." I don't feel that way as much anymore, but it's still the same feeling. If one of my patients gets admitted, it's somebody else that is really making all the medical decisions. But that's happening all over. I mean, I just read an article that said Kaiser is doing that. They're separating the in-patient docs from outpatient docs.

Mullan: This was three years, two years?

Capps: Well, actually, I ended up working in that network of clinics for five years. I had three years' National Health Service Corps, so I did it full-time for three years. Actually, I have to say, although I enjoyed it in a lot of ways, by the end

of three years, it was becoming clear to me that seeing a patient every twenty minutes day after day for the rest of my life was not what I was going to do.

So after I finished my National Health Service Corps time, I worked part-time still in the same place, in the same neighborhood health center, and took advantage of the fact that I was then a Columbia University employee and went to public health school to get my MPH from Columbia in '85, and so I did that part of the time for two years.

Mullan: Tell a little bit about that. How did you fit that in and why did you do it?

Capps: Actually, I started out doing it, if I remember right, mainly because I sort of wanted a more public health perspective in my thinking. I mean, it was fairly vague. I guess it was partly because I felt like what I was doing was monotonous, and I wanted to do something else. I felt the need for more education or something. It was also because I felt like despite the fact that I got a really good education here in how to take care of individual patients and a sort of general sociopolitical sense of how health care policy and all that stuff can impact individuals and all, that I just didn't have the background to connect those vague things together. I wanted to really know what epidemiology was about and what community and social causes of diseases were about, so I could think about that in those terms better. I think that's why, at the beginning, I did it, and then gradually

as I got into it and met other people and took other courses, then I began to more develop the international health side of why I was interested in public health.

Mullan: Was it good?

Capps: Mostly, yes. There's a few required courses, like every place, that were sort of a waste of time. My own personal view is that no one can teach you to be a health administrator and that the courses about how a hospital is organized and stuff like that were not very helpful. But the straight epidemiology courses, there were some really good ones. And just learning that, learning what basic vital statistics are good for and stuff like that was good, and it was interesting, and I enjoyed it. So I managed to do that by working part-time and taking courses in the evenings and around my schedule.

Mullan: Was some of this in the clinic?

Capps: Yes. I worked part-time and took classes part-time. I think it took two years to finish, or two and a half.

Mullan: In seeking the MPH, you obviously had certain political precepts that you came into medicine with, particularly to Harlem with. How did that play into that, and did it have a relevance to your politics or not?

Capps: Yes, in the sense that I already had a notion that I knew on some level that a lot of disease has social causes as well as more medical, bacteriological, pathological, whatever causes. So I started out with that notion. Part of the reason I wanted more education was as a way to have a more scientific way of looking at it. I'm not quite sure how to explain exactly what I wanted out of it, but that background was already in my mind when I set out to learn epidemiology and to look at illness as a social phenomenon, as well as an individual one.

Mullan: Did it help, the MPH in general, epidemiology in particular?

Capps: Yes. It led me, if not in any concrete way, at least to be able to think about things a different way, to teach things differently to house staff and medical students, and to think about the problems my patients had in different ways. I'm not sure how much difference it made in what I could actually do about them sometimes.

Mullan: Did your sense of coming here and having a community of colleagues that was more political and more committed to social issues along the lines that you were, did that bear itself out, both during the residency and that National Service Corps off-site time?

Capps: Yes. The National Health Service Corps, at least when we started out in those neighborhood health centers, was some of the same people. Most of the people that were placed, both as National Health Service Corps scholarship recipients and other people who were hired, the majority of all of the internists and pediatricians were people who were residents of Harlem. So most of us were people who just stayed here and already worked at Harlem Hospital.

Mullan: Was there a conscious political agenda? Were you in particular or this group as a whole active in any particular role in its missions or causes?

Capps: The group as a whole really wasn't. There were varying levels of political consciousness, and there were some hospital-related things. Some of us had been involved in the CIR, especially during those years.

Mullan: That's the Committee of Interns and Residents.

