



By Laura Stephenson Carter and Fitzhugh Mullan, M.D.

# PRIMARY RESOURCE

**Primary care has often been overshadowed by the glamour of specialty care, especially at academic medical centers.**

**Here are some waypoints in the history of primary-care medicine—both nationally and at DHMC—plus profiles of two primary-care physicians with Dartmouth ties, excerpted from a recent book on primary care’s role in American medicine.**

A century ago, people got nearly all their medical care from a general practitioner—a doctor who treated pretty much everything that came along. Nowadays, a lot of people regularly see one or more specialists—from cardiologists to gastroenterologists. Generalists still exist, however. Today, they’re more often called primary-care physicians. And even they “specialize”—in family medicine, in pediatrics, in general internal medicine, or in obstetrics and gynecology.

Recently, managed care has made the term primary-care physician (or PCP, as it’s abbreviated in insurance-company brochures) more common but more controversial, since the PCP is perceived as preventing rather than facilitating access to services. Yet people still want a doctor who cares about them as an individual. A primary-care physician makes “a commitment to be the patient’s ongoing physician, as long as the patient wants, for everything,” in the words of Dr. Harold Sox, chair of medicine at Dartmouth from 1988 to 2001 and now the editor of the *Annals of Internal Medicine*.

On these two pages are some twists and turns in the history of primary care; dates and facts in gray are national events, and those in red are Dartmouth-based. And on pages 46-47 and 48-49 are oral histories of two primary-care physicians with Dartmouth ties, excerpted from a recent book.

In 1931, **87%** of physicians in the United States are generalists. But by 1960, specialists outnumber generalists. In the early 1960s, the first generalist residency programs are established.

Upon arriving at DMS in **1968** as chair of medicine, Dr. Thomas Almy (a gastroenterologist) advocates establishing primary- and ambulatory-care clerkships and creating a new category of regional faculty members, now called adjunct faculty, to mentor students in their private practices.

In **1969**, the American Board of Family Practice is established. As of 1970, the percentage of U.S. generalist physicians drops to 37%.

DMS becomes one of the **first** medical schools in the Ivy League to have a family medicine department.

---

DARTMOUTH MEDICINE’s associate editor, Laura Stephenson Carter, offers here some highlights in the history of primary care. The accompanying profiles are excerpted from a book by Fitzhugh Mullan, M.D., titled *Big Doctoring in America: Profiles in Primary Care*. A noted medical educator and policy activist, Mullan collected oral histories from 15 primary-care practitioners, including a DMS alumnus and a longtime member of DMS’s adjunct faculty. These chapters from Mullan’s book are condensed with the kind permission of the University of California Press. They are ©2002 by the Regents of the University of California.

---

ment, with the 1971 creation of the Department of Community and Family Medicine.

In 1972 and **1976**, Congress passes the Health Professions Education Assistance Act to support training programs in general internal medicine and general pediatrics.

In **1975**, DMS establishes a community-based, primary-care clerkship. It is one of the first medical schools in the country to recognize the need to offer students clinical training in outpatient and ambulatory-care settings, not just on hospital wards.

The **1970s** mark the emergence of two new nonphysician primary-care disciplines—nurse practitioner and physician assistant.

In **1978**, the Department of Community and Family Medicine at DMS establishes the Primary-Care Cooperative Information (COOP) Project, made up of primary-care practices throughout the region. The project does quality assurance studies, conducts primary-care research, improves practice management, and offers continuing medical education. Project members share information via a computerized data system.

There are **150** family practice residency programs in the U.S. by the 1970s (and more than 450 by 2000).

In **1979**, the Maine-Dartmouth Family Practice Residency Program is established.

In the late **1980s**, DMS revamps its third-year clerkships, doubling (from 20% to 40%) the amount of time that students spend in outpatient settings.

By 1988, only **33%** of all U.S. physicians are generalists.

In **1989**, DHMC opens a primary-care office on Buck Road in Hanover, N.H., and over the next 10 years helps improve access to primary care by opening branches of the Hitchcock Clinic throughout the region.

In the early **1990s**, the network of preceptors for DMS's primary-care clerkship is expanded to include private practices all over Maine, Vermont, and New Hampshire. The Medical School also launches a longitudinal

primary-care course for first- and second-year students; now called On Doctoring, it makes DMS a leader in giving students clinical experiences early in medical school.

