Interview with Carol Garvey
Date: April 2, 1995
Interviewer: Fitzhugh Mullan

Mullan: This is April 2, 1995. We're at the home of Dr. Carol Garvey, sitting on her porch on a spring afternoon, the first day of daylight savings, with some sun that comes and goes. I wanted to chat with Carol about her background in family practice, but where I'd really like to begin is with you telling us a little bit about you in terms of your background, where you came from, and just a little bit of biography, starting way back when.

Garvey: I grew up in Baltimore, went off to college [Radcliffe College], sent there by my parents primarily for two reasons: one, to find a husband; and the other to learn enough about literature and art and music to entertain myself at home when I was taking care of my future children. I succeeded in finding a husband, and he was not at all enthusiastic about my sitting at home and having children. He was the son of two physicians and decided that I ought to go to medical school. He decided this in the spring of my senior year, when I was already signed up for a master's program in teaching, because I thought I would actually be a teacher when my children were in school. I didn't have any pre-med courses, having majored in English literature and taken some art and music courses along the way, too.

So I got a teaching job and took courses at night school and summer school, pre-med courses, and two years after graduating

So I took geology, and that was where I met Tommy, in December of freshman year. I didn't take any more science courses until my senior year, and what happened there was, I had taken a statistics course, which I thought was good preparation for teaching, in my junior year. My parents happened to live next door to a physiologist at [Johns] Hopkins [University], who had known me much of my life and needed a statistician for the summer. So I worked for him between junior and senior years and found his work fascinating. So I actually did take a freshman chemistry course and a freshman biology course--the biology course was second half of senior year--figuring that they might be useful when I was teaching. And I thought they were great, but it didn't occur to me to change directions, other than maybe to use that in teaching, until March or April of senior year, when Tommy insisted that I wasn't going to be a teacher; I was going to be a doctor.

Mullan: Tell me about your youth and your background and your parents' or family's attitudes towards a young woman's education. Were you born in Baltimore?

Garvey: I was born in Baltimore, although my father had been from New Jersey and his parents had been from England. My mother had grown up in Baltimore, and her family had been there forever. So I went to a very traditional girls' school.

Mullan: What was the school?

Garvey: Bryn Mawr School. My mother had gone there, my aunt had gone there, my grandmother had gone there, and that's where I went to get a job after I graduated from Radcliffe, because that way I could live at home and save money for medical school. I taught three classes, and actually my science came in handy. Of course, I hadn't had very much. I wrote and said I would teach math or English, and the headmistress said, "We have all the math and English teachers we need. Teach science."

I said, "Well, I haven't had much yet."

She wrote back and said, "Stay a day ahead of the kids," because they were desperate for a science teacher.

Mullan: What had your science been like at the Bryn Mawr School? In terms of women and science in the epoch of the fifties, sixties, when you were in school, what kind of signals did you get, as you recall?

Garvey: I think the expectation, that being the fifties, was that we were all going to grow up to be housewives. There was a lot of emphasis on getting into the Seven Sister colleges, but that was really a status thing. It wasn't to prepare us to go on to graduate school. It was a wonderful time to be educated as a woman in the sense that since they couldn't threaten us by saying, "You're not going to get into the graduate school of your

choice." The teachers had to make us love what we were doing, and so I think there was much less teaching to tests than there is now.

If we were considered to be smart girls, we were supposed to take lots of languages, so that really we only had one year of high school in which we could take a science course. We had a choice of physics or biology, and there again, if you were a smart girl, you took physics. If you were a dumb girl, you took biology.

Mullan: That was the only option or the only year in which you had science as a possibility?

Garvey: That's right; senior year. The girls who couldn't make it in languages could take biology one year and physics another year, but that was very rare, so most of us just graduated with one year of high school science, and it was either biology or physics. There was no chemistry taught at the school.

Mullan: How about math?

Garvey: Yes. I did take math all the way through, so I had had a little bit of calculus.

Mullan: Let's go back to your family for a moment. What did your parents do and what sort of expectations or what sort of

launch did they give you in terms of your own professional identity?

Garvey: My father was an architect. He had grown up as one of three boys, the middle of three boys. As I said, his parents were English, and his mother had been educated as a pharmacist, and her father had been a doctor, but she used her pharmacy training only until the age of twenty-seven, when she got engaged to my grandfather, or got married to my grandfather, and moved to this country, where he had moved first to take an academic position in Toronto, and then ultimately he moved to Bell Labs. He was a physicist. So my father had grown up with a mother who didn't work. She never got credentials in this country.

My mother had grown up one of three girls and a boy. The boy went into the family business, which was really the only option offered to boys in my mother's family, and that was the woolen business, and the girls were really not expected to have careers. My grandmother hadn't gotten around to finishing high school; she just didn't think it was important and her parents didn't think it was important. My mother had gone to a junior college and then to a nursery training school.

Mullan: Nursery as in--

Garvey: Nursery school.

Mullan: Sitting amid these flowers, I wondered if there was a horticultural streak.

Garvey: No. And she ended up as a kindergarten teacher. She worked, I think, really because architects don't earn a lot of money, but I think if she'd had her druthers, she would have been at home full time. In fact, she did a lot of hand-wringing over even the time and energy that the teaching took from her mothering, and she really felt that mothering was the only appropriate career for a woman, and that teaching was okay as long as you made sure that your hours were limited to the hours when your children were in school. But she thought it was really immoral for a mother not to be home when her children were home from school, for a mother not to have the same vacations and that kind of thing.

Mullan: How many kids were there?

Garvey: Four. I was the oldest of four. So it was never proposed to me that I have any career other than teaching. Teaching was kind of an allowable profession. It might come in handy if I also married a husband who wasn't very good at earning money. But that was really it. My brother became an architect, my first brother, and the younger one became a builder. I think, in retrospect, I would have loved architecture, but it just wasn't offered as an option.

Mullan: So there were definitely different presumptions, at least, if not signals, in terms of boys and girls.

Garvey: Clear-cut, very explicit. I think perhaps if I had been part of a family that had only daughters, that possibly my father would have been more oriented towards having his daughters end up with professions.

Mullan: He had no other outlet; he might have tumbled to that.

Garvey: Right. I certainly see that in families which have only daughters. But I think my mother's goal would still have been to marry us off as soon after college as possible.

Mullan: As you proceeded really out the other side of college, as you headed towards sciences and towards medicine, how did they respond?

Garvey: My father was pretty neutral. He never particularly encouraged me, but he didn't say anything particularly negative, and I suspect that he didn't want to be in conflict with my mother. My mother was strongly negative, and she kept preaching to me that it was inappropriate for me to get more education, that there were plenty of men who had college degrees, but not a lot of men who had more than college degrees, and that a man was not going to marry a woman with more education than he had. So

that the more education I got, the fewer men would be available for me to marry.

Mullan: Very pragmatic.

Garvey: Oh, absolutely. Tommy was not eager to get married right after college. He wanted to continue the relationship, but he just wasn't feeling, I guess, grown up enough to get married, and my mother, at least, was afraid that he never would.

Mullan: She was worried that he would never come back and pick you if you stayed on in the sciences?

Garvey: That's right. Absolutely. Absolutely. So she was very upset that I was pursuing this, and when I told her that I had gotten into medical school, she burst into tears.

Mullan: Tears of--

Garvey: Not of joy. She really felt that it was a very wrong-headed thing to do.

Mullan: I want to come back and touch on English, but let's pursue this for a moment. Did she come around? What was the evolution from that point?

Garvey: I think that she was somewhat relieved when I got married, but then she was worried about my childbearing. I think she finally began to relax a little bit once I had had a child. And then her friends, when they would say, "What is Carol doing?" and mother would say, "She's a doctor," her friends would say, "Oh, isn't that wonderful." So eventually she began to listen to her friends. So I guess maybe somewhere between five and ten years after I had graduated from medical school, she decided it was nice that I was a doctor. And then once I was back in this area in '76, having graduated from medical school in '69, she found it handy to ask me for small prescriptions for things, because she's very Scottish. If she called the doctor and he said, "Come in for an office visit," and she knew she didn't need an office visit, but she could get a prescription from me without having to pay for an office visit, she liked that.

Mullan: How about your dad? How did he take it all?

Garvey: I have absolutely no idea how he has felt about it, other than he also finds it handy when his seborrhea acts up, to get a little steroid cream from me without having to track down his dermatologist.

Mullan: Let's go back to English for a moment. What was entailed in your decision to major in English and how did you feel about it both as literature as you approached before college

and in college? Was this something that was convenient or was it something that you really were excited by?

Garvey: I was excited by it. Two of my high school English teachers had gone to Radcliffe.

Mullan: That influenced you in picking Radcliffe?

Garvey: To some extent. My father had gone to Harvard. My mother did not want me to go to Radcliffe, because she thought only weird people went to Radcliffe; she wanted me to go to Wellesley, where "nice girls" went. But my teachers encouraged me. I loved writing, and my teachers encouraged me there, and I really enjoyed reading, enjoyed poetry. I didn't particularly like history, because that was memorizing a lot of dates. I took the languages because I was considered to be a smart girl, and that's what the smart girls were supposed to do, but I really wasn't turned on by languages.

The only science I had was the little bit of physics, which was okay, but not particularly exciting. So English seemed very logical to me and, again, something that would be a source of entertainment throughout my life. I think I'm very interested in how people live, and I don't see literature as being completely fiction; I see it as being a lot of psychology and also representational. I'm not a big science fiction fan, but I love eighteenth and nineteenth century novels, because to me they

present a picture of people living in other centuries. I'm always interested in how people live and how people think, so I enjoyed it.

Mullan: Have you continued reading and/or writing over the course of your life?

Garvey: For a long time I didn't get to do any recreational reading, and then in 1982--I just didn't feel I had the time for it--I joined a book club, mostly NIH [National Institutes of Health] wives, and, being compulsive, I tend to do the assigned reading, and it's been wonderful because it's really been an excuse; I mean, I "have to" read this novel because it's assigned for book club. So in that sense, yes. The little bit of writing I've done has really been mostly commentary on what's going on in medicine. I've written just little things, editorials and things mostly, for the county medical society bulletin. I haven't done any real scientific writing.

Mullan: Has your reading, particularly in previous years, been useful to you in your practice? Is literature in any way connected to how you see your work or see your patients?

Garvey: Probably not in a direct way, although I frequently point out in *Wuthering Heights* the fact that people catch colds in *Wuthering Heights* and they're sick all winter because they

don't have antibiotics, but they do get better, most of them, eventually. It's very interesting to get that perspective. And probably just my interest in family psychology is in some way reinforced by the reading, but it's not a very direct connection.

Mullan: How was the transition from being an undergraduate English major to being a full-time student of science? How did you find both the transition, and then as you got into medical school, did it go well or was it swimming against the current?

Garvey: It was frustrating trying to get in, because in that era the medical schools had very strict quotas for women. Cornell had 5 percent and most of the others had 10 percent. So I was really struggling against the quotas, as well as just the effort to get in all the science and that kind of thing. Once I got in, I didn't really feel as though I was having to deal with any particular sexism within the medical school teaching situations.

Mullan: You went to Cornell?

Garvey: No, I went to Columbia.

Mullan: And Tom went to--

Garvey: NYU [New York University]. The science, as I mentioned, I really found fascinating. I did have trouble with

biochemistry. I just wasn't that well grounded. I had a summer organic chemistry course at Hopkins, but that hadn't really implanted itself very firmly in my mind. But things like anatomy, anatomy is a very visual thing, and I'm very visually oriented. I loved anatomy. And physiology just made so much sense. It's just inherently so reasonable and rational that I didn't have difficulty. I just found it wonderful. It was like just exploring new territory.

And then when I got to the clinical side, it was that much better. I mean, to some extent, obviously, the first two years are like learning Latin, which is kind of a dreary task in just all the rote learning that's involved, although the facts in themselves are inherently interesting; it's just making yourself learn things. Then the clinical work I just loved, and I loved the interpersonal aspect of it right from the beginning and really just bonded very strongly with the first patient that I ever worked up and still have two of her paintings that she gave me. She actually died about six months after I had first met her.

Mullan: What was her condition?

Garvey: She had had rheumatic heart disease. She had come into the hospital in congestive failure. She had been discharged after that particular admission, but she was having ever more frequent episodes of congestive failure. So then she got a valve

replacement and died of complications. I don't think she ever got out of the hospital after her valve replacement.

Mullan: She was a painter?

Garvey: She called herself a black Grandma Moses. It was really a recreation, and the paintings that she did were copies of pictures in magazines that she liked or greeting cards that she liked. These are kind of rural scenes, the two that I have. She said she wanted to get the pictures framed and asked if I would arrange for the framing for her. And so I did, and then once I'd gotten them framed, she gave them to me. I didn't know she was going to give them to me.

Mullan: How did you like Columbia?