Capps: Yes. And in those years there was, other than just basic union activity, a lot of activity around the possible closing of public hospitals, the actual closing of Sydenham. Several of us were involved in going and working as volunteers in the emergency room as a sort of a symbolic gesture, to keep it going after the city had said it was closed. But aside from those things, there wasn't any very specific other activity that everybody did. I

continued to be involved in some of the "save the public hospital system" movement and some of that stuff.

Mullan: So you've had training here. You've had your National Service Corps period. You've had your MPH, and you were poised to make decisions about what to do. What did you decide, and why?

Capps: Well, at that point, because I had finished with the National Health Service Corps, I'd just finished my MPH, it had been clear to me for a while that I wasn't going to spend my whole career being a regular doctor in a neighborhood health center, that I wanted to do something else. Partly because of contacts made with one of the professors in the School of Public Health, I'd gotten a little bit of experience in seeing projects in developing countries and decided that I wanted to do something in international health. I happened to be able to just, again, be in the right place at the right time to go and work with this project in El Salvador. So I did that. The middle of 1985 was when I left and went to work Central America.

Mullan: How was that?

Capps: I was there for just about two years, from '85 until '87.

Mullan: What was that like?

Capps: I really liked it, and I suspect I would have stayed longer if it hadn't been for the fact that you can't make a living doing that. It was an entirely volunteer thing. It was living in a small rural area, a small project with a couple other North Americans. There were also some foreign church workers of various kinds, nuns and priests and stuff like that, because we were working in a project that was run by the Catholic Archdiocese of San Salvador. That was a health project in a conflicted area during the civil war in El Salvador. We were living in a small town of about 2,000 people, living in the parish house, running a small clinic there and working with a network of essentially village health workers that were, again, sort of chosen by the church structure and their parish priest because that was really, at that point, one of the few mechanisms for sort of getting people to be able to do that and be protected enough by some institution to do that. So we participated in training them, following up their work in their community, visiting them, and delivering medications to them and stuff like that.

Mullan: Was the war active at the time?

Capps: It wasn't like being in the middle of battle or anything, but there was certainly a lot of military activity. There were times when we could see planes bombing areas up in the mountains. There were lots of times when we were stopped by the Salvadoran military and told that they were doing a military operation in a

certain place and we couldn't go there, or we were stopped and asked what medications did we have, who were we taking them to, what were we going to do with them. So we were frequently under suspicion of activity.

Mullan: And in terms of how you were treated?

Capps: Personally, for us, there was not really much more than that kind of harassment and not always being allowed to travel to the places where the health promoters were. There were a couple times when the health promoters themselves were detained and taken to military bases and their medications were confiscated and stuff. There was one case of a promoter who was shot and wounded by a military helicopter that was just shooting at people who were walking on a particular road, under the assumption that anybody walking on that road must be a guerilla.

Mullan: The promoters were the workers, local workers?

Capps: Yes, they were volunteers. Most of them had had extremely little formal education. That's a sort of an aside, but another--

Mullan: Hold on for a second.

[Tape 1, Side 2 is blank. Begin Tape 2, Side 1]

[Note: Tape two seems to have been recording on a voice-activated recording machine, and therefore some of the conversation is lost. This is indicated in the transcript with [unclear].]

Mullan: This is tape two. Tape two, second side, didn't record. So this is 2A. There is no 1B.

We're continuing talking about the promoters.

Capps: Yeah, health promoters. I guess I'm making an English word out of what they were called in Spanish, but they're essentially village health workers. Some of them, a few of them, had as much as sixth or seventh grade educations. Several had only second or third grade educations, and there were a couple in very isolated areas who had no formal education at all and were pretty much illiterate, although they could read a little bit. So the challenge was to teach them not only the environmental sanitation things and the simple stuff like rehydration for diarrhea and that sort of thing, but because a lot of them were in conflicted areas that all of the government health services had been moved out of, many of them became essentially the barefoot doctor for their community. So we were also teaching them to use basic antibiotics, to treat parasitic infections, to treat malaria. So we were taking people, some of whom barely knew how to hold a pencil, to give primary care.

Mullan: It was two years over there?

Capps: Yes.

Mullan: As you looked at how you divided your labor and what you did, how much of it was laying on hands, how much of it was teaching, and how much of it was public health activities?