By the **1990s**, just over 30% of U.S. physicians are generalists, though the number of medical school graduates has doubled since the 1960s so there are now more generalists in absolute numbers.

In 1993, **35%** of DMS graduates enter generalist training and DHMC establishes a New Hampshire-based family-practice residency jointly with Concord, N.H., Hospital.

In **1994**, the Council on Graduate Medical Education recommends limiting the number of specialists to just half of all physicians. As a result, more medical students begin to pursue generalist careers.

DMS is one of **14** medical schools selected in 1994 by the Robert Wood Johnson Foundation to share \$32.7 million to develop programs to increase the national supply of generalists. The goal is to have 50% of all medical school graduates go into generalism.

DARTMOUTH MEDICINE's Fall **1994** issue contains a cover article on the Robert Wood Johnson grant and DHMC's commitment to generalist education.

In **1996**, the American Medical Association, the Association of American Medical Colleges (AAMC), and other leading medical groups ask for federal incentives to increase the number of generalist physicians.

In **1997**, DHMC establishes the William Boyle, Jr., M.D., Community Pediatrics Program, incorporating into the training of pediatric residents home visits, work with community doctors, and contact with school health clinics and parent conferences.

In the late **1990s**, interest in primary care peaks and starts to decline. Some policymakers start to argue that there are too many primary-care physicians and that generalist training programs should be cut back.

In **2000**, DMS strengthens its community-based teaching. The Office of Generalist Education is renamed the Office of Communi-

ty-based Education and Research, and its charge is expanded to include research and evaluation of the educational process.

Over **300** community-based preceptors in more than 150 practices throughout the region work with DMS students as of 2001.

There is mounting evidence by **2001** of a shortage instead of a surplus of specialists. The aging of the U.S. population is creating a demand that's expected to outpace the predicted supply. The American College of Cardiology, for example, estimates that by 2030 the need for cardiologists will rise by 66% but the number of cardiologists by only 1%.

DARTMOUTH MEDICINE's Summer **2001** issue contains a feature on DMS's pioneering role in community-based teaching.

The **first** national database of primary-care physicians goes online in 2002. The Primary Care Service Area Project—developed by Dartmouth and Virginia Commonwealth University—is used by the federal Health Resources and Service Administration to define primary-care shortage areas.

In **2002**, DHMC's Section of General Internal Medicine hires several new primary-care providers and opens a Dartmouth-Hitchcock Clinic office in Lyme, N.H.

In a press release about the **2002** National Resident Matching Program, the AAMC reports that "data from this year's residency match, which serves as an indicator of career interests among medical school graduates, shows a decrease in applicants matched to generalist positions."

In **2003**, Dartmouth-Hitchcock institutes a "Find a Primary-Care Doctor" line to help patients identify primary-care providers located in their own communities.

The AAMC says national **2004** Match results show that family-practice programs have experienced a steady drop since 1996.

**30%** of DMS '04s are entering primary-care residencies. And the DMS Family Medicine Interest Group learns it is the 2004 recipient of the American Academy of Family Physicians' Program of Excellence Award.



**I was asked from time to time, “Isn’t general practice boring, seeing the same thing all the time?” Actually, I thought it brought far greater diversity and much more enjoyment. I saw eyes, I saw hearts. I did rectal examinations, I did feet. I pared corns, I delivered babies. Everything.**

## **Eugene McGregor, M.D.**

### **A good life in Lisbon, N.H.**

*Eugene McGregor was born in 1916 in Lisbon, N.H., and practiced medicine there for nearly four decades. A 1938 graduate of Dartmouth Medical School, he now lives in Concord, N.H. His spare but direct way with words is evident as he reflects here on his days in practice—some 14,000 of them. He thinks life for a country general practitioner grew easier as the century progressed, with the arrival of surgeons and obstetricians to share the load, but he has mixed feelings about the advent of medical insurance.*

*Continuity and community marked his career. McGregor left northern New England only for his last two years of medical school and four years in the Army. He never used a horse and buggy, but his practice represents a bridge back to those who did, to their fledgling science and their powerful art.*

In 1948, I returned to Lisbon, N.H., where I was born, to start medical practice. The idea of becoming a doctor hadn’t really occurred to me until I was in high school. I had watched my father struggle during the Depression. He was a banker, and banking in the early ’30s was a difficult, sad business. The idea of being a physician and being your own boss was extremely appealing to me. There was also the fact that physicians wouldn’t have to bear arms if we went to war—and certainly there was some suggestion of war in the ’30s. And I liked the sciences and did reasonably well in them.

