Estes, Dr. Harvey
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Justin Barr, Moderator
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This is an interview with Dr. Harvey Estes moderated by Justin Barr 20 February 2007 Durham, North Carolina.

HE: I graduated from Emory in February, 1947. I was supposed to have begun an internship there under Dr. Stead, but he left Emory to go to Duke in December 1946. I stayed at Grady hospital in Atlanta under his successor, Dr. Paul Beeson. I finished two years of residency and one year of fellowship there. Then in 1950 I got snatched into the Navy for active duty during the Korean War and when I got out in 1952 everybody that I had known that Emory had gone with Dr. Beeson, who had been appointed as chair at Yale. Those who had not gone to Yale had joined Dr. Stead at Duke. So when I got out of the Navy there was nobody left in Atlanta. I came here and joined my former mentor, Dr. James Warren who had come here with Gene Stead so I came here too, to finish up my residency and a fellowship.

JB: What was your residency and fellowship in?

HE: Cardiology. So I became a cardiologist at the VA hospital in Durham – well, first I finished about six months of my residency that I needed for my boards and then stayed on as a cardiologist at the VA and then joined the faculty at Duke in 1953, mid- year, about July. And I have been around ever since.

JB: Out of curiosity, did you deploy to Korea, or were you stateside?

HE: Stateside. I had one year at Bethesda at the Naval Hospital there and one year teaching electrocardiographic techniques to flight surgeons at the naval air station at Pensacola. So one year at Bethesda one year at Pensacola. Not Bad.

JB: get to see the country.

HE: And then I came back and that's when I came to Duke.

JB: When was the idea of a PA first floated around, or when did you first hear about it?

HE: It evolved in Gene Stead's head, but it evolved for a reason. The person who followed me in cardiology at the VA was Henry MacIntosh. Henry Macintosh went on to head the new cardiac catheterization lab at Duke. And the cath lab operated with nurses as assistants. This was the beginning, I guess, of the national nursing shortage, but they could not find nurses as assistants for the cardiac cath lab. Henry Macintosh was really desperate, and he talked to Eugene Stead, his chief, about how to get around the situation. Gene Stead was an innovator and he said “well does it have to be a nurse?” “No, it doesn't have to be.” It has to be someone who is intelligent, responsible, and who is willing to learn. So, who might fill those shoes, meet those criteria? Henry began to think of ways of doing it and he thought about firemen. Firemen have jobs that occupy

them for three days a week, roughly, and then they are off for three or four days and many of them take other jobs. Henry said let's see if there are firemen who want to moonlight. So he found three or four firemen who wanted to do this and thought they could recruit sufficient numbers to meet their manpower needs. This worked and they found firemen to be satisfactory assistants. Then somebody suggested that there were navy corpsman who were assisting in a new catheterization laboratory at the Naval Hospital in Norfolk. So Henry had a bright idea; instead of getting firemen, who have to be trained from scratch, let's see if the Norfolk cardiac cath lab has people who have been trained already as hospital corpsmen to become cath assistants. When they are discharged, we can bring them here and hire them full time.

JB: Do you know what year this was?

HE: My guess is 62, 63.

JB: So they started using firemen in the late 50s?

HE: In the early 60s. It was not 50s, it was 60s. So Henry began to recruit people from the Norfolk Naval Hospital. He recruited several and they came here and were quite satisfactory, they did a great job. So I think this may have been the antecedent to Gene Stead thinking about hospital corpsman and medics of various types as recruits for various jobs around the hospital. But all mixed up at the same time was another experiment Gene Stead was involved in which was an interesting experiment with the nursing profession. He felt that the nurses could do more and should do more, and he thought that nursing education was downright miserable because it was stereotyped and it really didn't teach them about many things that they were able to learn. So he struck up a partnership with a faculty member in the nursing school who had similar opinions. Her name was Thelma Ingles. She was a Ph.D. level nurse -- you have heard about her -- she was very receptive to an expanded role for nursing. So she and Gene Stead put their heads together, you probably heard this from others, and started a Masters level program for nurses in which they, in effect, had a clinical internship. Thelma Ingles tested this idea first by becoming an intern herself with Gene Stead as he made rounds on wards. She spent a sabbatical year doing that. She felt at the end of this year that it would be a very good basis for a Masters level nursing degree. They applied for approval for a Masters level training program for nurses. They accepted a class and put them through a full year of training at the end of which the National League of Nursing declined to approve the program, saying it didn't have proper faculty. All the faculty were not nurses and that was one of the requirements, that all were properly trained. Thelma was fully engaged as a faculty member with the program. She didn't count because there were physicians involved, who were not approved and the accreditation group turned it down, which infuriated Gene Stead and infuriated Thelma. He was then out to find something to take the place of his failed, rejected program. So the PA program followed very quickly after that program failed. Gene Stead was a very unique individual. He made up his mind and he had the resources. He didn’t ask questions, he just did it and he’d figure it out how to justify it later. He began to talk this thing up, and as the head of the biggest and most influential clinical department at Duke at the time, he had many associates