Capps: Probably less than half of it was actually doing medical care myself. We did run a little clinic in the village that we lived in, but only saw patients a couple days a week there. The other days we were out traveling and either giving courses to the health promoters or visiting their communities or having follow-up. A significant part of the time was teaching.

Mullan: Whose aegis were you under?

Capps: The organization that paid our stipend and travel was a small non-profit organization called Aesculapius International Medicine. We basically got small amounts of grant money, private donations. The person who started it had the idea of putting health workers in situations of conflict when government health services weren't working.

Mullan: So you were opposed to the government per se. You weren't with the FMLN?

Capps: No. In fact, one of the things that allowed us to work the way we did, and one of the things that was important about

the way it was set up was working directly within this program run by the Catholic Church. That allowed us to be politically neutral, although much of the military structure didn't consider us or the Catholic Church neutral. But it did allow us to continue to live in that area, because we couldn't have even lived where we lived without a negotiation between the church and the military. A lot of times to even get to our home, we had to present credentials to get back to our home.

Mullan: How would you characterize the experience? Was it fun? Was it educational? Was it career-altering?

Capps: Most of the above. I loved it. As I said, I might still be doing that work if I could have found somebody that would pay me to do that kind of work, and I guess probably because it was so different. I happened to like El Salvador a lot. I just enjoyed working there and living there. But it was also very different to teach these people. The health promoters were really extremely enthusiastic. They had to be. They were mostly people who were church activists, catechists, and people who really cared about their communities, and so they were extremely eager to learn. It was fun to teach them, but it was also a challenge because it meant developing whole new methods, and I had no background in education of barely literate adults.

Just as an example, we used *Where There is No Doctor* as the basic textbook for what we did. It's a wonderful book in terms of being a way to take a symptom or a problem and lead you

through what you do to decide whether it's really serious or not and what you can do about it, but the trouble is it's really heavily dependent on being able to use an index to find what it is you're looking for, and we realized that even people who could open it up and read a paragraph and understand it pretty well had no idea how to use an index. If you told them to look up a word that started with an S, they would start at A and look down the whole index until they found something. They had no concept of where something falls in the alphabet and how to look something up in an index. And so we said, well, we have to back up and teach them how to look up things in an index. So those kinds of things were constantly a challenge because of their whole social background and educational background.

Mullan: What did that do your politics?

Capps: I guess it reinforced a lot of things I already thought, both in terms of the health politics, in terms of the level of disease and unnecessary suffering that happens when people are just completely abandoned by the government and not given the basics of environmental sanitation, water, and latrines, and all the things that most of these communities didn't have at all. Also, obviously, I already was, of course, not in agreement with what the United States was doing in terms of its support of the Salvadoran military, and what I saw made it clear that I was right to think that.

Mullan: So you came home, finances governing that somewhat?

Capps: Right.

Mullan: What did you have in mind at that point?

Capps: Well, when I came back, I was hoping to find some way to continue to have something to do with international projects, and I have, although it's sort of a juggling act to keep up with doing short-term things in Central America and having a full-time job here. I just assumed that I was probably going to go back into working in urban primary care and come back to New York, which I did. Actually, the other thing that happened was that the same person who had been my mentor turned up, having left here and gone to Columbia to be a vice president of Presbyterian Hospital, and Presbyterian Hospital was at that time starting a very similar network of neighborhood clinics in the Washington Heights-Inwood area,

Mullan: This is Gerald Thompson?

Capps: Yes. He used his powers of persuasion again to convince me to work as medical director and at the time I joined it, there was only had one very small clinic of this network. It later became five clinics. So I helped plan and start several of the subsequent ones.

Mullan: This is in the Columbia-Washington Heights area?

Capps: Yes.

Mullan: And that was between '87--

Capps: I was there from '87 to '90.

Mullan: What happened?

Capps: Well, in some ways I liked that a lot because it was a mixture of clinical and administrative work. I don't really like administrative work a whole lot but I think I do it reasonably well. I participated in all the planning and the meetings and inspections by the state health department. But I also was back teaching Columbia medical students.

Mullan: They rotated through these clinics?

