DAVID LOXTERKAMP

Dr. Fitzhugh Mullan,
interviewer

Mullan: We're on the porch of Dr. Loxterkamp's house in Belfast, Maine, on a sunny afternoon, the 11th of July, 1996.

Loxterkamp: The feast of Saint Benedict.

Mullan: How did you know that?

Loxterkamp: I keep track of these things. It's important, I guess.

Mullan: And I'm looking at his cat rolling in the sun, his herb garden, his very environmentally correct swing set, and it's just a beautiful day. Thank you for having me.

Loxterkamp: You're welcome.

Mullan: I want to start quickly with your background. Where do you come from?

Loxterkamp: I grew up in Rolfe, a farming community in western Iowa, a town of about 750 people. My dad was a GP in that town, and I wasn't born there. I was born in Sioux City and found my way to the Saint Joseph's Orphanage, where my father and mother picked me up, and I'm one of three kids. All of us are adopted, and by the luck of the draw, I ended up in a doctor's household.

Mullan: Do you know anything about your biological parents?

Loxterkamp: I don't, and that's another story, which I've chosen not to pursue. Both of my parents are now dead, so there is an opportunity from that point of view, but I don't have a great deal of interest in opening a Pandora's box. I have a nice family now, so I'm not needing another.

Mullan: How old were you when you were adopted?

Loxterkamp: Young. I think around two months; six weeks or two months. So I don't know anything other than that.

Mullan: Tell me about growing up in Rolfe, Iowa, with a GP dad.

Loxterkamp: It was generally good. I felt very secure. I felt special. That is, we had money where others didn't. We took vacations when others didn't. We went to the New York City World's Fair, like everyone else, I've since discovered. I always had the notion that I would leave home one day, go to college, and do something with my life different from my friends, which largely amounted to farm and staying around.

I didn't know my dad very well, because he died when I was 13, and I think that's not only colored the style of practice I'm in, but also my relationship with Lindsey. Lindsey lost her mother age 14. And so we both always had this shared interest in the impact of death on families, on the importance of the dying process, and basically a hospice philosophy. Lindsey's very much involved in hospice, and I've kind of moved into that, not

knowing that that's what, in fact, I was doing, but it turned out that way.

Mullan: What did your dad die of?

Loxterkamp: Heart attack. Like most of the family doctors in Pocahontas County. There was a crop, after the war, much like the crop of new family practice graduates who located in Scowhegan. You've probably heard of that group up there. Well, Pocahontas County was settled by GPs of a comparable age, my father among them, John Rhodes, Clyde Smith, Harry Pitlock, and many of them ended up dying in their fifties and early sixties of heart attacks. My dad was 49. I'm not sure it was matter of working too hard. I think it was a matter of smoking too much, probably drinking in excess, and the stress of it all.

Mullan: He was a classic on-the-go GP?

Loxterkamp: Again, I can't vouch for that, although I'd like to know more. When I ask about it, I get largely platitudes about how good a man he was, how good a father, and I don't get a lot that I can believe about his work and life. But the little I remember is we always left for vacations late, sometimes a week late, at least an hour or two hours late, and we didn't go very far. I remember, growing up, we would vacation on Labor Day and Memorial Day weekend. You know, we would go at the beginning and the end of summer, which was okay with me, because I had lots to do in Rolfe in the summer, and it was fun.

As I say, I felt very well prepared coming out of that little community. I mean, it was a community and I had friends, and my parents had friends. It was a close knit farming community. People worked hard and got a good education. The roads, like the rules, were straight and flat.

Mullan: What size population?

Loxterkamp: Seven hundred fifty.

Mullan: And did you stay there for high school?

Loxterkamp: Yeah. At the time, it was not consolidated.

Mullan: And then what?

Loxterkamp: Went to Creighton, where my father went to college and medical school. I went three years there, five years at the University of Iowa. I was married once before, and met my first wife at the University of Iowa. We both decided to go into family practice. I really never thought of anything other than family practice.

Mullan: She was a medical student, too?

Loxterkamp: Yes, she was.

Mullan: So you went three years to Creighton and finished at Iowa?

Loxterkamp: No. I got accepted into medical school after three years. In fact, for a while I geared myself to get in after two. You know, it was that whole competitive thing of, well, if smart kids get into medical school, smarter kids get in after three years, and the smartest get in after two. But then I realized, you know, that it was insane, and I wasn't enjoying myself, so I cut back to a three-year plan. And, you know, in medical school I kind of realized how foolish it was to hurry things. So I took a year out of medical school, which evened me out with my first wife. She was a year behind me. We were both interested in family medicine, and ended up in residency at York Hospital in York, Pennsylvania.

Mullan: Which year did you graduate from medical school?

Loxterkamp: '79, and I was at York from '79 to '82.

Mullan: And was the culture in Iowa supportive for medical students to choose family medicine?

Loxterkamp: Yeah, largely. I mean, it was still a minority who went into family medicine. And I was recruited to go into internal medicine, especially by the cardiologists, where I had an interest. I was always kind of at their throats, wanting proof that CABG and caths were necessary and effective. But I think a lot of that was because my father died of a heart attack, and I was just curious about the whole thing and wondered, "if he had had a bypass like my uncles, would he have lived?"

So, yes, it was supportive of family practice. Bob Rakel was there at the time, although there is a bit of hypocrisy in that, because he traveled all over the country promoting family practice, on a national level, but not on a local level. He did nothing to encourage us locally to go into family practice except lend his name to the institution.

Mullan: Was he the chairman?

Loxterkamp: He was the chairman.

Mullan: In terms of your own thinking about family practice, was it largely sprung from your family circumstance and your father, or was there some other mind-set that entered in that suggested that's the way you wanted to practice?

Loxterkamp: There are probably several ways of answering that, and I haven't sorted it out, but I think a large part of my going into family practice was to find out who my father was. I didn't know him very well, but have always attributed to him my more positive qualities, a sense of humor, a certain way of relating to people. Even though he stopped going to church for a long time, I also attribute my interest in religion and Catholicism to the time he did go to church.