Garvey: Very much. It's a very clinically oriented school and very rigorous. They really exposed us to all the subspecialties, and, of course, as a generalist now, the fact that I had two weeks of ophthalmology and two weeks of ENT and two weeks of dermatology and two weeks of orthopedics and two weeks of urology, you know, at least it's not totally unfamiliar. Obviously, I've had to boost those areas of knowledge a bit since then, but certainly I felt that we were much better prepared than students who had gone to schools with a lot of electives, who really used them to explore one or two areas that they were

interested in entering and just had vast areas of the human body that they'd never touched.

I precepted Harvard medical students when I was doing my family practice fellowship, and they could graduate at that point without ever doing a pelvic exam, because OB/GYN was an elective. Medicine was required, but they weren't required to do pelvics on medicine.

Mullan: How about the culture at Columbia in terms of the institution? How did you like it and how did you feel about your life as a medical student versus your life as an undergraduate?

Garvey: Well, as a medical student versus an undergraduate, clearly a medical school is a trade school, so that I was a little taken back that we weren't expected to think, we were only expected to memorize in the first few years, after having spent four years being taught to think.

When I got to the clinical side, one of the things I found disturbing right from the beginning was the emphasis on what was referred to as "fascinomas." The residents would call from downstairs at three in the morning or whatever and say, "I've got a fascinoma for you down here in the emergency room," and they would be really thrilled if they could admit a fourteen-year-old with acute rheumatic fever and Sydenham's chorea. Great, yeah, that is a fascinoma.

But one of the first patients that I had was a thirty-six-year-old black man who had come into the emergency room with bilateral pneumonia and a temperature of 105. Because he wasn't a fascinoma, he was put back in an ambulance and sent to Harlem Hospital, and Harlem apparently said, "Look, we've got patients in the halls. We don't have any room," and sent him back to Presbyterian. He was looking pretty sick at that time, and so Presbyterian figured, well, it probably isn't a good idea to send him to yet another hospital, so the second time around, Presbyterian took him. He got better, but I was just so horrified that they would send someone out who clearly needed to be hospitalized merely because his disease wasn't interesting enough for them as a teaching institution. I think that was really when I became interested in public health and the whole problem of medical care access, and that aspect of Columbia I really found despicable.

Mullan: Were there others in your class or were there faculty who allowed you to explore or develop that broader-based interest? Either politically or educationally, were there people who were supportive of that?

Garvey: Not particularly. There were, in our class of 120, two of us who did not intend to go into medical specialties at the time of graduation, and to the best of my knowledge, most of us have gone into medical specialties. Actually, I decided to go

into public health at that point. The two months of electives that we were allowed in our senior year, I spent really kind of dabbling in a whole range of public health things. I went to Sinai's Department of Community Medicine, which was, I think, about the only community medicine in New York at that time.

Mullan: Was Kurt Deuschle there?

Garvey: Yes. With two students from the University of Vermont, who were also doing electives, we did a little research project on parasitic diseases. I don't really even remember the details, but we met with a health officer in Harlem and got data. I just don't even remember what the thrust of the little study was.

But I ended up also going up to Montefiore's Social Medicine Program and Martin Luther King [Jr.] Community Health Center and getting to know those people a little bit. I went to a wonderful post-hospital nursing unit that Montefiore had and talked to the nurse who had set that up, and that was revolutionary. I mean, there wasn't really anything between hospitals and home or permanent nursing homes, but this was kind of a post-hospital rehabilitation center. And ended up immunizing people against the flu, because there was a flu epidemic during that period of time, and I did that in a health center. Went on restaurant inspections, talked to the director of maternal and child health programs for the city, and just really kind of explored.

Mullan: Did you craft this yourself or was there somebody at Columbia who was a mentor?

Garvey: I had gone to Harold Brown, who was the head of the Public Health Department at Columbia and who taught us our first-year course in parasitology, and I guess he may have been the one who sent me to Sinai. I don't really remember. Sinai provided some focus, but then I think I kind of bounced around and heard about this person and that person. I don't think that there was one guiding person behind it.

Mullan: As you approached the end of your undergraduate medical education, how had you begun to see the future? What was your vision of what kind of doctor you were going to be?

Garvey: My vision was that I was going to go into public health.

Mullan: What did that mean in your mind at that time?

Garvey: I wasn't sure, other than I wanted my goal to be to work on access to care. In fact, when I talked to Dr. Brown, he was the one who pointed me towards getting generalist training. He said, "Don't just go get an M.P.H. Get yourself fully trained in some branch of medicine, because you'll have a lot more credibility if you're board-certified in something."

That was 1969 that I was graduating. Family practice was just becoming a certifiable specialty, but there were no family practice residencies in the Washington area. We were coming down to NIH for Tommy.

Mullan: He had finished his--

Garvey: He finished two years before, because I was studying, getting my pre-med courses his first two years in medical school.

Mullan: So he had done two years of internal medicine?

Garvey: Right, at Roosevelt. So I went to the Hospital Center, which had--

Mullan: Which is the Washington Hospital Center.

Garvey: Right. The thing is that their internal medicine program, you could do straight internal medicine or mixed internal medicine. I did mixed internal medicine, which allowed me to do eight months of medicine, two months of pediatrics at Children's, and two months of OB/GYN. Then following that, I did a year of regular internal medicine and then took a couple of years working at Group Health. But when I was doing my internal medicine, I actually did it in a year and a half, because I cut

back my schedule a little bit--well, fifteen months--because I had Tommy right after my internship.

But I'd been very upset by the way they had the clinic system arranged at the Hospital Center. What they had was block rotations, and each intern took a one-month block rotation to medical clinic. I don't remember what point in my internship I hit the outpatient department, but what I saw was that a patient's "dij" level tended to be changed every month, depending on whether the intern of the month thought that the level was too high or too low. This was before you could draw a dij level, so it had to be done clinically. And the diuretics might be changed because one intern might be more comfortable with one than with another, and I thought that the care was absolutely horrendous.

So I went to the chairman of the Department of Medicine, Jim Curtin [phonetic], who was extremely approachable, and said, "I would like to see the outpatient department changed, and I would like to see interns assigned an afternoon every week and follow the same patients through their entire internship year and also do that as a resident." I think the residents had block rotations, too, in the clinic.

So my year of internal medicine residency, my second postgraduate year, I had three months off with the kid, and then nine months in the outpatient department and six months inpatient. He said in those nine months, that if I could reorganize the schedules, meet with all the specialty attendings, get them to agree to have all the specialty clinics held in the

morning, because they were kind of random, some were in the morning, some were in the afternoon, and you couldn't have the intern's continuity clinics in the morning, because mornings were when they made their rounds. So I had to make sure all the specialties would be in the morning and the general medicine be in the afternoon. But he said if I could do that, he would let me rearrange the entire medical clinic system.

Mullan: Could you? Did you?

Garvey: And I could and I did, because I figured that would improve the quality of the care for the patients.

Mullan: And established a continuity of rotation.

Garvey: That's right. I also had picked up some of my own patients, and one of the things when you do that block rotation, you would go through the specialty clinics, too, so that you would do pulmonary and oncology and whatever. What I found was that oncology had the greatest continuity because of the fact that most of the patients came back every week instead of once a month. So in my one-month rotation, I got to know a bunch of patients.

So then I had also asked for permission to go to oncology clinic even before I finished my internship so I could see what happened to these patients, and ended up, after my three months

off with the kid, continuing to follow the oncology patients and go to oncology clinic for the rest of the time I was there. And then the last six months were just straight ICU and general medicine, regular medical rotations.

Mullan: What do you have in your mind at this point? Where did you see yourself headed?

Garvey: I wanted to get an M.P.H. and I wanted to finish a residency. By that time, there were more residencies available.

Mullan: In family medicine?

Garvey: In family medicine.

Mullan: Did you have in your mind family medicine?

Garvey: Yes.

Mullan: You appreciated it was a coming thing and you wanted to connect with it?

Garvey: We had also vacationed in the Caribbean, and part of our vacation consisted of going to hospitals and seeing what hospitals were like on these small backwards islands. We were going to little islands; we weren't going to the big resort

islands. We would see congenital heart disease untreated. We saw osteogenesis imperfecta and reproved LA baby [phonetic] and all kinds of things. We saw a tetanus case, things that we hadn't seen in our New York City or Washington, D.C. settings. We were very interested in going back to a tiny island and maybe practicing for a few years, so I wanted generalist training because we would have been the only doctors on that island and would have had to deal with everything.

Also, I figured that if I were going to be a health officer or something, that I really needed to know about children and obstetrics and adults and just needed the whole range of primary care. So it was really, again, with the idea that I was going to go into public health, that I wanted to do family practice. That just seemed like the most logical preparation.

Mullan: How did you head for Group Health and what was that like?

Garvey: One of my attendings at the Hospital Center, Nelson Goodman, who's still practicing in the area, practicing in Bowie, was working for Group Health at that time. I was looking for part-time work, because I had been doing the regular inpatient rotations for the last six months at the residency and not seeing too much of my child, so I wanted to spend more time with him. So Nelson suggested I look for a part-time job at Group Health and knew that they had some part-time positions available. So I

worked in their walk-in clinic three days a week, which was a perfect schedule because it got me out into the real world three days a week, but gave me the majority of my time at home with little Tommy.

Mullan: And keep your medical practice on a predictable basis.

Garvey: Right, absolutely. I went in and worked my eight hours and went home, and that was it. I did that for a year and a half, and then I wanted to get back and finish my training. I figured my options were University of Maryland for the family practice and Hopkins for the M.P.H. or Harvard for both. Again, Tommy decided to direct me, and he thought it would be much better to go up to Harvard and get the M.P.H. and finish my family practice training. So I went into Harvard's family practice fellowship program and did that and finished that.

Mullan: They had one at this relatively early date?

Garvey: Well, you know, Harvard always has its nose up for money, and I think it might have been Robert Wood Johnson was then funding family practice training.

Mullan: That was, what, about 1975?

Garvey: This was '73, and so then '73, '74 I got my family practice. At that point, the board did not require that you do two years. They would allow me to count the two years of internal medicine with the family practice fellowship to qualify for the boards. Now you've got to do it at least two years in one place in family practice.

Mullan: So this was a year of the fellowship and then a year of M.P.H. subsequently?

Garvey: Yes, and then I got the M.P.H. in the next year. When I was getting my M.P.H., I also worked in a neighborhood health center, a regular Section 330 neighborhood health center in a Title X program doing family planning. I did that through that M.P.H. year, I think a couple of evenings a week or something like that and then through the next year, and I think we expanded from two sessions to three sessions as the health center had grown. Then I worked half time at Boston City Hospital in their so-called primary care center, which was in fact as crummy a medical clinic as any city hospital might have. There was nothing primary care about it. They had no evening hours, and it was not particularly patient-friendly. It was just a regular old medical clinic with a fancy name.

Mullan: A word about the Harvard training program, because I'm not aware that they have family practice at Harvard today at all.

Garvey: They don't, and the year there convinced me that getting family practice training or generalist training in a specialty-oriented institution is not a good idea.

Mullan: Where did they even have it and who would have taught it?

Garvey: They had it in a little building that was kind of equidistant from Brigham and from Children's, and Beth Israel and Boston Line In [phonetic] were another block further. So it was well located, and when our adult patients got sick, we admitted them to the Brigham and worked them up as regular residents. When they were admitted to Children's, we worked them up. We didn't do deliveries. We did some prenatal care at the health center, and we had some instruction from the attendings at the Brigham and we learned to put in IUDs and fit diaphragms and that kind of thing. We could take electives, and I took weekly dermatology at Beth Israel, which was terrific. And I took some time, I think a month or something, in the emergency room at Mass Eye and Ear.

So you had access to things, but what I didn't like about it was that at both the Brigham and Children's, we were made to feel like second-class citizens. We weren't really part of the real pediatrics program or the real internal medicine program.

The teachers were an internist who had trained at the Brigham, who was kind of young and idealistic; a pediatrician who

had trained at Children's and who has subsequently gone into straight family practice; and a so-called family practitioner who had been recruited from the hills of New Hampshire and who didn't seem to know a whole lot. In fact, I ended up during my M.P.H. year going up to New Hampshire to do a rural health project, and I found myself in the community in which this person practiced. I didn't know he was from there, but when I interviewed people who then asked me where I'd come from, what I had done, and heard that I had been in the program with this guy, they said, "Oh, boy, he was a menace. We were so glad to get him out of town." He was doing laminectomies and cholecystectomies with no surgical training. Our impression was that he was not terribly knowledgeable. He didn't think that trichomonas was a sexually transmitted disease; he thought it was a woman's problem and that men didn't need to be treated if their wives had it and that kind of thing. But because he was the only one who had practiced as a generalist, he seemed to have great credibility with the institution.

Mullan: So the program, as far as you know, lasted for a while Johnson funded it and then it faded out.

Garvey: It lost its accreditation. I think there were so many other better programs coming along. And at that point, Robert Wood Johnson started funding primary internal medicine and

primary pediatrics, and so Harvard jumped on that bandwagon and I think no longer had any real interest in promoting--

[Begin Tape 1, Side 2]

Mullan: This is side two of Carol Garvey on the first tape, continued.

Garvey: They really didn't have a lot of people around who were interested or enthusiastic about teaching the course or teaching in the fellowship. We did have some input from Mass Mental Health, too, which was good, but it's better to teach primary care in a primary care setting.

