GENIA ENGLSH

August 10, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: What is your date of birth?

English: July 8, 1932.

Mullan: We're at Dr. English's house, in, I believe, it's south Cle Elum, Washington.

English: That's right.

Mullan: It's the 10th of August, 1996. It's a spectacular, hot August afternoon, in the Cascades, or on the east side of the Cascades. We're actually not in the house, but we're in--

English: I call it the "kura," which is Japanese for a storehouse.

Mullan: And it's next to the house itself, which is marvelous. In any event, we're here to talk about Dr. English's work as a family physician, and a physician over the years. Why don't we start back at the beginning, and tell me a little bit about yourself--where you were born and grew up.

English: I was born in Malaysia, in a small town called Ipoh. My father actually was a pediatrician, but functioned as a generalist, trained in Edinburgh. When I was fourteen, after the Japanese war, after the Second World War, was sent to England. They went with me and left me there--to high school.

Mullan: In England?

English: In England. Went to Oxford. This was a public school, meaning it's private. So I did my two years of schooling there, and qualified for college entrance. Did my undergraduate at Oxford University, one of the women's colleges there, called Lady Margaret Hall [phonetic], and continued on to medical school there.

Mullan: Before we get to medical school, tell me little more about growing up. Your family is of what background? Are you Malaysian?

English: No, I'm of Chinese heritage. I think my father's people went to Indonesia. My mother was from Hong Kong. She was a nurse, and met him in the course of his work, and they got married. I'm the youngest of seven.

Mullan: And then you moved to Malaysia at some point?

English: Yes. They did. I don't know when.

Mullan: Malaysia then was "Malaya," I believe.

English: Malaya, and it was a British protectorate, so we had British citizenship. It being colonial British, we always thought of schooling as being best in England, and so that's why I was sent to England. All the children, all of the seven children, were really sent away to schools, because there weren't good schools in Malaysia. So I have family in Australia, because they went to college in Australia, and a brother here in California, who went to school in Canada, to McGill, for his medical degree. So we've been dispersed. I have a brother who went to Cal Tech. It's kind of like Asian Jewish diaspora. Education was extremely important in the family, so that's the reason they sacrificed family--the sense of being an intact family--for the education and teaching of the children.

Mullan: Where in Malaya, or Malaysia, were you, and what was it like?

English: Well, this is a small town, Ipoh. I think about 150 miles north of Kuala Lumpur, which is the capital now. It's really a tin mining town. I had about three years of school before war broke out, and then much of my education, I was self-educated, reading books from my father's library, and Gray's *Anatomy*, when I was little, and things like that, you know.

Mullan: That's a hell of a picture book, Gray's *Anatomy*.

English: Yes. [Laughter] Great, especially for young people, who were curious. We had tutors who came for mathematics and Latin. I went to a Catholic orphanage to learn German, Latin, typewriting, and embroidery, because the Japanese would not allow English to be taught. So that was a very good experience.

Mullan: The orphanage had a school?

English: Yes, a school for the orphans. So I really joined in and learned what it was like to be in an orphanage.

Mullan: Was that because you were separated from your parents?

English: No, no. Just so that I could have something to be learning.

Mullan: Since there wasn't school. The Japanese occupied Malaysia during the war?

English: Yes.

Mullan: What was their attitude towards Chinese, and what was the war like for you and your family?

English: Well, because monitoring of us as a family. But other than that--I remember we had a septic tank with a drain field in a large cement cylinder above ground, we emptied all the gravel

and my Dad pub his bottles of medications in it then we replaced the gravel. We did this as a family at night to hide them from the Japanese.

Mullan: I don't understand. The medications that he had?

English: Yes. His extra stock of medicines for his work.

Mullan: So he would come and pick them up?

English: Well, he would take them in to his surgery when he needed them. But this was his stash of medications.

Mullan: Oh, this was your father's?

English: Yes.

Mullan: Oh, I thought maybe it was your brother. I'm sorry.

English: No, no. The news went around town that he was involved with the British so there was a little bit of surveillance from the Japanese.

Mullan: Was the war fought in your area at all?

English: Well, the day war was declared in the Far East, we were shopping and the car was strafed. There was a plane, and it

machine-gunned down the street, and we were just getting into the car, but we had bullet holes in the car. So that's how we discovered that we were at war.

Mullan: But once the occupation took place, [unclear].

English: No. Everybody went to Singapore, because they said the British said Singapore will never fall. And, unfortunately, the guns were pointed out to sea, and the Japanese came through Thailand, through the land, and so Singapore fell. We went by rail to Singapore, two days. Took us two days, even though it's like maybe three to four hundred miles. It took so long because the train was repeatedly bombed, and I remember diving out of the train, and how hot the earth was when it fell on me. I thought I was hit by a bullet, but, in fact, it was just earth, hot earth. So that was a very stark experience of the beginnings of war, for me. I was nine years old then.

Mullan: And when you got to Singapore, there was no--

English: Actually, the takeover was very peaceful. There was some looting and the usual things that happen in wars, I would imagine. But we weren't in danger.

Mullan: But then you turned around and came back to your village, your town.

English: Yes. During the war, we grew our vegetables. My father bought two cows, and learned how to milk. I would take the cows out to pasture during the day. They were tied up, and I would take them to a different spot each time, and I would just sit and watch the cows, and played with ants and grasshoppers and, you know, just nature.