Mullan: He was Catholic?

Loxterkamp: He was Catholic, yes. I was raised in a Catholic family. And so I think a simple, probably overly romantic

version of the story is that I am just trying to follow in his footsteps, find out who he was, find out what kind of life he had, why he did the things he did, what choices he made, what happiness he found. But on the other side of the coin, I'm suited to small town life. I grew up in a small town, loved it largely, wanted to see the world but was very happy with this smaller scale. The doctors in my community were well respected. John Rhodes, who became my family doctor after my father died, graduated first in his medical school class at the University of Iowa. He was on the Board of Medical Examiners for the state. In other words, his signature was at the top of my medical license after I graduated. So I always thought that a country doctor could make something for himself, just being a country doctor. So that was another part of the attraction.

I don't know that I ever listened to the rhetoric of family practice. Probably one of the strongest influences I had for going into family practice was reading Wendell Berry and coming to an understanding and realizing about culture.

Mullan: Wendell Berry?

Loxterkamp: Wendell Berry wrote the famous book, *The Unsettling of America*. He basically is a proponent of generalization, of not specializing, of getting away from mono-culture and a narrow path. He's written a lot about agriculture and farming, but the metaphor applies to medicine.

Mullan: What is the book called?

Loxterkamp: The Unsettling of America and, really, many essays and novels and poems. He lives in Kentucky. I read his book when I was a senior in medical school and just fell in love with it. That was an influence. Another simple answer that's more quotable than probably true, if people go into ophthalmology because they have bad eyes, I think people go into family practice because they have family situations they would like to understand or rectify. And that was certainly true in my family; there were problems in my family with my sister and my mom. My mom was probably depressed most of her life. She and my father bickered a lot, especially after they drank. My sister has had many problems. So, you know, I wanted my new family to be better, to be different, so family practice was a way of putting emphasis on relationships in the care of patients, and so I did that.

Mullan: And why York? And what was York like?

oxterkamp: York because I needed to match with my first wife, Land that was the place we got in. We ranked other places higher, Montefiore in the Bronx. We'd ranked Hunterdon in New Jersey, higher. We'd ranked a Group Health Cooperative of Puget Sound, you know, just nice places to go. But York, in fact, was very good to me. It was lousy for Karen but very good for me, and I learned a lot, and we developed a great camaraderie, my class. We were called the Gang of Four after, obviously, the political dissidents in China.

Mullan: Were there four in your residency class?

Loxterkamp: There were six. One left after the first year because he was unhappy. The straw that broke the camel's back was that he got sued. He was named in a malpractice suit for missing a neck fracture when he was on his ER rotation. That would have devastated me, too. I probably would have gone into library science or something. So he left, and then Karen left after our separation. So we were down to four, and the four of us were really well suited for one another in family medicine. We had a great close-knit group.

Mullan: Good program?

Loxterkamp: Good program. Learned a lot of--everything I needed except how to deliver babies. So I went out to Iowa and did a rotation in Sioux City, where I was born. In fact I saw many women at the--I forget the name of the home. There's a home there for unwed mothers where my natural mother probably stayed before my birth. Anyway, I delivered probably 150 babies in a six-week period and felt very comfortable after that in obstetrics.

Mullan: The separation and divorce, did medicine and medical practice have a hand in that?

Loxterkamp: I'm sure it did. I don't think about it often. It was a stressful time, no question, and I think most people would say "Yeah." I mean, if we had a chance to work it out, do you think it might have been different? I don't think so. I think we were ill-suited for one another. I don't think we would have

had children, which seems inconceivable to me now. I think I was attracted to her because she was a powerful woman, more powerful than my mother, able to cleave me from those bonds, and that was very useful for me early on in our relationship. After that, it lost something. We also let too much water pass over the dam, mistakes and hurt feelings and that sort of thing. But I don't think it would have been different. It just would have been more protracted and strangulated, oddly enough, in a more supportive environment.

Mullan: Has she remained in family practice?

Loxterkamp: No. She went into psychiatry and now lives in Washington, D.C.. So she stayed in medicine, actually finished out at Hunterdon, where we had interviewed, and later went into psychiatry.

Mullan: So what happened after York?

Loxterkamp: After York, I went to Chicago, where I met Lindsey, and I worked on the South Side at the Claretian Medical Center, which is a community health center serving an Hispanic-black urban population. I wanted to live in a city before moving back to Iowa. That was my goal. I learned medical Spanish and I began a master's program in anthropology at the University of Chicago, got my master's, and while I was studying at the University of Chicago I met Lindsey, who was working in the Seminary Coop Book Store. She was wearing a diner t-shirt, and I was being nosey and inquired after her love interest in diners.

She loved them nearly as much as I did. So we began that way. She was involved with someone else at the time, but we overcame that obstacle, and after two and a half years in Chicago, which we both really loved, we moved to Maine. There's a certain amount of energy that one has to expend to live in the city, and one has to overlook in terms of personal safety. You make sacrifices. It's not that you don't make sacrifices living here, but I had my car broken into and a rock thrown through my window.

But after it became obvious that neither of us really wanted to live in Chicago (or live in the Midwest, for that matter) and that Lindsey and I were serious, we tried to make some decisions about where to go. All our friends were leaving. My friend Pete Kerndt, who's from a small town in Iowa, and became a great friend of mine during medical school, was leaving. He's now is now chief AIDS epidemiologist for L.A. County. He was moving to California, along with many of our Chicago friends. A couple of friends in OSHA left for Cincinnati. So we wanted to leave, too, and settle down. Lindsey didn't want to stay in the Midwest and I didn't want to move to an urban environment.

Mullan: Before we move on, what was it like being a family practitioner in an urban setting with any number of specialists close at hand?

Loxterkamp: Well, it wasn't like the other environments I'd been in. You know, I'd been at York Hospital, where the majority of doctors in that hospital were specialists; University of Iowa, where, you know, you kind of trailed behind the second-year

resident and the chief resident and the junior attending, you know, that sort of thing. I was on the South Side, and this was really frontier medicine. I was probably--this is my modesty coming through--a year out of training and felt like I was as smart as any of the other attendings there. Many of them were foreign. Many of them, I think, may have had some difficulty getting work elsewhere. I was in a suburban community hospital. It didn't seem like an urban situation.