Mullan: How was [unclear]?

Garvey: It was interesting. I think the instruction was of high quality. I loved the health care administration, which had kind of a mini-course on economics, which, of course, had never occurred to me as something I should have taken in college. But again, like gross anatomy, it was like another language. It was entering new spheres that had been totally mysterious to me before then.

But it was a funny place. The building, I think, was a metaphor for the school itself. It was a new building and it had great big windows overlooking the Harvard Medical School quad and

little teeny windows facing up towards Mission Hill and Roxbury, where the community lived. There was no orientation towards Boston or Massachusetts or medicine in the United States.

One thing I'd seen at the Hospital Center was lots and lots of tuberculosis. I saw tuberculomas of the brain, I saw tuberculous peritonitis, I saw Pott's disease, I saw tuberculosis affecting the kidneys, and there were, to me, a lot of issues that came up about case-finding, about isolation procedures, and all those kinds of things, and I couldn't find any course work that was relevant to that.

There was a course that dealt with tuberculosis in the Third World, and so I went to the teacher of that course, and he said, no, he didn't know anything about tuberculosis in the United States and he really couldn't help out. I was also concerned about hepatitis and how we dealt with that epidemiologically or how you dealt with patients and their families and the hospital staff and all of those things.

So I and a couple of other M.P.H. students who had been practicing physicians went to the administration and said, "We want to know something about infectious diseases in the United States." The school was very accommodating and put together a spring course once a week, and they brought up someone from the CDC [Centers for Disease Control] to talk to us about tuberculosis, because there just wasn't anybody who could talk to us about that. But it was a good course and it also dealt with vaginal organisms and the outcome of pregnancy, which was totally

new to me. It, I think, was relatively new as a consideration for pregnancy outcomes, other than gonorrhea and syphilis, which people knew about. But strep infections and things like that was new territory. So they were very responsive in that sense.

I also went to Alonzo Yerby [phonetic], who headed the Health Services Administration at that time, and said, "Hey, how about something about public health in this area?" We had a five-day elective between first and second semester, which they encouraged us to use to become computer-literate. Then they had a five-day intensive computer course. But he offered to put together a five-day course for us in public health in the area, and that consisted of lectures in the morning and field trips in the afternoon. So Julius Richmond came and talked to us about community health centers, and then in the afternoon we went to the D___ Community Health Center and saw that. We did get a chance to go to the Region 1 regional office in Boston and also to the Boston Health Department. So it was kind of a little bit of redoing what I had done in medical school, in terms of getting around to see things.

Mullan: So it was useful, but it wasn't a great experience, the M.P.H.?

Garvey: It was an enjoyable experience. The other thing, I'd gone in as a straight Health Services Administration person, but then I'd gotten so interested in the aspects of the Title X

program, because I was working part time in the Community Health Center in a Title X program--

Mullan: Then being family planning.

Garvey: Family planning, right. So I started taking population science courses and ended up doing a project, and I don't even remember what it was, but it was a family planning thing, met other people in the population department and ended up getting a part-time job doing site visits to Title X clinics throughout Massachusetts for the state Department of Health. So I really enjoyed that, too.

Mullan: What happened next? We're up to 1975.

Garvey: Tommy was at Mass General and wanted to do another year there.

Mullan: He was doing gastroenterology?

Garvey: Right, he was doing research in gastroenterology as a G.I. fellow. So that was why I put together the half-time job at Boston City.

Mullan: That was the year following.

Garvey: Right, and continued at the family planning clinic.

Mullan: Had you now taken your family practice boards?

Garvey: Yes. I took the family practice boards in '74, as soon as I finished the training.

Mullan: You were now a certified family doc in search of an outlet.

Garvey: Right. So we came down here in '76, because Tommy went back to NIH. What I really wanted to do was work in a Section 330 in a neighborhood health center community health setting, in which I figured I might be able to do kind of medical director and a practitioner kinds of things, where I could kind of combine some administrative work with primary care, because a thing that had happened to me along the way was, I got addicted to patient care. So I had seen myself as going into public health, because I thought that one could do so much more by looking at the forest than by looking at the trees, but there's a lot of personal gratification in taking care of patients, so that I really wasn't ready to step back and say, "Okay, I've had it with patients. Now I'm going to go get an administrative job."

I came down and interviewed with Montgomery County [Maryland] Health Department. There were, of course, a few health centers in downtown D.C., but Tommy IV was still very

young. I didn't want to do heavy-duty commuting. I wanted to live in Montgomery County and work in Montgomery County.

The health department was very welcoming, and they said with my background I could work in the well baby clinics. I said, "What happens if the baby comes in with a strep throat or fever?"

"Oh, then we send them to the emergency room. We don't take care of sick children here." That didn't sound very rewarding.

I could work in the T.B. clinic. I said, "What if a patient has something in addition to T.B.?"

"We only take care of the T.B. They have to go somewhere else if there's something else going on with them. But in a few years there's going to be Shady Grove Hospital, and we think we'll have a health department primary care clinic there." But until then, the health department didn't seem very appealing because there really was no patient continuity experience available, no comprehensive continuity experience.

So I went back to Group Health and said, "Could I work for you part time?" They said fine. They always had part-time positions. So I ended up working a day and a half for them, while looking for something else, and went first to Bureau of Community Health Services, because that certainly seemed the most in line with all the things that I was interested in.

Mullan: This was Public Health Service?

Garvey: Right, which had the Title X and Section 330, which were really my great interests, where I turned in my résumé and was completely ignored. So I went to others. I went to I think it was the Bureau of Health Professions at that time.

Mullan: Bureau of Health Manpower.

Garvey: Health Manpower, yes. Bob Graham was the director of that program at that point. He was very pleasant, but it didn't sound very interesting. I interviewed with various other people, but the bureau still sounded like the most interesting.

And then Tommy met a woman in an elevator, an nephrologist at NIH, who lived next door to Jordan Popkin, and somehow the fact that he had a wife who was a doctor and who was looking for a job, and she was a woman doctor and was kind of interested in helping women doctors, she said, "I'll call Jordan and see if there's something in HSA that would be of interest."

And so Jordan Popkin interviewed me and got me an interview with John Marshall, and, I think, Phil Killam [phonetic], too. But in any case, when they actually looked at my résumé, they said, "This is real-live person who's actually worked in a health center. That would be unique in the bureau to have a doctor who actually practiced in one our clinics." So I got a job there.

Mullan: What was the definition of the job? I remember we interacted at that point a number of times. How many years was that, which years?

Garvey: They told me in October of '76 that I had a job. It took until the end of January actually to be brought on board. They said, "You've got the job. Just fill out the papers, and we'll call you when everything's processed." They still hadn't called me by the first of December, so I started calling and I badgered Phil Killam. Finally, I said, "I can't afford not to be working. I have to be on board by the end of January or I just can't work here. I'll have to go get another job." So they brought me on board January 31st of 1977.

Mullan: So this period is January of '77 through--

Garvey: October of '81. I came on board as a medical officer. There was a division that was supposed to kind of function across the divisions. It was doing quality assurance, but it turned out it was mostly MCH. I was really working directly under Mary Egan [phonetic] and Vince Hutchins.

That was an interesting experience, because when I got there I was told that the health centers and the health departments needed a quality assurance document for quality assurance standards, what to do, immunizations, and that kind of thing. I said, "Okay, when do you want it?"

They said, "One month. We want it by February 1st."

I said, "How do I get it?"

"Well, you write to AAP and you get their standards, and then you figure out how to do the quality assurance."

So I went to the library and I read up on quality assurance structure process, outcome, and all that kind of stuff, and I got the AAP standards and I put together guides to pediatric services. I guess I was supposed to do obstetrical, too. So that was January 31st I came on board. February 28th, I handed them the guidance, and they said, "What? You did it in a month!"

I said, "Yeah, you told me to do it in a month." Apparently nothing in the government got done in a month.

But then I had done it, and it seemed pretty straightforward, because all I had done was basically transcribe the academy standards from ACOG and AAP, and then put together chart forms that they could use and self-assessment things that they could do for chart reviews. I said, "Well, it's ready to go."

They said, "Oh, no, it can't go out. It's got to be circulated first. First we circulate it among the bureau, and then you revise it, and then we circulate it to the regional offices, and then you revise it again."

Mullan: Government.

Garvey: That's right.

Mullan: Why don't you give me a summary of those years, because I'm anxious to move forward to the primary care practice years.

Garvey: In those years, I was in that--I think it was Division of Clinical Services, but then I moved over towards the end of that year as a medical officer for Community Health Services. And then Marty Wassermann came in as the chief medical officer and was there for about a year. But then when Marty left, they decided that even though I was only half time, I could be the chief medical officer. So after Marty left, I was chief medical officer for the community health, migrant health, whatever, all those programs, wrote the internal quality assessment PCRR, which is just going out the door now, I understand, being replaced with some new form data set deal.

Then in '80 or maybe early '81, I moved over to be deputy director of the Office for Planning under Bill White. I loved the 330 programs, but I also had a lot of connection to the Title X, so I was very happy to move over there.

Mullan: You were doing all this half time?

Garvey: I was doing that half time. And then when little Tommy got sick, he was diagnosed September 25, and he was just going to need so much.

Mullan: Of 1981?

Garvey: Of '81, right. So I quit as of October 1, because clearly he was going to need heavy-duty chemotherapy. He was needing a lot of surgery and radiation.

What I had done meantime at Group Health, I had come there '76, fall of '76, and in the spring of '78, a couple of things had happened. A patient of mine who I had seen a lot, she'd had a lot of things, she'd had complications after gall bladder surgery, so I got to know her pretty well, and I got to know her husband because he would bring her in, and they were both forty-seven years old. One Saturday the husband called because he was having pain in his left shoulder, and he was told not to come in, because it was 11:30 on a Saturday morning and the doc could leave at twelve if he didn't have any patients. In any case, he called later and asked to come in downtown, and they also told him he didn't need to come in, that he probably had osteoarthritis of the neck, and to take analgesics, and he died at home with a cardiac arrest.

I was very upset with my colleagues for being too lazy to see somebody in distress. I was upset with the system which discouraged care by offering the doctors no incentives for seeing patients. I mean, there was a disincentive to see patients. The more patients you saw, the harder you worked, but you didn't get anything extra for doing it. So it just seemed like a patient-unfriendly system of care.

One of the doctors, the second doctor who turned this guy away, then decided that Group Health needed to pay more for

malpractice insurance, that the Group Health physicians should have increased liability coverage. They were covered to the same extent that the doctors in the community were, but this guy felt all of a sudden that he needed more than that, and he probably did if he were to practice medicine that way.

And then there was another issue, which was that at Group Health we only had to be on call once a month or something like that. They wanted to be able to moonlight, and this was a consumer-run cooperative which was set up so that the doctors would be well rested. Patients wanted to be taken care of by doctors who hadn't been up all night. So the patients who ran it said, no, you can't have outside employment if you're a full-time Group Health employee.

So the doctors went on strike, because even though those who were paid for full time wanted to moonlight elsewhere, and they also wanted more liability coverage. I thought it was a very selfish strike and worked to the detriment of patients. So I was a scab; I worked downtown. I did pediatrics, I did surgical follow-ups, and I did internal medicine until the strike was over, and then I decided that was it for Group Health. I really didn't want to work there anymore.

Tommy had been doing a little bit of practice one night a week with an old NIH friend of his, so I asked whether I could see patients several times a week in his office, and he said, "Sure." So I started seeing patients and had gone from three

sessions, as I started off in '78, up to pretty heavy-duty half time by the time I left the bureau in '81.

Mullan: This was at Group Health?

Garvey: No, in private practice. I entered private practice in '78.

Mullan: So the Group Health experiences you described culminated in '78.

Garvey: Right. I left in the spring of '78, took the summer off from practice to spend a little more time with my kid, but I was still working half time at the bureau, and then in the fall of '78 started private practice. And actually, at open season some of my Group Health patients left Group Health and came to see me in the private practice.

That was interesting, going back to something you said early on. The person that I went with, Tommy's old friend, took me right over to the medical society and said, "Register with their patient advocacy referral service, because that's the way to build a practice. If people call up asking for doctors, the medical society will refer them."

I started getting lots and lots of referrals, and a lot of the practice started with high school girls, because it was a time of feminism in the high schools and girls would get to the

point where they were having periods, they didn't want to go to the pediatrician, and their mothers would say, "You can come to our doctor."

They'd say, "No, your doctor's a man. I want a woman doctor."

So the mothers would call the medical society, desperate, and say, "I don't know any women doctors. Do you know any woman doctor who can see my daughter?"

Eventually I was getting so many new patients that the person that we were associated with--he'd sent me over there in the first place--got very angry with me and felt that I must be diverting patients from him, that I must have told the medical society that since I was the new person in the practice that I should get all the referrals and that he didn't need any. Of course I'd done nothing of the sort, but I was upset at his accusation.