When I graduated from high school in 1933, a lot of my classmates couldn’t afford to go to college. With the scholarship that Dartmouth offered, I could go there cheaper than I could go to the University of New Hampshire. I worked all the time I was in college—summers, too. I “hopped” bells every summer at a big resort in Whitefield, N.H. For those of us who worked, there wasn’t much of a social life.

I was accepted to medical school at Dartmouth, too. I had the idea then that I would be a general practitioner, but I didn’t know where. I do remember that I didn’t want to be subservient to anyone if I could help it, except maybe my patients. Medical school was very, very enjoyable. Our class was small—only 20 students—and Dartmouth did a deluxe job of teaching. We all had to transfer for our clinical training because Dartmouth was only a two-year preclinical medical school back then. I went to Rush Medical College in Chicago. I was in a class of 105 there.

It was quite an experience to go from Hanover

to the west side of Chicago. I’d never seen poverty like that in New England, even during the worst of the Depression. We worked on the wards at Cook County Hospital, where we really learned. We also saw patients at Presbyterian Hospital, but they mostly had private doctors and we did less with them. Most of our patients were from Europe. Chicago then had the largest Czech population outside of Czechoslovakia, the largest Polish population outside Poland, and so forth. We often had to use an interpreter to get a history or a physical.

At that time, obstetrics for the poor in Chicago was handled in charitable clinics. The women came to the dispensary for their prenatal care, but they were delivered at home by teams of medical students. We went to tenements and apartment houses and tried to establish a somewhat sterile field with rolled-up newspapers, some hot water, and a pair of gloves. That was about it. The first time you went out, you went with a student who had been out before, and he taught you what he knew. You could call an assistant resident from Presbyterian Hospital, who would come out and try to help you, but sometimes there were disasters. I had one. A patient was pregnant with her first baby, which was in a posterior position, and she couldn’t deliver. Finally we got the assistant resident out, and he tried to use forceps to rotate the head. I was giving her ether, which I had never done before, and I was scared to death. Friends of the patient came in to hold her legs. We were using the dining room table. One guy crawled under the table and vomited. It was an awful mess. We got the baby out, but I’m not sure how well.

For my internship, I came back to New England, to Maine General Hospital in Portland. It was an 18-month rotating internship with no pay. Interns got room, board, and laundry, and that was it. We were on call every other night and every other weekend. Then the war came along, and I got called up; I served in Panama in a 1,000-bed hospital.

When I was discharged from the Army, I decided I needed more training, particularly in obstetrics, if I was going to be a general practitioner. So I returned to Maine General Hospital for a surgical residency. Then a woman in Lisbon offered to lend me a sum of money to buy a house and start a practice. Lisbon had had three doctors in the 1930s, but only Dr. Pickwick was left and this woman didn’t like him very much. He was getting older and was a crusty character. I decided to take her offer.

I guess the fact that I probably had more training than most of the local doctors helped with starting the practice. And more than a few people apparently didn’t much like Dr. Pickwick and came to



**This picture—capturing Gene McGregor during a rare moment of rest, with district nurse Louise Clark—is one of the few photographs he has of himself at work; he was far too busy with the here and now to think about posterity.**

me right away. I hired Isabella Smith, who had graduated from Lisbon High School two years ahead of me and trained as a bacteriologist at Simmons College; she did my bookwork and laboratory work and stayed with me until she retired in 1982. My wife, Phyllis, was a tremendous help. She was a nurse and took care of the office and helped with the patients. She'd listen to my gripes and answer the phone for me at night when I was away or busy.

I used the Littleton and Woodsville Hospitals, both a bit of a distance and in different directions. It could be nerve-racking, keeping everything covered. My wife used to have to come out and flag down my car on the road if there was an emergency, or she would leave messages with the town's telephone operator. I used to call up the operator and say, "I'm going to Lyman today to see so-and-so," so she would know where to track me down. It worked fine—far better than most answering machines these days.

I made house calls all my life. I think that's the way medicine should be practiced. A doctor should be able to see people in their homes, to see what their hygiene is like, to look in their refrigerator. I probably made three or four house calls every day.