Mullan: This is where you admitted patients?

Loxterkamp: Yes, and my community health center was all primary care. I felt very supported. But it was a hell of a drive coming from Wrigleyville to the South Side, via Lake Shore Drive to admit patients and deliver babies.

Mullan: That's a good commute. But it was a viable practice situation?

Loxterkamp: Yes, it was, and it still is. I still get literature, information from them on their reunions and gatherings and so forth.

Mullan: As you thought about the next moves, how did you pick Maine?

Loxterkamp: Well, I liked the idea that Maine was rural, Lindsey liked the idea that Maine was East, and we had a friend of mine from residency living in Biddeford, David Strassberg and actually

lives in Kennebunk and works in Biddeford. I'd been in the habit of coming up and having Seders with him. Actually, I'd been having Seder meal with him during residency, and we continued that for the years that I was Chicago. And so he said, "Why don't you come on up and see Maine." And so we got there, and we thought, well, maybe it would be good to go into practice together. I tried to introduce that topic, and he really wasn't ready that the point. I think he really wanted to establish himself. He wanted to do things his way. He has later, I think, regretted that because he's approached me about coming down there. But he said, "Go on up the coast. Don't stop here. See Maine. This isn't Maine." So I did, with the intent in mind that I would get as high as Belfast, turn around, and go back.

I knew that they were interviewing people in Lewiston. My program was to go through a town that I thought I liked and stop in, ask the hospital administrator if they needed doctors. I can't think of any hospital administrator who would say no.

Mullan: What year?

Loxterkamp: This is 1984, the summer of '84, early summer, because we moved up here in late summer. Yeah, Seder. It was Passover of '84 that I first came up here. Lindsey and I then came back later, and we both really fell in love with Belfast.

Mullan: What did the hospital administrator say here? What happened?

Loxterkamp: Oh, he had great plans. He tried to recruit me for a little place called Liberty. There's the Donald Walker Health Care Center there that was looking for a doctor. I would have been willing to come, but they didn't want me. I still don't have the whole story on why. But I met Tim there. We came into town, Lindsey and I, and it was a beautiful, hot summer day. I don't know what you saw of Belfast coming in, but it has beautiful architecture, a sense of history. It has a glittering ocean lying off its edge. I was quite interested in Jungian psychology, at the time, and it attracted me, this great depth of an ocean.

We met the obstetrician who had moved here from Iowa. I suppose you always need to have a mythical story about your origins, and so this is mine: I came in to meet him and there was a receptionist working. I inquired after her name and how long she'd been here, and she said, "Oh, I'm married to the obstetrician." Her name was Nancy. I inquired as to where she was from. Was she from Iowa, too? And she said, "Oh, yes, I'm from Iowa, northwest Iowa." Since I'm from northwest Iowa, it picqued my interest. I said, "Whereabouts in northwest Iowa?" She said, "Near Fort Dodge." "Well, I'm acquainted with Fort Dodge," I said, "Can you tell me where near Fort Dodge you're from?" And she said "Pocahontas County." I said, "Well, I know that county. I was born there. Whereabouts in Pocahontas County?" She said, "Rolfe."

Well, to make a short story even shorter, my father probably delivered her in that small town which we both shared as our home. She met her husband when she went off to school in Des Moines. Anyway, so there was a lot of karma going down, I felt.

I met Tim out at the Liberty Health Center, the Donald Walker Health Center, and Tim was as relaxed and as comfortable--

Mullan: This is Tim Hughes?

Loxterkamp: Tim Hughes. The first thing he did was inquire as to where I was staying that night and if I needed a place, and basically he put us up, he put Lindsey and me up, and served us breakfast in the morning. And I really felt good about this place, and my instincts served me well.

Mullan: So that settled it in terms of your coming?

Loxterkamp: That settled it. Even when I was rejected out here, at the Donald Walker Health Center, I knew that this is where we wanted to come. And so I came, and I asked Tim, "You think you could use another doctor in your office?" And he didn't know, but he thought, "Why don't you come and we'll find out." So I did, and within three or four months, we were working together as partners. And the rest is history, as they say.

Mullan: Tell me about the practice, how it has developed.

Loxterkamp: You're going to get two different stories on this for sure. Three years ago, I kept a year-long journal, and it's going to be published this spring by the University Press of New England, and I wrote a little bit about that. In fact, I sat down, much like you and I are sitting down, with a tape recorder and asked Tim a little bit about why he doctored and what he

liked about doctoring, and didn't get very far. In fact, I think Tim a little bit resented what he saw as my putting words in his mouth or using his words for my purposes. We've always had edges to our relationship that I don't quite fathom, I don't think Tim quite fathoms, but, clearly, we're the most compatible in the county, and we're good for each other, and we trust each other and support each other, and all else of doesn't matter very much.

So that has been one constant since 1984. We've fought the same battles. We've gone through the same crises. Unbeknownst to us, we had the same interests in journalism, in solitude, in books. We consider ourselves "inquiring minds," and we're very much alike in many ways, although if you asked me to define it, or say why that is, Tim would probably refute it, and I'd refute whatever Tim had to say. We're separate people. We're independent, and dare not speak for each other. So he'll speak for himself, and I'll kind of shoot my mouth off.

The practice over the years has grown from just--well, it's really quite amusing in the sense that we started out in a little building that had three examining rooms for three doctors. One was a cardiologist, who spent a lot of his time with his hands in his pocket groping himself or stroking his beard, a very curmudgeon kind of fellow, and some of my best images of him are taking a slip of paper with a note from a patient whom he really didn't want to hear from, crumpling it up and throwing it in the wastebasket or seeing someone come in who he didn't really want to talk to, and hiding in the back sample room until they went away. I mean, he was just an odd little fellow. He practices

now in Augusta. But he was one of the first characters, Tim and this doctor.