Mullan: Was your father's medical practice an influence on you?

English: Yes, I would say so. There was the expectation that every child would be a physician.

Mullan: Every child in the family?

English: Every child.

Mullan: And how many of you were there?

English: Three out of seven.

Mullan: They're physicians?

English: Yes. It was unspoken, but Dad was a big influence in the family. He was highly respected, feared. In fact, in doing family pictures when we have orientation with the new residents, I always would draw him as a tiger, represent him as a tiger. He was never abusive in any way. He was very gentle, but an

extremely firm person. You knew what he meant.

Mullan: His influence was strong. Was the practice of medicine appealing or intriguing to you?

English: Well, as a child, he had what the British call a dispensary, which is consultation rooms, with a pharmacy and X-ray room. As a child, I would go and help with washing the bottles for the cough medicines. Prescribing was different then. You had a pinch of this and a pinch of that, so many fluid drams of this or that. As a child, it was fascinating to watch him put these things together, to smell them. In fact, when I was at school in Oxford, and had a sore throat, I would yearn for his medicines. I had been raised on them. When I had a cough, I would just miss his cough medicines. So I would say, yes, we spent a good deal of time with him. We would make house calls. We would go with him. He would pile the children in the car, and we would wait for him. And then he would be paid by chickens and eggs and vegetables, milk. Very little money changed hands. It was really a rural-type practice in those days.

Mullan: And did he stay there?

English: He stayed there until his death, yes.

Mullan: When was that?

English: It's awful that I don't remember the year, but he was sixty-one when he died. So this must have been about 1959. I graduated '58, and he knew that I had graduated. So that was a good thing.

Mullan: So the end of the war came. You would have been then about fifteen?

English: About thirteen, maybe, yes.

Mullan: And this was about when it was decided that you should go to England?

English: Yes.

Mullan: Did others of the family get dispatched at the same time?

English: Yes. One sister, the sister who is older than I am--there are three girls, three boys, and then me. I was really a sort of an accident. But the sister closest to me left Singapore just before it fell, on a ship that was destined to go to England, but it was bombed, and it was diverted to Australia. My two elder sisters were there already, in Australia. So somehow they found each other, and they were at Melbourne University there. The rest of the family were in Malaysia, after the war.

Mullan: Did your brother return from the underground?

English: Yes. And he's the one who went to Cal Tech. He went into physics, into nuclear physics, and did further training, did his Ph.D. in England, worked in Switzerland, went back to China, committed suicide. It was during a Red Guard uprising. They had thought that because he had lived with Dr. DuBridge [phonetic], who was the president of Cal Tech, that his connections with the U.S. were--that he might have been a spy, and because he had run away and gone to the British underground, that he was a British spy also. And why would he want to come back to China? So he was highly persecuted in China in those days. It was a very sad thing, because he was a very idealistic person. He would sit by the rivers, and think about how to--he was just a thinker. He was really a very intuitive, abstract person.

Mullan: So you arrived in England, age thirteen.

English: Fourteen.

Mullan: Fourteen. Did you have a family? Who was your base there?

English: No. Well, the headmistress was my guardian. Let's see, how did I ever get there? I think a friend of my mother's, from Hong Kong, was a friend of the headmistress, in Oxford, and that was the connection.

Mullan: And at that time you did speak English?

English: Yes. We were raised speaking English.

Mullan: What other languages did you speak at that point?

English: Well, you know, my mother and my father spoke different dialects of Chinese, so English was their common language. So that was no problem.

Mullan: Did you ever learn either dialect?

English: I learned a little bit of my mother's dialect, which is Cantonese, not enough to make a speech, just sort of kitchen Cantonese. I was raised in a very protective fashion. We all had amas, women who slept by our beds, and took care of us, sort of like a nanny. And when I went to England, all of a sudden, I was alone, and I didn't know the value of money. Whatever we wanted before, we had asked for, and had gotten. And here I had to budget and learn how to make things stretch out. In those days, the exchange was different. I think my parents were only allowed a certain amount each six months, of conversion from Malaysian dollars to the British pound. So even though they wanted to give me money, it wasn't possible. So I had to learn to ration my expenses.

Mullan: So you were in Oxford, in a secondary school, and then

you went on to University Hall in Oxford. When was it you decided to study medicine?

English: I think I went to Oxford High School for Girls with the mind that I would prepare for medical school. What I needed was science, which I didn't have at all. I had three years of schooling before that, and so there was a lot of catch-up to do. I worked horribly hard, just to get caught up. A big influence for me was the biology teacher, Miss Brown, who is now dead. And the other big influence was the music teacher. When I was depressed, I would sing. She would get me to sing. In fact, she got me into voice training, and I think she was really instrumental in how I adapted to life there, in retrospect.

Mullan: This was at St. Margaret's?

English: This was at Oxford High School for Girls, which is the public school, which is private.

Mullan: But it was somewhere along here that you really settled on pursuing medicine, when you were admitted to Oxford.

English: Well, I think before I went to England, even. The expectation was there. I enjoyed watching the way my father worked.

Mullan: When you were admitted to Oxford, was it to study

medicine?

English: Yes.

Mullan: And what was that like?

English: I "majored" in physiology, and I remember the day Roger Bannister broke the four-minute miles, because I was at a tutorial, and my physiology tutor had trained with Roger Bannister, and a phone call came with the news, and we didn't continue with the tutorial after that. We just celebrated.