So I want and talked to the lady who ran the referral service, and she said, well, no, this Peter Bent Brigham-trained internist, who had been chief resident at the Brigham, had never gotten around to taking his boards. She said, "First of all, the consumers are now asking for board-certified physicians. Second of all, family practice is much more popular than internal medicine. They'd much rather have family practitioners. And third of all, we have so many people calling and asking for women."

So the fact that I was a board-certified woman family practitioner meant that I was getting five referrals for every one that this non-board certified, but extremely well-trained and qualified internist male was getting. So the practice really grew very quickly, and eventually I really had to start turning down referrals from anybody, because I just had enough patients.

Mullan: About when was that?

Garvey: In '86, we were joined by another woman, an internist.

Mullan: When you say "we," who is that?

Garvey: Actually, at the point the original person that we had joined with had died.

Mullan: The Peter Bent Brigham-trained?

Garvey: Yes. He had pulmonary fibrosis and died at the age of forty-seven. But a friend of ours had bought his practice in '83 and was in practice with us, and Tommy again was doing a little bit of practice, a couple of mornings a week.

Mullan: When you left the bureau and for a while when Tommy, the younger, was so sick--

Garvey: Basically, big Tommy also quit working. He was splitting his time between NIH and FDA [Food and Drug Administration]. He left the federal government at the same time and started consulting to the pharmaceutical industry from home. He would go in to the practice two days a week, I'd go in three days a week, and he'd be doing his consulting from home.

But what happened was that since the practice was really growing, even though it had been relatively small at that point in '81--I mean, it was a half-time practice--as the time was available, new patients filled it. So really, by the time little Tommy was finished his treatment, it had expanded into pretty much a full-time practice. And that would have been '83, or really '84, early '84, he was really out of the woods. In '86, we took on another partner, and we took on a female because the demand for females was high.

Mullan: Was she a family physician?

Garvey: She was an internist. There weren't many family practitioners around in this area. There's a lot of room for them, lot of demand, still, but there's just not many of them. But I found that she was not getting new referrals because she was an unknown person. I had become known in the community, so I was getting referrals. I would be so busy with new patients that if my patients would call up sick, she'd end up seeing them because she had all this time. So my patients weren't getting

continuity, and she wasn't getting new patients. So I guess after she'd been with us for about six months, I told the medical society to stop sending me new patients, so that she could get all the new referrals, and then I really had to start turning down colleagues, too, except for family members of people who were already in the practice. So from '87 on, I would sometimes see patients, if things weren't too hectic, referred by colleagues or referred by friends of patients or referred by other patients, but for the most part it was just family members of people who were already in the practice.

Mullan: Did you have hospitalizations?

Garvey: Oh, sure, yes.

Mullan: At various hospitals?

Garvey: We had joined staff with Suburban when we went into private practice in '78, we joined the staff of Shady Grove when they opened in '80, and then I had also joined the staff of Holy Cross, because I occasionally had patients there, but an even bigger factor was that Tommy was getting a lot of his chemotherapy there, and on the staff I was able to park in the doctor's lot. Parking there was almost impossible for patients. [Laughter] So I could park there.

But it was really not a good use of time, to spend time driving among the various hospitals, and the problem is that there's so much paperwork that every time you'd for a patient, you'd end up going back just as often just to sign something that had been overlooked. If you call in a phone order in the middle of the night, then you had to go in, even if the patient is long gone. And since we were covering for other people, we really just found that it was too much of a burden. Patients we hadn't admitted, we'd call in an insulin order at 3 a.m., and then we'd have to go in the hospital just to sign the insulin order. So we ended up cutting back after a while just to Suburban, and that really did make more sense, although now that I'm with GW [George Washington University Health Plan], we're on the staff at Holy Cross and Shady Grove, because that's where the GW program goes.

Mullan: What I'd like to explore next is your recollections and observations about being a family practitioner in a populated, generally well-to-do community that is well stocked with specialists, how that has been both from the point of view of professional identity with your fellow physicians and others and what it's been like in terms of clinical work and how patients respond to you and how it's been for in terms of satisfaction, identity, etc. So why don't you just associate what it's like to be a family doc in Montgomery County, Maryland.

Garvey: Professionally, I would say it's a slightly awkward situation. At Shady Grove, they have obstetrics, which, of course, they don't at Suburban, but they're a little uncomfortable with the idea of family practitioners doing obstetrics. I don't want to do obstetrics, so that's not an issue, but you know before you even ask the question that there's a little hostility about family practitioners doing this.

At Suburban, because I was covering with a bunch of internists, I always got notices for the internal medicine meetings. I never got any notices on family practice meetings, even though all my credentials said family practice. I didn't even realize, until I'd been on the staff for a number of years, that they had a family practice department. I thought that family practice and internal medicine was treated as one department there, and by the time I found it out, I was used to going to the internal medicine meetings and liked them fine, and it was a chance to see my husband, who also went to the internal medicine meetings, and often it was the only time we'd see each other in a busy day. So that I would say professionally it left me a little bit without an identity.

Mullan: Who are the family docs at Suburban or in Montgomery County? Are they old GPs [general practitioners]?

Garvey: At Suburban, a lot of them at that point were older GPs or people who may have had a variety of training in other

countries, but couldn't get certified as specialists in anything here. At Shady Grove now, I think Shady Grove has become a focus for some of the people trained in family practice who have settled in Montgomery County, so they currently have, I think, a growing and vibrant department. The department was just quite small at Suburban.

And, of course, the useful thing about being in the internist meetings was that the internal medicine subspecialties were there, and certainly as a generalist I very much depend on the specialists when I put people in the hospital. If I'm going to admit a heart failure patient every two years, it might be a little more often than that, but a lot can happen in terms of therapeutics in that period of time, and I'm going to ask for the help of a cardiologist. The same thing with acute respiratory failure, which might only happen every five or six years in my practice; I'm going to call a pulmonologist. So it was useful to be part of the internal medicine department, because I did get to know all the subspecialists, and I think it was actually easier dealing with them and using them and finding ones that I liked than it would have been if I had just gone to family practice meetings and hadn't met all these other people.

In terms of patients, as I mentioned the Medical Society Referral Service found a great demand for board-certified family practitioners. It's a very popular idea with patients. One of the other ways in which my practice grew was that although the teenagers who had come to me because they wouldn't see the

parents' doctors grew up, went off to college, married and settled in many parts of the country, many of them, it began to occur to their mothers that the only doctor they had was an OB/GYN. They hadn't had a child in fifteen or twenty years. They were beginning to have some complaints that the obstetrician couldn't deal with, especially if it were high blood pressure or something like that. So that what I ended up with as a much bigger part of my practice than teenage girls was the mothers of the teenage girls.

Then I've also had a lot of that generation then start bringing me their parents. That, to me, has been one of the nicest things about family practice, to see three generations of a family, and there are a couple of families in which I've had four generations. I've got one fourth generation on the way, too, because one of the teenage boys in my practice is about to become a father and says I will take care of his baby. But it's got a very high rate of acceptability among patients, and I feel that's really the heart of the satisfaction.

Mullan: How would you characterize your practice, or can you quantify it? Is it predominantly women as opposed to men, predominantly one age group as opposed to another? How has it developed?

Garvey: I would say the largest plurality is women within five years of my age, up or down. I would say I probably have three-

quarters female, one-quarter male, and certainly I go completely across the age span. I don't have a lot of young children in the practice, because my coverage was internists, so I didn't take children under the age of six until I joined the GW plan, where I'm with other family practitioners. Now I'll take them from newborn on, but I haven't accumulated very many at this point.

I certainly have many fewer elderly patients than a regular internist does. I've always kind of wondered at the idea of making geriatrics a separate specialty of internal medicine, because one of the things I did when I was at the Hospital Center was kept track of the ages of my patients, and the average age was seventy-two. So as far as I was concerned, internal medicine is geriatrics training. But I have a lot of middle-aged patients, and at GW I'm getting more young adults, too.

Mullan: Maybe we should pick up and just do the GW chapter, because we stopped short of that, and then I want to come back and ask more of the big-picture questions. Recently you have moved from your semi-independent private practice into an arrangement with George Washington University Health Plan. How did that come about and how does it work?

Garvey: I've always enjoyed teaching. I feel as though I'm teaching the patients a great deal of the time, too. I really did want to become a teacher. I started teaching Georgetown [University] students, gee, I guess probably ten years ago in my

practice, precepting them in my practice, and then doing some classroom teaching downtown for the first-year students at Georgetown. GW approached me and asked me about precepting in my office, which I also did.

But then I understood that George Washington was going to start a family practice residency in the county, and I thought that teaching in a residency program had a great deal of appeal. So I started talking with Rusty Kallenberg [phonetic], who's head of the Family Practice Division at George Washington, and said, "When this comes about, I'd be interested in precepting some residents and maybe coming up there for an afternoon a week or something like that." So I just kind of kept in touch with them.

The September before last, I was really just kind of touching base with them and saying, "I know your residency is coming up in less than two years, and I just want you to know that I'm still interested."

He said, "We're still interested in you, too. Why don't you just move your practice up and join us in Rockville."

I said, "Oh, no. I love my office. I love my staff."

They said, "Well, we'll take your staff, too."

I originally said no. Then I sat down and started thinking about it, and one of the things that's happening to, I think, everybody in private practice in the last few years, it wasn't happening until maybe the last three years or so, is every January 1st or so we'd get a bunch of requests for record transfers, and often with sad notes, "My employee has changed me

to MDIPA or some other health plan, and I'm sorry I can't be your patient anymore. Please send my records to Dr. So-and-so." To me, that was a loss to lose the patients. I didn't have a lot of trouble replacing them, but you lose the relationship with the patients.

Meanwhile, the OSHA regulations had been passed, which had all kinds of Mickey Mouse requirements. The only, I think, useful part of the OSHA regulations was that all your staff should be immunized against Hepatitis B, which my staff already was. The CLIA regulations had come in.

Mullan: OSHA being the Occupational Safety and Health Administration regulations relating to--is it medical practice personnel?

Garvey: It's blood-borne pathogens, to protect the staff.

Mullan: CLIA is the Clinical Laboratories--

Garvey: Laboratories Improvement Amendments of 1988, which weren't implemented until '92, I think. But the state of Maryland, anticipating CLIA, since our Senator Barbara Mikulski had introduced CLIA, had in '86 implemented rules that were pretty similar to CLIA's, and they would come around every year and do a twenty-six-page survey of our laboratory and require that the only person who works in the laboratory recorded every

night that she had disinfected the counter tops, that she had recorded every day that she had checked the temperature in the refrigerator and the temperature in the incubator.

Mullan: This made for very cumbersome stuff.

Garvey: You bet. That she had not only done controls, but then had graphed the controls. She couldn't just record them; she had to graph them. And so she was spending six hours a week, in addition to her forty hours of lab work, doing paperwork, first for the state and then for the state and the feds, which was making the lab very expensive to run. I was getting to the point where my prices were having to go up almost every year, and I felt that there were plenty of people who were willing to keep paying those prices, but that there were also people who couldn't, and I didn't want to lose them as patients. I don't want a practice which is socioeconomically uniform.

Mullan: So you accepted the GW offer.

Garvey: So I accepted the GW offer. That seemed to get me out of all the administrative hassles of running a practice. The prices dropped. They charged less than I was charging, and I would have had to increase my prices. It also did offer me the opportunity to practice with other family practitioners so that I

could take younger children, and, of course, the opportunity to participate in building up the residency program.

Mullan: And most of your patients came with you?

Garvey: Yes, most of them have come. Of course, a couple months ago we got the usual raft of changes. And basically what GW has done, which has been terrific for me, is that they have said, "Your patients can remain fee-for-service." And they hired my bookkeeper to teach the GW people how to manage fee-for-service patients. They hired my nurses. So that worked out well. Actually, with the open season, a lot of my patients decided to change to GW.

Mullan: To come back.

Garvey: That's right, where they could come and see me at much less under GW than fee-for-service.

Mullan: Let's go back to the big picture. I'm very interested in learning your experiences, as I say, with colleagues and with patients, and let me just push on a little bit. Family practitioners are often seen in the world of specialties as less competent or less able, so that sophisticated patients would rather go to more highly credentialed and more highly specialized individuals, both because of the competencies or the alleged

competencies, as well as the fact that these "sophisticated patients" can make a determination if they need to see a gynecologist or an internist or a surgeon for a given thing. What is your experience with that?

Garvey: GW patients don't have a choice; they have to go through us. The non-GW patients will often call an orthopedist directly. For a lot of the other things, for the medical subspecialties, they may ask to see a subspecialist, but they want my referral, because then they have somebody that they know that I trust.

And then the other side of that, which I think is one of the most important aspects of being a family practitioner, is that I become the patient's advocate in the subspecialty system. I also become basically an interpreter, a translator, because the specialist may not speak in terms which are as accessible to the patient. So the patient my go to a specialist and the specialist may tell the patient what he thinks is going on and what the treatment should be, but the patient will then call me and say, "What did the specialist say to you? What do you think I ought to do?"

Mullan: Sort of the upside of gatekeeping, the positive side of gatekeeping, where you can be ombudsman.