Each doctor had an employee. The cardiologist had hired the bookkeeper-receptionist, and Tim had hired the nurse. So for two doctors there was one nurse and one receptionist and two examination rooms, and it was the most--really, I mean, again, I don't want to be too critical, but it was one of the most disorganized practices I could ever have imagined, and the only reason I did it is because I liked Tim and I wanted to be here, and also I had no basis for making a good decision. I mean, we just basically stumbled into each other.

From that point, within six months the bookkeeper was charged with embezzlement of the cardiologist's fortune. Lindsey, who had come in as my employee, realized that she couldn't work with this woman. Tim and I realized that it wasn't working out. We separated ourselves from the cardiologist and started to build a practice, and over the last twelve years we've become a fairly efficient, profitable business without, I don't think, sacrificing too much of the family environment we started with.

As we get larger, we sacrifice more and more. Right now there are three family doctors. Lisa Nielson just joined us a year and a half ago. Three family doctors, a PA, an office manager, a bookkeeper, a cashier, a receptionist, a lady who faces the computer most of the day, five nurses who split four full-time positions. It's big, by our standards. And as a consequence, trying to keep that unit together is hard. We don't know every patient like we used to. We don't know the employees

as well. We don't take an active interest in their personal lives like we used to.

And we don't get together as a group as often as we did. It used to be that we would go places at twice a year, the whole family practice, and that everyone turned to me or Tim for their medical care, for their personal problems, for counseling. To some extent it still happens, and it's nice when it does happen, but it's becoming more and more a business and. At this point in time, we're on the verge, as is all of America, of deciding whether or not we want to become part of a larger organization. I'm not sure that there's any real advantage in it for us, because we have a good office manager, but we hear the rumblings that this is the way things are headed, and it would be nice to integrate health care in Waldo County. It is such a disorganized array of doctoring. Good doctors, but just no one talking to one another and coordinating care very well.

So we're on the verge, Fitz, and right now things aren't as good as they were--well, let me just back up a little bit. After we were together about five years, we got restless. We had accomplished what we set out to do, which was to get our feet on the ground financially and learn how to care for patients. Lindsey and I, too, had gotten our feet on the ground. Clare was born in 1988, and we overcame that great obstacle of deciding to have children, and we purchased this house, and things were going pretty well. We were making, you know, less money than most of my medical school friends, but far more than I made when I first came here. But we were getting restless, restless in a professional way, wondering whether this was the right place to be. A number of friends we met after first moving here, had

left seeking their fortunes elsewhere. Winters seemed long, springs too muddy.

So Tim and I both settled upon--kind of simultaneously, although I may have taken the lead from him, the notion of taking a sabbatical to see a different part of the country, to do something different, to see if this is what we really wanted. Tim went to Costa Rica--you can talk to him about that--in 1989. And so for one year, while he was away, I really worked like a devil. I was really a solo practitioner, delivering 75 or 80 babies, seeing tons of people in the office, working very, very hard.

Mullan: You didn't bring anybody else in?

Loxterkamp: We didn't, no. I didn't quite know how to do that, and, really, there is some truth in the proposition that you work more efficiently when you're on your own. You may die younger, and you may not live as happily, but you work more efficiently, and it was an efficient way of getting through what I saw as just a one-year shot. It was good for me, too, because, I am by temperment drawn to partnerships, and that has left doubts in my mind. When I was in college, my friend Bill Demars and I did everything together. We studied and traveled and undertook projects together. When I was in medical school, George Shoephoerster and I put on workshops for primary care, organized a trip to Washington, D.C.,to learn about rural health care reform, and so forth. And when I was in residency, my partnership was a group of four. When I got here, it was Tim. And it was Lindsey. So Tim's departure was a chance for me to

prove to myself that I could survive a solo year. I saw it as only for one year, and so I really put my nose to the grindstone and did it, did it well. I knew, after that year, that I could make it on my own, I mean, not without a very supportive office and specialty back-up, but I knew I could do it, and that was important to me. And I also knew that when Tim got back, he would let me go for a year; this would be the exchange. This has really kind of bonded us in a way.

Mullan: Was the person who was not here drawing a salary during that year?

Loxterkamp: No. You had to draw your salary from wherever you went. So he was paid by a residency program in Costa Rica as a member of the faculty. And I was paid by University of California-San Francisco and basically worked at the family practice program at San Francisco General Hospital, learned a whole lot about AIDS, and began writing.

Anyway, in the course of that year, I finally realized that Belfast was not only where I wanted to be, but where "real medicine" is practiced, right here. You know, the center of the medical universe is not in university medical centers, but here in Belfast, here in any number of these small towns across the country. That became very clear to me when I saw medical students learning from first-year residents, interns learning from senior residents, senior residents learning from junior attendings. Who did these people learn from who had any experience taking care of patients?

So when we came back, Lindsay was relieved to return to the community and the simplicity of our lifestyle, I welcomed back the kind of practice I had. In addition, I was renewed in the belief that what I'm doing here is worth doing, worth writing about, worth talking to others about. And so I think part of what I wanted from San Francisco was to find a way in which I could contribute to family medicine in a larger way, other than just earning an income, and other than being a part of this community. I kind of felt that here, being a doctor, you're adequately paid for what you do; you're not a martyr. And living in a community, well, if you're part of that community, the contributions kind of equal the rewards. So I wanted to do something kind of extra. And so that's partly how writing has entered in my life.

Mullan: Tell me, on the practice side, how is the income? How do you handle it? What trends are there? How does a family doc fare in this community?

Loxterkamp: It depends on how much you think you need. Family doctors do very well. I make ten times as much as my patients. You can't live in a community, I think, and not realize the discrepancy between your income and theirs. We've had a gradually increasing level of income for the past--well, I shouldn't say that. We became a rural health center three years ago, and in that year we doubled our income.

Mullan: This was federally supported?

Loxterkamp: Yes. But it's just a rural health center, not a federally qualified rural health center.

Mullan: But that means you can charge a special rate which is advantageous?