Mullan: How were the Oxford years socially, personally, and also medically?

English: They were difficult sometimes. Very lonely, very few women. I was in a women's college. It was extremely structured. Even in high school, I was living in a private boardinghouse, because I didn't want to board in the school, where lights were out at a certain time, and I didn't like that. So what I'm saying is that I really wanted to feel a sense of my own personal control. Having to knuckle down to work was difficult for me, without family around to talk to. It was a very lonely

Mullan: Which years and which ages were these?

English: For college, that would be three years, eighteen to

twenty-one. 1951 to 1954. I graduated with my bachelor's, '54. And if you elected to do extra, you could get a master's with one extra year, and I did that.

Mullan: Was that clinical med?

English: I did that in biochemistry. It was within the honors school of Natural Science, they call it. Because I was very lonely, I met a Rhodes Scholar at a party, and his name was Tony English. We dated and got married. That's why my name is English.

Mullan: Was he a Rhodes Scholar from the United States?

English: Right. From Anaconda, Montana. Tony's father could not accept what I was. I guess he had never met any Chinese. He couldn't accept that I was Chinese. And there were a lot of problems. His father died without forgiving his only son for marrying a Chinese. So Tony became extremely depressed, and because of that, we came back to this country. He never did finish his Ph.D. A letterman at Stanford, Annapolis--really very high-pressure kind of trajectory for him, but he just couldn't reconcile himself to having hurt his father. And so we came back here and we found a therapist, and he started work at Convair in San Diego, California. The marriage was just not working. We got a divorce.

Mullan: And when was that?

English: That was 1959, '60, thereabouts.

Mullan: When had you gotten married?

English: Gee, I have to think. It must be '53 or '54.

Mullan: You were married for six or seven years?

English: Yes, seven years. Right.

Mullan: And what had you done professionally during that time?

English: During that time, I qualified through medical school, and I interned in England.

Mullan: I don't know the English system.

English: The English system, the bachelor's is part of medical school. You do physiology, biochemistry, and all the rest. And then the three clinical years. So medical school, as we know it here, was a four-year span, with three years undergraduate in the sciences--so, basic sciences.

Mullan: And then it's three years of clinical?

English: Yes.

Mullan: Isn't that six? Three and three?

English: Yes. No, it's seven, because extra year of--

Mullan: I thought you said four.

English: Extra year of master's.

Mullan: Oh, there are four clinical years, along with three undergraduate years.

English: Three undergraduate years, with one extra year for a master's, and then three years of clinical. And then after that, I interned at the hospital at Oxford, and did another year of obstetrics.

Mullan: And this was after you had gotten married, you were stable?

English: Right, right. Now, he was in the military, in the Navy, part of the time that I was going through my medical school, so even though we were married seven years, we had lived together, well, barely more than three years.

I was house officer to a hematologist at the Radcliffe Infirmary at Oxford. He was head of Internal medicine, and much

of my work was related to getting blood samples for research with obstetric patients.

So when I came over to this country, I applied to Stanford, and got a fellowship in hematology, after the divorce. Just to get away from San Diego, I went up to Palo Alto, and did a year of hematology fellowship. That was a difficult year because of my own personal problems, but also a lot to learn, with not having done internal medicine, but having a fellowship.

Being a non-U.S. citizen, and being a foreign graduate, I needed to intern two years for California State boards. I passed the boards, but had to fulfill the internship requirement. So one year was spent interning at Mercy Hospital in San Diego, and the second year in a hematology fellowship at Stanford University. This year was also recognized as an internship year. At the end of that one year of internship in San Diego, we got divorced. The following year I went to Stanford.

Following the Stanford fellowship, I went and continued a fellowship, an NIH [National Institutes of Health] fellowship, at Scripps Clinic and Research Foundation, and was in the Division of Biochemistry, in hematology. So it was bench research, purifying and characterizing a beta globulin, for two years. During those two years, I spent a lot of time wondering what it was that I wanted to become. So it was almost as though now is my beginning of commitment to medicine. I needed to have experienced those other things in order to kind of get a sense of what I wanted, for the direction that I wanted for myself.

Mullan: Which years were the Scripps years?

English: That was '62 to '64 or '65. I was staff there for a year. So during that time, Clem came down to look at a job as head of research at Scripps Clinic. I was the low man on the totem pole, and they asked me to drive and show him around. We went to the zoo and we got to know each other. I would write and ask him for samples of radioactive heme for my work, so there was some correspondence and phone calls. A year later we got married..

Mullan: Where was he?

English: He was here at University of Washington. So because of marrying him, and that's about five years' interval from my divorce to marriage to him, there was a lot of thought given to what should I become in medicine. I couldn't work in internal medicine here, because they had a nepotism rule. Family medicine was just starting up.

Mullan: "Here" being at the University of Washington?

English: Yes. With my background in England, being sort of a hodge-podge mixture of general medicine, but the emphasis of training was to be a generalist, I thought, "Well, yeah, I'll give that a try." So at that time, Ted Phillips was on sabbatical. Kent Smith was acting head.

Mullan: Ted Phillips being the chairman of the Department of Family Medicine at the time?

