TIM HUGHES

Dr. Fitzhugh Mullan,
Interviewer

Mullan: What is your date of birth?

Hughes: July 14, 1950.

Mullan: We're sitting on the deck of Dr. Hughes' home overlooking Penobscot Bay, is that right?

Hughes: Right.

Mullan: And it's headed towards sundown on a beautiful July evening, it being July 11th, not quite his birthday but coming hard on it, and with a smattering of boats and Isleboro Island in the background, and a picnic table between us. I'm glad to be here, and I wonder, Tim, if you'd tell me a bit about where you were born, where you grew up, and how you grew up.

Hughes: I was born at McDonald's. In Cleveland, the obstetric hospital is called McDonald House, and when we were kids, we always thought we were born at McDonald's. So I was born at McDonald House in Cleveland, Ohio and grew up in a well-to-do family--my father was an executive, business executive--in the country, but not in a community area, rather a farm house surrounded by woods on three sides and suburban sprawl on one

sides. I went to a private school and had a fairly isolated childhood, I guess I'd say.

Mullan: Isolated in what sense?

Hughes: That my friends were upper class, well-to-do people, and I didn't have too much exposure to poverty or suffering or pain, but I did take trips in high school, initially with my father and then later on on my own, I guess mostly--only to Latin America, I guess, come to think of it, but to places where I saw poverty and saw a different way of living.

Then I went to Dartmouth College and mostly had fun, especially for the first two years. I goofed around. And then halfway through, I decided I'd better do something with my life, and at that point, in a naive fashion I decided I would either go into writing or medicine. I'd gotten a lot of awards for writing at the time, but I thought that that wasn't a worthwhile venture, a worthwhile way to spend one's life, and so I thought that the best thing to do for one's life was save lives, and so I decided to try to go on to medical school, and I succeeded, much to my surprise.

Mullan: Had you liked science?

Hughes: No, I never liked science. I still don't like science, and I don't really fit into the medical mold, I don't think.

Mullan: How did you find taking science?

Hughes: Oh, I did okay in it, but I wasn't interested in it so much. I majored in English literature.

Mullan: So you applied to medical school?

Hughes: So I applied to medical school, and I got into three or four of them and decided to go to Case Western Reserve.

Mullan: What years were these?

Hughes: '68 to '72 I went to college, and '72 to '78 I went to medical school. I was in medical school six years, because I took a couple years out. After one year of medical school, I decided I didn't know what the hell I was doing. The dean then was a well-known dean, well-known for his liberalness, and--

Mullan: Fred Robbins?

Hughes: No. It was before Fred Robbins. It was Dean Caughey. I remember going to ask him if I could take a year off because I felt lost, and he said, "Yes, but there's one rule. The rule is that you need to come back within three years, because we had one person actually come back after thirty years, too long." So I thought that was a pretty reasonable request.

So I took a year off, and I worked on the border between California and Mexico in a small United Farmworkers' clinic, with Cesar Chavez, and there I met my future wife. It was probably a seminal year for me. I worked in a rural area, and I learned about the community of farm workers, and I learned about what it's like to be in a family, a Latin American family. And that gave me direction in medical school, because the following year I took another year off. I went back for my second pre-clinical year, and then following that, I took another year. I looked at primary health care projects in Central and South America for the year. So basically, my wife and I--then wife; we were married in between--hitchhiked down from California through Mexico and Latin America and we used the search for a primary health care project as an excuse to get out into the country and see people.

I decided, after doing that, that I didn't want to work in another country, in another culture. So I went back to medical school and finished off.

Mullan: Decided you didn't want to work medically?

Hughes: I didn't want to work long term in a developing country that was non-English speaking, at least.

Mullan: Why was that?

Hughes: It became clear that the solution to health care problems in developing countries has to come from within, within

the country, and what people really need is teaching, and it has to be teaching from within the culture. So a foreigner has relatively little to contribute.

So I left that right there, that whole idea of going off and, I suppose, saving the natives, whatever, at that point and went back to medical school, chose family medicine because of my prior year off.