Garvey: Right. Certainly when I do put a patient in the hospital, I know that I have to call and ask specialists

elementary questions that people with a large hospital practice wouldn't be asking, but on the other hand, it's usually very important to the patient that I'm still involved in their care, and even for the kind of simple-minded things. Simple-minded to the doctors are not simple-minded to the patients, things like getting the kind of diet that they want or like, getting something for sleep that agrees with them, getting something for constipation, the things that are routine, that don't really take an M.D. to do, but you still need somebody to write the orders. It may be just harder getting the best supportive care from someone who just doesn't know you. So I feel as though I have a real function in the hospital, even--

[Begin Tape 2, Side 1]

Mullan: What are the prospects for the growth of family practice in a community like this? If one could argue that you've been doing it for more than a decade and you're, at least until very recently, one of the few people, to my knowledge, who is doing that, that is, a recently trained family physician in general practice in this tally. First of all, I guess, is that true; and secondly, why have more not come and will more come in the future?

Garvey: Well, it's not so true, because I think that the GPs are retiring, but because there are more and more family practice

programs available all the time, there are more and more family practitioners available for all parts of the country, including this. So I think that younger family practitioners, a few of them, are coming back to this area, probably not in as great numbers as specialists. I think the specialists end up coming, say, to work at NIH, and then they decide to stay in the area. There's nothing to draw the family practitioners back to this area.

I think that the market for family practitioners is very good, and the managed care programs are actively seeking family practitioners and basically primary care internists and pediatricians, and they don't feel that there are enough of them around. The specialists, on the other hand, people are suggesting that they go get retrained so they can become generalists. Some of the obstetricians at Shady Grove are interested in working kind of a trade with our family practice residency program in that, yes, they will precept them in OB/GYN, but they'd like a little CME in generalist things, because they would like to be able to offer primary care to women patients.

I think that Montgomery County will clearly have more family practitioners just by virtue of graduating family practitioners from the GW program, because I think it's very common to stay in an area where you've trained. A lot of our applicants are from local medical schools, from Maryland, Georgetown, GW, and Howard, or people who have grown up in this area and want to come back. So I suspect that the vast majority of people who go through this

family practice residency, and that will turn out six people a year, will choose to settle in the county and practice right in this area.

Mullan: That's exciting.

Garvey: Yes.

Mullan: Back to the question I asked a little bit before, are there patients, in your judgment and experience, who are generalist-inclined and others less so? Clearly, particularly when you are a rare bird, there's a lot of self-selection that goes on in those who found their way to you. But in your experience practicing both with them and observing the community in general, are there people who are disinclined to generalist care and are anxious to have the cutting edge that were available at every visit?

Garvey: Of course, the people who really don't want to see family practitioners never cross the threshold, so I don't know who they are. But my sense is that almost everybody wants a family doctor, and there certainly are plenty of sophisticated people who want to see a left great toe specialist when the left great toe hurts, but they still want to come back and process it with their family doctor.

I have patients whose self-referrals I really can't control, but who will come back and say, "I saw my rheumatologist last week and my allergist the week before and my ophthalmologist before that, and my ophthalmologist doesn't want me to take aspirin, but my rheumatologist does. What do you think I ought to do?" So wanting a subspecialist on the cutting edge doesn't seem to preclude also wanting the family doctor to process the recommendations with.

Mullan: We touched this a little bit before, too, the attitude towards generalists in general or family physicians in particular among your colleagues. You, I believe, have been very active in the county medical society. Tell us a little bit about that and how you are seen in that community as an unusual entity, a family practitioner.

Garvey: I actually, I think, became visible in the medical society because of my interest in public health. I joined the Public Health Committee of the medical society, and then I became chairman of the Public Health Committee, which put me on the executive board of the medical society. While I was chair of the Public Health Committee, I founded something called the Primary Care Coalition of Montgomery County, which is an organization which the health department and the medical society and representatives of the five hospitals, now GW and other interested parties--community ministries, United Way--participate

in community clinics, mobile medical care. So I think it was actually more as a public-health-oriented person than as a family practitioner, per se, that I became visible.

The people who are president of the medical society are people who just become visible, and specialty seems to be irrelevant. The current president is a dermatologist. He was preceded by a plastic surgeon, preceded by me, preceded by a cardiologist, preceded by an orthopedist, preceded by a neurosurgeon. The specialty doesn't seem to have too much relevance.

It does have some relevance when the medical society is trying to form committees. The state medical society, which I am now treasurer and a member of the board of trustees, formed a committee last year to look at the idea of a medical society-sponsored HMO or PPO, and because Maryland in general is so laden with specialists. I think there are three ophthalmologists on our board of trustees for the state medical society. They wanted me on that board because I was one of the rare family practitioners that they could find that they knew and that they could put on the board, because clearly, family practice is important.

I think for a lot of the physician hospital organizations that are forming now--every hospital is trying to form them--again, the family practitioners are in great demand. Everybody wants family practitioners there at the core, because that's what the employers want to buy. They want to buy access to family

practitioners. They don't want to keep paying for access to specialists.

So I don't think it was a big benefit or detriment in terms of becoming active or becoming a part of the hierarchy of the medical society.

Mullan: In terms of another kind of colleague, the non-physician provider--the nurse practitioner, the physician assistant, nurse midwife--how have you seen that developing in this area, and what are the relationships, particularly between generalists either in your practice or you observe, and nurse practitioners or other non-physician providers?

Garvey: That's really an interesting area, and it's an area that is a concern to me. I worked a lot with nurse practitioners in Boston, because there were some nurse practitioners at Boston City Hospital, and I worked very closely with the nurse practitioner at the community health center, and we had a very well-functioning collaborative practice in which I was there for my three sessions. There was an internist who did internal medicine for two or three sessions a week.

When the doctors were there, the nurse practitioner functioned as a nurse. She'd do the vital signs, she'd take a little initial history, but we did the examination and the treatment. When we were not in the clinic--she was there full time--she would do the follow-up. She would check diaphragms for

fit, she would do things like blood pressure follow-ups, and she'd also do some primary acute care. So if a patient of mine or the internist came in with, say, a urinary tract infection, Pat would order the urine, evaluate the results, and usually call me or call Betty, depending on whose patient it was, and say, "I've examined the patient, I've looked at the urine, and these are the findings. What do you want to do?" So that she really functioned as a practitioner when we weren't in the clinic, and there were some things that she could do under protocol, and she functioned as a nurse when we were there. So that we knew her very well. We knew what her skills were, and she got an opportunity to work both with us and also semi-independently, doing her own evaluations.

When you look at the cost of medical care and you look at the functions that a generalist performs and you see that, say, I might be doing a bunch of camp physicals in the spring and in the fall I'm doing a lot of sports physicals, school physicals, that doesn't take a whole lot of heavy-duty smarts. It's pretty straightforward, and, gee, do you really need somebody with all this training and a hospital-based residency to do a camp physical? No, you don't need a hospital-based residency to do a camp physical. Do I want to turn it over to a nurse practitioner? Absolutely not, because that's when I get to know these kids.

If you first see a patient with a temperature of 103, who's writhing in pain and you're trying to figure out what to do with

the kid, but you have no rapport and no knowledge of that kid, I think taking care of his acute problem, you might as well be an emergency room doc. So I've never been really tempted by the idea of sharing my practice with a nurse practitioner or a PA. Although I have the greatest respect for their abilities, I'd be jealous. I don't want to give up the contact with the healthy patient.

I also do feel that my ability to care for a very sick patient is to some extent improved by knowing the patient when he or she is healthy. I want as much knowledge of that patient. I ask them what they eat for breakfast and what they eat for lunch and what they eat for dinner and what they snack on and what their hobbies are and what their husbands do for a living and are there any health problems in the family, do they have any pets. All these things, I feel, give me a context for treating the patient. So if I turned over the routine stuff to somebody else, I don't think I could be as good a doctor.

Mullan: There are those who argue that the future is non-physician providers and specialists, and that the generalist's role can be relegated to the non-physician provider and at a lower level of training and a lower level of recompense, and where you really need to pay your high-cost training and your high-cost care is with a fleet of specialists that will work directly with non-physician providers. Can you talk about that?

Garvey: It is a hypothesis which strikes fear in the heart of every family practitioner, and I disagree with the premise. Going way back to 1975, '76, when I was doing the site visits for the Massachusetts Department of Public Welfare and the Title X program, what I noticed very clearly, going around to the different sites, and these were basically sites just like the one that I was in, where there would be a doctor who came in for a few sessions a week and a nurse who basically ran the clinic and was really responsible for anybody who called or came in between, this was really before nurse practitioners were widely available and it was before the training was at all standardized, so you could go off for a six-month program and all kinds of things. And there were people who were not nurse practitioners, also, who were basically in charge of some of these programs.

The difference in the charting and the quality of the program varied greatly, and the top being a nurse, who I don't think was a nurse practitioner, but she had been an intensive care unit nurse before she'd been a Title X clinic nurse. So if a hematocrit of 22 came back, she'd know, "Gee, this could be a problem, I'd better do something about it," whereas some of the people who had just gone from nursing school into outpatient nursing, they get back an abnormal lab result, they would record it and ignore it, because they didn't have any kind of a context.

I think that when you've seen and had to deal with serious illnesses, that something which might not be very striking, but

which could in fact be an indication of something very dangerous, would have a lot more impact.

I had a patient who probably would not have been cared for, even in the future would not be cared for by a non-physician. It was a woman who had been treated for a cancer several years before. She had come in for a routine physical, and she had a small nodule in her navel, which she had noticed but she hadn't worried about. It was about the size of a pea. But knowing that she had had an intra-abdominal malignancy a few years before, I sent her to the surgeon right away. I mean, this was not some little umbilical hernia. Even over the course of ten days it took to get her under the knife, she had developed huge palpable metastases in her abdomen. I think it's the kind of thing which a relatively minor physical finding could give someone without more training a false sense of security. He might say, "Let's check that in a couple of weeks," or something like that.

Mullan: So your feeling is that the assurance of the quality of care and the vigilance in the hands of lesser trained people will not be as good?

Garvey: I don't think it can be as good. There's always a balance between how recently you've acquired your skills and your book learning and how many years you've had to observe things, and certainly a nurse practitioner or something will over the decades acquire more experience and be perhaps much more astute

than somebody who comes out of a hospital-based residency and has only been in practice a couple of years. But I still think that hospital-based training does give you some experience that you can't get purely in an outpatient setting.

I think if you took somebody and said, "You have a nursing degree, but I'm still going to put you through a medical internship and residency," perhaps you can be just as skilled a practitioner in that situation, but I don't think that with lesser training you can have the same level of knowledge.

Mullan: Managed care is obviously a big part of the picture now and presumably in the foreseeable future. You've talked a little bit about it in terms of your own patient perturbations that it's caused with your practice. How do you see it as a structural element of the system? You observed at least a version of managed care all the way back in the seventies. Are you for managed care or against managed care? What would your wisdom be on managed care?

Garvey: I consider managed care in general to be "K-Mart medicine." I was very idealistic when I started to work at Group Health, and I really liked the concept of an HMO which did not penalize a patient for being sick, where supposedly it was revenue-neutral whether you came in healthy or sick. What I found was that a system which supposedly has the door always open has to find a way actually to keep the door closed a great deal

of the time. So I would find that very pushy people could send in a seventeen-year-old child because the child had a bigger pimple than usual, whereas a very unaggressive person, like the husband of my gall bladder patient, could die at home without care because it was not easy to talk their way in.

You had to talk your way into the place. They had something like an intentional six- to eight-week waiting period for physical exams at Group Health, and sometimes even for regular appointments. In fact, the director was quoted in the *Washington Post* shortly after I left as saying that he really thought that most acute-care appointments should have a long waiting period, because most acute problems would go away by themselves, and then the patient wouldn't need the appointment.

I don't know what the balance is, because clearly it's not just the doctor-driven incentive to bring patients in for all kinds of things. Patients are absolutely unlimited in their ability to demand care, as long as somebody else is paying for it, and you certainly notice this when you're prescribing something and you say, "You have bronchitis, and I think doxycycline will work very well for you, and I think you'll like it because it's under twenty dollars for the whole prescription."

And they say, "Oh, yeah, but sipro [phonetic] worked really well for me last time, Doc."

I say, "Yeah, but that's seventy dollars."

"Oh, yeah, but my insurance pays for it." They want the latest and the most expensive if their insurance is going to pay for it.

I think that something like a medical savings account, in which the first dollar is paid for by the patient and there was some incentive not to spend, but always the backup of insurance if your expenditures exceed a certain amount, would be a far more sensible thing, but it's obviously much more difficult to administer. So I don't know what the answer is.

But managed care, I'm not convinced it saved money. What it's become now is one of the most profitable sections of the stock market, because the various business people have found that managed care, which I think started off as Blue Cross/Blue Shield, asking for second opinions and things like that, they figured if you can ratchet down the doctor's pay and you can ratchet down the patient's access and still rake in the kinds of dollars that the insurance companies were raking in, then you can pay a lot of money to stockholders, and that's what they're doing. If managed care were something in which all the dollars went to patient care, I think it would be a much less vicious system of care than it is now. But now it's a profit-driven, anti-patient, anti-physician system, and it is "K-Mart medicine."