English: Right. Just before John Geyman came. Kent Smith had completed a psychiatry residency, I think, on top of family medicine. Kent said, "Why don't you come and work with me." I forget why there was a connection, but anyway, Kent was looking for new blood, as it were, to build up the department. So I said, "Sure, I'll come. I'll volunteer." I didn't want to have a commitment, because I wasn't sure if I wanted to do family medicine at that time. So that's how I started in family medicine. So my background, really--I'm not boarded. My background is pretty checkered. Through working with chronic diseases and dying leukemic children and their families, I got interested in, you know, what is family all about? What did I miss? How do we talk to people who have a sick person in the family? What's the impact of this on the family? Questions like that. So that got me interested in not the diagnosis part of medicine, but into the behavioral aspects of medicine.

Mullan: When you got your feet on the ground in the Family Medicine Department, that was 19--

English: 1976 or so.

Mullan: How did we get from 1965, when you met Clem?

English: Oh, you're right. Well, I took seven years off.

Mullan: Having troubles with your numbers.

English: Yes, I know. I took seven years off, to have two children. Clem and I would do research projects together. We went to Peru and did research. He consulted for World Health [Organization], and we did a lot of traveling to developing countries, and worked in different places. So there is a gap there. How can I explain that? So that was '65 to '75.

Mullan: You've done very well. Two children and a lot of travel.

English: About '75, maybe '74, I started volunteering, and just precepting, just being around and talking to the residents, working with the residents, and that type of thing. And then I decided, yes, I wanted to do this. So I came on as faculty in '76. I don't know when John Geyman came. Was that around '76? I think. Anyway, I remember that it was the same year.

Mullan: How did you feel about arriving with what you characterized as your checkered, or hodge-podge past, as a faculty member, in what by 1976 was an established discipline? How did you feel about it, and actually, how did it work? Were you able to see patients and teach?

English: Yes. You know, I owe a great deal to the way teaching happens at Oxford, which is one-one-one tutorial, and sort of almost a Socratic questioning way of teaching. I was comfortable with that, and in working with residents and teaching, that's how I would work. So I felt well accepted as faculty, even though I wasn't boarded.

My experience in internal medicine was helpful. During the internship in San Diego (that was a rotating internship, so that gave me a little of this and that). I had a lot of OB experience, and that was helpful. It's almost as though my patients who came to me, who stayed with me, were self-selecting into counseling-type patients. With time, I was seen as the person that people who had difficult patients would send their patients to. So I had that function. It's evolved that way.

Mullan: And did you teach psychosocial, in particular?

English: Only individually, to each resident, as I talked to them, as I made rounds, and that type of thing. It's not formally physician teaching at that time. We started having psychosocial, cultural rounds, because that was the time that the boat people came over, and a lot of questions about, "How do we view the patient in the context of their culture?" So I got interested. I've always been interested in anthropology, so I got interested in the context of the patient. I think that was probably the beginnings of what I'm doing now. There was a man from Harvard called Arthur Kleinman, who was a psychiatrist, who

ran these rounds.

Mullan: Which rounds?

English: The psychosocial, cultural rounds. He was very influential for me. He went to China, worked in China, and could speak Mandarin, and he understood the Asian point of view pretty well, and he interpreted a lot of things for the residency.

Mullan: At Seattle?

English: At the Family Medical Center, University of Washington, down in Seattle.

Mullan: So he was influential?

English: Yes.

Mullan: So tell me, from 1976 on, what you did, how you spent your professional time.

English: I was part of the residency, and when Clem's lab moved to Providence, which was 1980, I think, or '81, I moved over to Providence Hospital, and that is one of the network residency sites, with a strong affiliation with the university. But while I was there, I worked mostly with a psychiatrist, coordinating behavioral science. So that was really good for me, in that I

started something new for myself. Much of what spurs me is curiosity. I had to learn a lot in order to fulfill that role, and a lot of clinical behavioral skills were through Wayne Katon, who was professor of psychiatry, who was working with me there. My training really is not formal. Much of my background is not formalized, and that's my style of finding out things without going to school, as it were.

Mullan: Consistent right from four years old.

English: Yes.

Mullan: So, from 1980 on, you were on staff at Providence Hospital, teaching in their family medicine residency. And that's where you remained from 1980 to--

English: 'Til '88, I think. Then we started building the house here. I took two years off, and I heard then that in Yakima they were starting a new residency--they were re-starting a residency, which had folded, because there was lack of support from the community, and funding was difficult. So this new residency is funded by the two hospitals there. It's not funded by the university, just affiliated. The new director had been one of my residents at the university hospital, so I know him well.

Mullan: Who was that?

English: Mike Maples. A young man. So, Wayne Katon, the psychiatrist, said, "Did you know that they're starting this?" I said, "No." Wayne would come up and visit me here, with his family, and one day he told me this. He said, "If you're interested in helping out, why don't you give Mike a call?"

So I did, and I said, "What are you doing for behavioral science, Mike? Have you thought about it yet?"

He said, "I'm still struggling with internal medicine and obstetrics curriculum."

So I said, "Well, let's get together and talk about it." So that's how I landed in the job that I have now. What I do now is I coordinate behavioral science.

[Begin Tape 1, Side 2]

Mullan: This is Dr. English, tape one, side two. Continue.

English: Since I did not know any of the psychiatrists or psychologists mental health people in Yakima, my first task was to really get to know them and for them to know me. Since there's no university there, you have to find people who would teach, and so a lot of that was just facilitating relationships, to begin with. So we spent two years, almost, sort of gearing up for the residency program, preparing for it. That process was very challenging, very exciting, and it brought me to know the community physicians there.