Mullan: Because the farmworkers needed family docs or that setting invited family medicine?

Hughes: No, because of the community aspects of working in a Latin culture. The rewarding parts for me are the fact that every person has a story and every person is connected to a whole bunch of other people and they all interrelate. That's what interests me.

So I went back, and I finished, and at that point I thought, "Well, maybe I'll do family medicine in this country, but in a HispanoAmerican culture." So I went and did a residency in Fresno, California, a family practice residency for three years. Then I started getting back to this idea of going to another country.

So in the last year there I did a *locum tenens* in New Zealand. We had decided to go to New Zealand, try to live there for a while. I got a job and had spoken to all of the major people in general practice in New Zealand, and everybody was in favor of me coming except for the licensure board. There's no

reciprocity between the United States and New Zealand, and you can't get a license to practice medicine in New Zealand if you're an American graduate. I had a job. I just didn't have a license, and I couldn't get it. So we came back here in '82.

Mullan: You'd gone to New Zealand?

Hughes: We'd gone two times to New Zealand. We came back to California with no job and nothing to do, and so my wife Cris and I, bought a truck, and we drove across the country looking for a place to settle, and we ended up almost settling in a place a couple hundred miles further northeast of here, the most northeasterly town in the United States, called Lubec, which is extremely isolated. The hospital is thirty miles away, so it would be a long drive to do daily rounds. We decided that was too much, and we came back here. We ended up here in '82.

Mullan: How did you come to Belfast?

Hughes: There was an ad for a local clinic in the nearby town of Liberty. It was the same ad that my partner David Loxterkamp answered two years later.

Mullan: But you didn't go to Liberty?

Hughes: I went to Liberty initially but in negotiating the contract with the then head of the hospital here, it didn't seem

as though it would be safe for me to sign on the dotted line. All I wanted to do was not lose money. I said it would be okay if I didn't make any money for the first few years, but I just didn't want to lose my own money. I wanted a guaranteed salary of $7,000 a year. I figured that's what I could do to break even.

Mullan: In terms of what you had to pay to set up?

Hughes: Rent and food, that sort of thing.

Mullan: Malpractice?

Hughes: No. They were going to pay for setting me up, but I just needed living expenses, which $7,000 in 1982, that's not very much. But they wouldn't do that. So I decided to back out and work in another community clinic near here and then just settled in.

I started working in Searsport, where we are now, with a cardiologist who was here, and it was clearly a primary care place to work. People wanted a doctor to deliver their babies and etc. So the cardiologist left, and in the meantime David Loxterkamp had come. So that was two years later.

Mullan: There were other family docs in town at the time?

Hughes: There were two or three others.

Mullan: And they weren't interested in partnering?

Hughes: The history of this town is that no one had been together in practice except for David and myself. There have been a few associations but no real partnerships.

Mullan: Do they cross-cover?

Hughes: Yes, we cross-cover.

Mullan: So this seems a long way from the border, a long way from international health. How does it square with the directions you started in?

Hughes: Well, it doesn't at all. I mean, these are different directions, and I've taken years off since then. In '89, '90, I took a year and worked with McGill University, setting up a family medicine residency program for the country of Costa Rica. So that was a continuation of this desire to do something in another country, and it was good because it was teaching, which is what my conclusion was ten years before, that that's what was needed. And it was good because it felt like I was setting up a continuing program. I wasn't just going down there and teaching people how to deliver babies or whatever, and leaving. We were teaching teachers. It was a process of figuring out what family medicine means in another culture. It's a very context-dependent concept, generalism or family medicine.

Mullan: Did it take root?

Hughes: Yes. I haven't kept up in the last couple of years with my friends there, but it was thriving years later. When McGill pulled out two or three years after I left, it was thriving.

Mullan: Your work here has coincided with a significant growth in the visibility and credibility of primary care, maybe less in the eighties, but certainly in the nineties across the country. There have been more students choosing primary care. There have been more family practice residencies set up, etc. Have those influences been felt by you in practice one way or another? Is the currency of primary care different in this community than it was when you started?