Loxterkamp: That means that we get paid for seeing Medicare and Medicaid patients in the amount of what it costs us to see them. There's a formula, but basically we get paid about fifty dollars per Medicare/Medicaid patient whether we see them for a complete physical or do a surgical procedure or just see them for a hypertensive check-up. So since, at the time, 70 percent of our practice was Medicare/Medicaid, which is a pretty hefty lot, and partly because few other people in town were taking Medicare/Medicaid, it meant that we doubled our old salary of $45,000 a year. We could have named our price basically. I mean, we said, "Well, ninety seems reasonable. Ninety seems fair," and so we agreed upon it, not knowing really whether it would all work out. It just seemed peculiar that someone would pay us whatever we asked.

Mullan: Asked in terms of your per-visit cost?

Loxterkamp: Yeah. Well, what is factored into legitimate expenses is our salary, our retirement fund, what it costs to pay our employees, upkeep of the office, all reasonable expenses, but all things that we'd kind of let slide because we just couldn't afford them. I mean, we had no retirement fund. We were paying pretty low on the pay scale for employees. We didn't have a lot

of equipment in our office that many other practices provided because we just couldn't afford it. So all of a sudden we went from being a very marginal practice financially to being very comfortable, really. And it's been hard for me to raise our income since then because, again, the large discrepancy you see between what you make and others make in your community. Also, I'm working no harder than I did five years ago when I made half as much money. So that's difficult to reconcile. But we can now pay our employees a decent wage, plan for our retirement, and stand a chance of recruiting new partners.

Mullan: That must be very powerful. As a magnet to get people into rural practice, I would think that would be enormously helpful.

Loxterkamp: It's enormously helpful, but probably will be gone in a year or two. You know the politics better than I do, but they talked as if these sort of things will be phased out or simply axed.

Mullan: Talk a little bit about your practice, who comes, how family medicine is seen the Belfast community. How do you slide into the pecking order of practitioners?

Loxterkamp: Well, I've written a lot about this. Starting out in practice, we--I'll just say, I hoped that my patients would reflect what a good doctor I was by being well educated, articulate, monied. They would choose me amongst the other practitioners in town. They would show their gratitude. They

would get better. You know, all the things that every good patient is supposed to do. And it was a bit disheartening to find people who came in with their chronic diseases that were largely the result of social factors well beyond my control: poverty, unemployment, work sites that were poorly maintained or just dangerous, like logging and lobstering. As I said, 70 percent of our patients were either Medicare or Medicaid. The majority of these Medicaid. So coming to terms with that was difficult for me.

I kind of accepted it in Chicago when that was what the health center was set up to do, the Claretian Medical Center. And I do have a sense that taking care of poor patients is something I want to do. But I also wanted a balanced practice. I didn't want just a Medicaid practice. I didn't just want a Medicare practice. I wanted a balanced practice. That's why I'm in family medicine. So I suffered through patients whom we would deliver and then take their kids to the pediatrician because he was a specialist or because they had insurance that would pay for it, or would go to the obstetrician, not because they might get a better experience there, but because he charged twice as much and the insurance paid for it. So that kind of grated on me, but over the years I'm learning to accept it.

Mullan: And the Medicaid patients were not being accepted by the practitioners in town?

Loxterkamp: Well, there would be limits set on how many new Medicaid patients they would take, if they took any at all, or you would hear a lot of comments about the Medicaid patients,

their level of ignorance or stench or laziness. This was the undesirable element, as in most communities. But it never bothered Tim. It never bothered Scott, our physician assistant. This is well before Dr. Nicksen came. And I think that helped me a lot. You know, it helped having others around who saw these people as valuable and respectable. And, of course, as I got to know them over time, you learn that survival in poverty in Waldo County takes a lot of stamina and a lot of grit, and, you know, you learn to respect the people more and more the longer you live with them.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Loxterkamp, tape one, side two, continued.

Loxterkamp: So I would say 90 percent of my best stories, or maybe all of my best stories, are about these kind of patients. We also do medical examiner work in Waldo County, which is exciting and bizarre and a little bit morbid; I should say a lot morbid. Do you know what I mean by that?

Mullan: Tell me.

Loxterkamp: We're the county coroners, Tim and I, for Waldo County, and so when a person dies for unexplained reasons or they haven't had an attending physician, or they've been involved in an automobile accident, it becomes a medical examiner's case, and we go to the scene, or at least we go to the body and try to determine whether or not the circumstances account for this death

or they don't. And if there's any question, we talk with Henry Ryan, who is the chief medical examiner for the State of Maine, and we ship the body down for his autopsy. And believe me, there are some fascinating stories of medical examiner cases in Waldo County. If you had a day, we could drive you around and I could point out a hundred different scenes that represent a fascinating case, each and everyone.

Mullan: Fascinating in terms of foul play?

Loxterkamp: Oh, no. Suicide, all kinds of tings. You learn about depression, or schizophrenia, or the fine line that separates living and dying in terms of an accident, such a fine line. I'll just give you one example. I was called to a scene in which a car had slipped into a pond, and it was early evening, and the man was traveling on this road and negotiating a curve that he probably had negotiated a thousand times. But for some reason on that evening, whether it was the beer or two that he had sipped at the neighbor's up the road, or the sun was in his eyes, or whatever, he overcorrected for the turn and ended up on a grassy slope. Now that wouldn't have been so bad except that it had been raining the last four days, and the dew was already collecting on the grassy slope, and he hydroplaned down the hill, tried to stop--you could see the skid marks--but he kept going. Well, that wouldn't have been so bad, but he was approaching the creek bed, and as he was approaching it, in an effort to avoid it, managed to turn his car sideways so that when he went over the creek bed, he flipped it upside down into the creek. Now, most creeks in Waldo County are a foot and a half deep, but this

happened to be the deepest part, a little pool that was eight or ten feet deep. And that wouldn't have been so bad except that he hit his head and knocked himself unconscious, presumably, on the rear-view mirror or the dash board, and drowned. And that's the difference between living and dying, you know, those little things, those little factors, that if any had been missing, the man would be alive to tell about it.

