BEACH CONGER

Dr. Fitzhugh Mullan,
interviewer

Mullan: What is your date of birth?

Conger: August 12, 1941.

Mullan: Why don't we go back to the beginning, and tell me a little bit about your birth, and subsequent development. Where did you grow up?

Conger: I was born in New York City, but I was raised in suburban New York, first in Hastings, on the Hudson, and then I spent most of my conscious childhood in Pleasantville, New York, which is a suburb about thirty miles outside of New York City, known as the home of *The Reader's Digest*. I went to high school there, and then went to undergraduate school at Amherst College, where I was pretty sure that I wanted to be a doctor, but I also thought about becoming a Russian scholar, and then went to medical school at Harvard.

Did two years of training at Boston City Hospital, and then went to the CDC [Centers for Disease Control] for two years, and had one more year of training at the University of California in San Francisco, where I worked in the Department of Community Medicine, and wound up running a health clinic back in the days when the government thought it could improve the condition of poor people by improving their health, for six years, before I came out here to Vermont in 1977.

Mullan: Let's crank back a little bit and go through in more detail. What took you from New York City out to Pleasantville, with your family?

Conger: My parents were both writers. My father worked for the *New York Herald Tribune*. It was the only job he ever had, until the *Tribune* died, and then he died about six months later. My mother wrote children's books, and then worked for *The Reader's Digest*. So they had lived in New York City before I was born, and then moved out into the suburbs. That was kind of their upward mobility. As I said, my mother went to work at *The Reader's Digest*, where she worked until she retired, and then died.

Mullan: She was a writer?

Conger: Well, she wrote children's books, and then she was an editor of condensed books. As she used to be fond of saying, that when she first started doing it, she felt that it was sort of presumptuous to do this, but after a while, she began to realize that even the best writers could be improved upon, and she lost her reservations completely. So she edited condensed books, and did that for probably fifteen years or so. She started working again when I was--oh, it must have been more than that, it must have been twenty years--she started working again when I was probably twelve or thirteen years old.

Mullan: What was Pleasantville like to grow up in?

Conger: Pleasantville was your basic town, sort of a suburban town. It's all that the name implies. It's a town of about 5,000 people, just far enough out that most people who live there did not commute to New York City, but a substantial portion did. It was very middle-class. We had one African-American town. His name was Sidney Poitier. [Laughter] Now, that was when I lived there. It may have changed somewhat, but I don't think so, because I go back to visit my sister.

I went to a small high school there, where probably 60 percent of the kids did not go on to college, but 40 percent did, and those, by and large, tended to be the ones who came from educated people who worked in New York City. So you sort of had an educated class and a working class.

Mullan: In your family or immediate periphery, any doctors that played a role?

Conger: I had two uncles who were doctors. One is a urologist. He's still living, and he moved to Florida to retire, and didn't want to stop working, so he became a dermatologist for the VA [Veterans Administration], which is fairly flexible. It's a recruitment of physicians. And the other uncle, actually on my mother's side, started out his career as a chest surgeon, got multiple sclerosis, and became a podiatrist. I'm not sure that either one of those had an influence on me. I was not particularly close to either one of them.

I think that my decision about becoming a doctor was basically because I did well in school, and that was one of the things that kids who did well in school were supposed to do. I

remember, earlier in high school, I thought that I might was going to become an engineer of some kind, but I lost interest in that, or whatever. It would have been a disaster, because I have no sense of engineering or design of space.

Mullan: So engineering was not where you wanted to head?

Conger: Well, somehow it just sort of disappeared from my plan. This was when I was a high school student, and by the time I was going to college, I knew that I intended to become a doctor. When I was in college, I sort of lost interest in it, just because I went to a liberal arts school, and people who became doctors were somewhat frowned upon as being narrow-minded in their view, as sort of a general view, I think. But then I said, "Well, I might as well go to medical school," and I did.

Mullan: What did you major in?

Conger: Russian. I went to Russia in 1962. When I came back from there, I thought it would be more interesting to become a Russian scholar, but I think it was just a little bit too scary, in sort of a sense. I would've gone to Moscow for a year, and I couldn't quite see far enough on the horizon, whereas medical school was pretty clear. So that's what I did.

Mullan: And as you faced medicine, did you have any notion about what that was, what you wanted, what kind of doctor you wanted to be?

Conger: I was sure that I was going to wind up being the Surgeon General, or something like that. From the beginning, I thought I was interested in public health. A lot from, let's say, the first year. But second year of medical school, I took a course in epidemiology from a guy--I think his name was Poskanzer--and he was a neurologist. He was a neurologist, but he was an epidemiologist, and I think he may have even been at the CDC. He taught an introduction to neurology course, and he was an interesting person, so I took this epidemiology course, and I thought it was fascinating. He must have been, because he used a lot of the teaching materials that come from the same course that I took when I became an EIS officer. Some of it was very simple and straightforward. This was before chronic diseases were even a dream in the CDC's memory. It was things like a salmonella outbreak, talking about cholera, public health measures. That really appealed to me, and it became especially appealing when I realized that I had a choice of either going to Vietnam or finding some other alternative when I graduated from medical school, and that one of the deferments you could get was in Public Health Service, so that I went to the CDC after I finished my medical residency, with the intent that I would probably stay in the Public Health Service.

I really enjoyed the time that I spent in Atlanta. I thought that that substantially raised my estimation of the federal government probably to the highest point it's ever been in my life. [Laughter]

Mullan: Why don't we do medical school first, and then crank forward.

Conger: Okay.

Mullan: You went to Harvard for medical school.

Conger: I went to Harvard for medical school.

Mullan: How was the experience?

Conger: Well, I didn't find medical school very interesting. Certainly not the first couple--I should take that back. The first two years I found kind of tedious. I don't think I applied myself, particularly. I found that it just wasn't very interesting to me. It was a lot of just stuff you had to learn. I'm not real good on the compulsive learning, so if it wasn't interesting, I would tend not to study it. I'd take physiology, and I didn't do very well. In fact, I even remember my first semester, there was a course, it was in some kind of physiology, and I got a "D" on the test, which was to describe the course and relations of some lymphatic something or other, and I just kind of lost interest in it.

So I got called in to the dean's office, because they were sure I must have been having emotional problems. You know, when you get accepted to Harvard, you must be qualified, and therefore, if you're not doing well, you're having some problem at home. I had just gotten married, just before entering medical school, to someone I--you know, as sort of typical of the fifties and early sixties--hadn't known for a long time. We knew each other in college. And so he asked me all these questions about how I was doing at home, and was my home life happy. I didn't

understand why I'd been called in yet at this point, and I said, "No, I think that's fine." Anyway, it was because I got a "D" in physiology. So then I realized that it was in my interest to have been a little bit unhappy, otherwise there was something wrong with me. So that was sort of the first two years.

Mullan: The second two were better?

Conger: Second two were better. I enjoyed the practical stuff. I wound up at Boston City Hospital doing my medicine rotation, which I just loved. I just loved the City Hospital, I think, in part, because I didn't quite feel socially up to the Mass General and the Brigham. You've been in a city hospital setting. It's much more egalitarian. I don't like to say you can get away with a lot more, but it's much more forgiving, both in terms of what the patients expect from you and the way people treat each other. And so I really liked being at City Hospital.

I decided, probably after I finished my clinical rotation there, as a second-year student, for physical diagnosis, that that's where I wanted to do my training. I did my medicine and surgery rotations there, and then I went on to do my internship and residency there.

Mullan: During medical school, you went to Mississippi.

Conger: I went to Mississippi. Well, Jack Geiger [phonetic], I'm not sure whether he had founded it, but was one of the leading spokesmen for the Medical Committee for Human Rights, gave a talk at the medical school, or in Boston somewhere. He

was at Boston University, and he had this grant. He was a newspaper man, if I remember correctly, for the *[Boston] Globe*, or someplace, and he developed--I don't know where he got it from--anyway, he developed this mission about the concept that health care could be used to raise people out of poverty, or, really, institutional control, as you know, because you were down there with me.

It was a very appealing idea to me. That may have been also part of the thing that sparked my public health interest. I don't remember any of the details of what he said. Actually, I think I have a chapter about that in my book. But he really captivated me, and he was a very charismatic--I guess is a good word to use--person. I met him afterwards, and he told about this plan he had. He'd gotten a grant from Office of Economic Opportunity to set up this clinic in Holmes County, Mississippi, and he was looking for volunteers, and so that's what I did the summer between my first and second year of medical school, it must have been.

Mullan: Second and third, it must have been second and third.

Conger: It was second and third?

Mullan: Because it was my first and second. You're a year ahead of me. Summer of '65.

Conger: Okay, okay. I thought it was between--no, you're right, between second and third. Because between the first and second,

I worked in a laboratory for a surgeon, doing clinical research. That's right. So between my second and my third.

We trundled off to Pittsburgh, where we spent some time being trained, and then I was taken out of Holmes County. My wife, who was also similarly politically inclined, was teaching math at Tougaloo University, at Jackson, Mississippi, for that summer. I wound up living in a house of a sharecropping family that was about five miles outside the town of Lexington, was the county seat. The reason I think he picked Holmes County was because it was the most prosperous black county in the state, and had a relatively larger independent black population.

I got down there, and I was full of sort of grandiose concepts about what I was going to be doing. It was a remarkable experience for me. What I wound up doing, basically, was working for the local chapter of--well, there was sort of a combined organization. I'm not sure if SNCC was the group that kind of was in charge. John Lewis was certainly important in this. I wound up doing voter registration and school integration stuff, and filling out forms. And that was much more useful than anything.

The one medical experience I remember was being called to this house of a child who had a seizure. The child is lying on the bed seizing. At this point, I probably know something about the idea that children may have febrile seizures, but that's about it. So I said, "Well, we'll have to take them to the hospital. This is terrible. The child's having a seizure!" And the mother says, "Oh, no. This is just a seizure." They had put him on the floor so he wouldn't hurt himself. "And besides, they won't see us at the hospital." And I'm just horrified. Here's

this child, who I assume is going to have something terrible happen if they don't go to the hospital, and the family accepted it. I'm sure they were very familiar with it. That was my one medical experience. They never asked me anything again. [Laughter] They thought maybe I had some pill or something I could give the child.

Then we came back from Mississippi, and we had the spirit, if not the religion, and decided that we wanted to be active in Boston, sort of medical politics. So we integrated a housing project in Roxbury.

Mullan: You and your wife?

Conger: Me and my wife. We were the only white couple in this housing project, because the city of Boston at that time was in danger of losing all federal money, because they had a problem, both in south Boston, where they had no blacks in white housing projects, and in Roxbury, where the opposite was true. It was $44 a month for the housing project, which was also kind of a nice benefit. My wife was on the board of the local--I've forgotten what they're called, the Community Action Board, of some variety. I was involved with the Boston arm of what Jack Geiger was doing. He was also going to be setting up something in Roxbury, through BU, or was it through Tufts? I think it was Tufts. It was Tufts, definitely. He had been at BU, maybe, but Tufts had the grant.