under him that did what he said. So he pulled together his department and said “we’re going to have a PA program.” He appointed several people to put together the basic framework of the program, which was not very well planned, to be honest. Gene Stead was an unusual educator. He was an educator of physicians and had been since the mid-40s, but his techniques were about as unformatted as you could get. He boasted that he had never in his entire career held a lecture in his department, and indeed he didn't. He didn’t have courses in which you learned about internal medicine or cardiology or anything of that sort. He said doctors learn by taking care of patients, and if you take care of patients as they come in the door and handle the problems which they bring to you and learn as much as you can about these problems as they present, you will learn everything about medicine. You will not learn it in a specific order, but you will nevertheless learn it and you will learn it well and in proportion to its importance because common things come in commonly and rare things come in rarely. But they still come in. His chief teaching session when he was at Grady in Atlanta which continued when he came to Duke was a teaching exercise called Sunday School. Sunday School because it was always on Sunday morning at 10 o'clock. At 10 o'clock on Sunday morning every member of his department congregated in one lecture hall, and one resident was selected as the discussion leader. This was planned months in advance. The selected resident had to prepare a discussion of the problem that was being discussed that day. They at least gave the resident the option of choosing the topic. The resident chose his own topic and then another resident found a patient that had presented with that problem. That patient was brought down to the conference room and was there for the presentation of his problem. Dr. Stead and all the other faculty were lined up in the front rows and would ask the patient questions and would explain in simple language that this conference was for the purpose of helping that person by discussing his problem, helping young physicians learn about his problem, and what could be done. “All these people in the front row are gathered here to put our attention on your problem.” That was his teaching technique. This was absolute hell for that resident. And they dreaded it for months, but they did it and they learned a hell of a lot, and many of them became specialists in the topic they selected. For example a pulmonary disease problem: it would probably end up with that discussant being a specialist in pulmonary diseases because he became known in that residency group as a person who knows everything about that problem, having spent months studying and putting together the conference. Well, that was just Gene Stead’s technique, and Gene Stead didn't think a lot about formal curricula and learning objectives. Stuff like that is very popular nowadays. So he said to Henry Wallace, who was one of his junior faculty at that time, to plan the curriculum for the PA program. Find people to lecture, I’ll find you a place to teach. There weren’t many students –three, four. So they tucked them in little corners. The concept at that point was ill-formed because at the time, thought that they would be largely doing more or less technical tasks for a doctor in an office. The would learn how to do EKGs, how to do venipunctures and how to help with little things, but the concept that they would be the primary giver of care was not developed at all at that time. People were fearful of that, and I guess we went to all kinds of lengths to avoid talk of independent practice. I was a junior faculty member at the time and I taught the students how to take an electrocardiogram and read them, because that was my specialty. I taught a class to teach them how to do that. But the course was not – nobody had sat and thought about what kinds of problems they would