Hughes: I don't think so. I don't know. I don't think my relationship or standing in the community has changed any. I guess that's sort of what you're asking. It doesn't seem like it to me. I'm not a political person. I don't hang around with doctor issues much, and I don't think it has made any difference. In my personal family life, I have felt the change. My parents are eighty-four and eighty-two, and my father was involved with the Cleveland Clinic Foundation for many years, and so his care has always been specialist-oriented. But the older he gets and the more frustrated he gets with fifteen doctors for fifteen different ailments, the more he appreciates my approach to health care. So that's kind of neat.

Mullan: That's not the system changing, but your dad changing?

Hughes: Right. But he is representative of his generation who built the specialist care system.

Mullan: The practice you built is unusual in this community in that it's a partnership, and as I understand it, now with another physician, a PA, and a number of ancillary people, it's a sizeable operation. How do you feel about that? You're running a small business. Is it what you saw yourself doing?

Hughes: No. I mean, it just happened. I really don't like the business aspects of what I do. I just kind of avoid it. It seems to run okay. David's been more responsible than I have been with the financial aspects of that.

Mullan: Where do you foresee it going?

Hughes: No idea. I don't know why, but I would rather have been an employee, just not have to deal with all that.

Mullan: Do you see heading there? That's one option.

Hughes: I mean, I want to be connected to a community and now I have a place where I belong, and we've built something that exists, an entity that I am an employee of. I'm an owner of it too. But I don't know.

Mullan: The theme of community has always been strong for you from your first inklings that you wanted to go into medicine. Tell me a bit about how that has been realized through your life and practice here.

Hughes: Well, this is a small town. What more can I say? Everybody here is connected to everybody else, and one of the values of bringing up a daughter here is that everyone knows who she is, and when she begins to experiment with who she is, that will probably be cloying for her, but it'll also be reassuring and provide a structure for her, that people will tell her who she is. I won't. Other people will. I think that those connections in a small town are important. People know me as a doctor, and now they know me as sort of the town historian, and they know me as the crazy guy that walks out to the monument on the ice, and they know me because I row down to the harbor every night. So there's all these different hats that I wear.

Mullan: So the sense of community that you sought exists here?

Hughes: Yes. I don't know if I consciously went after that, though. It happened. It's a nice place to be. I didn't begin life with this idea. I was naive. I thought the idea was to do good. "Now, what's the best way to do good?" And things kind of went from there. I didn't have a grand plan for my life.

Mullan: But this theme of connectedness which many people, but certainly many physicians, don't recognize or value is one that certainly going back to the time with the farmworkers and the first year of medical school has been in your mind, and you certainly seem to have captured it here, which is not something people always do, even when they have an idea.

Hughes: I think I've always valued a different type of factual knowledge or pursuit of knowledge or truth than is generally accepted in medicine. In medicine we search after the scientific truth, the objective reproduction of tests, and this other way of searching for truth, which is through the stories of people or when things seem right, it's a little bit more intuitive and a little bit more nebulous, but both ways of searching out truth are based on belief. So I think it's just as valid. And that's where I've come from, I think. It's not that I reject scientific truth, but it just seems like there's other valid avenues to find out what's going on and to find truth.

Mullan: Tell me more about that.

Hughes: Well, I'll give you an example. A medical example would be a woman who I saw last week. Ten years ago I delivered her baby and hadn't seen her in those ten years until I was in the laboratory here in the hospital. I was on the phone in the lab, and I heard a "Code five, physical therapy. Code five, physical therapy. Code five, physical therapy." I don't know what code

five is. Nobody knew what code five was. So I opened the door to the lab, and twenty people were running down to the physical therapy department. I didn't know what Code 5 was, so I kept on the phone. Finally somebody opened the door and said, "Dr. Hughes, you're needed down in physical therapy."

I hung up the phone, and I ran down there, and there was a woman who was shaking uncontrollably on the exercise machine. It was this woman, Brenda, who I'd delivered ten years before and hadn't seen her since. We got her on a stretcher, and she was shaking uncontrollably and we wheeled her--

Mullan: Seizing?