Mullan: Columbia Point.

Conger: Exactly. Yeah, it was Columbia Point. There wasn't really anything useful for me to do, but I went to meetings. I got involved somewhat in politics there. I wound up getting involved in the politics at City Hospital when, my first year that we had the "heal in", which was, theoretically, sort of a combination of improving patient care, and getting money for house officers.

Mullan: This was when you were an intern?

Conger: This was when I was an intern, right. But we lived in Roxbury for the last two years of medical school and the two years of my internship and residency. We moved out of the housing project because we were no longer economically eligible when I graduated from medical school.

Mullan: How was that experience?

Conger: It was an interesting experience. Certainly living in the ghetto at that time was very different. People used drugs, used alcohol, and kind of fell asleep on the sidewalks, and it's hard for me to judge, because I haven't lived in that environment, but certainly the concept of violence and fear, regardless of your ethnic group, just didn't exist. It was just a very poor place. I lived very close, almost next door, really, to where Louis Farrakhan lived when he was growing up, and you look at his descriptions.

It was a poor ghetto, but the issue of violence and personal safety was not an issue. Even though I was there when Martin

Luther King [Jr.] was killed, and there were riots, and I remember sitting on the stoop of our housing project, watching the local convenience store burn, and that was sort of considered to be entertainment, but nobody felt at personal risk. I mean, nobody was hurt. These were old, dilapidated buildings. Coming from the background I came from, it certainly provided me with a view of life I hadn't had, and which I really haven't had since I moved here. I've sort of gone back more to my roots. But I think it gave me an understanding of the fact that there is, even in this country, a way of life which has just nothing to do with what goes on in a place like Vermont.

Mullan: Was it tough on your wife?

Conger: No, she loved it. She were sort of cast out of the same mold. We've since divorced, but in that respect, we were very similar. She was a mathematician who had gotten a National Science Fellowship to MIT [Massachusetts Institute of Technology], and was teaching at Northeastern, at Simmons College, and was driving a taxi part-time in Roxbury. My son was born in the housing project.

The two things I remember about living there, most vividly, the first one was we had bought a washing machine to do his diapers, because that was the cheapest way to do it. We were trying to decide where to put it. We had just gotten it, and we were sitting in our living room, and somebody starts trying to break open the door. There were two doors into the apartment, for some reason, one through the living room, and the other room through the kitchen. We saw someone force open the kitchen door.

There was one of those latches, and we see the cutters coming out, and we said, "Hey, we're in here!" thinking that that might make a difference, but it didn't. So at that point, we decided we were going to put the washing machine in front of the door. So we moved it in front of the door, and we stood there, and held the washing machine in place until they went away, and that's where we put the washing machine. That was the closest--and whether we would have been at any personal risk about it, I don't know.

One other time, somebody came in and stole a television, while I was in the room, sleeping. I was working night duty. They just walked in, broke open the door, stole the television, and left, and didn't bother to disturb me. I was right in the same room. But that could happen anywhere.

But my favorite experience, which actually is almost impossible for me to exaggerate, was my next-door neighbor. I'm now third- or fourth-year medical student, so I still don't know much, but I'm coming and going in a white coat. My next-door neighbor was a taxicab driver. One day, his wife comes over to see me and says, "You've got to see my husband. He needs to go to the hospital, and he won't go." So I went over to see him. He's sitting there watching television, and he's got a Band-aid on his forehead. So I said, "What's the matter?"

And he said, "I've got a headache."

And, you know, I'm a dutiful medical student. I've got this long list of questions you ask about a headache. I said, "Well, when did it start? Did it come on suddenly, or did it come on gradually? Does it radiate, or do you feel sick to your stomach?" I ask him all these questions, and he answers them,

and he kind of looks at me. We didn't know each other very well. We said "Hi" to each other. He sort of figures this is something he has to go through. And then I said, "What's the Band-aid for?" And I thought it was some kind of--you know, people sometimes do funny things to make them feel better. They'll put a Band-aid over it, you know, like you do for the kid.

So he takes it off, and he says, "That's the bullet hole."

I said, "What do you mean?"

He said, "Well, I was driving my taxi, and I went to let my fare out, and the guy put a gun to my head, and said, 'Give me your money, or I'm going to shoot you.' And I said, 'No,' and so he shot me."

I said, "He shot you in the head?"

He said, "Yeah."

I said, "With a bullet?"

He said, "Yeah."

I said, "You've got to go to the hospital! You've been shot in the head!"

And his wife said, "See, I told you he'd say that. Listen to the doctor."

He says, "No, if I go down there, I'll sit around for five hours, they'll take an X-ray, they'll say there's nothing they can do, and they'll send me home again."

I said, "No, no, no. You've been shot in the head. I'll call an ambulance."

He said, "I'm not going to take an ambulance."

He goes down to Boston City. Five, six, seven hours later, he comes back.

"What happened?"

"They took an X-ray, they said there's nothing they could do, and they sent me home." [Laughter]

So now, whenever anyone comes in for a headache, the first thing I ask them is has anybody shot them.

Mullan: The decision to go to Boston City for your residency was, in part, as you described it, because of the comfort you felt in the City Hospital setting?

Conger: Yes.

Mullan: Between the Mississippi experience, your political experiences, living in the ghetto, and the choice of City Hospital, did this describe kind of a political approach to medicine that you developed? What were you thinking at the time?

Conger: Well, I was thinking at the time that I wanted to help people who are poor. I don't think "underprivileged" was invented yet. But that was where I wanted to work, that was a goal in life that I considered desirable, and that was what I wanted to do in my life. And I think it was both because I felt it was more rewarding, and because it was certainly more comfortable for me. I remember distinctly being extremely uncomfortable as a student in both the Mass General and at Peter Brent Brigham Hospital. Partly, I didn't feel smart enough, you know; that everybody there was so smart. Partly, it just seemed a little too classy.

I remember when I was doing my physical diagnosis, or maybe it was gastro, anyway, I was doing something for Mass General,

and I was sent by my instructor to examine this patient, who was in what's called the Phillips House. There are several different parts to the Mass General. Well, this is where the Shah of Iran would go. This was the real private wing. I arrived there. When you get to the bottom of the place, there's a reception area. So I told them who I was, and they said, "Well, we'll call up and see if she's receiving now." And I went up to this private room, where the patient was dressed--it was a woman, and she was dressed in a very nice--she was made up, she had on her nightgown and stuff. She was a woman maybe in her sixties, and she was being served a cocktail by the nurse. She was in there for alcoholism, or for alcoholic liver disease. But that experience just sort of reminded me that I just felt ill at ease in this.

Boston City Hospital was dirty, it was a mess, and everything was falling apart, and I felt at home there. I did my training at Boston City. When I went to the CDC, I worked at Grady Memorial Hospital. Then when I went out to San Francisco, I was at San Francisco General, and the clinic that I set up was in the poorest area of San Francisco. It was basically where the homeless people hung out. I won't say where they lived--well, it's where they lived, the heroin addicts and the alcoholics. It was sort of the Bowery equivalent in San Francisco, called the South of Market area.

Mullan: But as an intern, as house officer, you were politically active as well?

Conger: Yes.

Mullan: And you had participated in the strike?

Conger: Yeah, well, it was a "heal in." We didn't have a strike. We didn't discharge any patients from the hospital, because we didn't feel that we could leave, you know, walk out on our patients. The doctors could do that relatively easier than the rest of the system. The demands on the nursing, on the dietary, were just impossible. It only took two days before the hospital was swamped with its capacity, when we didn't discharge anybody.

At that time, I was vice president of the house office--well, no, I was not an officer at that time. It was the second year in negotiations when I was the president of the house office. A guy named Phil Caper [phonetic], who has also become very much of a political person, he worked for Ted Kennedy, and he now runs a consulting firm in Cambridge. He was the president.

So we were negotiating with the City Council for, theoretically, we thought, for improving the conditions of the hospital. Well, in the end, what happened is probably what you would expect, and that is that we sold out. Were we getting paid at all then? Not initially. No, $100 a month we were getting. So we wanted a raise, and we wanted laboratory services, we wanted improved patient--more nursing, all kinds of stuff. We were meeting with the city's labor lawyer. We had hired a labor lawyer on our side. So then they said, "Listen, this is what we can do. We'll give you whatever you want for pay, but we're not going to do any of that other stuff. We don't have control over that. You can do whatever you want, but if you want to settle

this, we can give you this now. If you fight it, you may not get the money you want."

So the house officers were getting sort of tired of this. They were getting a little tired of the "heal in." So we settled for our money and the promise that they were going to work on the other. We thought at that time that that was a victory. I honestly can't say, looking over the next year or so, that I can remember anything we achieved in terms of actual patient care. Because, as our lawyer said, "Listen, he knows that you're going to leave in a year. They don't have to deal with you. You're not a valid organization. You're lucky right now. But he'd just draw it out long enough, and that's another set of doctors coming in." So it was sort of an illusion of control over the environment at City Hospital, but it didn't make any difference, except it did get us some more money.

Mullan: You stayed for two years?

Conger: I was there for two years.

Mullan: Rather than finishing, you went to the CDC?

Conger: Yes. I signed up for a deferment for the military, and if I remember correctly, you had to do it after two years. In other words, I went there because that's when I was told that I would do that, and I knew that I would have one more year.

Mullan: Even as you left for the CDC, did you have a sense of what kind of doc you wanted to be? You had chosen internal medicine.

Conger: I thought I was going to be in the Public Health Service, that I was going to be in public health. I never had the faintest idea that I would go into private practice. If you had asked me at that time, I'd have said, "No way." The last thing in the world I would want to do.

Mullan: So you went to CDC?

Conger: I went to CDC.

Mullan: You liked it, but--

Conger: I liked it a lot. I liked Atlanta. I had a lot of fun. I sort of fulfilled my social needs by staffing rural health clinics in southern Georgia, where the local doctors, who, of course, were all white, wouldn't go, because public health clinics were a Communist plot. However, they wanted to make sure that the poor black people got birth control, and I was in the family planning division. That's the division I picked. You go down there as an epidemic intelligence officer; you aren't assigned anywhere. And then after an introductory course, you pick some division you're going to work in.

I wound up picking the family planning division, because the issue of contraception and birth control was an interesting one to me. So that the clinical kinds of things I did was traveling

to these rural health clinics. It's just exactly what you would imagine. A very pleasant, extremely condescending white nurse is ushering in her black clients. I would virtually never see the faces of these clients. I would come into the room. They were already in the stirrups, covered with a sheet, drapes around so that it was physically difficult for me to get around and talk to the patient, which was intentional. I would be either checking an IUD, or putting an IUD in. That was what they were doing. That was the contraception that was used, because birth control pills, they didn't know how to take.