I used to start hospital rounds about 9:00 a.m., so I didn't interfere with breakfast and the cleaning up of patients. Then I'd go to the other hospital, and maybe make a house call or two. I had office hours in the afternoon. At first I had open office hours from about 1:00 to 4:00, and in the evening from 7:00 to 8:00. At certain times of year—flu season, for example—the waiting room would be packed, and other times I had nothing to do. In the 1960s, I went from open office hours to scheduled appointments.

Lisbon has always been a pretty poor town. We had a wood-working mill and later a shoe factory. The mill did not offer any health coverage, so people had to pay as best they could. Blue Cross came along in the 1950s, and I think probably 15 to 20 percent of my patients had it. By 1985, when I retired, maybe 75 percent of my patients had in-

surance, including Medicare and Medicaid. A lot were still not covered, though. Health insurance was a great improvement in many ways, but it made things so complex it drove me nuts.

Around 1956, a very well-trained surgeon named Harry McDade came to Littleton, and I realized that it was foolish for me to continue doing surgery. I kept on with obstetrics, delivering babies until the '70s. Fetal monitoring had just come in and caused quite a commotion, but quite frankly I despised it. I gave up obstetrics about 1976.

Over the years, of course, I dealt with a lot of family problems. Alcohol certainly was a problem. Even when drugs for the treatment of alcoholism came along, they didn't help much. But drugs were a non-problem when I began in practice. I don't think there were so many sexual problems either. I remember one patient telling me a problem she had of a sexual nature, and how shocked I was that she had come out with it. I'm sure I didn't offer her any advice whatsoever. I occasionally saw women who had been beaten up by their husbands; I would try to get them to prosecute, but they never did.

When I retired on July 31, 1985, I tried to get someone to take over my practice. I even advertised. But no one was interested, so I simply closed it up. Eventually Littleton Hospital took over my office and arranged for two Littleton physicians to use it on a part-time basis, as a satellite of Littleton Hospital. But I don't like it. I think we're producing a nation of gypsy physicians. They go where the best money is, and they stay a short time. Then they're off and away.

I saw general practice become family practice, and that was for the good. When the American Academy of General Practice—now the American Academy of Family Physicians—was founded in 1947, I joined immediately and kept up my membership. When I started practice, there wasn't this whole array of specialists. You were forced to take everything on and do the best you could. When I began I probably took care of 95 percent of what came along. A general practitioner today ought to be able to manage 85 percent of everything he or she sees; the question is which 15 percent you should refer.

I enjoyed my years in practice, but I wasn't sorry to get out when I did. The number one reason was the litigiousness of patients, physicians, everyone. The second reason is that Medicare and Medicaid got us into a bookkeeping system that is monstrous. You have to sign documents that say everything is true, and if it turns out not to be true you'll be sent to jail for 10 years or fined \$2,000. Signing those papers used to irk the hell out of me.

I was asked from time to time, "Isn't general practice boring, seeing the same thing all the time?" Actually, I think it's the reverse. When I was a resident, I thought about going into urology. But the problem with urology was that I would have spent the rest of my life looking at penises and bladders and kidneys. In general practice, you're looking at a tremendous range of medical conditions. It's true that you can't have every bit of knowledge at the end of your fingertips, but you can find it relatively quickly. No, I thought that general practice had far greater diversity and much more enjoyment. I saw eyes, I saw hearts. I did rectal examinations, I did feet. I pared corns, I delivered babies. Everything. The whole works.

Being a general practitioner is not necessarily easy on your family, however. I think my wife felt at times that it was too much because we were up all hours of the day and night, especially with deliveries, and it was a very hectic schedule. But it was a good life.



**I was petrified. Suddenly I was dealing with everything—from train wrecks to broken wrists—some things I’d seen a hundred times but some things I’d never seen. I was *the* doctor. Windsor had no diagnostic radiologists, no backup orthopaedic surgeons, no backup anything.**

## **Beach Conger, M.D.**

### **A contrarian in Windsor, Vt.**

*Beach Conger was born in 1941 in New York City and grew up in suburban Hastings-on-Hudson and Pleasantville, N.Y. From 1977 to 2002, he practiced general internal medicine at Mt. Ascutney Hospital in Windsor, Vt. During that time, he also held an adjunct appointment on the Dartmouth Medical School faculty, serving as a preceptor for medical students’ primary-care rotations. He reflects here on his quarter-century as the quintessential small-town physician.*