Mullan: You enjoy the medical examiner work?

Loxterkamp: I do. I always hate it when I get the call, but I always learn something from it. It's kind of like when you go to the ER in the middle of the night, you always learn something from it, even though you hate the call.

Mullan: What is the acceptance of family practice in the community, both the public community and the medical community? Your practice, as you characterized it, is heavily Medicaid (as in poor) and Medicare (as in elderly). Is that because you are family practitioners, or because you all are young, principled, and prepared to take on that kind of practice?

Loxterkamp: There are a number of reasons, Fitz, but Waldo County is now rising in affluence. We now have MBNA, this big credit card company that's going to employ 1,000 people, more and more insurance plans, HMOs, that sort of thing, and so right now we're probably only 50 percent Medicare and Medicaid, and probably more Medicare than Medicaid. Early on, we got all the patients that no one else wanted.

Mullan: When you started?

Loxterkamp: When we started, yes. I think that's fair to say. It wasn't just being in family practice. But also we never restricted our practice. We never said, "No. We're only going to take 5 percent Medicaid," or "We're only going to take two Medicaid patients a month." We kind of always had our doors open. We felt that was what family practice was about. Both Tim and I believed it, and probably even more than that, neither of us had large debts whereby we needed to make the money which would force us to restrict our Medicaid clientele. So I think we both felt we got a good shake when we started out, and so why not.

Mullan: Are there other family practitioners in the community?

Loxterkamp: Yeah. There are three others. Outside of Lisa, Tim, and myself, there are three others. There used to be a fourth who just left because--we hear different stories about it, but I think its because he didn't make the money he was expecting to make. He'd been here three or four years and couldn't bring home what he had wanted. It's a good group, and the surprising thing is that people, when they move here, stay a long time. I've been here twelve years, Tim fourteen, Tom Maycock sixteen or eighteen, David Thanhauser the same. You go down the list, and very few people move away. And so, as a consequence, you earn your points not from your training, not your credentials, but you earn your points by length of service, by just being here, people

getting to know you, people seeing that you're committed to this area, committed to your patients, and willing to work for them.

Mullan: Does the rest of the medical community respect and accept family practice? Is that changing over time?

Loxterkamp: They do. I think some of the new ones don't understand family practice, which is always an issue.

Mullan: Some of the new ones don't understand?

Loxterkamp: Some of the new specialists don't quite understand family practice. Maybe that's not fair to say. They don't know quite how to interrelate. Sometimes it's hard to pinpoint when you have such a small population to study. You don't know whether it's a matter of personalities and part of a larger picture. But an intensivist, in particular, an obstetrician, in particular, who had moved here recently really didn't know how to work with us. They knew how to put up with us. They knew how to take referrals from us, but they didn't know how to work with us, and that's posed some problems. But everyone else--you know, really, I don't mean to romanticize practice here, but we're all here for the long haul. We all are each other's neighbors. We're all trying to take care of the same patients. We all depend upon each other one time or another for one thing or another, and that really does make the difference. It is not a matter of specialists versus the generalists. It's probably more a matter, in this community, of insiders versus outsiders.

Mullan: In the big picture, you know, there's a lot of talk about the move towards generalism in student preference and increased fill rates, etc., and presumably more generalists coming out of both expanded family medicine programs and more internists going out into practice and out on fellowships. Are those breezes felt here at all? Is there a sense of the practice market moving in a generalist direction or not?

Loxterkamp: We're already in a generalist direction, and have been, and will be. I mean, we're just too rural, I think, to be any other way. Probably twenty years ago, the hospital administrator faced a red line budget and a floundering hospital, and began recruiting specialists who could do lots of procedures: general surgeons, internists, orthopods, the whole line of specialists, even if they were only part-time. If they could do procedures here, he was interested. And over the last twenty years, he's been enormously successful at keeping our hospital in the black. Well, enter a number of people who came, not because he recruited them, but because we just found Belfast. We were all primary care doctors. Tom Maycock, David Thanhauser, Tim Hughes, and I, we just found this place. We weren't invited here, and as a consequence, it kind of maybe spoiled the plan for having a specialist enclave. Now, I don't think the administrator cared, really, if Belfast had specialists or generalists. He just wanted the hospital to be full and procedures to be done. Now there's a little bit of tension. He wants to be a player in this larger movement towards getting everybody under one umbrella, and he sees the economic value of generalists. But his way of correcting our shortage of doctors,

is to hire people to fill slots, you know, like changing a spark plug, and I don't like it, and I see probably the biggest obstacle to good doctoring is itinerancy. I believe that being in one place for a long period of time helps you become a good doctor from the point of view of knowing your patients, knowing how to care for them, and realizing that your relationship is reciprocal.

So the notion of people coming in and working in a urgent care center or an express health care clinic, and then in a few years moving on, I see that as a negative trend that I sure hope doesn't continue in Waldo County, and if I had the energy and wherewithal and interest to organize something different, I would, but you know, unfortunately, I don't. I would rather write, and I'd rather not work as hard. So I'm kind of a deadbeat family doc. As you probably know, it takes an enormous amount of time and energy to make that kind of a difference, even in a small place. I probably will have to declare myself in a year or two or five with regard to our health center, vis-à-vis the organization of health care in Weld County.

Mullan: What does that mean?

Loxterkamp: Well, that means make a decision about whether or not I join the larger organization.

Mullan: Which is on the horizon?

Loxterkamp: Yeah. The hospital already manages the Donald Walker Health Center in Liberty. They put up a new health center

in Stockton Springs. They've just taken over the rural health center in Brooks, and they want to take over the Islesboro health center out on the island. They basically see their role as setting up these little satellite pods where family doctors, or internists or pediatricians would work, and feed the hospital. That's their vision of health care.

Mullan: a primary care network?

Loxterkamp: Yeah, only they don't care whether its primary care or not. They just want to have warm bodies filling slots, really. I don't think the administrator understands the concept of family practice or the importance of relationships in taking care of people. He needs someone in this building from nine in the morning until five at night.