I remember the first time I was examining someone, and I would talk to them as I was examining them. This was a habit that I'd picked up somewhere else. I told the patient that everything looked fine, and her IUD was still in place, because I could see the string hanging out. And she said, "Oh, no. I don't have an IUD." I said, "Oh, yes, you do." She said, "No, no. They took it out last year." And I could see the nurse sort of gesticulating at me. So I said, "Do you want to see it?" She said, "No, no. That's okay." And the nurse is saying, "That's fine. You've taken the Pap smear. She can go." And so she got up and left. The patient kind of gave me a quizzical look, I think. The nurse then explained to me that the patient had come in the previous year. She was complaining of a lot of cramping and bleeding, and she wanted her IUD out. But because she had thirteen children, they knew she really shouldn't get pregnant again, and so they told her they had taken the IUD out, but they hadn't done it. But she had done much better since then. And, of course, the patient did not believe me, that the IUD was still

in there. What am I? I'm this Yankee doctor. What do I know? She believed the nurse. So that was what that was like.

Mullan: What was the EIS, Epidemic Intelligence Service, experience like?

Conger: That was fabulous. It wasn't so much on a social front, but there was a sense there that you were solving real public health problems. Our dedication, I think, was improved by the sense that if we didn't do this, somebody would be glad to take our place, and we could always go to Vietnam as a medical officer.

When I arrived, the CDC did nothing other than infectious diseases. It was relatively in the backwaters of the political spectrum. When I arrived, there was a fellow there, Carl Tyler [phonetic], who had set up family planning services. He was a gynecologist who had become an EIS officer. So we were beginning to do contraceptive evaluation.

When I was there, New York City had just passed its first unlimited abortion law, and I got involved in doing surveillance of outpatient abortions in New York City, which was kind of fun, tracking down deaths, you know, because people were coming up from all over the country. It was a very interesting epidemic issue, and also a political issue. For the first time, I think the CDC recognized that tracking down salmonella outbreaks, eradicating smallpox, [unclear] infections, those things were not quite at the same level of debate as what's happening in abortion clinics. It had just begun to become where I think it was being injected more politically into the mainstream, but this was back,

you know, '69 to '71. AIDS hadn't been invented yet. Legionella [phonetic] was discovered when I was there. That was a lot of fun.

I still thought at that point that I would be interested in staying in public health, but I had one more year to do in my training. My wife said she wanted to go to San Francisco. It was sort of her turn. We had been in Boston together, we went to Atlanta because I had to go there, so she wanted to go to San Francisco. So I took my second year of residency at the University of California-San Francisco, in which I had a rotation that gave a lot of elective time. I wound up working in a methadone maintenance clinic, working in one of the ghettos, in the projects in San Francisco, trying to help a group get together a grant for some federal money, which was just all over the place at that time, for health issues. And then discovered at that time that they had gotten a grant to set up a health service clinic in this part of the city, and they asked me, would I want to run that, and I said yes.

Mullan: This was the at the time you'd finished your service?

Conger: I did one year of residency there, so this was while I was in the middle of that year, they got the grant. So I actually started working on that while I was finishing my residency. This was in 1972.

Mullan: And this clinic was where, again? Where in San Francisco?

Conger: It was south of Market Street. It was just off of Mission Street. It was right smack in the area where all the--you know, run-down hotels. And it had an interesting history. There was a clinic there, which was called Canon Kip [phonetic]. It was some bishop, Kip, I guess, who had set up this clinic, let's say, thirty years ago, to serve these poor people in this area. There were these two doctors, who were in their mid-seventies, who were retired Army doctors, who came in one day a week and volunteered their services. It was open one day a week, maybe two days a week. The way it worked was, it was first-come, first-served. So you would arrive in the morning--because I started working there before we actually had the grant--and all the people who wanted to be served were sleeping on the sidewalk, sort of waiting to get in.

Everybody there got Vitamin B-12 shots. This medicine sort of took me back to years before I had practiced anything. So we took it over, and it had a completely different focus. It was a much more structured thing. We had lots of money, we had employees, we had outreach. We were treating, doing preventive medicine, going door-to-door. There was also a large immigrant Filipino population that lived in the same area, and they were just the opposite. They were very stable, upward mobile. They came from upper classes in the Philippines, and even some of them were doctors, working as housekeepers. But there was this sort of dynamic tension between these homeless alcoholic, heroin addicts and the Filipinos, who lived together, and did okay on the streets, but in the clinic, the Filipinos wanted it to be their clinic, and after a while they became more employees there.

The alcoholics tended to not show up as much. I did that for six years.

Mullan: Those were what years?

Conger: From, let's say, January of '72 until July of '77. I liked that, too. I sort of felt that was a good combination, because I discovered that I actually liked doing clinical medicine, that that was something I did want to do, that public health planning had been a lot of fun, but I really enjoyed patients.

Mullan: So the notion of doing population medicine faded in favor of doing clinical medicine?

Conger: Right. Well, at that time, of course, I had the illusion you could do both. I didn't see any reason you couldn't. You could always combine everything. The idea of planning on the basis of the population that my clinic was serving, I'd narrowed my scope somewhat. I was no longer planning to become Surgeon General. But if someone said, "Would you want to become director of the city's health clinics, at some point?" I might have said yes to that.

Mullan: This was a very active time, as I recall, in San Francisco, in terms of free clinics and clinics.

Conger: Oh, yeah. Oh, yeah. I worked in the free clinics. I worked in the Berkeley Free Clinic, which is even more of a free

clinic than San Francisco. Exactly. The free clinics were all over the place, and there was a lot of federal money coming in for setting up these neighborhood health centers. I can't remember now, but our budget doubled about every two years. We had started off with myself, one part-time doctor, two employees. By the time I left, we had three doctors, fifteen employees, and there were three other clinics on the same grant. We were seeing over 2,000 people a year in our clinic alone.

Mullan: That took you to '77.

Conger: Took me to '77. Then what happened, was that I remarried.

Mullan: You'd gotten divorced?

Conger: I'd gotten divorced and remarried.

Mullan: All during the San Francisco years?

Conger: All during the San Francisco years, yeah. We had a basic Berkeley experience, in that my ex-wife and my current wife, Trina, we all lived together in the same house. It was a big house, and we just kind of gradually switched. She wound up with someone else, and I wound up with Trina. We had a child. She is from Norway, and what we discovered was that--

Mullan: Trina?

Conger: Trina.

Mullan: And you had a child with--

Conger: With Trina. I have two children from my previous marriage, who are now, at the time I'm about to leave, ages ten and six. And we decided that we really didn't like living in the city. This had nothing to do with anything else. She had finished her first year in law school. My focus changed, really, after I met her. A lot of it had to do with some simple things, such as she wanted to be closer to home, being Norway. We wanted to be somewhere where we could ski in the winter, because that was a very important part of her cultural life, where there was snow, anyway. So we decided we had to leave. Plus, there was this horrendous drought. This was in '76. There was no water, and it was a real nuisance, and we decided, "This is crazy." We were driving four and a half hours to go up to the mountains every weekend we could, so we thought we should leave the city.

We thought we might go to Montana for a while, where I had a good friend from medical school who lived, but we decided that was a little too much country. We went and visited. So we came and visited Vermont. I had never spent much time up here at all, even though I came from New York. We went to the Trappe family lodge, which is this beautiful place, and we decided that Vermont was a pretty nice place. We came at Christmas time. It was snowing all the time, it was beautiful. We said, "We could live here." At this point, I'm not thinking anymore about, "What am I accomplishing with medicine?" but I'm thinking about my life, and what it's going to be like, and the kids. So the idea was that

she needed to finish law school, so we were going to find a place where she could go to law school, and I would get a job somewhere near the law school.

I didn't at this point have any real sense of what I was going to be doing, but I figured it would be basically the same thing. So I looked around the law school. See, we thought the law school was in Burlington, Vermont Law School. We figured Burlington is the only city in this state. And I actually had interviews set up with the medical center there. I thought, "Well, they'll have some kind of clinic that'll be taking care of poor people. I've got all these qualifications. I'll fit in somewhere."

Well, we got back this very nice letter from University of Vermont, saying, "Well, thank you for your inquiry, but we don't have a law school. The law school you want is in South Royalston," which is a town about twenty miles from here. We looked in the map. South Royalston has a population of 250 people. Now, I come from suburban New York; she comes from Oslo. I thought Burlington was a nice small town. We looked there. We said, "Jesus, there's nobody there. Forget it. We're just not going." She said, "No, no. Let's look and see. We'll draw a circle around the law school, and see if there's any signs of civilization." So we draw a circle. Lo and behold, what pops up but Dartmouth! Now, remember, I come from New York and Massachusetts. Dartmouth, to me, is not a cultural center. Dartmouth, to me, is one of those places where, if you had a girlfriend and she went up there, you were worried about her coming back alive.

Mullan: It was on the edge of the civilized world.

Conger: Exactly, yeah. If that, you know. I'd never been up there. I thought, "Dartmouth. Jesus. Well, at least it's an institution. It's an academic institution." And I looked at it, I said, "Well, they've got a medical center there. It's got 350 beds. That really isn't much at all. But they'll have place for me, and we'll work it out." So I wrote a letter to the Department of Community Medicine, telling them about my résumé, and sort of waiting for this, "My God, we can't wait for you to come and help us out." I said, "I can do epidemiology, whatever you want."

Mullan: Why don't we hold.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Conger, tape one, side two.

Conger: So, literally, what happens is, I get back a letter. I get back an envelope from the chairman of the Department of Community Medicine, and inside the envelope is a letter from a doctor in Pittsfield, Massachusetts, in which he has asked whether or not there's anybody on their staff, or residents who are looking, who wanted to be an internist, because he's looking for someone to join him in his practice. So this is the response I get to my inquiry about job opportunities. Well, it didn't take me long to get the message that they weren't tremendously

excited about the opportunity of having me come to work there. So I said, "Well, this isn't going to work."

In the meantime, I was reading through the *New England Journal of Medicine*, to look, you know, just to see. So there's an ad that appears in the newspaper. It's a community hospital where a doctor's retiring, and they want an internist to come. It sounds like a nice opportunity, and you write to this box if you have questions. So I write to the box, and it turns out to be in Windsor. So I looked on the map, and it turns out Windsor is not very far from Vermont Law School. I said, "Well, this doesn't seem very promising, but what the heck. We'll go out." We have very good friends who lived in Stowe, and I thought, "Well, this is a good chance. I can go out. It'll be tax-deductible, and I can go skiing up in Stowe."

So I came here, and I visited the place. It was hard for me to believe. Except when I was in Lexington, I'd never seen a hospital this small. It sort of reminded me of that, in a way. It was almost intriguing to me that, you know, all my real experience has been at these huge city hospitals, and here I come to this thing that almost seems like a doll hospital. There's like twenty beds, everything is all right here. Everybody knows everybody. And, of course, they were very excited to see me, and that probably is what made me decide to take the job.

I came in and I spoke to one person, one of the doctors who worked here. He said, "Oh, you don't want to come here. There's no patients to see. Nobody comes to see you." This is the guy who was leaving. But I thought, "Well, what the heck? They want me to come. They're going to guarantee my salary, and I can do this for two years, and then in the meantime, we'll figure out

what we're really going to do." Well, that was nineteen years ago.