Mullan: Given the trends in the system, which include managed care, it includes more primary care, it includes more non-physician providers, and a host of other potential changes, how

do you see the future if we look down the road twenty years, particularly from the point of view of someone who's dedicated her career to generalism, to the generalist approach to patients? How do you see it faring with the perturbations of the foreseeable future?

Garvey: It's hard to say. I can only imagine that as far as the payment mechanism goes, the pendulum is going to swing far enough that people are going to become outraged enough that we will dismantle the insurance system. I was terribly disappointed that the Clintons didn't succeed in doing something with health care. I think they got too ambitious and they tried to accomplish too much. I think if they had taken kind of a Lyndon Johnson approach and said to Congress, "See, the country wants this and the country wants that. They want universal access, they want noncancelability, they want no pre-existing condition exclusions, figure out how to do it," that maybe we could have gotten something that allowed the states some flexibility and still provided those features, because even the system as it was five years ago needed to be overhauled, and I think we need to get the insurance companies out of it.

Even though I rail against the inanities of Medicare, I think, in fact, a single-pair system is where we should be, and I can't imagine our not being there eventually, if not in twenty years, than twenty-five years, hopefully in five years.

I think the idea of having a primary care provider for every patient is so inherently sensible that regardless of how it's funded, that we'll continue to go in that direction. Whether those primary care people are going to be physicians or non-physicians, I can't imagine that we're going to change completely. Even in Group Health, when I was working there, actually I worked with nurse practitioners there. We had doctor/nurse practitioner teams, but we really functioned side by side. The doctor had his or her own patients, the nurse practitioner had her own patients, but the doctor was available to the nurse practitioner if her patients came up with something that was beyond her ability. And, of course, the doctor did the hospitalizations of the patients if the nurse practitioner's patients needed to be hospitalized.

I think that there are enough people alive who are used to going to doctors and who would like to continue going to doctors that there will certainly be a demand for the foreseeable future. But I also think that more and more people are getting accustomed to seeing non-physicians and that that will have increasing acceptability, also.

So I don't know. I can't imagine the primary care physician disappearing completely, because I think there are people like me who like to deliver that kind of care. In fact, there are specialists now who deliver primary care, simply because they treat a patient for something that's serious. Say a rheumatologist or a gastroenterologist may end up so involved

with a patient around a serious problem that that specialist will end up seeing the patient for the minor problems, too, that it would just seem beside the point to go off to somebody totally new who doesn't know the patient. If your first problem in a new town is serious and you off start with a subspecialist, you may never establish yourself with a primary care doc. And there are some specialists who really get a lot of satisfaction out of having patients they consider to be their own patients and for whom they provide all levels of care.

Mullan: I think that trying to scope out the future, with all the changes going on, is very, very difficult, and I agree with you. I'm concerned about the notion of generalism, even as it gains credence, which I think it is in this epoch, will also be routinized in a way that will make it easier to devalue in the sense of moving it down the hierarchy of skills and saying that lower-skilled people can do it. Even as it arrives at a point of prominence, it's also liable to simplification or devaluation. That's a real challenge.

Let's go back to the big picture, back out of the trees to the forest. I was interested and I was asking about your original majoring in English, because in talking to a number of people about their interest in primary care, it often comes up that people who have either started in directions that were not headed towards medicine, or even as they went into medicine their interests were other than traditionally scientific, who seem to

enter into the tunnel or into the chute of medical training, scientific training, and out the other side select a broader discipline rather than a narrower discipline.

As you look back at your own career, I realize you had some strong influence along the way that said, "Go down this path," but as you total up all that you've been through, your enjoyment to practice as a generalist and your vision of the world as a generalist, how does that relate to your earlier experiences in life? Do you have any thoughts about what contribution your youth and your pre-medical training has made to that?

Garvey: I think coming from a non-medical family, other than my great-grandfather in England, who, of course, I never knew, I didn't have perhaps some of the snobbery that comes along with being in a medical milieu from the beginning, so that being a doctor is kind of good enough without having to prove myself by becoming a sub-sub-subspecialist; whereas I think perhaps people who come from medical backgrounds, like my husband, or people who have gone through the sciences, where you seem to get the most credit for knowing the most about the least thing--I mean, you pick one little area and you know everything about this gene or this chemical or whatever, and you become an expert--I think that not having grown up in a scientific or medical milieu, that kind of expertise had no particular social value for me.

Also, not seeing myself as the primary breadwinner gave me the option to really just kind of follow my own preference and

not think, "Gee, as a cardiac surgeon, I could earn a lot better living than I could as a generalist." I wasn't even worried about having to support myself as a teacher. The financial aspects have never been part of the consideration, and I think that they are. If you had gotten married in the first year of medical school and have three children by the time you finish your residency and you think you're going to have to support them all, and you're married to somebody who doesn't work, who's been at home with the three children, that factors into your choice of specialty, and for an extra year or two of training to be able to have three or four times the income of a generalist, may seem to be attractive or to be worth it.

Also, though, I was a generalist because I felt that it was the best training for public health, which is really still a great interest. One of the advantages of the GW program, it's not just a straight family practice residency; it's a community-oriented family practice residency, and there will be an effort made to probably have the residents work in a community. There is something called Community Clinics, which is not a Section 330 center, but it is very similar in its concept, to have them do various projects with the health department and that kind of thing. So it will be very much integrated with my own interests.

Mullan: In terms of things we haven't touched on, and we've touched on a great deal, is there anything else that's occurred to you that you'd like to add to the story?

Garvey: No, I think we've touched on a lot of things.

Mullan: Good. Terrific. Thanks.

[End of interview]

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CAROL GARVEY

Fitzhugh Mullan

Interviewer

Mullan: Would you give me your name and spell it?

Garvey: Carol Garvey--C-a-r-o-l G-a-r-v-e-y.

Mullan: It is the 5th of January 1997 and we once again are in Dr. Garvey's house for a catch-up interview. It will be short and to the point but I wanted to come back and ask a little bit more about your experience with your son's illness which we touched on several times in our earlier interview but we really didn't talk too much about either what happened or how it affected you both as a physician and as a person. So maybe we'll start just describe a little bit about how it came about, what it was, and what happened medically.

Garvey: It was of course totally horrifying. Also I think it was extremely educational in learning what patients go through. Tommy went off to camp, a rather rotund child who had been teased by his classmates. He came back--

Mullan: How old?

Garvey: Eleven. He came back from camp--

Mullan: This would have been 197--

Garvey: 1981. --he'd gone off, I guess, weighing about 100 pounds and he came back weighing 86 pounds. So he had lost 14 pounds in four weeks. He (unclear) just looked like a different person. We said "Tommy, you lost so much weight. How did that happen?" He said, "Well, I was very active and the food wasn't as good as your cooking." He was thrilled because he had been called "Fatty" at school and he didn't like being fat. We took off the day after he returned for Cape Cod for a vacation together and the first night he woke up and said "I have an earache." We didn't have any instruments with us because we were on vacation so we had no way to deal with it so we gave him some aspirin and got up and the next day he was fine. His ear didn't bother him during the day. Over the next few nights he got earaches at night not during the day. We went over to visit a friend of ours on Martha's Vineyard and told him--we planned to visit him anyway--but told him that Tommy had ear pain. We actually went to an emergency room because Michael didn't keep his stuff at home, looked in his ears, couldn't see anything that looked unusual but decided, well, we'd treat him for (unclear) externus so we gave him cortisone drops which didn't make much

difference. Then over the next few weeks after he got home he began to get a really stuffy nose. So we figured maybe it's pressure on the eustachian tube that was giving the problem but a really stuffy nose wasn't unusual because T-three has such terrible allergies. So, okay, the kid's developing allergies. Not wanting to get deep into treatment of a family member we took him to an ENT person who said, "Oh, yeah, he's got bad allergies" and put him on Tavis-D. Then he developed purulent discharge from his nose and so we figured maybe he had a sinus infection. We took him to his pediatrician who said, "Yes, he's got a sinus infection" and put him on Bactrum (phonetic). After a few days he developed a rash--we obviously couldn't stay on Bactrum--we called the pediatrician back and he said, "Well, take him to Bruce Feldman" who was a somewhat more eminent ENT person in a kind of friendly neighborhood. The ENT person we had taken him to originally. Bruce Feldman tried to irrigate his sinuses and could not get water through his nasal pharynx. He tried to be very low key but said, "You know, why don't we get a CT scan. Try to set one up next week." This was a Friday. We obviously weren't up to waiting until next week and we called up Suburban and got him on the schedule for nine o'clock that night. Actually an acquaintance of T-threes from NIH was on duty at Suburban in radiology and saw a large nasopharyngeal mass which he said could be a benign vascular tumor of preadolescent boys--I

forget the name of it--that was bothersome but not malignant. So we pinned our hopes on it being that. We tried to reach Dr. Feldman, called his answering service repeatedly throughout the weekend, never got a return call. Monday morning I took Tommy to school, called Dr. Feldman from the school to find out whether I needed to come and pick him up early to take him to see Dr. Feldman again to discuss the CT scan and he said, "Did you give him breakfast?" I said, "Yes." He said, "Well, then, I can't operate on him today." Oh, that was my first experience with how awful weekends are for patients especially if answering services and doctors don't respond. He said, "Take him right over to Children's and we'll do a narcoriogram (phonetic) today." We did. He then had his biopsy the next day and we got the diagnosis the day after that.

Mullan: The diagnosis being?

Garvey: Rabdomyocin sarcoma (phonetic). I had tended to be optimistic--I'm just always optimistic--and my husband is just the opposite. He always wants to anticipate the worst so that he can't be disappointed. We got the diagnosis and then, I guess, about five o'clock on Wednesday night, and then I guess really benefitted AT&T by calling everybody we knew up and down the East Coast. I guess David Nathan (phonetic) who was up in Boston

(unclear) Harbor, called NIH people and then a friend of ours put us in touch with a guy named Paul Peebles who was a pediatric on call locally. Paul came by at about ten o'clock Wednesday night. He sat down with us and went over everything and said that he actually thought that Hopkins was preferable to either Children's or NIH. At Children's the technology was such that he would have had to had his palate split in order to get at the base of the tumor and do a definitive procedure as opposed to the biopsy that he had had. Whereas it could be done endoscopically at Hopkins and that was new technology. Only Hopkins and (unclear) had it at that time. They didn't have that surgery at all at NIH so he could have gotten Chemo but he couldn't have gotten surgery. I think he could have gotten radiation at Children's. He could have gotten surgery and Chemo but he would have gone to GW for radiation. They don't have pediatric radiation oncology at GW just kind of general. At Hopkins he could have gotten surgery, radiation and Chemo. We took Paul's advice and went up to Hopkins. Of course, T-three and I were just absolutely devastated and Paul said, "Well, you know, we really have to be honest with Tommy. We have to tell him what's going on." And he said, "Now, you can do it or I can do it. However you want to do it." Well, T-three said, "You do it, you do it. I couldn't possibly tell him." I wouldn't have minded telling him but T-three kind of assigned it to Paul. We went in and Paul

introduced himself to Tommy and sat down very earnestly and was straightforward telling Tommy, "You have a tumor and it's going to require a lot of treatment" and kind of went through some of the things that Tommy could expect in terms of the work-up and everything. "I want you to feel you can ask me any question at any time. So, do you have any questions now?" Tommy looks at him and noticed that he had one finger missing. He said, "Yeah, I have a question--What happened to your finger?" Paul had cut it off as a child in some accident. Interestingly, even though Paul thought he had told Tommy everything, we--it took us a few days after his discharge from Children's to get everything set up at Hopkins and then we had to go back down to Children's to pick up his X-rays and Tommy was very--getting kind of impatient with all of the rushing and bustling and he said, "What is all this about?" I said, "Well, you know Sweetie, it's really important to do all this stuff as quickly as possible when you have Cancer so you can get started on the treatment." He said, "Cancer! Nobody said I had Cancer. Why didn't you tell me I had Cancer?" So tumor he saw as an unacceptable euphemism. We went up to Hopkins and there he had bone marrow biopsies and LPS and all kinds of stuff and ultimately, actually, several, a big diagnostic surgical procedure. A definitive surgical procedure.