It's a different kind of work, really. I ate a lot of

lunches with a lot of doctors, found out what they did, whether they would have the mind-set, or the willingness, or the capability to teach, and sorted them out by trial and error. They would all be invited to give talks and residents would evaluate them.

We're at the phase now that we know what we want to do. It's the third year of our operation. This has been a growing process for me, personally, to be doing this. I maintain counseling practice there at the residency. The residents and the faculty refer patients that they feel need psychosocial handling, and so I see those, whether it's depression, anxiety, or things that primary care people do. I refer them when it's necessary. So within the residency, we are now developing a model of the family physician. We're integrating behavioral science.

Mullan: Is that unusual for family medicine residencies?

English: Yes, in the sense that the integration is modeled by a family physician. Here at the University of Washington, there are thirteen residencies, and out of those, two have family physicians as coordinators, and I think it works better.

Mullan: I'm not clear. There are thirteen residencies.

English: Yes. Each residency has behavioral sciences.

Mullan: Thirteen family practice residencies?

English: Right.

Mullan: Affiliated with University of Washington?

English: Yes, right. In Montana, in Wyoming, in Idaho--

Mullan: Part of the WWAMI network?

English: Yes, right.

Mullan: And two of those have--

English: Ray Maestas at Providence now, and I, are the only two physicians who coordinate behavioral medicine.

Mullan: So the others [unclear] the emphasis?

English: Yes. The other behavioral science coordinators are psychologists or social workers. They're not physicians. They have always struggled with credibility. They do a great job, I feel. We meet together, it used to be once a quarter, to talk, sharing ideas and curriculums and things like that, networking. And they have always felt that they were considered as dealing with the touchy-feely stuff, and the residents don't have time for it. It's not as well accepted. There's always been a

struggle. I think when it's coordinated by a family physician, somehow it's different. We can prescribe medication. The orientation is different. We deal with taking care of the patients, in the whole sense. We see them in the hospital. Many of the behavioral science coordinators don't make rounds with their residents in the hospitals, and so there's a gap there.

Mullan: I'd like to ask about both your technique, your approach, and also about behavioral science, clinical behavioral science, in family medicine, because this is an important facet of the overall generalist world that actually I haven't heard much about from many of my interviewees. You mentioned way back, when you got started in this career, or in this direction of your career, you think maybe one of the reasons was an interest in sort of scoping out your own family, and your own psychosocial needs, as it were. Tell me more about that.

English: Well, the separation from my family was a trauma, and I had to adapt and cope with that. When I was in high school, I had a sister in law school in London. She married a Burmese, a law student who went back to Burma to find that his father had married him by proxy to some other person, so that she is now one of two wives. And she stuck her head in the oven. When I was sixteen or seventeen, I had to go each weekend to see her. I was the only family in the country that she had.

Mullan: She tried to commit suicide?

English: Right.

Mullan: But did not succeed.

English: Yes. And she was in a mental institution in London, which was a very different type of thing in those days than what we see nowadays. A small room, with a little peephole. It was very different. She had electro-convulsive therapy, and she got better. But I spent a lot of time with her, and began to understand suffering.

This morning Clem was asking me how is it that I got interested in behavioral medicine, and I think it was seeing someone close to me, and wondering, "How can I help this person?" And then in hematology, as I was saying, dying leukemic patients' families, things like that, I would wonder, "Now, what can I say to these people, to be helpful?" And that was the beginning of my interest in the physician as a facilitator of communication for therapy improvement of some kind.

I don't call what I do as "therapy." I call it counseling, because a lot of what I do is educational. I explain to people what's going on, and then I question. I ask them, "What are different ways that you can look at this? What are the options?" And so, in a way, it's what people call cognitive brief therapy now, but it's really because I'm curious as to what is best for that patient.

Mullan: Have you engaged in any therapy yourself? And is there

any school to which you personally or professionally subscribe?

English: Yes, when I was going through my divorce, I had about three months of therapy, and I still hold that psychiatrist very dear in my heart, even though it was just a short time, because there was such a bond. I learned a lot about transference and counter-transference during that time. Now I run a Balint group, and I run a group both for practicing physicians in Yakima and in Takimush [phonetic], which is another small town.

Mullan: Why don't you describe, for the purpose of the interview, briefly, what a Balint group is.

English: Michael Balint was an Austrian psychoanalyst who worked at the Tavistock Clinic in London. He started off by conducting an experiment with fourteen general practitioners, to get together regularly to talk about difficult patients or patients that were concerning them. They were to learn from each other, and the emphasis in England, at that time, was to understand the patient. In the U.S., there is perhaps a greater emphasis on physician awareness.

Mullan: Are patients still used as the subject?

English: Yes, right. Patients are still presented to the group for understanding of the patient, but the emphasis is on what is it about the physician that makes this a difficult patient.

Mullan: My impression was that Balint himself, the Balint groups he ran, did have a lot of self-awareness, self-insight, as part of it.

English: Yes, yes. Well, in understanding the patient as well as yourself as the physician, you understand the dynamics of the doctor-patient relationship and what you need to do to be helpful.

Mullan: Are those well received?

English: They are in Yakima. They were at Providence in Settle. I'm not so sure about the university. It's had its ups and downs.