Mullan: It worked, I gather. You liked it?

Conger: Yeah. I mean, again, I didn't want to go into private practice. That was my one reservation about taking the job, but I sort of felt, since the hospital was guaranteeing my salary, it wasn't really a private practice. I realized it had nothing to do with what I expected to do in life, or considered my training to do, but this is what we had agreed to do, and it was the only job I could find near the law school, so I took it. And I loved it.

After about six months, the only time in life that I'd ever really been anxious, where I was daily petrified, because I was used to coming from these places where, if somebody had a problem, there was always somebody around to help you deal with it, or to deal with it, and here it was just the opposite. I mean, you dealt, in one way or another, with everything, whether it was a train wreck or a broken wrist, something I'd never seen before. People just expect for you to take care of it. And so I was just always anxious, especially the emergency room stuff. People would call me because I was the doctor. There wasn't a backup orthopedic surgeon, or a backup something. I was the doctor.

Mullan: What was the medical community like then?

Conger: Well, there were four internists here and one pediatrician. We had a surgeon who covered four hospitals, and that was it. Now, of course, Hitchcock is not far away. Hitchcock is half an hour away. So we weren't remote, you know. It was an ambulance trip to get to real medicine, if you want. The hospital was pretty well-equipped, physically. Until very recently, no one had ever done things like resuscitate people from a cardiac arrest. They had this ancient machine that was about six feet tall and four feet wide, that was used to defibrillate people. We didn't have a ventilator. These things don't necessarily bespeak primitive medicine, but the doctor who I replaced was a GP who had been here for forty-five years, and he delivered babies, he did surgery, he gave ether anesthesia, but he didn't do modern internal medicine.

I was not the first person of this type to be here. There had been another doctor arrived five years before me, and another one two years, so that this was beginning to evolve into--they had made changes, they had asked for different things. But I hadn't been doing much of anything. I was running an outpatient clinic. If somebody got sick, I sent them to the hospital. I might see them and visit them, and I was an attending once a month academically, but I didn't actually take care of people. I didn't start IVS, I didn't put in any tracheal tubes, I didn't put casts on people. I prescribed drugs, and I talked. So it was a big change for me, for about six months, until I kind of got used to things.

Mullan: Did you like it?

Conger: I was anxious. I can't say I really liked it then, and if you had asked me during that period of time, I would have said, "I'm not sure I'm going to stay with this." I didn't feel at any point that I had to give it up, but it wasn't comfortable. Plus, I felt so isolated, out here in the country. What if something happens to your plumbing or something? I didn't know anybody. Pleasantville was the most rural thing I'd ever been in, which was a suburb of New York City. So it was anxiety-provoking. I was anxious more time than I'm used to being, and I'm not usually an anxious person.

And then I got used to it, and realized that you do what you can do. I was treating someone, and I don't remember what it was that went wrong. I think it was a person who was having chest pain, and I gave them some medicine, and they died. I was convinced that the medicine I had given had contributed to it, whether it had or not. I said to the family, I just felt awful, and they could see it. They said, "Doc, don't feel bad. You did the best you could. He would have died anyway." This was not a long, long time ago, but they were used to the concept, which people are not as used to now, that you go the doctor, and things may well turn out worse than if you hadn't gone. I mean, that was an acceptable premise for a lot of people, even back then, that you sort of hoped things would get better, but they wouldn't necessarily.

It's sort of the big difference, I think, between what I would call old-fashioned primary care and new-fashioned primary care. Under old-fashioned primary care, which I think I experienced at Boston City Hospital, where the ethic was, as you probably know, you did everything, whether you knew how to do it

or not. It didn't matter, you just did it. But the difference was, there, if the person died, you didn't have anybody looking over your shoulder. And up here, where you did everything you possibly could, if you didn't know how, and you thought you could figure it out, you'd give it a try. And if you failed, or screwed up, people accepted that.

The first time I put on a cast--I mean, it's a small example, but it's a good one. Patient comes in, he's got a colles [phonetic] fracture. It's not displaced, it's nothing. Well, I never set a cast. No one ever showed me how to set a cast. When I graduated from medical school, internists were a big deal. We were in charge of a lot of things. We didn't have cardiac cath work being done; there were no endoscopes been invented. We didn't even have ICUs in those days. But we didn't do anything beneath us, like orthopedics.

So even if I worked in the emergency room at Boston City, I never even saw the broken bone. It went somewhere else. So I was pleased enough--well, the tech told me the bone was broken, and I don't know if I would have seen it. I might have, and I might not. So I said, "Well, you got a broken bone. You need to see the orthopedic surgeon." And he said, "Well, how am I going to do that?" So I asked the nurse, and she said, "Well, Dr. Shoemaker's over in Claremont. You can call him up, and he can go over there." Claremont's about half an hour away. So I said, "Okay." So I told him, I said, "Well, you've got a broken wrist. You have to go over to Claremont." He said, "I'm not going over to Claremont. Can't you set it?" I said, "No, I've never set a broken wrist before." He said, "Well, I've never broken a wrist before, either." I said, "Well, you want me to do it, I'll do

it." This is sort of my Boston City ethic coming. I thought, "Well, what the heck?" So he said, "Okay." I said, "I'll have to get the nurse to help me." He said, "That's all right."

So I put on this cast. It must have weighed 150 pounds. It was just a huge thing. And I was quite pleased with it. I just kept putting more and more plaster on. The nurse says, "You're going to have to take that off. You're going to have to take it off." And when he came back a month or so later, and I took it off, I realized what she was talking about.

But that was sort of what we did. There were a lot of things I just gradually started doing. The general surgeon could help me out. I started reducing some fractures. Certainly it isn't what an old-time GP did. I mean, if I assisted the surgeon in surgery, it was basically the same kind of assistance that a medical student would do, and I wasn't going to deliver babies. Last time I delivered a baby was on Massachusetts Avenue in Boston, in a snowstorm, when I was an intern. So I didn't do that stuff. It wasn't that primitive. But I certainly did a much broader scope of medicine, and I think I practiced more intense medicine than what primary care seems to be today. And that was because people expected me to.

Mullan: More intense in what sense?

Conger: Sicker people. When Swan-Ganz catheters, for example, started becoming available, well, we got some, and so I started using them. I never used them before; no one ever showed me. But I just started doing it. This was when I was with Boston City; somebody said, "Go do an LP." How do you do it? You know,

see one, do one, teach one--maybe you saw one. The ethic was, we just started doing these things.

People did not want to go to the medical center. They were afraid that if they went to the medical center, they would die. Hitchcock is not a big medical center, and it's not far away. The town is 9,000 people. But the ethic here--I remember, one person once had an eye problem, and he had to go. He was a diabetic, and he had a bleed. He said, "Oh, no. I could never go up there. It's too big." So even in this, you know, interstates, modern hospitals, people had that ethic. I was not likely to send someone to a specialist, unless it was a surgical specialty. You know, somebody needed to have neurosurgery done, for example. Cardiac surgery, back when I first got here, was something that just almost wasn't done at all, so that wasn't an issue. So I did very little referring.

Mullan: Why don't you give me a sort of thumbnail--because there are a number of things I'd like to ask about--how the practice, your practice, in relation to a large practice, evolved from 1977 until the present? You have how many docs here now?

Conger: We have six doctors here, five and a half full-time equivalents.

Mullan: And those are all internists?

Conger: Those are the internists. We have two pediatricians. We have the same general surgeon.

Mullan: Rotating?

Conger: Yeah, but except now he's sort of--I don't want to say he's semi-retired, if he ever sees this, but he only practices here, which is the equivalent of semi-retirement, because there's not enough business here to keep a full-time surgeon busy. We have an orthopedic surgeon, full-time, here, and we have a variety of visiting specialists. GYN, who have been coming right along; urology, which was new; ophthalmology, which is new; ENT, which is new; dermatology, which is new; neurology, which is brand new; gastroenterology, which, of course, is new. We've managed to keep out cardiology, but that's the only one.

Mullan: And these folks visit from where?

Conger: They visit either from Hitchcock, or they have set up a private practice, in which they circuit-ride a series of three community hospitals, of which we are the smallest. So specialists are all around me again. Patients are the biggest difference, although patients here, I think, are still vastly different from--at least what I know from my friends in Berkeley, let's say--they're now much more likely--they want to have a test done, and they want to at least consider a specialty referral option. I may be able to talk them out of it, because I know them well, but that issue comes up on a regular basis, so that I do a lot more referrals.

The gatekeeper concept--I've always felt that the idea is, as I like to say, that we open the gate, and then close it once they're in. We're not keeping people out, we're getting them in.

I think that my practice is evolving more. I have one substantially younger colleague, who does much less than I do. He would never consider setting a broken bone. He rarely removes something from the skin. I mean, these are not big deal things, but he just doesn't do those. He won't drain an abscess. He won't insert an IUD. As I said, these are not big deal things, but these are things that I've just sort of done. I still do most of them, and I'm less likely to refer someone than he is. He's well trained, he's smart as hell, but his ethic is that primary care involves as much knowing whom to refer to as in taking care of the patient.

One of the intriguing things--I don't think I saved it, but I can dig it up easily enough. Several of our physicians have become employees of what is now Lahey-Hitchcock, which is a huge physician organization. They put out a little brochure, and one of the things they put out is, "What is primary care?" to explain to you. What they explained is, "Primary care is the doctor you go to, to help you figure out which specialist to see." That's, in essence, what they said. I see that despite the emphasis on primary care, at least here that's more and more what's evolving. Someone's got Parkinson's disease. "Well, should I see the neurologist?" I say, "I don't think so. I can give you the drugs." "Well, wouldn't it help for me just to see him, in case?" Now, I will probably wind up not making that referral. The younger physician refers everybody with Parkinson's to the neurologist. He takes care of them also, but now you have two doctors instead of one, which is good for business, of course.

Mullan: Yes. Why don't you describe, in that '77 to '96 period, how the medical marketplace has changed, and how your role in it has changed, or the roles around it.

Conger: Well, somehow, the marketplace, I think, has changed primarily because there are more doctors. The insurance issue, the managed care issue, for us, has not been a problem. Part of the reason it's not a problem is that there is no competition here in primary care, as opposed to some places. The patients who live in this town are going to have to come to see someone in this group, by and large, unless they hate us all, in which case, they could travel some distance. But people don't tend to do that as much for primary care. So that the people who live in this town and this area come to see us. They've always done that, they always do that now. They, by and large, expect that this is their community hospital, and if they don't like me, they'll find someone else that they can at least put up with.