Mullan: All those were separate or just he had one surgical

procedure that was --

Garvey: He's had--he had two separate procedures up there. guess one--the first one--was 16 or 17 biopsies. They went into every saw (phonetic) in his cavity and did multiple biopsies in every sinus cavity. I guess that was the first one because they wanted to know whether it had gone beyond the nasopharynx (phonetic) because the thing is it was all in the back of the throat and it had put so much pressure on the sinuses that all the tissues were all distorted so that they really couldn't tell what was tumor and what wasn't. So the tumor had been kind of amputated at Children's as part of the--you know it was an amputation biopsy but there hadn't been any attempt to go deep into the underlying tissues. So it was the first procedure he had. That showed no extension beyond the original bed of the tumor. The second procedure he had was removal of the tumor base which had invaded the outer but not the inner table of the skull. They removed that. Actually, when we decided to go up to Hopkins it turns out we knew the Chairman of Pediatric Oncology, Bridget Levanthal and the Chief of Pediatric Surgery whose name I don't remember, was quite well known and had been written up a short time before for having done some wonderful throat cancer surgery procedure on some child. We called Bridget and said, "You know, Bridget, should we go to Dr. So and So for the surgery?" and she

said, "Oh, no, he's a lower pharynx man, you need an upper pharynx man." And so she steered us to Michael Holiday, who is an upper pharynx man. Actually, between the time he was at Children's and the time he went up to Hopkins and there was only like a week's difference, he developed numbness of the right side of his upper lip. We were really concerned about an involvement of facial nerves. Holiday is just renowned for being able to pick tumor off of nerves. Luckily it hadn't invaded the facial nerves but it was certainly compressing various nerves. He was really able to remove it completely and alleviate all the pressure.

Mullan: And did he get radiation and Chemo?

Garvey: Yes. He had 4500 rads of radiation which ordinarily would have been six weeks but because of Christmas and New Year's ended up going somewhat longer which was just as well because at the same time they started his Chemotherapy they had him on 24 cycles of intravenous therapy with Actomyocin (phonetic) D, Cytoxin (phonetic), Pristine (unclear), and that was at four week intervals and then they had him on 12 cycles at six week intervals of Intratracheal (phonetic) treatment with Methotrexate, Dexamethasone, and a third agent, I don't remember what it was. And the intrathecals (phonetic) just horrifying--

you know, they put right into the spinal canal because of the fact that it had invaded the outer table and basically they treat head and neck rabdos (phonetic) pretty much the way they treat leukemias (unclear) the C&S.

Mullan: His radiation was limited?

Garvey: The radiation, what they did, the protocol, he was randomized into an NIH protocol which--where the difference in treatment was between Actomyocin (phonetic) D which he was in or Abemycin (phonetic). The other thing was that the protocol included whole brain radiation which we were very upset about because it does tend to stop some of the maturation of the brain and result in significant detriment in IQ. As it happened, Paul Peebles had a child one year older and a child one year younger; Bridget Levanthal had five kids, one of whom was close to Tommy's age and I think that they kind of thought about it and thought we wouldn't want our kids to have six weeks, 4500 rads of whole brain radiation. The pediatric radiation oncologist was Moody who had been in Matthew's South, Tommy's freshman dorm and Moody has a daughter two year's younger than Tommy. So I think all these people with children around the same age said, "We wouldn't do this to our kid, we're not going to do it to yours." They didn't quite put it that way but that was--

Mullan: So that was the protocol?

Garvey: So much for the protocol. What they did was, they did what they call shrinking field. They started with a large field but then rapidly shrunk down to just the area around the tumor. Which, of course, unfortunately includes the pituitary gland. I mean there was no way the pituitary gland could avoid the 4500 rads. The Actomyocin D (phonetic) acts to amplify the effects of radiation so that this being head and neck--with head and neck tumors there's a lot of oral mucosa (phonetic) damage. You know, temporary damage. Not necessarily permanent. They also with the radiation they made molds of his teeth and they had him do fluoride treatments in these molds throughout the period of the radiation so that he had some way to protect his teeth from radiation.

Mullan: How did he handle all of these therapies?

Garvey: He was such a good kid. He was--he really understood the people trying to help him. He had small things, they were difficult to stick but two of our friends Mike Jacobs who had been an intern when I was a medical student at P&S and who practices on the Vineyard, in fact he was the one who took us to the emergency room so we could look into Tommy's ear and Debbie

Goldberg who was a class behind us in college and practices locally here. Both worked on him to teach him self-hypnosis. He would leave his hand behind for people to stick and the rest of him would go to Colorado back to camp. He really knew the self-hypnosis to kind of enable them to stick him without yanking his hand away--it was his instinct initially. Another problem was that he had really a catharsis (phonetic) kind of kinetic (phonetic) reactions with all of the anti-emetics (phonetic) but he was very, very sensitive to the emesis (phonetic) producing effects of all the Chemotherapy agents. And as long as you didn't distract him, he would hypnotize himself to try to control his nausea. But if you'd come and say, "Tommy, how are you?" that would break his concentration and he'd barf all over the place. He generally lost 10 pounds every time he had Chemotherapy. His weight actually ended up shortly after the radiation at 65 pounds down from 100. The radiation was terrible because it caused so many oral sores. He couldn't eat and he also was nauseated from the radiation as well as from the Chemo. Once he got--maybe a month or so out beyond the radiation, when the effects of it wore off, they were very tenacious (phonetic). I mean in the beginning it was like nothing and then as he had more and more radiation it wasn't just the oral sores but complete lassitude (phonetic) and he wasn't in school that whole year although he had home tutoring. I guess around February he

was still--he was on the tail end of his radiation, he had a seizure which I think was just the cumulative effect of the radiation and the intrathecal (phonetic) and all the other stuff.

Mullan: When did you have a sense that he was out of the woods?

Garvey: The problem with the Chemo was that we could never feel he was out of the woods. The data--when he was diagnosed we were told that for his stage, of course, medical school we heard 80 percent of the kids with rabdos (phonetic) died. We were devastated. We were assured by Paul that 66 percent were surviving at this point. Actually, by the end of the two years the data was showing that 75 percent were surviving. So they were making strides even as Tommy was getting the treatment. But the problem was that he--the further he got into treatment the longer it would take his bone marrow to bounce back. The second year of treatment was actually in a way more horrifying than the first. We put him back in school the second year which meant that he got exposed to everybody's germs. He would have five days of Chemo when he couldn't go to school, he'd barf and he'd be losing all this weight and then he would really work hard to start eating when he got his appetite back. Then the third week he'd hit his nadir with his white count and pick something up and he--the last year of therapy he was usually in the hospital twice

a month. Once for the first three days of Chemo because they were afraid that with his vomiting he needed round-the-clock hydration to avoid the cytox (phonetic) and damage to the bladder. Then once later in the month because with his nadir he'd get a fever and he'd go in and get triple antibiotic therapy which is horrifying, too, because No. 1 the infections themselves could have been lethal; No. 2, you know he was getting tobramycin (phonetic) which could wipe out his kidneys or deafen him, you know, just really heavy-duty antibiotics. So the whole thing was just an exercise in (unclear) to the very last treatment. The 24 cycles didn't actually finish until 27 months. They actually stored it because he'd get white count was too low, or he'd be too sick, or whatever so we would have to postpone the Chemo.

Mullan: How was his classmates with him having loss of hair and loss of weight? How did--

Garvey: Actually when he went back to school the first day he came home from school crying, not because of his classmates, but when he left school he was in the 98th percentile for height. When he went back a year later he was in the 50th percentile for height. And so all these kids that he had towered over were now towering over him. He was very upset by that. Most of his classmates were very protective and very concerned. There was

one kind of bad apple who was not a nice kid anyway who gave him a hard time but generally they were very protective. Bizarrely, three weeks after he was diagnosed the brother of a classmate of his was diagnosed with acute leukemia. The school was kind of freaked out--they had these two kids diagnosed within three weeks of each other and I think his class in particular because Tommy plus this classmate's brother. Then, of course, you've got them all thinking about the Kennedy kid who'd been about 10 years before.

Mullan: This was at St. Alban's?

Garvey: Yeah. Yeah. He had osteogenic sarcoma (phonetic). The year that he was back in school they had a school trip to King's Dominion and there were some kids there who were kind of saying, "Hey, what's that funny looking kid doing? Why are you bald?" You know, really kind of giving him a hard time and his classmates very much came to his defense. We actually were told at the beginning of treatment to take him to "Amy of Denmark" who has a wig shop in Wheaton across from Wheaton Plaza and NIH sends all of their patients there. And we were told to go to "Amy of Denmark" before he got far into the Chemo because Amy would work with--you know, look and see how his hair looked and then give him a wig that would look like his own hair. That was fine, we

went off and did that and it was kind of (unclear), he lost his hair all over one weekend. He wore the wig for maybe a week or two and then he found it was kind of hot and scratchy and he really wasn't interested in wearing it and he wore wool caps in the winter time just to keep his head warm but he really wasn't interested in the wig. What he did do with it was he'd go down to the end of Garry (phonetic) Road, stand on River Road with his wig on and then when cars went by he doff his wig the way a person would doff his hat (laughter).

Mullan: His father's sense of humor.

Garvey: Right.

Mullan: Tell me about you. How was it for you?

Garvey: It was, as you can imagine, incredibly stressful and actually at that point I was still working for the Bureau of Community Health Services. T-three was working for FDA and both of us decided with the schedule that we had that there was no way that we could continue working for somebody else. Tommy had talked about doing consulting from home or doing consulting--he hadn't really thought about having an office at home--he thought about just (unclear) an office--but leaving the FDA and doing

some consulting eventually anyway but this kind of hustled that process along. I'd been half time at the Bureau and half time in practice. Well, actually a little bit less, I think it was pretty much 80 percent time with the Bureau at that point. What we did was we kept the practice going and one or the other of us would go in for part of every day. That meant that one or the other was usually here. Tommy did very well, I mean he had several clients right away which was very lucky. One of the things that Paul said to us in the beginning was that it was going to be very stressful and that he wanted us to go into family therapy and he found us a wonderful person that we started going to. I think that--in addition there was a kid who was two classes ahead of Tommy and was diagnosed three weeks later, a year after Tommy was diagnosed a neighbor with an 18 year old daughter, we knew because she had been counselor at the elementary school day camp that Tommy had gone to, was also diagnosed with rabdo and--

Mullan: (Unclear)

Garvey: It was back more, well it wasn't really nasal pharyngeal (phonetic) it was retro-orbital (phonetic) I believe. Her parents ended up splitting. She died and I think that put even more stress on the relationship but I think that Paul as a

pediatric oncologist had seen the stresses that were put on a marriage. Actually, even in spite of the therapy, which we did for a year but then with Tommy being in the hospital twice a month, it became difficult really to even be available for family therapy, so we stopped the second year and ended up then going back a little bit after it was all over--after Tommy's treatment was completed. I nearly ended up going back and doing some very intensive work with her because I tend not to be very vocal in my expression and of course, as you know, T-Three (phonetic) is. What happened, I think that the dynamics were that he fretted about everything, he, you know, after Tommy's radiation treatment you say, "Well, there go a few more IQ points" he couldn't attend the intrathecal (phonetic) treatments, he just found the first one so horrifying that I had to take T-Four to all the subsequent ones. Because of that he got a lot of emotional support from everybody because everybody said, "Oh, yeah, poor Tommy's falling apart. Oh, Carol is so strong" and so I wasn't getting any emotional support because everybody thought well I was just handling it so well. I would see things that would worry me but I felt that I couldn't discuss them with Tommy because it would send him off the deep end and felt that I really couldn't turn to him for any support. It ended up being very resentful, very angry at him and really feeling as though I had kind of had to go through this ordeal alone where he had gotten both support from

me and support from everybody else. Of course, you know, he said "Well, if you had ever said you needed support, I would have been happy to give it." No, I wasn't falling apart, I was just expressing myself. You know, I think things were just so tense in those circumstances and there was just--I mean, there were so many scary episodes--we were vacationing on the Cape and Tommy got a fever and Paul had told us whenever he has a fever, he's got to get a white count. So we called some random lab in Hyannis and said, "Can we bring our child by for a white count?" We did it and then they could call back in an hour and give you the results. And I called back and asked what the white count was--the total count was pretty low, 1100, 1500, something like that--and so she started reading off so many lymphs, so many monocyte (phonetic), what about neutrophils (phonetic)? None. This just kind of struck terror in your heart so we called Paul and he said, "Take him into Children's right away." We did and then they--

Mullan: Children's in Boston?

Garvey: In Boston. And they had a whole unit for pediatric oncology. Then they put him in a four-bed ward and the kid across from him had aspergillosis (phonetic) pneumonia and so we weren't too happy with a zero neutrophil kid in the room with

somebody with aspergillosis pneumonia. He went off on a camping trip with St. Alban's when he went back to school in the Fall and they were out in the middle of nowhere when he developed a fever and so luckily there were several teachers. One teacher and a group of six boys had to trek back to civilization, find a motel, call us from the motel, of course the five other boys were thrilled because apparently the first night had been cold and wet--so they got to sleep in a motel for a night. You know, we had to drive two or three hours out across Virginia and pick him up and took him directly into Holy Cross. I don't know--then there was the time that we thought he had appendicitis and we didn't have a functioning car (laughter)--we'd get him anywhere and ice storms when we were taking him to radiation--just one disaster after another.

Mullan: As a pediatrician, I've always wondered what it would be like to have one of my kids, sick different from being sick myself and then what effect it would have on my practice or my attitude towards practice. What did it do to you?