Hughes: Well, to all external appearances, she was seizing. We wheeled her past her mother in the hallway, who was an employee in the hospital. We'd just thrown a sheet over her, and she was just making all kinds of racket, and we just wheeled her as fast as we could down to the emergency room and got an IV going, gave her some Valium and oxygen. She had two or three more episodes, and each one seemed a little bit more bizarre. A couple of times she was banging her head. During one of them she was talking to me, and she was talking with her lip pulled down on her face so that it just seemed very strange. Later she couldn't move her leg. She could walk to the bathroom, but she couldn't move her leg on exam.

So I looked at her chart, and she'd seen a couple other doctors, and she'd had these spells. Apparently she'd been

seeing a neurologist in Augusta. So I called this neurologist up, a woman, and she said that she was fascinated by this patient, she thought she had an extremely rare neurologic condition, and she was scheduled to have muscle biopsies done the next day, and she'd had MRIs and EEGs done, and everything was normal, and yet she has these spells.

There was another note about how she'd consulted another neurologist in another town, and so I called that one up, and I got the same story, only he said--"I doubt if it's a seizure." But he'd referred her down to Portland, to another Neurologist who'd done MRIs and EEGs and also had referred her to Hanover, New Hampshire, a nearby Tertiary Care Center for further MRIs and EEGs and exams under Amytol anesthesia.

Anyway, several neurologists had seen this woman, who had had all the same tests done, and it soon became clear to me that this woman was not having seizures. I don't know if I know what she was having, but she was not having seizures, and also, she was like this and she couldn't move her leg. She could walk to the bathroom, but she couldn't move her leg on exam.

So what do I do with this person? It was fascinating to me to try to put together this person's story and trying to figure out what was happening and then how to deal with it. The neurologist, the one in Augusta, was persistent in her belief that this woman had a rare neurologic disease, and I was quite sure, I still am quite sure, that she does not have a neurologic disease but that she has a psychiatric disease.

I decided to confront the patient and began talking to her in language that I expressed that I care for her and that I believe that she cannot move her left leg, but I also believe that this lack of being able to move her left leg is a message to me, it's a communication to me that something is wrong in her life. The day I confronted her, her symptoms cleared, momentarily, then they came back. I don't know if that was cause and effect or not. I discharged her to go back to the neurologist to finish the work-up, and then I told her, "I believe that this work-up is going to be negative. I believe you do not have a neurologic problem, but I want you to finish with the specialist, and then come back and see me, and I want to see you." And she didn't show up. So she may still be in the clutches of the neurologist.

But I think that she's a good example of the two approaches to this woman, and neither of them have found an answer yet. But one approach is to do a lot of objective testing, which is valid, and the other approach is to look at this woman's life and look at her, her past, and look at her context, and try to figure out what the heck is happening with her. They both might have truth in them. So that's what I mean. That's an illustration of another way of looking at truth.

Mullan: Are there particular belief systems--that's not quite the right word--that inform or influence your practice and your thinking, religion, philosophy, scientific perspectives?

Hughes: I don't know, other than what I just told you.

Mullan: But there's not a particular camp or school of thought, psychiatric, philosophical, religious that you draw, that you've read or studied, that you would say informs your work?

Hughes: Not that I know of. I'm not a devotee of any school or anything like that.

Mullan: Is religion important in your life?

Hughes: No. I don't go to church. Actually, my wife does go to church, and when she goes to church, I go out to my best friend's house, who is a dairy farmer, and we milk cows together. There's nothing more religious to me than shoveling cow manure, standing behind these beasts that give us pure milk, and shoveling their shit. It's humbling.
You have to actually stand in the gutter with boots on and shovel the cow manure into a big wheelbarrow, and then you wheel it out and you dump it in a big pit.

Mullan: And that gives you meaning or gives you--

Hughes: I don't know. It's humbling. Good question. It's a rejuvenating thing, a recharging that I can do that seems to have a spiritual dimension to me.