Fifty percent of my patients are on Medicare. Of the other 50 percent, probably a quarter are in some kind of capitation. I mean, everybody has managed care. The only difference it makes to me is I have to fill out more forms. It doesn't really affect the nature of my practice at all. What has changed, as I said, one big difference is that if somebody came in with a headache nineteen years ago, it was no problem. I would talk to them. I would talk to them about the headache, and unless I was really worried, and was going to do an LP, because we didn't have CAT scans then, there was no question about doing a CAT scan. Now, the chances are better than fifty-fifty that if somebody comes in with a headache, they know about a CAT scan. I'm not saying they

had one headache, but it's a bad headache. They came to see me, the doctor. Or it's recurring headaches. They're more likely to wind up with a CAT scan, and they're more likely to bring it up, but I'm still not that excited about it. It just doesn't do anything for me. Unless I feel a patient has a problem, I don't want to get a CAT scan for a headache. But a patient will expect that. That's just one example.

I think it's also true that the patient is likely to call me about medication. "I read about using this stuff for arthritis," which, of course, I don't know about yet, because they heard it on the radio. A joke about public radio being the worst thing to happen to primary care. You know, somebody heard about it on the radio. People are interested in medicine. Newspapers, which don't have anything better to do, are always printing stuff about this, and people read about it, and they're educated. Patients, when I came here, were not educated. They came to me. Typical response, "What are you here for?" "That's what I came to find out." I used to think that was some kind of a funny joke, but what they literally meant was, "I don't know. I don't feel so good. You're the doctor, you figure it out." Which not only gives me a lot of latitude in terms of where to go with things, but it shows that the person is not involved in what's going on.

Patients now, even here--and I'm excluding the people, let's say, who have moved here as I have, who are really flatlanders in disguise. I mean, they live in Vermont, but they were educated in Boston, and they lived in New York City or something. They live up here, but they really think "city." I'm talking about a farmer, you know. Now, the difference is that if I say to the farmer, "No, I don't think you need to have a CAT scan," he'll

say, "Okay." But then I'll always be wondering, "Well, maybe I should have gotten a CAT scan." Or, more commonly, if he asks about the referral, and then he doesn't do as well, then I'm going to say, "Well, you know, I guess maybe I should refer him, because then if he doesn't do as well, at least I referred him, and he won't feel badly." So I order a lot more tests that my heart is not in. As I say, I'm almost never proud when I order a CAT scan. And I make a lot more referrals than I would otherwise want to.

Mullan: You described the two populations, the flatlanders in disguise and the local farmers, or local folks. Within either group, particularly the latter, is there an economic spread? Are there folks in this area who are pretty poor?

Conger: Yes. We have some very poor patients. Vermont is sort of deficient, with respect to aggregates of poverty, to concentrated poverty, but isolated poverty is quite common. We also have sort of the distinction--there was a maximum security prison in Windsor. It was the last place in the state to do executions. There were also several factories here. They built a large apartment complex, which was initially designed for factory workers, and then when the factories left town, became the homes for basically the people who were related to the people in prison, and that sort of brought in an underclass.

Mullan: Related people?

Conger: Yeah, you know, wives who came with their kids, because their husbands were in prison, and they wanted to be near them. The prison has been closed for twenty years, but is now a senior housing place, which is very nice. It's been closed for more than twenty years, because it was closed at least two or three before I came.

But what happened was that this area became a mini-underclass, and so Windsor, in fact, has a microcosm. The building itself, if you look at it, looks like something that was airlifted out of the Bronx. It's a big, huge brick structure. There's nothing anywhere like it in Vermont. So we have this small population. I had a case of lead poisoning when I first got here, a kid who lived in this back porch, and ate lead, you know, just like in urban--we have class variation, we don't have ethnic variation. Except for some immigrant Vietnamese and a few black children, who have been adopted, it's still a white culture, but there is a class difference. I often think, you know, that one of the differences up here, is that when you're poor and run down, you sort of do it on the merits, because you aren't being discriminated against. But it's not concentrated, the way it is, let's say, in what's called the northeast kingdom, where you go up and it's 50 percent unemployment up there, and people don't have money, and they live in shacks with no electricity. But it's present, it's not pervasive, and most of my patients get by okay.

Mullan: In terms of the economics, or the economic range, for the practice, managed care has come, but it really has not pushed your practice around as yet?

Conger: No, not as yet. Medicare is a form of managed care, but suppose they were all on a capitation plan. I mean, our largest third-party payer has just been bought out by Kaiser Permanente. What I like to think is it wouldn't make any difference to me at all. I don't know which insurance my patients have, and I don't bother to check. I figure, since I make enough money, I'm not really worried about changes in that. I think unless there were competition between physicians, it isn't going to have the same impact here as it does in a place like California, where you have plans competing for each other, and there are real issues about the patient jumping--if a patient jumps from one plan to another, I'm still the doctor. I have patients who have gone through three plans in the last five years. I'm always the doctor. If they're in California, they would be changing doctors. But because there's nowhere else for them to go. Everybody comes to us.

Mullan: Is the group arranged as a group, in terms of partnership, or are you a solo within the group?

Conger: We're a partnership, legally. Our financial arrangement is closer to solo. What happens is we share the expenses equally, but each one of us gets the revenues we bring in, so we don't share the revenues, except in some areas--laboratory tests, and things like that. So that if one of us works harder, that person will make more money. If another person wants to work half-time, then they'll make half as much money, and it doesn't affect the other people, except call schedule.

Mullan: As you watch the kind of wars between what has come to be called medical generalism or primary care, and the ongoing, at least until very recently, prodigious growth discussions from this vantage point, what has it meant to you, in general, and what has it meant to you personally, in terms of your world view as an internist?

Conger: To me, personally, it hasn't made much difference, and I think that that's primarily because I have an extremely established practice. I've been here for nineteen years. Most of my patients I've had for a long period of time, and given the nature of the relationship they've expected with a physician, they still look to me primarily for their guidance. A patient of mine who goes to a medical center and has something recommended is still quite likely to want to check with me on whether this is a good idea. I had, I think, a somewhat irritated cardiac surgeon call me once, whom I referred up there, saying, "Well, we think the patient needs to have his mediastinum opened up because he's gotten a post-operative infection, and he wants me to check with you." So it hasn't affected me as much.

Mullan: That is, the incursions of the specialist?

Conger: That's right.

Mullan: Because of patient loyalty or patient connection?

Conger: Exactly. The other thing that happens is there's a lot of natural selection, that the patients who have stayed with me

are the patients who expect that type of a doctor. In other words, you know, there are six of us here. Some of us do more than others, and, in fact, the patient always has the option of getting medical care up at the medical center, in which case they'll have a primary care doctor, who really is just a traffic cop. When that patient goes in the hospital, if at three o'clock in the morning, he has chest pain, he's not going to get out of bed and come down and see that patient, or if they need to have a sleeping pill. The intern or the resident is going to take care of it. The people who really want that will go up there for their care, and will not come to see me, so that there is some natural selection. The patients who accept this premise still come to see me. It's a bit more of a nuisance.

Mullan: Which is a bit more of a nuisance?

Conger: Having all these specialists. I have more access to specialists than I would like to have. You know, it's kind of like having too many restaurants to choose from. You're also more likely to eat out when you have a lot of restaurants, and I'd really rather eat home. Take neurology, for example. Neurologists, you presume, can't do anything useful. I mean, they're very smart, but they can't do anything for their patients. Well, you can prescribe pills. Well, I can prescribe a pill. So even if you need a neurologist to make a brilliant diagnosis, theoretically what would happen is you would send the patient to the neurologist. "I want to know if this patient has Parkinson's disease." "Yes." "Well, we're going to use this." "Fine." Then I can do that, and I will do that. But the

neurologist will keep them coming back also. Why? Because they need to see patients.

And you can tell, for example, in cardiology, which is the best example. It used to be that you would never send anyone to a cardiologist, because there wasn't anything they could do. Maybe listen to the heart murmur, and say, "Oh, yeah. This is--" But I can order an electrocardiogram now. I mean, you don't listen to the heart anymore! But now what happens is, you send someone to a cardiologist if I want them to have a cardiac cath. That's the only reason I do it. Now, the cardiologists who have been around for a long time will then immediately be done with them. Why? Because they want to go back in the cath lab. But we have more cardiologists than we know what to do with. So some of them aren't quite busy enough. So they're going to see the patient to follow-up, and they're going to adjust his medications for congestive heart failure or his anti-hypertensive medicines. They won't say, "Don't see Dr. Conger." But then, at that point, I have to say, "Well, what's the point here?" And so I'll say to the patient, "Look, there's no point in you seeing both of us." "Well, but I want you to be my doctor." I said, "I understand that." They don't mind seeing both of us, but it gets to be a bit of a nuisance, and that's the worst it gets. I will sometimes say to the patient, "I don't think you should go back to see the cardiologist anymore," and they will say, "Fine," because their primary bonding is with me. But it is a bit of a nuisance, because I don't like to do that. And so I have to write the cardiologist, and say, "I've made this change in the medicine, and I'll follow them."

Mullan: In the last two or three years, as primary care has become, at least in policy circles, and to some degree with medical student choice, more popular, have you seen any change in behavior, other than physician to patients?

Conger: No. I think that what is the current definition of primary care--now remember, I'm really in a backwater here--but at least my view is that the current definition of primary care is really primary triage. Take an institution like Hitchcock, which now has, I think, seven or eight hundred doctors. Their view of their primary care component of this is to bundle them in specialists, and that if you're sick, you really should see a specialist, because, you know, they're smarter, and that's true. As I was saying to a medical student, I said, "You know, there isn't any disease for which there's someone who is not smarter than I am." I'm using too many negatives, but you understand what I mean. There's always somebody smarter than I am for this disease. Therefore, I could always send somebody to somebody else for anything. That's not what I choose to do, but I see what's cropping up here more commonly.

There's a group practice, which was established in Woodstock, of younger physicians. They don't even come to the hospital. Somebody gets sick; they send them to the medical center. If somebody has chest pain, they send them to the cardiologist. And they're quite content with that relationship. Now, that person has a primary care doctor, but the primary care doctor does substantially less with that patient than a GP, and less than what I would say as an old-style internist. My partner is fond of saying that we are dinosaurs. You know, we once ruled

the earth, but there's no longer enough of a habitat for us, and we're becoming extinct. A younger internist in these days, at least from the ones that I've seen, they're not going to ever set a broken bone. They're not going to take care of a patient in ICU; they're going to transfer him to the cardiologist. We don't have a cardiologist here, so if we're going to have ICU patients, I've got to take care of them.

Mullan: Does the arrival of family practice on the scene make a difference? Has it made a difference?

Conger: It hasn't made a difference to us, because we don't have any family practitioners in this town. It has made a big difference to the pediatricians.

Mullan: In the sense their patient population now is being competed?

Conger: Yeah. See, my families are grown-up families, by and large. If there's a thirty-year-old person who wants to see me, that's fine, but they're going to see me once every ten years. My patients are over sixty-five. Their families are sixty-five-year-olds. They don't see a family practitioner as offering anything different from what I do. The big difference is, in the younger population, where the parents of children want to see the same doctor, and under our system, that means two different doctors, and it might mean three, once you get pregnant. The people who choose that have made a substantial difference. But my patients don't get pregnant. I can't remember the last time

I--well, I shouldn't say that literally. Very few of my patients get pregnant. Very few of my patients have family members who need to see a pediatrician. So a family practitioner basically offers the same thing that I do.