Capps: Well, actually, at that time, some of the residents did. The medical students didn't. But at that time I ended up teaching a public health related course to medical students. They had to do a little project related to public health and there was a small series of lectures on health-policy-related things. I was the course director of that course for a couple of years.

I precepted residents in the clinics, did some of the administrative organizing, had a small patient panel myself. In terms of the mixture of work, it's not very different from what I do now. I guess what finally made me decide that I didn't want to stay there anymore was just that I didn't want to deal with the high-level administration of Presbyterian Hospital to the extent that I had to. It was a difficult situation, because being a private hospital, there was all the tension of how much resources would go into these places which were essentially not going to make the hospital any money, and in fact were going to lose it. A substantial portion of the patients were not covered by any kind of insurance. So they were doing it, at least on the part of some of the high-level executives in the hospital, I think they were doing it because they felt like they had to do something in the community. It would not be politically possible to go on having their entire patient population being rich people from northern New Jersey and Saudi Arabia. [Laughter] It was always a big political deal, and it was just too much. I didn't want to be close to the high-level administration of a fancy private hospital.

Mullan: You decided to come back here?

Capps: Yes.

Mullan: And what happened?

Capps: Well, actually, I then got into yet another different interest. I was offered a position that was partly paid for by a grant. There still is a large NIH-funded community program for clinical research, an AIDS grant that's here. It's part of a multi-centered trial network, and the person who's the chief of Infectious Disease here hired me to sort of help get that project started here and to help organize a better outpatient service for the infectious disease service. So essentially for two years, despite the fact that I had no sub-specialty training, I was in the Infectious Disease Section. Most of my outpatient patient care was with AIDS patients and helping set up some of the procedures around some of the research studies, to renovate and reorganize the Infectious Disease Clinic, and provide a whole range of services, both medical and social, and other stuff for AIDS patients. I worked on that in 1992.

Mullan: Does it feel like you're in the right spot now?

Capps: Yes. Aside from all the problems specifically related to this hospital and difficult times for public medical care in New York City, I actually do like the mixture of things that I was talking about before, because I do teach students now, mostly clinical teaching on the outpatient side and on their in-patient medicine clerkship. I have a part in helping run the residency program and the teaching that goes along with that. I am also in charge of the general medical clinic, as well as having my own

patient panel. I wake up in the middle of the night thinking about schedules. That's life.

Mullan: How much clinical work do you do there?

Capps: I have two half-days and another half-day precepting residents in the general medical clinic. I still have one half-day that I work in the Infectious Disease Clinic seeing not all but mostly patients who are research participants. That's what I do clinically.

Mullan: And what is happening around the state? You're obviously in a good position to judge.

Capps: It's hard to explain, because I think there's some contradictory things. On the one hand, I think many of us who felt disrespected in the days when we were residents fifteen years ago, in terms of wanting to be generalists and how if you were really smart you would have been a cardiologist, that clearly has disappeared. My present boss is a cardiologist, and one his more recent jokes is what do you call a cardiologist in California, and the answer is, "Waiter." [Laughter] So some specialists have begun to realize that they're not in the driver's seat anymore, and it's pretty easy to gloat over the fact that you picked something that's now in demand more than it would be if I had done a fellowship.

But on the other hand, we have the difficult economic problems, and the trend toward managed care and more control over what you do and how you can care for patients, which we haven't seen nearly as much of here yet as I'm sure is going to happen and has happened in other parts of the country. The other thing that makes it difficult now is another round of threats to the public hospital system. All hospitals, public and private, are downsizing and consolidating services and ending services, etc., etc. It's especially difficult here. There have been a lot of nurses laid off at this hospital. There's a few doctors that are going to be laid off soon.

Mullan: Even staff-level docs?

Capps: Yeah. Most of them are part-time, but there's even going to be a few full-time attending physicians who are just going to be laid off just because there's not as many in-patients that need this many doctors. I don't disagree that the way we've organized ourselves and the way that doctor services are deployed in this hospital has been inefficient, but it feels like there's more and more left for each one of the rest of us to do.