Mullan: I know from what David told me that you have--I believe it's called a Thursday morning meeting, a staff meeting where you, as a group, try to relate to one another. Tell me about that and where that came from and how it works.

Hughes: David and I are really good friends, you know, in the deep sense, I think, and we each grow from each other. We've done that ever since we've come together, and I'm not sure where the genesis of that all came from. It might have been David's longing for more personal connection. And then Mary Beth came on the scene, which is our psychological/social worker/counselor person.

Then also we came across an article written in the family medicine literature by a group in southern New Hampshire who had started a similar kind of a group in their hospital. I went down to visit that group and got permission to attend one of their meetings, and it was good. It was neat. People just talked about personal problems that they had had, personal, often medical-related. I think somebody was talking about a lawsuit that they were going through at the time, during the session that I was there. People let down their guard and took off their epaulets, everything that tells us that we're doctors, and we need that. We need to be human beings.

Mullan: This is the way you run the group? It's the entire staff?

Hughes: No. It's just us caregivers. Actually it began with David and myself. For two or three years it was David and myself and the counselor, Mary Beth. Then we invited Scott, who was our physician assistant for a number of years, and finally he came. Now he comes regularly, and now that we have our third partner, Lisa, she comes. And we've invited other members of the medical staff on the hospital. None of them have come except for two new people who are coming. They used to come. They come sporadically.

Mullan: Are you aware of Balint groups?

Hughes: Yes.

Mullan: He was an English--well, he actually wasn't. I think he was Continental, I've forgotten, Austrian or something, but he worked and practiced in England, and he used basically group psychotherapy techniques with practicing physicians. It was an important element of the early Family Practice Movement, or General Practice Movement, in the fifties in the U.K., and it had elements in common, it seems to me, with what you're trying to do, the philosophy being to make the practitioners more functional if there was a good and shared understanding of themselves and their issues.

Hughes: Yes. If I'm not mistaken, the Balint groups were focused on patients, weren't they? Patients were discussed?

Mullan: Yes, that's right.

Hughes: And in our groups, the focus is on ourselves, caring for ourselves. I think in the Balint groups it's caring for yourself in relation to your patient care, but in our meetings we're human beings first.

Mullan: And this has been useful, you feel, for the practice and for your relations with each other and yourselves?

Hughes: It was really useful for David and myself. The smaller the group, the more intimate it is and the more deep it is. So it was quite useful for him and me. Now that's it's bigger, it's a little less personal, but I think it's still an important issue. It's an important meeting that we give time, an hour each week for ourselves. It's a statement that's important to make.

Mullan: How about issues of privacy, both in regard to that group as well as the many issues you deal with your patients in the small-town setting? How difficult is it to maintain barriers appropriately?

Hughes: Privacy?

Mullan: Well, you're clearly privy to fairly intimate details about the lives of your patients, some of whom you also see when you go to the grocery store or the gas station. So are members

of your staff privy to some of that same information within the group, just within your own practice, if you're engaging very forthrightly about things that are going on in your life. There would be, I presume, items factual and attitudinal that are shared that are fairly personal. Problems with keeping perspective on that and being able to function while not disclosing or having others disclose information?

Hughes: Well, I haven't had that problem. I've certainly shared personal details and haven't felt that I'd been done wrong by anyone or anything. So I guess I don't have any problems with it. It's a tremendous privilege to be a doctor in a small town. I haven't had any problem that I can think of, with confidentiality.

Mullan: I can't remember if it was David, the discussion we were having, or whether it was an earlier discussion, but someone talked about living in the crystal glass in terms of being a doc in a small town where people are constantly watching you, observing you. Your amount of privacy is pretty limited. Is that an issue?

Hughes: Well I'm only a part-time doctor now, and so hopefully I'm getting a little bit away from the label, which is nice. It's nice to have more than one label in town because then people get confused; they don't treat you as just a doctor. I don't feel that. You can go downtown in your blue jeans, and they will

treat you like everybody else. There's a problem with being on call and being vulnerable all the time. That's the nature of the game. But I don't think we're treated like the generation before us, in which the doctor was sort of revered and also separate from his community, and suffered socially because of that. Maybe elevated but also alone. I don't think we're that way.