*“Today,” observes Conger, still a determined generalist, “I feel more like an endangered species than a role model. Kind of like the gray wolf or the cougar. It seems my feeding grounds are gradually being replaced by multispecialty clinics and CAT scanners.” Now a hospitalist on the faculty at Temple University School of Medicine in Philadelphia, he gave the following account of his life and work while he was still in Windsor.*

**M**y decision to become a doctor was basically the result of my doing well in school; that was one of the things that kids who did well in school in the 1950s became. I went to Amherst College and then to medical school at Harvard. I found the first two years of medical school tedious and didn’t apply myself much. The second two years were better. I enjoyed the practical stuff. I did my medicine rotation at Boston City Hospital, which I loved. I was not comfortable as a student at Boston’s upscale hospitals. A big public hospital is both more egalitarian and more forgiving in terms of what the patients expect and the way people treat each other.

Between my second and third years of medical school, in the summer of 1965, I went to Mississippi as a civil rights volunteer in Holmes County. I lived with a share-cropping family about five miles outside the county seat. It was a remarkable experience. Back in Boston, I helped open a clinic in the impoverished Columbia Point section of the city. These experiences gave me an understanding that, even in this country, there is a way of life that has nothing to do with places like Pleasantville.

I did my internship and residency at Boston City Hospital, then joined the Public Health Service. I was assigned to the Centers for Disease Control (CDC) in Atlanta, in a program called the Epidemic Intelligence Service. I thought I might stay in the CDC since public health appealed to me, especially given the choice between that and going to Vietnam. At first, I staffed rural clinics in southern Georgia; the local doctors, who were all white, thought public health clinics were a Communist

plot. In 1971, I was sent to New York to track complications and deaths from outpatient abortions. The CDC had just started to look beyond smallpox eradication and salmonella outbreaks, applying epidemiological principles to other arenas.

Then my wife wanted to go to law school in San Francisco, so I left the CDC and resumed residency at the University of California-San Francisco. During my last year as a resident, I spent time working in a methadone clinic in a ghetto area. Then the group that ran this clinic received a grant to take over a failing community health center; they asked me to run it and I accepted. Often when I arrived in the morning, I would see my patients sleeping on the sidewalk, waiting to get in. But I discovered, somewhat to my surprise, that I liked practicing medicine. It turns out that medicine involves a lot of acting, and I’m a bit of a ham. I enjoyed the problem-solving of public health, but it wasn’t as much fun for me as the one-to-one with patients. You can’t crack jokes when you’re investigating infant mortality, but you can with patients.

In 1977, I saw an ad from a community hospital in Windsor, Vt., that wanted to replace a retiring internist. I was dubious but decided to take a look. All of my experience had been at huge city hospitals and, by comparison, the hospital in Windsor seemed like a doll hospital. It had 20 beds, and everybody knew everybody. But I liked what I saw, and it turned out they liked what they saw. I took the job.

For the first six months, I was petrified because I was used to always having someone around to help deal with problems. If somebody got sick, I’d send them to the hospital. I might visit them, but I didn’t start IVs, insert tracheal tubes, or apply casts. I just prescribed drugs and talked. But suddenly I was dealing with everything—from train wrecks to broken wrists—some things I’d seen a hundred times but some things I’d never seen before. I was *the* doctor. Windsor had no diagnostic radiologists, no backup orthopaedic surgeons, no backup anything. It was anxiety-provoking.

Then I got used to it and realized that you do what you can. Especially in the beginning, I practiced more intense medicine than most internists do today, largely because people expected me to. I referred very few patients out unless they needed a surgical consultation. Now Windsor has six internists, two pediatricians, a general surgeon, a full-time orthopaedic surgeon, and a variety of visiting specialists. Specialists visit from Dartmouth-Hitchcock Medical Center 20 miles to the north or circuit-ride to a series of community hospitals, of which ours is the smallest. So specialists are once again all around me. I do a lot more referrals than



**Beach Conger is pictured examining one of the thousands of patients he saw during his 25 years at Mt. Ascutney Hospital in Windsor, Vt. He often was accompanied by Dartmouth medical students on their primary-care rotations.**

when I first arrived. Several of our physicians became employees of a huge organization whose brochure states, in essence, that “primary care is the doctor who helps you figure out which specialist to see.”