Mullan: Let me ask you a question, if I might, about how you see the world now, given your current situation and experience. Politics that in the anti-war days were fairly straightforward have evolved and preview politics as they intersect your professional life. Are there issues that you consider important

to you in your career, political issues and organizations, and if there are, how do you see those developing?

Capps: In terms of the politics of health care, there really have been a lot of changes, and I don't think that I or the people that I know imagined five years ago the kinds of economic pressures that we would face. But I think everybody feels the productivity pressure much more than we ever assumed we would. In addition, the fact that any thought of real fundamental reform in the way health care is delivered and financed seems to have disappeared. I am somebody who naively thought at the beginning of Hillary's [Clinton] task force that, you know, a couple of years from now all my patients will have some kind of coverage and I won't have to worry about these things anymore. I was just completely disappointed that nothing like that happened.

In fact, now it's sort of swung back so much the other way that we all see that there are more people who are uninsured or under-insured. In addition, at the same time, big cities like New York are trying to cut back on or even get themselves out of the business of providing health care. All of these things happening at once make it very difficult. So among the people who remain active in the health care system, we've found ourselves defending things that we thought were awful. Now we're fighting to keep Medicaid and stuff like that and to keep scantily funded and understaffed public hospitals because right now there's no alternative.

Mullan: It's a confusing time politically.

Capps: Yes.

Mullan: I know what you mean. Answers were simpler and clearer, and I think it's ironic that a lot of us are the in the posture of being against managed care. I won't say ironic, but there is a funny alliance between traditional academics and also activist academics or activist policy, medical policy people, being skeptical of HMOs, and negative. I think it's a losing battle, actually. I don't understand HMOs personally well enough to have a good sense of where to draw the line, what are the discriminatory points in the argument for or against. But it pains me, although I understand, well, when I see both someone like Jerome Prasier [phonetic] writing in the *New England Journal* or somebody writing in a PNHP [Physicians for National Health Program] sound about the same about managed care, that they're both against it and it's a travesty, etc. Well, yes, yes, but. I mean, it's [unclear] their discrimination and a clearer agenda than being foot-draggers. I don't have any political mentor or source that has given me a good read on that, and I'm not sure myself.

Capps: Yes. I think it's very complicated, and that's why it's so hard to figure out how to be a political activist around that as your issue. It was so easy to set up a tiger cage and say, "No more bombing of Vietnam." Now, its much more difficult to

really explain the PNHP-level argument about managed care and advocate for a system where everybody is covered economically in the same way, basically. So I think that it's not necessarily the philosophy of managed care, because I think there are some people who have some trouble, understandably, with sort of the gate-keeper aspect and giving primary care physicians the responsibility to make every decision about whether or not someone needs a particular service, and that being controlled by administrative rules and sometimes economic incentives.

But on the other hand, I think most people recognize that a system in which everybody has a primary care doctor and that person coordinates the rest of their care and is in charge of knowing what's going on with their health care all the time is actually a desirable thing to have, especially from the point of view of patients like our patients, whose primary doctor has been the emergency room and who come in and out of the hospital and who have no real primary care. The difficulty is, then, if that's also linked to the profitability of the company that does it and if it's linked to a whole system where there's a bunch of competing companies and organizations that have an economic stake in how the care is delivered, which then gives an incentive to primary care providers that their income depends on limiting care and to managed care companies to make money, essentially, which then, on a whole other level, gives them an incentive to not take in people that they think are going to be sick.

So if the whole country were one managed care organization that covered everybody and they couldn't refuse to cover anybody

and they couldn't give doctors incentives for denying people care, then it would be wonderful. Everybody could register with their primary care doctor and have primary care and have their care coordinated, and there wouldn't be any economic disincentives to giving people what they need. But that's obviously not in the cards.

Mullan: Let me ask another question about primary care, its current and future status. We touched on this a little. You're director of the Division of General Internal Medicine, you're clearly a SGIM, Society of General Internal Medicine, member. I see the journal. I'm presuming a little, but I would gather you're sort of at the leading edge of the medical generalist academic organization movement.

Capps: Yes.

Mullan: Is that movement prospering, and where do you see it going?