be seeing. I'll come to that later because we were called up on the carpet for that at a later point in the development of the program. Well anyway, when the PA program started, Gene Stead had convinced everybody in the medical school including his department chair compatriots that this was a good thing to do. And they recognized the problem. So, the PA program was launched. I guess it was 1963 or so. I may have been wrong in my previous estimate…it may have been the late 1950s when all that was happening with the firemen and so forth. Because they started training PAs in 63 because they finished in 65. They were in training when I became chair of my department in 1966, so they had have started at least in 64, 65. Well, at any rate, that date is in the literature. Well, we started, and the PA program marched along. The nurses were the only opposition and that was because of early publicity, some of it a little overboard. *Look* magazine ran a big article, and you know about that. Well, when the program began to graduate people, the fat was in the fire, because there we were sending them into practice before there was a regulatory mechanism to receive them in practice. We had an opinion from the state attorney general that there is nothing in the law that would keep a doctor from using a trained assistant to help him do things in the office, but that was the only authority we had for saying let's hire people to work with doctors. But at the same time we were answering requests from people all over the state because there was an acute shortage of primary care physicians and the primary care physicians out there could not get help, and they were desperate, and so we sent some of the first ones out to work with doctors over the state at about that time there was a national movement in the mid 60s to form departments of family practice because of this same acute shortage. There were no departments of family practice, or general practice, in fact family practice was a new term. It was general practice at that point. There was an American Academy of General Practice, but there was a ferment around the country because it was failing specialty. At that time training for general practice was: a year of medicine, and a year of surgery, six months of pediatrics, and 6 months of OB, or something of that sort. It was totally ad hoc, and very few people did it. That was one of the problems, but also in internal medicine people were going into cardiology, and gastroenterology and pulmonology. Nobody was finishing as a general internist anymore. So we were training these people, putting them out as being as an assistant to a primary care physician in various parts of the state, and we had no legal framework for doing so. About that time we had a movement in the medical school to start a department of general practice or family practice. This was opposed by most of the faculty at Duke, but we had 2 fairly prominent faculty members who were very dedicated to getting a department, and these two people had some influence. So the medical school formed a committee to study the problem. This is a well known avoidance technique: Instead of approving, they study it, study it and study it; do anything possible to avoid doing it.

JB: Who were those two people?

HE: One was Dr. William Demaria, D-E-M-A-R-I-A, a pediatrician, and he was influential because he was the pediatrician for almost every faculty family at Duke. He had cared for all of their kids. They trusted him and they loved him and he could do no wrong, but in this one thing: he was wrong. [laughter] The other was D. T. Smith. David T. Smith. David was a very respected senior member of the faculty. He was a professor

of medicine; he was also the first chair of the department of bacteriology at Duke, so he was both a physician and a bacteriologist. His expertise was in tuberculosis. D. T. Smith was convinced that we needed a generalist physician and so he and Bill Demaria began lobbying for it. This idea had some very potent support in the state because the president of the American Academy of General Practitioners was a North Carolina physician from down in the middle of the state, who was also a very strong Duke supporter and referral doctor. He sent all his patients to Duke. His name was Amos Johnson, and Amos had hired a young black man to work with him as an informal physician assistant, and that's a part of the history as well. Amos Johnson was probably the first person to train his own PA, and he operated with him as his assistant for 20 years. Well, Amos Johnson was in favor of this family practice department idea. The Dean at the time appointed a committee to study it and the committee concluded that we didn't need a department of family practice, we need a department of community health sciences, which takes sociology and organizational management techniques and computers, and designs ways of organizing medicine in such a way that doesn't have to be a family physician but it can be PAs and computers and artificial intelligence. Maybe we can help the doctor do things in a different way. I got a call in 1966 from Gene Stead saying that he would like to come talk to me, which he did. He said, he was on that committee, and he said we have created this department. I think it has some potential, and I'd like you to head it. Why did he pick me? He certainly didn't pick me because I was interested in family medicine or not interested in family medicine. I was a cardiologist doing cardiology at Duke. I had one advantage which nobody else in the place had and that is that I had been very active in the North Carolina Medical Society and was very involved in the politics of state medical affairs and knew more doctors in state than anybody else at Duke. A couple of years later I became president of the NC Medical Society but at that time I was very involved on a whole bunch of state committees, and had been involved in the state in the North Carolina Regional Medicine Program and things of that sort. In other words, I knew doctors all over the state, and I knew them very well and they knew me and they respected me. So I had an outreach that no one else had; certainly not at the level of the department chairs. So Gene Stead said "do me a favor and become the first chair of this department." And so without really thinking about it that much I did it and found myself with the title of department chair with one room and one secretary and almost no budget. I would have negotiated better had I known the game. [laughter] But nevertheless I became chair of the department. This was while Gene Stead was still active as the chair of the department of medicine. We started and we started developing a strategy for doing what I was supposed to do. We formed a computer division and we formed a preventive medicine division and a bunch of stuff that would help us do this. But the PA program was not a part of it. But Gene Stead came to me a few months after that and said, "look I am retiring at the end of 1966 and my replacement is going to be Dr. Wyngaarden who was then chair at Pennsylvania; and Jim Wyngaarden is going to come here and his interests are in research medicine and he would not give a damn about the PA program and if I leave it in his department its going to fail. So I would like you to take the PA program under your wing in this new department. It fits. This is a solution to the health care problem." So I became intimately involved with the PA program at that moment. Until that time, this had been Gene Stead's program in his department and I was one of the teachers, but I had no primary responsibility, but at the moment Gene Stead retired I