I actually have more access to specialists than I wish I did. It's kind of like having too many restaurants to choose from. You're more likely to eat out when you have lots of restaurants, and I'd rather eat at home. My practice is made up of patients I've known for a long time, and they tend to look primarily to me for guidance. A cardiac surgeon to whom I once sent a patient called me up, rather irritated, saying, “We think your patient needs to have his mediastinum opened up because he's gotten a postoperative infection, and he wants me to check with you.” That's patient loyalty.

There's a group practice of younger physicians in a nearby town who don't even come into the hospital when they're on call. A patient who's sick is sent to Dartmouth. Somebody with chest pain is sent to a cardiologist. These doctors are quite content with that kind of relationship. Younger internists will never set a broken bone or take care of a patient in an ICU—they'll transfer the patient to the orthopaedist or the pulmonologist.

**H**alf of my patients are on Medicare, and the other half have managed care of some type. The only difference it makes to me is that I have to fill out more forms. Part of the reason it's not a problem is that there is no competition in primary care. Patients in Windsor have to see someone in this group—unless they hate us all, in which case they'll need to travel some distance. Managed care will never have the same impact in a rural area as it does where you have all sorts of plans competing with each other and patients jumping from one plan to another. Here there's nobody else for them to see.

What has changed is that if somebody came in with a headache in 1977, I would have talked to them but, unless I was really worried, I would not have ordered any tests. Now, however, the chances are better than 50/50 that a patient with a headache knows about CAT scans

and expects to have one—regardless of the fact that I don't think one is indicated in the vast majority of cases.

We've also invented diseases in well people. When I was in medical school, if you identified a patient with high cholesterol it was really high—like 500—and they'd have huge globs of fat hanging from their eyeballs. Now we've lowered the cholesterol standard so nobody passes. This means there are people trooping in and out of the office all the time who aren't sick. People have gotten used to going to the doctor on the premise of not being sick. So when they get sick, they think, “I've got to see a different doctor. This is not my doctor for sick. This is my doctor for cholesterol and blood pressure. Now that I'm actually sick, I need a specialist.” And since everybody does get sick sooner or later, this kind of thinking has led to a doubling in the number of specialists in this country. Nobody discusses the fact that everybody's going to die sometime, and at a certain age maybe having hypertension isn't so bad because it's better to die of a heart attack than of Alzheimer's disease. I once told this to an 89-year-old patient who wanted to have her cholesterol tested; in one sense I was joking, but in another I wasn't.

What I like best about my practice is the interaction with people, though I have to admit there is a part of me that is energized by disease. But it's always upsetting when I have to pass along a bad diagnosis. I had a medical student with me one day when a patient's CAT scan came back with an ominous spot in the right lung. The student was excited and said, “This person's going to have lung cancer.” I responded, “If your sister had this CAT scan, you would not be excited.” A woman on chemotherapy just came in with a sore ear, terrified. I looked in her ear, and it was okay; she felt great and so did I. I have to have a certain number of sick people to fuss with or I feel I'm betraying my training. But I don't need a lot.

**I** do keep up with infectious diseases. In 1983, I diagnosed Legionnaire's disease in a hospital patient. After another case was identified, we found the source of the infection in the hospital's water heater and were credited with what has humorously been called the world's record for terminating a *Legionella* outbreak—two weeks. A press conference was held, and the hospital administrator asked me to speak at it. Legionnaire's disease in Windsor was a big deal.

At the press conference I joked, “This is nature's revenge. You put in buildings and nature says, ‘This is not what you're supposed to be doing,’ so it's got germs to try and combat you.” A reporter from the *Valley News*, said, “You've got a strange way of looking at things. Will you write an article about this?” So I did. Then they asked me if I'd write a regular column. I wrote on herpes, on why doctors lie. It was never serious, though I always told the truth. I enjoyed the writing, and after a few years I turned the articles into a book called *Bag Balm and Duct Tape*, which came out in 1988. I was off and running. My second book, *It's Not My Fault*, was published in 1995. Writing imposes a kind of discipline on me that medicine doesn't. My first and second drafts are usually gibberish. I have to rewrite six or seven times to get what I want. In medicine you don't usually have that chance.

But I love practicing in Windsor. I'm the senior physician in town. Everybody looks up to me, except the people who can't stand me. It's a very small pond, but I'm the biggest frog in it. So I keep treating sick people. I recognize the futility of it because I know they're going to die sometime. But it's what I do. ■