Mullan: The call schedule and the kind of steady pressure of being a family physician, appreciating now that you're working part-time, and we'll come back and talk about that, but for the many years that you were working full-time, how enervating, how problematic was that, and how did you deal with it?

Hughes: I just bluffed it through. I don't know. It's fun to really work hard too, you know.

Mullan: It was not troubling for you?

Hughes: It wasn't troubling for me to--I mean, yeah, there's times when you don't want to get up in the middle of the night and this sort of thing. I don't think I suffered. There are a lot worse fates people face.

Mullan: Let's pick up on the English major side of you in terms of your interest in writing and interest in things nonscientific, which I gather stayed with you, and now you're spending more time nurturing that side. Tell me about how it developed.

Hughes: I think it developed from the privilege of being able to sit in a room with a person and ask them anything that I wanted. I'm granted that privilege by society, and it's quite an amazing privilege. I found myself always looking forward to the social history part of the complete history and physical or whatever. I just couldn't wait to find out who this person was, where were they born, and where did they go to school, and where do I place them, and why are they the way they are, and why do they have whatever complaint they have, and that sort of thing. And so that started me going on this idea of that people are just walking stories.

So then I took some more time off, to David's grief, and I worked in an institute called the Salt Institute, in Portland, which is dedicated to preserving the culture of Maine. Basically it teaches you how to become an oral historian. They have a magazine that they put out. So I did that for three months, and then I came back here and, for no good reason, probably similar to you, I just wanted to get people's stories down. And so for three months--I gave myself three months to try and figure out whatever it was that I wanted to do. I didn't know. I just knew that I wanted to do more than medicine.

I picked twelve people out of the community, and I went to them and I said, "Can I hear your story?" And all twelve of them said "Sure." So I sat down and I think I did about a one-hour interview about three or four times with each one, transcribed it all myself, and then distilled what I thought was that person out

of all those however many pages it was, three hundred pages, of oral testimony, and then I gave it back to them, and it was really rewarding. It was really neat to do that. And that's how I got into this whole thing.

Mullan: When was this?

Hughes: It was about '92, something like that. And then at the same time, I had started talking to another friend of mine, Jay, who was the editor of one newspaper in town and then was the editor of the other newspaper in town, and he's a good writer, was editor of the *Maine Times* for a while. He's a good writer. I started going there every--I think it was Wednesday nights, exhausted from working in the office. I was teaching in Augusta on that day at Alex McPhedran's residency program. Then I'd come to Jay's house, and we'd just talk about journalism and literature and how to get it down on paper. I interviewed him, he interviewed me, we just started this mentor/mentee relationship.

Mullan: I'm going to turn the tape over.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Hughes, side two of the first tape.

Hughes: Anyway, Jay and I were getting together on a weekly basis, and he was teaching me the craft of journalism, of setting things down, observing and looking at things and then writing about it, but we needed something to do. And then into our life walked this filmmaker, Fred Wiseman, and he wanted to do a film about Belfast, and we got involved with thinking about that. Then Fred left and went to France and did a film on the Comedie Fran□aise for a year, and at that point, we said, "What are we going to do with this?" So we decided we would try to write a different kind of a history of a town, of our community, see if we could do something creative with it.

So that's what we're in the process of doing now. We've got a major grant from the Maine Humanities Council, and the hope is to write a type of history that is constructed from the community itself rather than from someone coming in and looking at it and saying, "This is what happened, and then this happened, and then that happened." We're trying to involve everybody so that everybody owns it, and then come up with a story that is a consensus but still a compelling story of our town.

Mullan: How far along are you?

Hughes: Our goal is to have it written and published by June of '98, and we just started seven months ago. So we're not very far along.

Mullan: And you're working about half time on it?