Mullan: What is the role of the family practitioner in the psychosocial and psychiatric needs of their patients? I raise it from several perspectives. For the most part, counseling and verbal therapies are required, both long periods of time and some duration of intervention, which is different than the way a family practitioner's life, or a clinician's life, is usually structured. And, then, of course, is the issue of training, and how much can you expect a family practitioner to intervene in these areas. Tell me a little bit about both of those.

English: My perception is that you have the possibility of patients coming back again overtime, even across generations--the

continuity seen in family practice. You don't have to do everything all at one time in one shot. You could use your fifteen minutes for some aspect, perhaps a concrete example of what they're struggling with, and deal with that, and then schedule them to come back again later, if they feel that they want to. But I think the most important thing is that element of trust, that patients feel that you have their interest at heart, that they can trust you with intimate information about themselves. It's always a privilege.

So what I'm saying is, you don't have to spend a whole hour at one time. You can say, "What should we work on today," set an agenda, perhaps just as you would with the chief complaint, addressing the most urgent issue first. And so, you know, say to the patient, "Today we've got fifteen minutes, or we've got twenty minutes, a half an hour. We'll just work on that." It's no different from a consideration of an organic problem.

Mullan: So there's nothing sacred about the fifty-minute or hour?

English: No, no.

Mullan: You can do therapy/counseling in fifteen-minute intervals?

English: Right. Yes. If the patient feels that that's the expectation, they're not going to overstep that time, or you can

be responsible for the time, or they can be responsible. It's a collaborative thing. It's no different from when you want to buy something, you go to a counter, and you say, "I need such and such," and the person will say, "Here's what's available."

Mullan: What about the matter of training? Certainly, if you talk to a psychiatrist, with their three or four years of residency, or a psychologist, with their four- or five-year doctoral degree, or even a master's-level social worker, they'll say, "You're a family doc. You don't have any training in this. I've devoted two, three, four, five years of my life to it."

English: I respect that. I think there are many things that don't need referrals to a psychologist or a psychiatrist. A lot of problems that we see are adjustment-type problems, a situational problem that is not either a personality problem or a characterological problem. It's something that's happened to that person, and if you can help them look at it a different way, reframe it, perhaps, for them, or help them entertain alternatives, change, help them change, whether it's drinking, or smoking, or a dysfunctional relationship.

Mullan: Depression.

English: Depression.

Mullan: Anxiety.

English: Yes, I see a lot of those. Much of what we see comes with an organic ticket. They come and they say, "I've got a bellyache. My child has a bellyache. Won't go to school." Well, you get the whole family together, and it becomes clear as to why the child has a bellyache, perhaps.

One of my big interests is in the use of the family as a resource. I think a lot of family docs see individual patients. They don't see whole families. It's not very easy to get the family together, that's true, because everybody works nowadays. But, again, if you make the patient feel, "This is important to you, and I'd like to do that. Let's work on it together. See if so-and-so can come in," most of the time they do.

Mullan: What about the use of medications? In your judgment, should family docs be prescribing psychotropic medication?

English: Yes. Most of us learn maximal effectiveness in medication through trial and error. It's no different in psychotropics. We've got a standard array of things that every physician knows about, and it's the willingness to try it. It's the trust of the patient that you're not going to poison them. I think not many people feel empowered enough, maybe, to use these. You can always consult a pharmacist. In my residency program, we have a faculty pharmacist as an on-site resource.

Mullan: Do you train your folks to use all categories of [unclear]?

English: Certain things. If it's a schizophrenic patient, we refer those. Some personality problems we would refer to a psychologist, let's say, and you don't need medications for those most of the time. But I think for the common depression, anxiety, panic, that we can use psychotropics. After all, we deal with Parkinson's. You know the kind of things that we use. We deal with seizures.

Mullan: It would be good if you'd give me sort of a summary statement of what you think the ideal role of a well-trained family physician is in appreciating and treating behavioral health problems. If you were describing the ideal outcome of a training program, or the ideal functioning of a fully-trained family doc in the behavioral psychosocial area, what would it be?

English: The ideal outcome of a training program with respect to behavioral health: First, the physician has to enjoy what she/he is doing, so she/he's got to want to do what she/he's doing. That's almost a given, but often we find this isn't so, in training. Most training family docs start in a residency program full of idealism. In order to preserve this, it would be important to understand and accept professionalism in medicine, anticipate and prevent the issue of burn-out and to maintain a sense of satisfaction in working in medicine. These are issues important to the physician especially when she/he is considered as "the agent of change" in helping the patient.

In working with patients, in order to be open to listening

and attending to the patient, the physician needs understanding and acceptance of his or her own self and own professional needs first. Acceptance of the patient with a non-judgmental attitude is essential. Empathy and trust are based on these. Then it's very important for the physician to understand the patient''s socio-cultural context--what sort of life has this person had, what's important and gives meaning to this person? In other words, who is this patient, what makes him tick and what is he about? To understand, to read between the lines of what the patient brings to you, to understand the particular cultural context, I think, is very important. The spirituality of the patient cannot be ignored. All this goes towards developing a sound doctor-patient relationship, making for a collaboration between the physician and the patient, the formation of a "therapeutic alliance." Especially when there is an organic problem, the physician can be educating the patient to an awareness of the possible psychological consequences of the illness. I think patients are open to a connection between the body and the mind when the discussion is timely and relevant. So the physician ideally acts as an educator to the patient. And not only the body and mind, but the spirit of the person of the patient comes into consideration. I have found this especially true in instances of patients with panic, also with anxiety and depression. In teaching the training physician, I like to emphasize a direct sensitivity, a sincere and honest approach in communicating with patients.