Garvey: As I mentioned earlier, it really made me aware of how terrible weekends are for patients. The first weekend after Tommy was discharged--I guess he was discharged on a Friday--and around 7:00 or 7:30 on Saturday night Paul Peebles called and he

said, "I'm just calling to find out how things are." It was about half an hour after T-Four had said, "You know, my lip is numb" which had sent us both into a panic. We didn't figure there was anything to be done so we didn't call anybody, we weren't sure what we should do, but just to have him call right after this horrible (unclear) was so incredibly comforting. The thing was, he had been discharged from Children's on Friday, he was supposed to go into Hopkins on Monday and so I wanted the treatment to start yesterday--I didn't want to wait for a couple of more days before we could get anything going. You know, when you do a biopsy you've got to wait two working days usually before you can get a result. If you get biopsed on a Thursday or Friday, Heaven help you--you've got to live through the whole weekend without having results. I think it's made me extremely conscious of how terrible weekends are. One thing that I try to do is harass pathologists to the extent that I can to get results before a weekend and then, of course, once you get results you have to at least figure out some kind of a plan of action. If I can't, at least to keep in touch with patients over the weekend.

Mullan: Do you tell patients that you've had a child who's sick? I mean, do you share that?

Garvey: Yes, and I actually--I still have a lot of patients in

the practice who were patients at that time and because our schedule was so much dominated by what was going on with him, they really had to know--I mean, if he went into the hospital unexpectedly, the patient might get called and rescheduled--so really the patients were very much aware of it.

Mullan: For the record, just to tie off the story, just tell me a quick word about what Tommy has gone on to do.

Garvey: Well, in spite of his cranial radiation, he went to Harvard. We, I guess Tommy-Three blamed Moody Wearham"s radiation for the choice of law school rather than medical school. Various other things along the way but--after college he did a year of travel and then he actually ended up working at Dana Farber (phonetic) Cancer Center for two years. He was very, very interested in cancer but I think what kept him away were two things: No. 1, he felt that, as a political activist, he could probably accomplish more with a legal degree than a medical degree in terms of helping people and he also had a little bit of paranoia--I mean living, working at Dana Farber, wearing the radiation badges, and being aware both of organisms and radiation exposure, he was a little skittish about putting himself in contact with potential carcinogens.

Mullan: So he chose law school?

Garvey: So he chose law school.

Mullan: And he's currently a second-year student at Georgetown?

Garvey: Right. Half way through and has now decided to go to medical school anyway.

Mullan: Well let's if we could, shift gears. When we talked last you were in full-time teaching practice and moved your practice to the GW Health Clinic but the--and you had evinced interest all along in public health and becoming more active as a public health practitioner. Since then that's happened. I'd be very interested in knowing how that came about--how you became the Montgomery County Health Officer and what it's like--how it conforms to what you thought it might be.

Garvey: It was really a fantastic development from my point of view. I had tried to stay in touch with public health while in practice--I'd been on the Public Health Committee of the State and County Medical Societies and actually had headed the one Public Health Committee of the local medical society. I'd been on various task forces for the Health Department, had done a

breast clinic every Friday afternoon for the Health Department as a volunteer and after having had the Federal Public Health experience was really very interested in doing local public health where you're really not just kind of setting the global parameters but actually getting down and getting things done. When Duncan came in--

Mullan: Duncan being?

Garvey: The County Executive of Montgomery County--

Mullan: First name?

Garvey: Doug--Douglas--he--

Mullan: Which was when?

Garvey: In--must have been '94 he was elected--so he would have come in January of '95. He really wanted to streamline government. He's a fiscally conservative Democrat and he felt that the country government had become too large. In fact, the Health Department was very administratively top-heavy. The Health Department had expanded some of its activities during the 80s and then had been forced to cut back. They had felt that the

cut-backs were only temporary. The way they dealt with it was they maintained their entire administrative staff while cutting back the clinical services on the theory that they'd need everybody in place once their clinical services were again funded. They really didn't see the handwriting on the wall that the clinical services were gone for good. Duncan's team decided to really clean out deadwood throughout the government not just in health and to combine health and social services into the County Health and Human Services Department under somebody named Chuck Short who had been doing, I guess, some aspect of social services prior to that. The other thing that was true of Montgomery County is that while the administrative personnel were pretty stable year-to-year, the health officer is a political appointment and so that with County Executive comes a new health officer. Health officer may not be the most important appointment in the eyes of the County Executive and therefore, there was often a considerable delay or a prolonged appointment process or review process so that the Health Department could go a year or so without a health officer and yet they obviously had to keep functioning. The administrative staff was actually capable of carrying out the administrative functions in the absence of a physician to guide them. They then recognized the fact that what they needed the position for was medical policy--that while the physician was the chief administrator that the

kinds of things like dealing with the (unclear), working on the budget, that kind of thing had to go on whether there was a health officer or not. They figured if they didn't depend on the health officer to do these things, they could with a half-time health officer. A retired internist named Bud Bernton who worked with me on the Primary Care Coalition which was something that--

Mullan: B-u-r-t--

Garvey: B-e-r-n-t-o-n. Horace Bernton, actually. When I was in the Medical Society--when I was Medical Society Public Health Committee Chairman I had gotten something going called the Primary Care Coalition which involved the five hospitals in the county and the two agencies that were serving--private agencies non-profit--serving low-income people (unclear) in community clinic. We'd gotten various other people in. But Bernton had really picked up on the idea after he retired and had really gotten the thing off the ground. He suggested my name as the half-time health officer and called me and asked if I would do it. I said, "Oh, I couldn't possibly do it because I had this new job--relatively new job--still with GW." I mentioned it to Tommy. He said, "Of course you can do it. That's what you've always wanted to do." So after about 15 minutes thought I called back and said, "Well, yes, I'll do it." And it really has been

just what I've been wanting to do and get back and grapple with the local issues.

Mullan: What do you spend time on? What's your focus--

Garvey: It's an incredibly diverse job. It's a Smorgasbord--I mean just everything--you know, Salmonella outbreaks--

Mullan: This is Carol Garvey - Side 2. Tell me again what it is that you do on a day-to-day basis. It's a Smorgasbord.

Garvey: Right. Mercury poisoning, Salmonella outbreaks, sick building syndrome, all kinds of things. The two things that I've felt was most important were assuring primary care services for young children who are medically indigent. And addressing the whole issue of substance abuse, especially in young people. I think that by focusing on these two areas these are really where we will not only realize the greatest financial savings, which I think are very, very important, but also the greatest reductions in, you know, human suffering. I think that they are even in some way related because I think if you take a child and you fail to do say hearing, vision, and language screening prior to school entry and a child enters school with significant impairments that will interfere with learning, that child's self-esteem is going

to be poor, the child is going to find much less meaning in school, is going to be more susceptible to substance abuse and acting act and basically doing counterproductive things. I really see early childhood primary care and preventive care as having huge implications, not just for keeping children physical healthy, but emotionally healthy, successful in school and ready to become functioning, productive, citizens as adults able to work and less susceptible to things such as substance abuse.

Mullan: One thinks of Montgomery County as a wealthy County. It is perhaps one of the most wealthy in the United States, population of 600,000?

Garvey: No, somewhere upwards of 810,000.

Mullan: When you talk about the public health issues you're dealing with, Salmonella, kids without primary care, the immediate thing that comes to mind is "Oh, Montgomery County doesn't have that." How do you deal with that, it doesn't mean those problems aren't there--

Garvey: Well, Salmonella cuts across all kinds of socioeconomic groups and becomes an issue in day care where you've got children being diapered, multiple children being diapered by the same

caretaker and that kind of thing. It is estimated that there are 80,000 uninsured Montgomery County residents. The majority of whom are not uninsured by choice but are medically indigent. They're working in jobs that pay by the hour, by the day, don't have benefits, a lot of the service industry jobs, a lot of the housecleaning jobs, a lot of construction jobs, landscaping jobs--so that these are people who are above the Medicaid level--Medicaid is obviously a form of insurance--but really well below the point at which they can afford individual insurance and work in jobs where either insurance is not offered or the co-pay is significant enough that it can't be handled on an income of $15,000 or $20,000 or whatever. Probably 25 or more percent of those 80,000 are children--between 20,000 and 25,000 children are medically indigent, uninsured. Where I think we've tended to be myopic and where I think we cannot be myopic is that we've made statements like "90 percent of the children who come to us for care are fully immunized by the age of 2." But we are serving at best 10 percent of the medically indigent children which means that 90 percent of the medically indigent children may be under-immunized at the age of 2. I think we have to take a more global view of things and say, "All medically indigent children are our responsibility." Not that we can necessarily pay for it out of County funds but I think as Health Officer and as a Health Agency the County has to take some responsibility for trying to assure

that mechanisms are in place for addressing this problem. Glendening just announced about a month ago--

Mullan: Glendening being the Governor?

Garvey: Governor Glendening, right. --a program thriving by three which he's proposing to the State Legislature and I surely hope it passes. That will guarantee medical care for pregnant women who are medically indigent and for children up to the (unclear) grade. If he's able to do that then I think No. 1: our job is still going to be "Okay, these benefits are available, let's make sure they're utilized." Actually, the State estimates that of the benefits that are available that only 30 percent of people who are eligible actually take advantage of them.

Mullan: That's medical benefits.

Garvey: Medical benefits. There's a program called, "Kids Count" which is not as comprehensive as what he's proposing--it takes care of children one to five up to, I think, 185 percent of poverty. He wants to do conception to up to 250 percent of poverty. But the "Kids Count" program is only 30 percent utilized.

Mullan: What's it like with your rich background in the

provision of individual's primary care services now moving to the population level responsibility? How do you find that transition? And you walk back and forth between it day-to-day.

Garvey: That's right. I think it makes me maybe more realistic in trying to plan interventions than someone who hasn't been in the private sector. There's a lot of perception that private practitioners should do this, should do that, that they should provide free care or reduced cost care without understanding the real administrative difficulties of say providing care to people who don't have cars. If your office is not within walking distance and people are relying on public transportation there is no telling when they're going to get to your office and if you're set up to see people on an appointment schedule, you don't want someone coming in 45 minutes late. You also don't want them coming early and bringing their three children because they don't have day care. A lot of the should become a lot less powerful when you know what people are really up against in an office practice.

Garvey: Are you able to teach about that? Are you able to translate your public office into your residency (unclear) training?

Garvey: Yes. That's actually, I think, been very useful because Montgomery County has some wonderful things in the Health Department. They have a Crisis Center which is actually Social Services, Mental Health, not so much semantic (phonetic) health but certainly very much a mental health unit which is open 24 hours a day, 365 days a year. I think most people don't know it exists but anybody can walk in off of the street with an acute emotional problem and get immediate care and whatever follow-up is appropriate. They also triage to the State Hospital, for people who need it they have a holding area--they can people for several days if they need to without actually considering it an admission, they're not considered an overnight facility but they do have beds where people sleep at night. The County has nurse case managers which as part of GW, I've actually been able to call upon and say, "This Spanish-speaking mother doesn't seem to understand, doesn't seem to be giving, you know, bringing the child in for appropriate follow-up, isn't giving the medications as prescribed" and the County will send a nurse into that home and help instruct the mother. I think that's also very good for the residents because then they begin to understand what resources are available in the County. The County has a wonderful substance abuse program--just a terrific substance abuse program but if you don't know about it, the patients don't have the advantage of being able to use it.

Mullan: A last question. As we've talked about, throughout your career you've been interested in public health side effects even though until recently you weren't devoting major parts of your time to it. Now you're doing it. How does it square with what your interests would be?

Garvey: I find it endlessly interesting because of the fact that I've been pretty close to the Health Department all along. There are not a lot of big surprises in terms of what it's like and it's a particularly exciting time to come in because of the fact that Duncan has worked so hard to restructure things. A lot of people who were very committed to the old system have decided to retire because they're not comfortable with the changes but that makes it a lot easier to implement the changes. Basically what the County has done is privatize the things that we do pay for--like we pay for family planning but instead of hiring docs to do it, we have Planned Parenthood doing it. Planned Parenthood has tremendous buying power--they get birth control pills at a much lower rate than anybody else can get them for--they have terrific experience--just a very, very high quality organization. Would--I would have done things a little different from what the County had done before then was say to Planned Parenthood, "Look we have all this real estate, all the clinics where we've been serving people, our clients are used to coming

to them, wouldn't you like to give your services within our health center?" In some health centers they have said, "Sure, we'll come and do services there on site" which I think is much easier for the patients and it also means we don't have to worry about getting the records copied and sent over because the records are already in the Health Department.

Mullan: How do you feel about it? You, Carol Garvey?

Garvey: I'm loving it. It's really, you know, I think life is a series of random events and private practice was the random event for me. It was not ever something that I had intended to do. It was very nice to do. I loved having one-on-one relationships with patients which, of course, you don't get out of primary care. It is piecework. It's the trees, not the forest. I've always really felt that the real challenge and the real chance to do something unique was to do public health. I think that if a private practitioner isn't there, there are plenty of others and we have a glut of doctors, especially in Montgomery County. We don't have a glut of people in public health and I think an individual can do a whole lot more in public health and accomplish a lot more. Do more good basically.

Mullan: So it's met your expectations?

Garvey: Yes.

Mullan: Good. Maybe we should stop at that. I've got one eye on the clock--