Somebody in this town might choose to see a family practitioner, but not likely, because they'd have to travel twenty miles to do it. We considered bringing a family practitioner into our group, in which case that person would function the same way we do, as basically an adultatrician. I think what the family practitioner has done, at least in this area, and it probably is different in really rural areas, you know, like remote rural areas, has increased this concept of triage, because the family practitioners in this area are not likely to take care of sick patients in the hospital. They do well-patient check-ups.

The biggest difference, really, has been that there's whole specialties now in dealing with people who aren't sick. That's allowed you to practice a whole different--I mean, when I came here, and I wrote about this, it really was not a joke. The doctor who I replaced, who was a smart, retired GP, when somebody came in for a check-up, he would say, "How do you feel?" And the patient would say, "I feel okay," and he would say, "You look okay." Because he didn't have time for well people in his waiting room. He had lots of sick people that he had to take care of. Now I see a lot of people who are not sick, who want to come in for a physical. Now, I can say to them, "Don't come in." And over the years, I've said that more and more often. Why? Because my practice is busier. But when they first came, and I wasn't very busy, I wanted to see them. I mean, how many

pediatric visits are there now per year? I bet you it's doubled or tripled since what it was twenty years ago. Why? Because you've got more pediatricians.

I mean, cholesterol hadn't been invented, virtually, when I was in medical school. If you had a case of high cholesterol, it was an interesting case. You'd call people. You know, they had huge globs of fat hanging from their eyeballs. You know, they had xanthelasma, their cholesterol was five hundred. Big hoopty-do. Now, everybody is potentially a patient, because we lower the cholesterol standard so that nobody will pass, which means what? There are people trooping in and out all the time who aren't sick. They get used to going to the doctor on the premise of not being sick. When they get sick, they think, "I've got to see a different doctor. This is not my doctor for sick. This is my doctor for cholesterol, and blood pressure, and maybe Pap smear."

So that's what family practitioners do a lot of. That's what younger internists do a lot of. They talk to people about health maintenance and things. But when you actually get sick, which is what doctors used to do, you go to the specialist. And since everybody does get sick, I think it's doubled the output.

Mullan: You're describing the system; you're not endorsing it?

Conger: Not at all, no. I'm not endorsing it. I don't know if it's possible to go back. I mean, I don't know anything about sort of the output, and what's happening. Well, I know a little bit about medical school, because we have medical students that

come down here. They designed this track in my specialty, what's called general internal medicine.

If I look back on my training, I would say that my most valuable training was the training I did in the hospital with sick people. The stuff with outpatients, you can learn as you go along, because it's not as urgent. And what's happened is, that in my specialty, that the idea of an internist who becomes a primary care practitioner taking a different track, that track is, stay away from sick people. Learn more about cholesterol. I didn't know anything about cholesterol when I graduated from medical school, except that it existed, and that there were some lipid disorders which I can't even remember now. But we didn't have drugs, so you could treat very easily. We didn't bother about it. I mean, hypertension--the VA study on hypertension was just being invented. PSA. I mean, you know, you can do a lot of things now with people who are perfectly healthy, and it doesn't require any knowledge of disease. I would not want to be doing that. I personally enjoy that, but I think the concept of primary care is not the same as what it used to be, and the people who think that that's going to reduce the use of specialists, I think, are sadly mistaken, at least based on my experience.

Mullan: Because you're describing primary care as a sort of triage, education, health promotion.

Conger: That's exactly right. There's a component that's been added, because, I think, if you were cynical you could say it's because we have too many doctors. We didn't have enough sick

people to go around. Even with inventing specialists, we had to find something more to do, and what we invented was diseases in well people. You come in, and I put this cuff around your arm, and I pump it up, and I say, "You've got hypertension." They say, "Well, that's the silent killer." Now the fact that everybody's going to die, and that there may be a point in your life where having a high cholesterol is the best option available to you, because you'd rather die of a heart attack than get Alzheimer's disease, is not an option that's discussed, although I bring it up.

I had an eighty-nine-year-old woman come into my office and ask to have her cholesterol checked, and I refused. She said, "What do you mean? You can't refuse." I said, "No, but can I talk you out of it?" She said, "Well, I don't want to have a heart attack." I said, "Why not?" "Well, I don't want to die." I have a whole chapter on this in the book. I said, "What are your options at this point? You're eighty-nine years old. Do you want to have a stroke?" "No, I don't want to have a stroke." "Well, then we could treat your blood pressure, but your cholesterol is not going to make you at more risk for having a stroke. So high cholesterol is the best thing you can have, because if you want to die--how do you want to die?" "I want to die in my sleep." "Well, how do you die in your sleep?" "Well, I don't know." I said, "Well, your heart stops. You need to have a heart attack. This is what you want!" I'm joking, in a sense, but in another sense, I'm not.

Anyway, so what happened was, students come in my office, and they're not interested in a patient I've got in the hospital now. He's a guy who's had a stroke, he's got renal failure, he's

got pneumonia, he was in septic shock, and I'm happy as a pig in shit with this guy. And he's an alcoholic! Boston City Hospital. Jaundiced, you know. Well, this guy wants to talk about cholesterol--the medical student. Not this patient's cholesterol. Or how do I feel about screening for prostate cancer? And my answer was, "I don't feel about that. It's not a very interesting subject to me. I'll do it or I won't do it, but it's not very interesting to me." And yet we have huge debates about it. Internists, they're against screening for prostate cancer. Now, we're in favor of a rectal exam, but we're not, because it's not cost-effective. I said, "It's very simple to me. If somebody wants to have a PSA, I'll do it. If their insurance doesn't pay for it, they can decide whether it's worthwhile. And I will discuss it. Well, it depends upon whether or not you want to find out if you have prostate cancer. It might help you; it might not. That's the end of my discussion."

[Begin Tape 2, Side 1]

Mullan: Dr. Conger. Tape two, side one.

The point you make about the expansion of medicine into wellness is something the nurse practitioners talk about at great length. They have defined primary care in that orbit--a less diagnostic, a less therapeutic, and more educational, supportive role, and that's what they kind of cleave to when they talk about they're doing primary care independently or under supervision. I think, essentially, I hadn't thought of it in terms of family docs and others, but certainly the internist, who, in fact, such

as yourself, does primary care, or what you might call secondary care, really carries over with the very sick patient, as well as the ambulatory one, is on tenuous ground. This is your dinosaur point, I think. I gather there's about to be an article in the *New England Journal*, by somebody who is seriously proposing that we adopt what I presume is something like the German model of inpatient and outpatient doctors, and just cleave it simply and permanently that way.

Conger: I think something like that is going to happen. I have said here, and I believe, that we have a cohort. Four of my partners, we're all within three years of each other in age. We all were trained in the era when internists were the proverbial king of the heap. Before, specialists were beholden to us, not the other way around. And we still, with some degree of variation, see that a substantial part of the reward of our practice is really sick people, who eventually die. As I said to the patient, "You know, if I treat you long enough, only two things can happen. Either I die, or you die." So that you deal with sick people, and you recognize the futility of it, because they're going to die, but you still fuss at it, because that's what you do.

Now, that's much less common, and I think you're quite right, that the evolution now is towards primary care being a very distinct thing from secondary care. You could really define primary care as wellness, and secondary care as sickness, and then tertiary care as special sickness. I know a lot about what happens with the family practitioners in our area, just because we know each other, and I know about how the hospitals work. I

get most of this from talking with the surgeons. But what the surgeon says is that if an older patient is sick, the family practitioner is going to refer the patient to Hitchcock. There are large numbers of clinics here, which are owned by the insurance company, CHP, in which the doctors work entirely in the clinic. Now, that's actually how I started my career at San Francisco, nineteen years ago. But when I came here, this kind of opportunity was very common.

I don't see anybody replacing me who will want to have the kind of practice that I have. I don't think that's necessarily bad, any more than the fellow I replaced used to deliver babies, and give ether anesthesia, which I would never dream of doing. I mean, medicine is--well, as you know, it is so many things now. It's kind of like cars. You start off with a small car, and it keeps getting bigger and bigger and bigger, until you have to have a new model come in, which is small enough to fill the need of the old one. As medicine keeps expanding, the thing is, you don't really need medical school to do wellness, and I think that's the sort of waste of it. I mean, the family practitioners. many of them, I think, are overtrained for what they do. Yeah, overtrained is perhaps a good word.

Mullan: I think you made a strong argument that the narrow general internist and the narrow general pediatrician is overtrained for what they do.

Conger: Okay, you're right.

Mullan: A family doc who is delivering babies, and who is taking care of kids, and in the nursing home, has a span of knowledge. But I can tell you, as a pediatrician, who was trained in the old days before you called it a general pediatrician, but essentially was trained for three or four years postgraduate, to do ears, and rashes, and an occasional Stevens-Johnson [phonetic]--but that's the rarity--and your bread and butter is fairly simple stuff that a nurse practitioner could do. I think those are the folks that are, in some ways, on the weakest ground in our system.

Conger: Yes, you're right. And certainly the family practitioner who does the full spectrum has to know a lot of stuff. It may not be--"intense" is not a good word to use, but I think you're quite right. I think all internists are dinosaurs. I mean, we should basically disappear quietly into the sunset, and remember the days of Osler [phonetic], and all those people. Let them put up a monument to it, and be done with us. And maybe pediatricians are not far behind in that category. This general internist stuff is just, to me, neither fish nor fowl.

Mullan: Well, let's stay on that for a moment, because that's an important point. The general internist who does the kinds of things that you continue to do, and does not duck them, who is not afraid to do GYN care, who is not unwilling to do GYN care, is not afraid to take on some simple orthopedics, obviously you don't consider that irrelevant, because that's what you do, but do you consider that not what the general internist ought to be, or what they're talking about when they talk about the general internist?

Conger: I don't see any necessity for reproducing me. There are enough options. That's an issue that I don't know enough about, but it seems to me that you're creating--you know, it's kind of like a bicycle issue to me, I bicycle a lot, and I have two bicycles. I have a bicycle for on the road, and I have a bicycle for off-road, a mountain bike. Well, they have a hybrid bicycle, and I don't think it's good for either one of them. It's probably okay in New York City. And I think that's what you're creating. I mean, why do you need this extra category of general internist?

Mullan: So are you endorsing the notion of an ambulatory physician, and a series of specialty-oriented inpatient physicians? Because it seems to me that's what you're subtracting out, if you pull down your flag.

Conger: Well, I would like to go back twenty years. I would like to see my type of person continue to exist, because I think it's a good thing. I just don't see how it's going to happen.

Mullan: Well, if you curtail the specialty population--

Conger: That's true.

Mullan: --and you limit the use of specialist activity to highly complex, very new, and otherwise cutting-edge or intricate kinds of things, and you train your generalist population, however it's defined, and groom to take on both the front-line and the secondary kinds of more intensive care, it seems to me that's a

model that's viable. It does depend upon snuffing the growth in the specialty population.