Mullan: You talk about the penetration of managed care, which I gather is not in Maine, and I presume not in Belfast, penetrated that blatantly yet, but is this the advance wave of the organizationally managed concept hitting here, that the hospital is girding itself or coordinating itself?

Loxterkamp: Yeah, quite definitely. The hospital wouldn't be doing this if they didn't see the need for it. Plus, of course, there is competition from outlying hospitals. People are willing to travel 50 miles now, or at least 30 miles, to have their baby delivered or to go to another doctor in another hospital for a surgical procedure. People are more mobile now and don't have community allegiance like they may have had before. They travel

30-50 miles to do their shopping, so they also travel that far to go to their doctors. There's also the need to be a more powerful bargainer with HMOs. There's an effort to control the market so that when an HMO comes, they have only one strong bargaining unit to deal with. That all is important, and, of course, if we are one of the outlyers in this large network, I don't know quite how that will hurt us.

Mullan: By outlyers, you mean be one of the satellites?

Loxterkamp: No. If we're one of the people outside the network.

Mullan: Let me come back to that and tie things together. Then I want to talk about you and the future. Let me just give you a couple of quick items to comment on. The non-physician provider, you have a PA in your practice, you have nurse practitioners in the community, I presume. How do you see the role of the generalist PA or nurse practitioner? What's your experience of them?

Loxterkamp: Oh, it's been good. Scott is great in our office. He's been practicing medicine longer than I have. He is wonderful with his patients, and he does a lot of good. What really makes me uneasy is the move towards the technician, the technical specialist in a hospital performing a lot of the things that were done by nurses and doctors in the past, which take us away from the hands-on approach to patient care. It is individual, and I think many of the Pas and the mid-level practitioners I've worked with, have been very good and know

their limits. a few are would-be doctors, but, by and large, most of them are very good. But what I really think makes a difference is the length of time in service, and the quality of the relationship you have with your patients, and anything that detracts from that is going to make for poor medicine. Anything that enhances it is going to make for better medicine. So people who go to school for two years, and who are hired and are mobile and can go from one job to another, make me a little nervous about their long-term commitment to a group of patients, and, hence, their long-term growth as a practitioner. That's the main thing.

Mullan: Religion. It's been a bit of a theme I've picked up on, Catholicism, to begin with, Jungian beliefs at one point. Maybe not fair to lump them in with religion. Tell me about what role that has played in your life and your work.

Loxterkamp: Lindsey was brought up in a Protestant church where she was cuffed into going to services and now really has a strong disdain for organized religion. She also claims that the fact that her mother was an avid antipapist has no bearing on anything. She's actually very supportive of my faith and the fact that I want to expose my daughter and son, Clare and Johnny, to the Catholic faith. It plays a big role. I think it's a big reason why I like hospice. I grew up thinking that there was a lot to be done around the time of death, and especially after a person died, and I was a part of the drama. I was the altar boy who went with the incense around the bier. Basically we--the priest and servers and the Sacraments, were responsible for

delivering the soul to heaven. I'm sure the dead made minor contributions in their lifetime, but I really felt that the ritual was important, and I saw its importance for the grieving family. Of course, in Catholicism ritual is always important, as it is in medicine. So the two really dovetailed in terms of how Saw myself in the world. I've always felt comfortable around those rituals, felt that they were a way of earning the trust of people who might not otherwise trust me or of talking more comfortably with people when I might not feel comfortable talking to them.

It took me a long time to respond to people who needed to talk about their faith, even if they were Catholic, but being an active member of St. Francis and exploring my faith there has really allowed me to see that whether patients talk in the terms I use or not, people have profound religious beliefs and spiritual insights, and that faith is really how we get by day to day. However we describe it, and to whomever we attribute power, that's how we all live, and that's how I practice. So I find myself having a lot in common with the people in this county, who are largely described as the most un-churched citizenry in the nation. Yet you find people, with incredible faith and incredible courage, incredible stories about their life and the obstacles they've had to surmount and that's what really attracts me to these people. Yeah, it's important.

Mullan: Do religious values play into the type of practice you have? Talk about your own response.

Loxterkamp: Yeah. Do you mean like my approach to abortion or doctor-assisted suicide or hospice?

Mullan: The whole gamut.

Loxterkamp: Yeah. I'm very much from the hospice background, and the notion of doctor-assisted suicide doesn't attract me in any way. If you're interested, you can read a little essay I wrote called, "a Good Death is Hard to Find," kind of a play on a Flannery O'Connor title, which basically suggests that people don't die good deaths. In death, we're usually ending something that we really love, which is life and the relationships we had, and to make it into a fairy tale or a matter of controlling pain, I don't know, it just grates against me. That's probably my faith speaking, that the dying are asking for a lot more to be done.

Mullan: You're against controlling pain, or you don't think it's being done?

Loxterkamp: That's not my focus. I think it can be done just like any other objective in medicine, but my focus is in learning about this patient's suffering. Why are they suffering? What can I do to help relieve it? Can I bring the family together? Can I talk to them? Can I talk about what needs to be done before they die? Are they afraid of it? Have they talked to their minister? Have they talked to their priest? Would they like to have the last rites? Basically, caring for this patient, sitting by them and not feeling compelled to do something for

them, to give them a shot, to do another chemotherapy treatment, that's not my focus. There are other people who do that and do it well, and I see the purpose in all that, but in hospice, even, there are people now who really want to have workshop after workshop on pain control, and after a while, what more do you need to about morphine and thorazine? You know these things. That's not where the real challenge is. That's not what's to be learned about this person who is dying.

Tim is very good at doing family meetings, and that's the thing that we've come to enjoy, and it really provides us with the greatest satisfactions of practicing medicine: being together with the family and talking about the importance of this person who is dying and what it means for the family to be losing them.

Mullan: And abortion?