Capps: I think it is prospering, although there's still some shifting of defining who is a primary care physician and who's a generalist. All the tensions between internal medicine and family practice are still there, although I think part of the reason it's prospering is because of that whole climate that I was talking about a minute ago where there's the appearance, anyway, that there's more demand for primary care physicians and

less for some specialists, that we're not all competing for the same positions, and that there are ways that you can differentiate how general internists are trying to function.

For example, as an organization, the Society of General Internal Medicine has grown a lot in the last five or ten years. Here there's more enthusiasm for especially the health services research stuff that a lot of people on the academic side of it do, and for educating medical students and residents in primary care. So that is really going very well, and there are vital and interesting things going on.

Mullan: How do you see the future? In other words, there is a great struggle going on between the reborn generalist movement, complete with gate-keeping, and the still powerful specialists and their continued preeminence in the reimbursement system. How do you think this is going to solve out five, ten years from now? What do you think? Is America going to have a generalist-based care system or not?

Capps: That's a little hard to say because it just hangs some on politics, which are never predictable in terms of who gets elected president and who controls the Congress and whose health reform agenda--although I suspect that a primary-care-based system is more likely to be what happens. That might not be the best for patients, though if it is controlled by competing for-profit managed care companies.

I think it's going to be more and more difficult for anybody to become any kind of subspecialist they want and go anyplace they want. I was very impressed by a study that was published in the *New England Journal* relative to the northern states, about Michigan, that said in order to support the complement of subspecialists that's at the University of Michigan now, they would have to have more than the whole population of the state in their HMO. If that's the trend, and we've already seen, for example, in anesthesiology that the number of people who want residency positions has decreased dramatically.

Mullan: Fascinating time for the book to come from it, both in terms of how the generalists will fare, as well as what we do [unclear]. The question of how generalists will fare, I've heard--and this is another question for you--there are those who are now making the arguments, a couple of arguments. One is that specialists do provide primary care and should be encouraged to do so. The second is that many elements of care that are professional in nature are best handled directly by specialists, and we don't need generalists monkeying around with dermatology, as an example. If it's a rash, send him to the dermatologist. It's more efficient, it's quicker, and that's an example that can made. Diabetics are handled better or have better outcomes when handled by a neurologist than generalists, so you ought to send your diabetics or whatever it was directly to an endocrinologist.

So, two questions. Do you think either of those, that is, the specialist being encouraged to do primary care, is a good

principle and will succeed? Secondly, do you think the role of generalism is going to be picked apart a bit by specialists playing the direct access to certain--

Capps: Well, in answer to the question about specialists doing primary care--I think it's possible, and I think there are certain populations of patients for whom it's reasonable. On the other hand, I think the majority of specialists, at least the ones I have contact with, are not that comfortable with some of the other issues of primary care. Anybody can learn how to give a tetanus immunization once every ten years, or a mammogram, but not everybody is willing to do the rest of women's preventive health care. Not everybody feels comfortable with figuring out what to do with somebody who has a sprained ankle. Your cardiologist is not likely to deal with minor orthopedics.

So I think those are some of the complications with figuring out how specialists would provide primary care. The less you do of primary care practice and the more you do of only your subspecialty, the less you're going to feel comfortable making decisions about everyday ordinary medical care.

Mullan: How does the specialist put them off?

Capps: That's certainly a reasonable worry. To a certain extent, a lot of academic medical centers already have that. I feel like one of the biggest drawbacks still, because we don't have very much managed care penetration, still to an academic

place where you have lots of every kind of subspecialist, but that's already happened to us. I mean everybody who has HIV can. But that's actually being forced to change by managed care, where everybody has to have a primary care doctor. Some people are convinced that that's okay, and other people aren't.

Mullan: Do you see in the primary care movement, the movement to primary care, intellectually, clinically, culturally, as political?

Capps: Very. There's certainly some individuals who look at it in a broader context. But at least in terms of what I hear in [unclear], doesn't have the whole context of causes of illness and the public health context. A whole lot of what I think was left out of even the best of the mainstream proposals for health care were formed [unclear] full acknowledgment of the contributions of [unclear] how are we going to pay for managed medical care and not how are we going to do whatever it is that needs to be done to make everybody healthier.