Hughes: Yeah, well, probably more than that. I don't know, probably half time. Two days working as a doctor is sort of like three or four days, and then the rest of the time is left for the history project and my family.

Mullan: And you plan to stay on that schedule until you get it done?

Hughes: Yeah.

Mullan: And do you enjoy the back and forth between research and medicine?

Hughes: Well, medicine is a real grounding for me. It keeps me connected to people. You sit in a room and you have to do something. You have a job, and you have to fix stuff one way or another, and that's your responsibility. And so it just connects me with the community. It gives me a label, as we talked about too. So I wouldn't want to lose that. I like doing both things.

Mullan: Are you able to afford it with the help of the grant? Is it coming out of your own hide?

Hughes: Not really. Right now I'm just living off of the medicine part of my salary, and I should be getting money through the grant. A lot of what we're doing is we're selling books

ahead of time, too. We've sold about 130 books now at $75 apiece, so that's partly how we're financing what we're doing. But I just don't feel comfortable using that money to pay myself until we've got a product.

Mullan: You're selling book futures?

Hughes: Yeah, right. Well, it's another way to involve the community, basically.

Mullan: Great. For yourself, what do you see in the future? How would you like to play this story on out?

Hughes: I don't know. I really don't. It's fun to write. It's fun to see people, and it's fun to be here.

Mullan: Do you see staying here?

Hughes: I see staying here until Rosie's grown up, until my daughter's grown up. And I like to travel, so we'll see. I can stay here.

Mullan: Tell me about the family side. I think you mentioned you met your wife when you were working with farmworkers. She was doing likewise?

Hughes: She was an outreach worker for the farmworkers.

Mullan: She was on a volunteer leave from--

Hughes: She was a college graduate. When I went back to medical school, she went back to get her teaching credential and became an elementary schoolteacher and did that for a number of years, and now is kind of in between and looking to see what to do next.

Mullan: She taught here in Belfast?

Hughes: She taught pre-school here in Belfast. She taught second, third, and fourth grade in California when I was doing my residency.

Mullan: And has medicine been good for family life or hard on family life?

Hughes: It probably hasn't been good except for that it brings in steady income. So it is good from that point of view. Certainly it's very time-consuming. And working part-time has helped that out immensely. I think if you work two days a week as a doctor, you're really working about a forty-hour week.

Mullan: And the rowing you've mentioned a couple of times. Tell me about what that is.

Hughes: Oh, it's just a way to get exercise and to get out. I'll show you my boat shed, if you want, after. I have a bunch of boats in there.

Mullan: What sort of boats? Is it what you row down the--

Hughes: Yeah. I have a racing shell and another rowing shell that's for when it's rough out there, and two or three kayaks.

Mullan: So it's a regular routine?

Hughes: I don't do it every night. I do it when I can and when the tide is right and when the weather is right. The routine part is that my dog and I go down along the beach together. So it is a routine, I guess, but it's not at a certain time every day, so many times a week, or anything like that.

Mullan: To go back to the big picture, as you've practiced medicine, family medicine, and observed from this vantage point the ebbing and flowing of the policies and issues related to medical practice, do you have any thoughts about where it's all headed, where family medicine is going? Any predictive value that you'd care to share?

Hughes: Well, I can tell you what my hopes are. I think family medicine has a lot to offer the world, the culture of medicine today, because it's based on healing illness instead of curing

disease. I think that's really important in our alienated society today. We don't pay attention to people enough in our medical system. I see that with my parents.

Mullan: In terms of how they're treated?

Hughes: Yeah. People just want to be cared for. That's what they want. They want to be cared for. And when I think about what I'm doing with medicine and this writing, this oral history , people want to be heard. That's what they want, and they want to be cared for, and they want to be listened to. That's almost more important than living for people. I started my life out with this idea that I would save lives and that was the most important thing you could do, but I think I'm changing my mind about that. The most important thing you can do is make people feel like they have a worthwhile and meaningful life. That's more important.

Mullan: Than saving or prolonging it?