Understanding of the patient needs looking at the

developmental stages in each individual patient combined with an understanding of each patient's family dynamics. The training family physician has the opportunity to counsel an evolving family when seeing the pregnant woman with her partner. Then there is advice in child-rearing in the following years. Often, we find a patient presenting with an organic symptom in either a child or a family member, and the real issue is one of family dysfunction. When a physician considers family function with the patient, inevitably the issue of the marital relationship surfaces, and then some judgment has to be made as to whether this is something the physician wants to address, is able to address with the patient or would feel better referring out to a therapist. Addictive behavior sometimes becomes the main issue. Some knowledge of addiction medicine is important for the generalist to have. We see its usefulness with teenagers, with nicotine, alcohol, food and other substance dependencies.

As with all medical practice, the gravity of any situation needs to be examined. It's like, you see someone in the ER, do you need to transfuse this patient, because he is losing blood, or not? It's no different. With the core knowledge of psychiatry and behavioral medicine acquired in training, the physician can then make a decision as to the gravity or complexity of the situation, refer the patient to a specialist when appropriate, oftentimes working with the specialist in maintaining continuity as with any medical problem.

Mullan: You've been engaged in a fascinating area of the family

practice movement, which perhaps receives less attention than other elements of medicine, general family practice in particular. As you look over this fascinating career that you've had, how do you feel about your work? How do you feel about the area that you have found?

English: Oh, I just love it. It makes me feel that what I'm doing is right. I can hardly wait to be at work. I love training. I love relating to the young--notice I've changed "training" to "relating." Just as you have a relationship with a patient, the relationship with a resident is as important, because you can bring along, as you would raising a child, the relationship a parent has with a child. It is that important also. If they feel that you believe in them, that they are good people, that they have potential, that they're bright, they'll do it.

So the phase I'm in now is, I'm learning that you don't walk into a program and say, "I'm going to a didactic such and such." The people who are at the didactic have to have a relationship with you, to really learn from you. And so opening yourself up a little bit is not a hazard. We all look for elements in each other to learn from, to model ourselves by.

Talking to Clem about a situation at work recently, where a resident was struggling with a difficult patient, I had said, "Why don't you reverse roles? Say to the patient, 'You be the doctor, I'll be you.'" Well, most of the residents were surprised, and there was this sort of silence. So I said,

"Well, what's the problem in doing this?" A lot of them said, "Well, isn't it a little silly?" And I said, "No, but your whole purpose is for the patient to understand the bind he or she is putting on you. And if you reverse roles and role-play, maybe that's a way to show them what the dynamics are."

Clem said, "Well, you know, a lot of people have defenses that don't allow them to do this."

One of things that I like about my job is that I am showing people I don't need to be defensive, and when I don't know, I can say, "I don't know, but let's find out." And that the young physician needs to have this attitude that, "I'm here because I want to help, not because I'm better, not because I know more. But you've come to me with a problem. Let's work on it."

Mullan: Let me ask a question from an entirely different area. You lived and worked in the United States over a period of rapid growth in medicine, and a period in which there have been many international graduates who had joined the workforce in the United States, both at the residency level and at the practice level, of coming into practice. As an international graduate of a very unusual and migratory nature, in terms of your global education, how have you felt about both being an international graduate and the treatment of the U.S. system, not only in your own experience, but as you look around, of the international graduate?

English: Well, I feel very privileged that I went to a good

school, with a good reputation, so I feel that people have accepted me because of that. I've struggled with being a foreigner and a woman, but came to a realization that people accept you if you are very honest, if you are up-front about things with them, no different from anybody else, if you have that attitude, then there's almost a self-fulfilling prophecy that things will be okay. So I don't have any chips on my shoulders about that.

I think it's a good idea to be careful about where people are trained. We have applicants for our residency from different countries, and it's always difficult to know what that medical school is like. In some instances, they've never touched a patient. They have mass lectures. The system we need in this country is an evaluation of schools abroad, so that we know better how to judge people. The trainee may be an exceptional person, and it's just unfortunate that he was trained there, let's say. The interview would show that. So, on paper, you have to make a judgment, and the judgment is, "Should I, or should I not, accept this person?" And the interview, the face-to-face talking with that person tells you quite a bit, about what sort of person they are, and how they have derived from their training.

So in terms of the foreign graduate, the international graduates, it's an individual basis, I think. We've had people from very, very small schools who have been wonderful. We've had people from this country, U.S. citizens, who have gone abroad to other schools, and come back and they weren't well trained. So

it's not a matter of who they are.

Mullan: Have you felt prejudice, either in your experience or as you've looked at others? And I define prejudice here as unfair judgments.

English: Yes, as a woman faculty, I have felt prejudice. In considering others, to be honest, I've felt like, "I have difficulty accepting this person, because he went to school in Egypt," or wherever, a small unknown medical school. And until I know that person, I have to get over that. I have to struggle to get over that. I think it's normal to have some degree of prejudice.

Mullan: You've seen the family practice movement grow and develop. How do you feel about that, and how do you feel about family medicine as it currently exists in the United States?