Mullan: Part of the argument with HMOs is the vehicle for population medicine. It's easy to make those arguments than point to managed care organizations that are doing a good job of that.

Capps: Right.

Mullan: But I think that the propriety at least ought to be thought about. A couple questions about you. Where are you headed? What would you like to be doing ten years from now, five years, fifteen years? Are you going to be at Harlem Hospital?

Capps: I don't know. I might be at Harlem Hospital if we continue to be involved with teaching residents and medical students. However, I can't any longer say I'm sure that that's what I want to keep doing forever and ever, because it just feels harder and harder every day.

Mullan: The practicing or the teaching?

Capps: No, just surviving in this environment. The teaching is difficult, for all the things I was talking about before, the mixture of international medical graduates and all the difficulties of the diversity of backgrounds. I find that, on the one hand, difficult, but on the other hand, sort of challenging and stimulating, and I like it sometimes. But with fewer nurses, fewer doctors, it's getting harder and harder to cover everything that has to be covered. It's just day-to-day more of a struggle to make sure that everything gets done that has to be done. Really, for the first time in a long time, I feel like I'm personally getting closer and closer to being burned out on this. As I have to do more and I have to juggle fewer people to do more, I don't know how long I'll last at that if the environment keeps going downhill. So that's one

consideration. However, in terms of the seeing patients and teaching residents and medical students side of it, I still very much like to do that.

I guess the other consideration is I'm still really attached to some of these international health things, like El Salvador and juggling, using up vacation to go work in El Salvador, I'm not sure how to keep doing those things into the distant future. So I don't know.

Mullan: Just so it works out when you've got it on tape about your internship, who, in terms of their origins, was that for one coming in today, ethnic origins?

Capps: They come from a widespread area of the world. For reasons I don't quite understand, we always get a lot of Africans from Nigeria and Ghana and a couple of other countries in Africa. We have a number from India and Pakistan and an occasional one from Latin America or Haiti or somewhere else in the Caribbean.

Mullan: The [unclear] service in the hospital, are they entirely IMG too at this point?

Capps: Some of them are. The ones that aren't are the ones that tend to be integrated with Columbia University. The surgical subspecialties, for example, are covered by residents who rotate. The orthopedics program is mostly American medical grads.

Mullan: The ones at primary Harlem Hospital--

Capps: Are mostly IMG. Pediatrics, general surgery.

Mullan: I see that one of the great themes of your career thus far is teaching.

Capps: Yeah. I didn't start out that way, but I discovered later that that's the part of it that I really like the best, actually.

Mullan: If you were going to talk about your life outside of work with all and it really started with your comments about learning medicine in Missouri, being a believer, you know, 10 percent, obviously the landscape has changed considerably in terms of the feminization of medicine, but both in terms of that theme as well as your personal life, how has all that developed for you, and how is your career?

Capps: Well, it's definitely easier now to be a woman in medicine, but I think to a certain extent, there's still a glass ceiling in academic medicine. On the other hand, I have to admit that the majority of division chiefs at Harlem Hospital are women. And in terms of the impact of my career on my personal life, I'm divorced, and I guess one of the other things that sort of makes me wonder exactly what I'm going to be doing in five years is I had hoped that by the time I was in my mid-forties I

would be able to have more of a life outside work than I have. And I don't know how much of that is because I personally am very compulsive and feel compelled to hang around for long hours, going over schedules and paperwork and stuff like that, and how much is really that that's the only way I can do a good job. In some ways I think it's easier for people who have kids to say they have to spend time with their family and have that accepted. I have less excuses to take time for myself.

Mullan: Your being in medicine impacted deleteriously on your marriage, do you think?

Capps: It probably did. I don't know how much of it was that, but it certainly was difficult being an intern and a wife. I think it's also still difficult on relationships between men and women that even men who try to accept feminism still have difficulty with women who are very independent, who earn more money.

Mullan: Do you have comments you'd like to make about medicine in general or generalism in specific? You've done some fascinating things, and at the risk of sounding like a career counselor, I'll be interested to see where it all leads to.

Capps: Yeah. Me, too.

[End of interview]

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