Hughes: Yeah. And that's what family medicine is all about, I think, is that it begins to shift health care from a curing focus to a meaning focus. What's most important for this person? Hospice is a good example. What's most important for a dying patient? It's not to keep them alive, right? We all know that now, but fifteen years ago we didn't know it. The thrust of family medicine, the importance of family medicine in the culture

of medicine, the world of doctors and all this sort of stuff, is that. We pushed the focus off to that side.

Mullan: As sort of a summary, are there things in terms of your practice and experience that we haven't explored? Obviously there are many things we haven't explored, but are there themes that you'd like to add or you'd like to talk about that we haven't touched on?

Hughes: I don't know.

Mullan: I always ask at the end, just to give you the opportunity, if I've missed something that somebody's been itching to talk about.

Hughes: No.

Mullan: I think the thing that's been most thought-provoking to me about our interview is the similarity of our entry into medicine. I was, in fact, a history major, but I was much more entertained by English and history, arts, than I was by the sciences. I was competent in the sciences and did well enough to do pre-med, but I'm frequently surprised that as I follow the trail of generalism, I find over and over again people who whatever their path into generalism, whatever practice they have, came from a similar kind of approach to the latter part of their youth. As they matured, their interests were in English or in

writing or history, and yet they had an itch to do something practical, which medicine was. As they got into medicine, they mastered the science well enough to become physicians, and yet they gravitate back to a kind of practice which accommodates a broader world view that is not defined simply by a scientific formulation or quantitative formulation, but has qualitative and intuitive aspects to it that aren't easily captured in the scientific paradigms that we all learn.

Just today, Alex McPhedran, a neurologist, the story on Alex McPhedran was he was a neurologist turned family practitioner. Well, he was a history major turned neurologist turned family practitioner. The common theme was history and the family practice with a siding into neurology, is the way I would summarize his history. So I find this theme endlessly fascinating, partly because it's replaying my own tape, which is always nice to hear, because as I went through that, I felt like a misfit. I had a lot of friends who were history majors and were going right to law school or economics graduate work or history graduate work, and I had a lot of friends who were pre-meds who were majoring in biochem, or chem and biology, who, parenthetically, found the first couple of years of medical school a piece of cake, as I struggled through the first couple of years of medical school, less well prepared and less inclined to the disciplines that became anatomy and physiology and biochemistry that we had to labor through. So it's always refreshing to find every time I can replay that with someone else.

Inexorably--and you wouldn't have defined it then, but it has for so many led back to a kind of practice that is generalist in nature, whether it's family practice or internal medicine or pediatrics. It does lead in that direction.

Hughes: But it need not. Neurology is another good example. Alex approaches a neurological problem from that point of view, from a historical perspective.

Mullan: I don't mean to be simplistic about it. Certainly you can have oncologists or surgeons whose--

Hughes: Whose approach is generalist.

Mullan: Who have a world view, who would be comfortable with and would be compatible a generalist point of view. But I do think there's a difference. And Alex said it himself, said, "The reason that neurology appealed to me at the time it did is because there was a set of skills which largely, at that point in time, the fifties, were, in terms of your skill in physical diagnosis and cognitive exercises connecting the physical symptoms and signs with a mastery of literature of neurological disease, but it had a definitiveness that was appealing. You could explain this reflex in terms of an understanding of the cracks in the spinal column, for instance." And that I would consider a non-generalist instinct, I mean that desire.

Hughes: Yes.

Mullan: Not that the generalist doesn't seek definition, but to be a good generalist, you've got to be comfortable with a great deal of lack of certainty, a great deal of ambiguity, which is often the way human disease--the human condition--presents itself. It doesn't present itself in DRGs that are neatly labeled and parked often, and at least the generalists are seeing very often, like your lady with her pseudo-seizure. There's a hell of a lot of ambiguity in that that you were prepared to embrace if she'd come back to you, if she's smart enough to come back to you.

Hughes: We'll see.

Mullan: Well, it's been good, and when you get the transcript back, if there are things you want to add, please do.

Hughes: Okay.

Mullan: Thanks for sharing this.

[End of interview]