Loxterkamp: Well, my wife is very pro-choice, and I resist the Catholic Church telling me how to believe, and I suppose I'm in that very wishy-washy nether land of saying, "Well, it's the patient's choice." I mean, I'd rather see them think about other options. Here I am. If that choice was offered to my natural mother, where would I be today? That plays a part. But it's something that really doesn't come up very much. Maybe people suspect that because I'm Catholic, they would not get far in discussing abortion with me. I don't know, but I would be sympathetic to their doing what they wanted, to go where their conscience led them. You should ask Tim about our Thursday morning groups that we've had for I don't know how many years,

but we get together one hour a week and talk about our lives, touch base with our personal lives.

Mullan: This is the group in practice?

Loxterkamp: In our practice. Mary Beth Leone and Tim and I started it six or seven years ago, and Scott then joined it, and now Lisa has joined it. Anyway, Mary Beth, in our group, is a social worker. She's Catholic. She's very strongly against abortion, and that has an impact on me. But I'd have to say that one thing I probably avoid more than promote in my practice is espousing my faith.

Mullan: Bring me up to date, if you would, on the family. You have two children?

Loxterkamp: Two children. I have an eight-year-old daughter and a two-year-old son. Lindsay and I had Clare on the second try, probably; we were in therapy trying to decide whether we could do this, whether Lindsay could cope, whether I would be there for her as a supportive husband. We had her, and even though she was in some ways difficult, as all first children are, they're always kind of the angels in the family, she was a challenge, and after a period, it was important to me to think about a second, and here he comes, John.

We had a hard time having John. Lindsay had two or three miscarriages. We didn't think we'd ever have him. Now sometimes we wonder why we wanted our lives turned upside down as much as

it is, but that's our life. Both of my parents are dead, so our only family is Lindsay's parents--her father and her stepmother.

Mullan: Let me tie things together here. What do you see in the future in terms of your own practice? Two parts of the question. What do you see in terms of the next twenty years in terms of the drift of medicine and particularly primary care, and what do you see in terms of your own activities?

Loxterkamp: Well, my own activities first. I expect Lindsay and I will probably die here, in Maine. I think we'll stay here, with the idea that from time to time we would take a sabbatical, and I would certainly keep up my writing. But, as I said, what provides the fuel for my writing is my life here, and I couldn't imagine changing it. So I hope to write, maybe twenty years from now, a second journal, which will update the first.

Mullan: We haven't dwelled on the writing at all. What does it do for you? What does it mean to you?

Loxterkamp: It means a way of sorting out what goes on in my life, and it means a way of contributing to family practice, which I feel indebted to, because it's done a lot for me. Being a doctor has been for me like an arranged marriages that somehow worked out. Arranged in the sense that my mother was very determined that I would be a doctor, and I was very determined to be one too, I'd have to say, for a variety of reasons. I also have an ego, you know. I'm not without that, and I kind of like to see my name in print. I kind of like to see a finished idea,

and I kind of like to see how that idea looks on the printed page, and, you know, that part of it, the artistic expression.

Mullan: Have you had much published?

Loxterkamp: Well, I've had a couple of articles published by Commonweal, one by DoubleTake, one coming out in the *New England Journal of Medicine* about defining the family practitioner. And a book coming out in the spring. I have a project which I've talked to you briefly on Ernest Ceriani and the *Life* magazine piece, which I'd really like to talk to you about some other time. So anyway, I've had some fun with writing and some minor successes, but I really don't have that much time to work on it. My goal is to write one or two things a year, one or two minor things, and then maybe every couple three years a major piece.

Mullan: That's great. So where do you see medicine heading?

Loxterkamp: I am not pessimistic about it all.

Mullan: Would you tell your son to be a doctor?

Loxterkamp: Yes, I sure will, or a priest, if priests can marry and have a sane lifestyle by then, or to be anything he wants to, and my daughter the same. Although, I would hate to see them enter into any kind of religious commitment the way the Catholic Church is now. It's just in disarray and I don't think it knows where it's going. But family practice does, more or less, medicine to a lesser degree, and it's still a good life. The

patients create us and sustain us. They teach us to be good doctors and to find happiness in our work.

There's some of my colleagues who'll never find happiness because they see only the money, or the procedure, or the diagnosis. If you get beyond that, if you can live with your work and accept your mistakes, I'm very optimistic. I cannot see a negative side. Even if I end up working for the hospital, making half of what I make, no longer being the agent of my destiny, I don't see that as being a critical factor. The critical factor is the patient in the room with the doctor, and the invitation to open up their lives to one another. That's what I see.

Mullan: You've touched on a lot of things. Before we finish, is there anything else you'd like to talk about?

Loxterkamp: One more thought, if I may. Let me say again that I do not fear managed care, do not believe it, or any other system of health care delivery, is powerful enough to destroy the potential of the doctor patient relationship. Even if the patient and I have just recently met, even if he is angry at me for waiting three weeks for the appointment and two hours to see me, even if we now have only five scheduled minutes together, there's a chance we will connect. There's a chance he will reveal his soul to me, and that I will have the courage to look.

What works against that possibility are things inside the doctor. How unfocused are we at that moment, how unsupported do we feel, how well have we come to understand the poignancy and

pain of the questions the patient is now asking? As I have said before, a career as an itinerant doctor, an uninvested doctor, limits the possibilities for professional growth. Not in the modern sense, where career is defined int terms of salary and rank. But in a deeper sense of being personally satisfied by your work, feeling a personal connection, growing through the human interactions.

The old notions about the frontier physician still persist. We are trained to work hard, take charge, and bear full responsibility. The negative side of that is that we have not learned sufficiently how to share the burden or talk about the toll of seeing pain and suffering on a daily basis. Managed care has been successful in throwing doctors together in financial as well as cross-coverage kinds of relationships. Can we take it a step farther? Can we begin to get to know each other, support each other, learn from each other about how to survive this most difficult of professions?

I feel very lucky in my current practice in that I have doctors around me who like and look after me. I have nurses who shelter me, employees who joke with me, a staff that picks me up. We have worked very hard to build that into our office atmosphere, and the pay-offs are manifold. This is where I would like to see medicine in the Twenty-First Century, talking about its accomplishments not only in technological terms, but human terms a well.

Mullan: Sure. Thank you, David.

Loxterkamp: You're welcome.

[End of interview]