Conger: They're like crabgrass. If you kill off the other stuff, they'll sprout up again. Unless our society is willing to say, "This is how many cardiologists we need in this country, and this is how many neurologists we need," then there'll be a need for us again.

Mullan: I think the health care reform experiment, or epoch, would-be epoch, or would-be health care reform epoch, proved that we are unable, I think unwilling, but certainly unable, as a society, to make tough and definitive decisions, or put that kind of decision-making power in the hands of some party, and that would have to be the government. So what you're left with is either no regulator, in the sense of controller, governor, or some kind of business-oriented regulator or governor. I think that's what managed care is, and I think one of the better aspects among the many complex and often negative aspects of managed care is in the collective, it will have a dampening effect on the market for specialty services, and therefore, presumably, drive the reaction back towards generalists and away from specialists, in terms of what people coming into medicine choose.

Conger: That's true. I think you could still do without the internist. My fundamental belief about medicine is that you learn medicine as you go along. I was talking to somebody from a local newspaper the other day, who was asking me about my

practice, because I'm sort of known around here. Most of the things I learned in medical school are absolutely irrelevant at this point. Now, not everything, but, I mean, a lot of things in physical examination have been replaced by tests. I use a lot of drugs that I never even had choices for before. The ones I had before, I don't use.

I mean, it's such a dynamic process that the product you produce after four years of training, even, has a half-life of what? I mean, you could even measure this. How long is that degree of training relevant to what you're doing? Not very long. So that if you say, "We're going to have two groups of doctors. We're going to have specialists, and we're going to have non-specialists." You've got to call them something. I don't care what you call them. And if you start curtailing the specialists, the non-specialists will take up the slack, and we'll start doing more.

I mean, when I came here, I started doing things I hadn't done before. Why? Because there was nobody else to do it. So you don't have to worry about who you train, as long as you make that separation, and it's almost cleaner to say, "Okay. I don't care." I mean, "general practitioners" is a nice word, but you can't use it. Family practitioners and specialists. The internist still is--we really are archaic, literally, because we evolved in the day when it was important for a doctor to go around and make a diagnostic pronouncement. Well, you know, that doesn't really exist so much anymore. An internist is probably no smarter in making a diagnostic pronouncement than anybody else, because you think of all the possible possibilities, you

look it up on the computer, and you order all the tests, and that's very commonly what occurs.

So I think you can still separate out, and there's a real question, I think, about whether or not well patients should be--there's a certain conflict of interest for doctors of well patients. It's almost better for well patients not to come to doctors. I mean, if you'd had wellness--I hate the word, but I can't of anything better to use right now--we call them "the pre-sick," let's say, or as "the yet-to-be-determined diseased." But those people really shouldn't be--I mean, the irony is that chiropractors could do as good a job, if not better, than anybody else in that, and a lot of them do, if they just get away from the manipulation stuff.

Mullan: They'd do a better job in--

Conger: In preventive medicine, because they can't prescribe drugs. See, you take away the privilege of prescribed drugs, and all of a sudden, your focus changes, because then you can't talk about anything else but prevention. But anyway, leave that aside. If you want to use nurse practitioners, or physicians' assistants, you certainly don't need hospital training to manage cholesterol, hypertension, Pap smears, PSAs, physical examinations, whatever you want to call them. If you want to include that in doctors' bailiwick, fine. It depends on how much focus you want to spend on it. But I think you could say, "We're going to train doctors to do primary care, including illness, and we're going train doctors to do specialty care." Then you can just start cutting back on the specialists, which, as you say, a

large managed care organization will do. And I'll bet--I mean, not only does hospital utilization go down, but I'm sure that the primary care doctors in those settings wind up doing more. I don't know that, I'm just guessing.

Mullan: That's a good question. I don't know. Let me change directions, if I could. As you have matured into your practice, in the state it's in now, what do you like best about it? What continues to satisfy you and turn you on about what you do?

Conger: It's just the interaction with people, who happen to be patients. I still have to admit that there is a part of me that's on the side of the disease. Somebody comes in and they have an abnormality, and I get a little excited. The problem is that I know most of these people, I've known them for a long time, so that I really don't want them to get a bad disease. I had a medical student with me one day when somebody came, and they had a chest X-ray that was a little bit unclear. It looked like there was a spot in the CAT scan. It turned out to be a nodule. The student was all excited. I said, "This person's going to have lung cancer. This is not very exciting to me." "Oh, yeah, that's right." Or the student feels an enlarged liver, and the student's all excited. "I've never felt an enlarged liver before." But this is a bad thing to feel. I said, "If your sister had this, you would not be tremendously excited."

I've lived in the community. I know everybody here. I know my patients. They're glad to see me; I'm glad to see them. If they come in with a sore ear--Friday, I saw a woman with a sore

ear, who was terrified. She's on chemotherapy, she's afraid. I looked in her ear, and it was okay, and she felt great, and I felt great. I like that. I have to have a certain amount of sick people to fuss with, or I feel that I'm betraying my training. But I don't need a lot of it, you know. I mean, I don't even need it every day. It's just a lot of fun to interact. People, you know, they give you so much benefit of the doubt, compared to anybody else, even religious people, I think. People want to give you credit for doing things well. I can make as much a fool of myself as I want, and people won't mind. I march in parades with these crazy outfits on, I write crazy stories in the newspaper, and because I'm a doctor, people like me.

Mullan: You clearly had a phase when--I'll call it politics, but that doesn't quite do it justice--when activities that would relate to change in the big picture were important to you. That is quite different than how you're spending your energies now. How do you square the Beach Conger then with the Beach Conger of today? I don't mean that to put you on the defensive at all. What's the relationship between the two?

Conger: I don't know. I guess it just turned out that I like this better. I like the other, too. There's a lot of actor in me, that's what it is, and medicine involves a lot of acting. I'm a ham, and I'm good at it. You can't practice that as well when you're setting policy. You can't crack jokes when you're trying to solve the problem of infant mortality. But somebody comes in to me, and I can crack jokes to them all the time.

"That's funny." It's as simple as that. But, you know, I can act out more the way I like to act out in one-to-one with a person, and the ones who don't like it go to my partners. I've got very serious partners. But I can joke with my patients. I can joke about their dying, their cancer.

I have a patient in the hospital who's got leukemia, and he wants to die. And every day he comes in, he says, "How come I'm not dying?" I said, "I don't know why you're not dying. I've done everything I can do. You've got plenty of time to be dead. What's the hurry?" Now, that's sort of fun for me. I couldn't do that if I were doing policy. You can't write that kind of thing in a policy. So that's probably what it is. But if somebody said to me, "You know, we'd like you to do some of that, and you can do this," I'd still enjoy it.

Mullan: Have you been active at all in local politics or medical politics?

Conger: Not the latter. I was active in local politics for a while. I was on the school board for six years. That's pretty local politics. I was the chairman of the school board, and that was sort of fun. I did that for a while, but you can only do that for so long, and then you have to either decide to go on to something else. The politics part, I don't have much truck with. What I really enjoyed was the problem-solving, which is probably what you enjoy. We have very serious problems, and trying to solve those, I mean, if somebody wanted me try and sit down and solve this problem we're talking about, about the specialists, that's to me a very interesting problem. I'd love to say, "Gee,

I'd like to work on that." And if I really felt I was trying to solve that problem, or solving the problem of, you know, whatever it is, whatever public health issue it is, access to health care, abortion, prevention, whatever it is, those are interesting to me, to solve. But it isn't quite as much fun for me as the one-to-one with patients.

Mullan: What are you going to do for the next twenty?

Conger: Well, I'll be here. I'm fifty-five. I think I will practice here until I retire, because, at this point, there's nothing else I really can do. I'm at the top of the heap here, both professionally and personally. I have an excellent practice. I'm the senior physician here. Everybody looks up to me, except the people who can't stand me. It's a very small pond, but I'm the biggest frog in the pond. It's a tiny pond. [Laughter] If I went into a bigger pond at this stage in life, it would be difficult.

I would like to write a lot more. I figure I'll practice for ten more years, and then if I'm in good health, I'll cut back in my practice, and start writing more.

Mullan: Tell me about the writing. Is that something that seemed to sort of come out of--

Conger: It came out of nowhere.

Mullan: Mid-eighties?

Conger: It must be something--my parents were both writers, as I said. The mid-eighties--well, what happened was--literally, what happened was, we had an outbreak here of legionella. We had two cases. Now, remember, I'm an ex-EIS officer. This was just sort of after it was being discovered about cooling towers causing things. This is sort of one thing I keep up with. I get my MMWR. Anyway, we had a patient in the hospital. We made the diagnosis of the patient. I made the diagnosis of legionella. We had another case, we found the source, and we set what was called the world's record for identifying the cases, and the source, and solving it. It was a matter of two weeks. Now, of course, we [unclear]. Anyway, there was a big press conference about it--big, locally--and the hospital administrator said, "Well, would you talk about this?" Because most people in town don't care about the hospital, but legionella was a big deal. They had an outbreak up at the medical center in Burlington. So I said, "Sure."

So we had a press conference, and people asked me some questions, and so they started asking me questions, and I sort of started joking about it. I said, "Well, this is sort of nature's revenge. What happens is, you start taking all these people, and putting them in buildings, and Nature says, 'This is not what you're supposed to be doing,' and so it's got germs to try and combat you with this." So there was a guy there from the local newspaper. He said, "Well, you know, you've got sort of a strange way of looking at things. Will you write an article about this?" So I did. I wrote an article about it. Then they put it in the newspaper. They said, "Well, would you want to write some more?" and I said, "Sure."

Mullan: Which is the paper?

Conger: It's called *The Valley News*, and it's probably got a circulation of, I think, around forty or fifty thousand. It covers the eastern part, north--well, it covers a corridor of maybe thirty miles long, and twenty miles wide. It's sort of centered in the Lebanon and Hanover area. So I said, "Sure." He said, "Well, send me a couple of samples, and I'll see about it." So I wrote a couple of articles. I wrote one on herpes, and why doctors lie, I think. I've forgotten what they were. A couple were sort of whimsical. And I sent them in, and so he said he liked them.

So every other week, I would submit a column to the local newspaper. It was called, "The Second Opinion," and it was never serious. Although I do believe that even though I was never serious, I was always telling the truth, and I was trying to make--it gave me a chance to ham it up, in print. I discovered I was pretty good at it, and I did that for about--well, I started out in maybe '83, for three or four years, and then somebody said, "Well, maybe you should put those together into a book." And so I said, "Sure."

So I took some of the ones that I'd culled, and I sent them to a publisher, and he said, "Well, I don't really know how we're going to use this. There's no market for it. But maybe you want to write it into something that fits together." So that's when I took the articles, and put them into this sort of diary that, theoretically, is my first book. Then I was off and running, as it were.

Mullan: Who did the hardcover?