English: I still have one foot in internal medicine. That's the way I feel and that may color my perspective. It's partly because I'm married to an internist, and partly because much of my early training in this country, at Stanford and at Scripps Clinic, was in internal medicine. So I'm not a typical family medicine representative. Undoubtedly, family physicians have been serving well the basic health care needs of people in this country and this has resulted in recognition and legitimization of family medicine as a separate specialty. Originally, there

was a unique opportunity for the specialty to regain a focus on the patient in the context of the family. The vision of family medicine is broad, the practice of family medicine is so broad that it overlaps with areas of other specialties, and this overlapping has blurred boundaries to the extent that now, with readjustments, as you know, primary care is actually being provided by diverse disciplines. Family medicine has become recognized as a specialty in its own right, yet with these overlaps of function (obstetrics being a prominent example) there is an intensifying competition from various specialties. This is of concern. Also, we now face managed care as well as escalating health care costs, so that there is a great deal of pressure to be fiscally productive in practice. Procedures are performed and popular. By necessity, the focus becomes less on the patient. So I am now concerned about the feasibility of maintaining a focus on the patient, of the danger of losing the uniqueness of family medicine.

Another consideration is the rapid growth of the body of knowledge, the enormous body of knowledge which physicians have to master. The necessity of keeping up, staying current is urgent. To some, this can be burdensome. There is a danger of limiting expertise to particular areas, and this then brings up the problem of the family physician becoming no different from a specialist.

Mullan: No different than a specialist in what sense?

English: In the approach to the patient, in the way they practice, meaning that they are very segmented in their way of dealing with the patient, not viewing the patient in the way the patient lives, the context of the patient. I think there's a lot being asked of family medicine as a discipline, very rapidly. The family doc has to be a good manager, of himself, his time, his family relationships, his staff and above all his patients. He has to be very defensive and careful nowadays. There isn't that sense of freedom a few years ago of the family doc being just here, trusted to provide good medical care. Now you have to be thinking about accountability, fiscal viability, involvement with managed care plans, you have to be thinking about how valid what you are doing is, how practical and cost-effective it is, conforming to a multitude of rules and regulations imposed on the way you practice, often by a third party, avoiding litigation. And he has to maintain collegiality with his peers.

I was telling you that I run this Balint group. They're thinking of selling the practice because it's too horrendous to have to deal with all the different HMOs and all the other business aspects of running a practice. And so they're saying, "Well, let's give our practice to a big hospital, or whatever, a bigger HMO, and let them handle things."

Mullan: This is the one in Yakima?

English: Yes. So there's a feeling that we're losing our original intent of helping the patient. We're now so beset by

the process of generating enough funds, of seeing enough patients. We're losing that, and I'm worried about it. Also, there is the incentives that are given to young physicians. It's too seductive. You know, "You can earn $170,000 right after your residency."

Mullan: Not in family medicine.

English: In family medicine. This is one of our residents.

Mullan: Whereabouts?

English: In Yakima. And that is very seductive. The constraints are that you see so many patients. It's becoming a mill. A lot of what you are questioning, "How can we do this in fifteen minutes?" Well, you lose sight of even wanting to do that.

Mullan: So the pressures are not necessarily conducive to the full practice of family medicine, including behavioral medicine?

English: Especially behavioral medicine.

Mullan: Tell me a bit more about your family. You have two children?

English: I have two children. My eldest is a girl. She's a

garden designer. She's twenty-nine. Darrell is a second-year resident at Duke University, in internal medicine. There's just the two.

Mullan: Have you enjoyed motherhood?

English: Yes. My children are wonderful people. Well, we have never wanted them to feel that they should be in medicine. Lisa, the eldest one, started in medical school, and was there for two years. Then she decided that she didn't enjoy that. Now she's in garden design, and she loves it. So it took a lot of courage for her to tell both parents, who are physicians, "This is not what I want to do."

Mullan: Tough, I would imagine.

English: Yes, and we've really respected her for that. My second child is son Derel, who is a second year resident at Duke in North Carolina. He is in internal medicine, considering a Pulmonology Fellowship.

Mullan: What about the future? What do you see for yourself, as you look ahead? Quite clearly, you're very engaged in what you've been doing.

English: Well, this is the problem, is I had a stroke. John may have told you. And there's seventeen years' difference between

Clem and me. My time with him is very special. We really learn a lot from each other. I would feel bad if I didn't give him my time, as it were, you know, devote time together. And so I'm struggling with my personal evolution and career, versus time together as a couple, and I've decided that he's more important, and that somebody else can do the training that I've been doing. Somebody else can do that job. That is not as specific as working together as a couple, and so I am going to retire. One of the faculty people was asking me about it, and I found tears in my eyes. I found myself very emotional about it, unsuspectingly. It caught me by surprise, and then it made me realize that it must be more difficult than I realized, to process.

So a lot of the time between now and then I'm using to really anticipate that loss, because it will be a great loss. It's a loss of growth for myself, I feel. I've really felt a terrific sense of growth at this Yakima job, because I've had autonomy in what I do in the residency, and I'm very much respected, and I've learned how to work with the community, with the physicians in the community, whereas at the university, it was all set. So I had to learn how to process other people's agendas.

Mullan: Clearly, you made a huge contribution to the university here in Seattle, teaching.

English: Hopefully. Hopefully so.

Mullan: Well, thank you. That was very generous.

English: I've enjoyed it. I hope it answered some of your questions.

Mullan: It does indeed.

[End of Interview]

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