Conger: Little, Brown did the hardcover. Of course, it sold very well, and still sells very well around here. In Vermont, it's pretty well known. In New Hampshire it's sort of known; Maine it's sort of known. Beyond that, some people know about it. Then I wanted to write another book. I took about three months off to do that.

Mullan: Dust jacket expert.

Conger: Well, but you never can tell. That happens to be true.

Mullan: You went to Norway?

Conger: I went to Norway. Well, we had a really Jack Spratt situation here. My wife, she's Norwegian, she wanted to go and be with her family, because her father was getting sicker and older. She didn't see him enough. My daughter was in the fourth grade, and she really wanted her to have some more Norwegian culture, so she was going to go for the whole school year, and live with her grandparents. We were all going over for a while. I'd been here about ten years, and I figured I could certainly take a sabbatical, if you want to call it that. So she had a contract with a local law publisher to publish a book on family law in Vermont, which is a fairly special interest, but they do that, sort of for a lawyer who's practicing in Vermont, wants to open up, and says, "What do I do?" That was her specialty. So she had a contract; they paid her to do it. I hadn't done

anything, but I wanted to write a book. So we went over to Norway, and I wrote, got my book done. She just couldn't get hers done. So, as I said, she had the publisher and no book, and I had the book and no publisher. Then I came back, and it took about, I don't know, six months or a year or so, before I got a publisher. I finally got an agent.

Mullan: How has that done?

Conger: It's done well. I mean, I wouldn't retire on it. As I say, the paperback is still selling. One of the bookstores here sells about five hundred copies a year.

Mullan: That's the [unclear]?

Conger: Right. The second book hasn't done as well. I think, partly because it's the same. It's a smaller publisher. Little, Brown didn't want to do the second book. They were taken over by Time, Inc., and they could've been less interested in something like that. Also, it's not as original, in a sense, because it's a repeat. Most of them from out of here bought the first one, and bought the second one, so I think I sold eleven or twelve thousand copies in hardcover, of the first one. This one's in its second printing, but it's about five thousand or so.

Mullan: That's good. Are you continuing to write?

Conger: I'm continuing to write. I'm not writing as much. I've got a pile full of things I want to write about. Like this guy I

told you about with the leukemia, I've got a great story for him. You know, the person who's waiting to die, and, you know, he's sort of tapping his foot. And he feels great, and his family's saying, "Well, we have to do something." And the oncologist, who he went to see, says, "Well, he's got to take--" This guy's seventy-eight years old, and he's having a grand time dying. I said, "This is the way it should be." He's also very, very clever. He's done some writing, and he has a wonderful sense of irony about these people who come in who want him to keep living, and he doesn't want to do it. Anyway, it's just a good story. I've got a whole bunch of them like that, but I need to take some time off to do it. It's just up to me to do it. I probably won't do it this year, but next year I'll take some time off and start writing again. I do a little--you know, you can't do it for an hour or two at a time.

Mullan: It's not the way to do it.

Conger: Right.

Mullan: Tell me about family life. Catch me up on that.

Conger: Well, let's see. I married Trina in 1973, and we have one daughter, who is now twenty-one years old.

Mullan: Is this picture--

Conger: That's her picture there. She's at Middlebury College, and is a skier, cross-country skier, actually has done very well.

She's going to become a teacher. She's fantastic. None of my kids have any interest in anything remotely resembling medicine, although, my middle daughter--this is my middle daughter and my son, over here--she got very interested in--last weekend, we had some friends visiting, and she had an infected cyst, and so I drained it, you know, on the dining room table. So she said, "Maybe I should become a doctor. That looks like sort of fun."

Mullan: How old is she?

Conger: She's twenty-five.

Mullan: What is she doing?

Conger: She is a consultant for an outfit called ABT Associates. Do you know who they are?

Mullan: Health policy, among other things.

Conger: Exactly. Well, she's certainly inherited her dyed-in-the-wool liberalism from her mother and me. She just wants to do good in the world, and she's a little frustrated that she has to do it--she's superb with computers and mathematics--that's her mother. So she likes to see her work as being politically useful, by proving that good things do work. How long she'll stay working for this organization, I don't know. She just graduated from Michigan School of Public Policy, and just got this job last September.

And my son, who graduated as an engineer, from UVM, is twenty-nine, and he kind of lost interest in engineering after a few years, went back to get a teaching degree, which he did last year, and is going to be teaching math and science in a middle school with twelve kids, right around here, in Sharon. So he lives nearby. He lives in a barn. He's very much into low-overhead life, and he's really excited about teaching. So I've got two teachers. And my daughter's a superb linguist. She speaks Norwegian, English, French, and Spanish, fluently. So she wants teaching foreign languages.

Mullan: And your wife, does she have a law degree?

Conger: My wife is a recovering attorney. [Laughter] She's probably recovered, actually. She got her law degree here. She went into private practice, which is not what she wanted to do, but you're sort of stuck here. One of the problems in the country is you sort of feel left out of the real problems of the world. She went into family law, and had an extremely busy and successful family law practice, which, you can imagine, can be very unpleasant, at times. She does a good job. Her job was to make sure that nobody was satisfied all the time. So she left that, and she became a family court magistrate, which is sort of the family court judge, at a lower level, in this state. She set up that system in the state in 1990. She did that for four years, and it got to be sort of the same thing. She said, "I just can't stand it." Because, by definition, you don't see the reasonable people. They don't ever come in front of the court. They solve their problem--so it was just so unpleasant. So she

decided to give it all up. She got a fellowship from what's called the Casey Foundation--do you know the Annie E. Casey Foundation?--which she did last year, and then decided she wanted to stay out of the law, and wanted to make the world better for children, and solve those problems. So right now, she's working for the Department of Children and Youth Services in Providence, four days a week. This is one of things that happens in this part of the world, is that if you have high aspirations, your families start moving further and further apart. So she leaves on Monday morning and comes home on Thursday night. It's hoping that a job will open up in Vermont, which is sort of similar, which it may. But she's kind of festering right now, because in her stage in the career, to do what she wants to do is going to mean moving around from city to city. I'm in the peak and decline of staying here, but she doesn't really want to leave this area either.

Mullan: How about your first wife?

Conger: She's a municipal court judge in Berkeley. We get along very well, probably better since we've been divorced than when we were married. She remarried. She remarried twice, actually, and this second one, I think, is going to stick. I still go down and visit her; she comes out here and visits us. She went to Boalt. She's a bit of an actor.

Mullan: She went to Boalt?

Conger: Yeah, Berkeley Law school. It's called Boalt. It's Cal Berkeley Law School. We moved there in '71, and she's been there ever since.

Mullan: Quick question. Could be a long one, but give me your quick snapshot of the future of medicine, twenty years from now. What will it look like? Particularly with the generalist perspective.

Conger: I'm not very good at looking in the future, but I would guess that within twenty years, we're going to evolve towards the kind of thing you were talking about, where you're going to have a real separation between outpatient doctors and hospital doctors, and where the management of care, at that point, will still be focused on controlling the dollars, rather than the personnel. Now, I suppose it might occur, as you said, that if insurers become large enough, which I assume is what's going to happen, then they can, in effect, control that by the number of people they take on their panel.

But the big issue is what the federal government is going to do. I don't follow this, but I would assume that they're so far and away the biggest payer--I mean, they are for me--that I don't see them as likely to do this. So I think we will spend more and more money on medicine, which I think is a good thing to do. What better ways to spend money than to see doctors? And that specialists are not going to be substantially eroded in the next twenty years. The problem in this country is that you're really going to have to have a dramatic change of ethic, because they find things that work better. I mean, you go to Norway, and the

specialists are kept under wraps, so they don't find things. They're working hard enough. They can't go out and invent new procedures and stuff. Even if they're available, they can't start using them, because there isn't enough time.

But in this country, they're just always finding new stuff to do. I mean, new ways of operating on the prostate. Look at laparoscopic surgery. Was that a real advance? Hell, I don't know. It certainly reduces morbidity of cholecystectomy, but I bet it's increased the number of cholecystectomies. I mean, now I'll come in, and it happens. People who wouldn't operate on them before say, "Well, we can do it now, because it's not as big a deal."

Mullan: I think we're going to have to get better at measuring that, because you look at any kind of technology--you look at the explosion in cesarean sections. Did it, in fact, eliminate morbidity or reduce mortality? The debate on that, as well as I understand it, is that it's not clear it did that. In fact, it created certain morbidities of its own, related to the much larger number of women who were being surgically handled. So there is a patent, apparent, often glitzy benefit of a new intervention, but when you really measure that across population well-being, does it really pan out? And I think we're not very good at measuring that, but at least it's suggestive. You haven't seen, for the investment in new technologies, any kind of measurable benefit. There's exceptions, obviously, but if you look at the statistics, they're not making us live longer, and they're not making us--

Conger: Live happier.

Mullan: --live happier.

Conger: Well, I think you're absolutely right. The best example is this guy--I mean, if I develop leukemia, there's no way on earth I would want to be treated. I've seen too much. You know, okay, I'm not willing to get an extra six months out of life to go through that. I'm not saying somebody else won't, but this fellow in the hospital with leukemia, who doesn't want to do it, is being hounded by his family and relatives. Our ethic is not able to take that approach you're talking about. I don't see that. And if it's going to come through the political process, it ain't going to occur. Because we have this fascination--which, I mean, it's sort of like we have a fascination with the automobile, we have fascination with medical care.

You go to Norway, people don't see medical care this way. They see it as sort of being a mild nuisance in their life. And I think it's because it's kept a lower profile.

Mullan: We've talked about a lot of stuff, and it's been a terrific interview. Is there anything we haven't touched on that you'd like to add?

Conger: Well, I don't how to phrase this without making it sound too absurd, but I guess if you really want to improve things, you should take people into medicine who aren't quite so smart, because it's like the space--we don't need a lot of new stuff. We've got plenty, right now. Why don't we just say, "Okay, we've

got enough medicine right now. We just won't make any more improvements, and we'll live with this a while. Maybe thirty years from now, we'll start working on it again." And if you had doctors who were not very smart, you know, sort of nineteenth century doctors, then we wouldn't invent new procedures. We'd just kind of muddle along, and things would stabilize. The rest of the economy would grow, I guess. We would just sort of stay where we are, instead of taking out larger and larger chunks.

So we should lower the standards for medical school. [Laughter] You see, then, if we're stupid enough, then the specialists won't want to take us. I mean, even though they're looking to expand, I mean, as you know, specialists are extremely elite. There's nothing worse than the transition from having come from a large medical center, to coming out here. All of a sudden, I become a creature. Now, I'm used to that, but the funny thing to watch is, we took a partner who had been trained at Hitchcock. She was a resident up there, she worked down here, and she just became infuriated that within two years, she was being looked at as an LMD (Local Medical Doctor). That was her home, her home base. But, of course, within two years, there had been enough of a turnover that house staff didn't even know her.

Mullan: Good thought.

Conger: That's my final.

Mullan: Well, good. Thanks.

[End of interview]

Index