took it over then it was mine. And this was in late 1966. I think he retired in December, 1966. That's when I got intimately involved with it; then it was my responsibility and I had the job of filling positions and organizing and so forth. And other people all over the country were beginning to do the same thing. So there was beginning to be a group of programs: one at Bowman Gray; the MEDEX program at [University of] Washington, Alderson-Broaddus College in West Virginia, etc. so we were beginning to be a critical mass of educational programs that were trying to train PAs, each in a different way at that time. Bowman Gray was quite influential at that time because Bowman Gray had a professional educator as their head of their program. This man knew all about educational techniques of a formalistic sort: teaching objectives, techniques of teaching, how you did it, how you organized it, and they pulled together a program that in retrospect was much more clearly delineated than ours. They started by going to a primary care office and asking what do primary care doctors do? What are the reasons that patients come into the door? And let's take the first 100 entries on that list and let's see what skills we need to teach to equip somebody to be an assistant to a primary care doc. Very logical, professional educator approach the problem. Bowman Gray organized their curriculum and their teaching program that way. We did it the old way, which was find the surgeon, tell him that he has the responsibility of teaching surgery and let him do it. Find an internist, get him to do it. Get an obstetrician to do it. In other words very nondirective, very loose. It might come out exactly right, and it might come out totally wrong. What Bowman Gray recognized, which we didn't at the time, was that the more you get doctors involved the more they are going to teach these people what they are interested in, and not what the primary care doctor is interested in. After 5 years you are going to have an assistant to the tertiary specialist at Duke rather than a primary care specialist in East Overshoe. I'm getting a little ahead, but I think it's important to know that we were, in effect, behind the educational eight-ball at that point and without really realizing how askew we were likely going to be a little bit later. At the beginning we did it fairly well, I think, because people tried to put themselves in the shoes of the primary care doctor and tried to educate the PA that way. But as time went on, we began to get more and more people who were specialty inclined and instead of getting a mature surgeon to teach - who knew what it was like to be a surgeon in a small town, we tended to get to get junior faculty who were involved with their laboratory interests and who did not know what a PA needed to know. We worked hard to structure the PA as a legal entity within North Carolina. We put together conferences, by this time it's the early 70s, we are involved in trying to get laws passed that will allow the PA to practice with a physician supervisor. We were successful in getting legislative authority for PAs to practice in North Carolina and this became a model for many other states. We regularized the training of PAs in what has become the Duke model, which was 15 months of didactic instruction and nine months, roughly, of clinical instruction. Then we helped the AMA get an accrediting mechanism there so we could assure that the PA programs that were training PAs were doing a good job. We helped form an accrediting body with representatives from the American College of Physicians, American Academy of Family Physicians, pediatrics, and surgery, PA representatives and representatives of training programs, and this became the body that put their stamp of approval on all programs. The problem we were facing at that time was one of no regulation. I remember that one program in Atlanta wanted to train PAs in six weeks and give them a

certificate that they get hang on the wall “I am a PA”. We didn't think that was right, and it wasn't right. This was a commercial venture. You could pay a large fee, come to Atlanta for six weeks to get training, and emerge with a certificate on your wall that says “I'm a PA.” We eventually prevailed because the accrediting mechanism made it necessary that a training program be accredited before it could say I am training PAs. The reason I am going into detail is that we got caught in our own trap. We sailed through this accreditation procedure with no problem, but about five years later the accrediting group came to Duke and said, “your program is getting awfully specialized and we don’t think your program is going to be effective in training PAs for the real world.”

JB: What year is this sir?

HE: I would say mid 70s. They said “you’ve got a year to turn your curriculum around.” So we had to go borrow from Bowman Gray and learn how to do it, which we did. The Director of the program at that time was a physician named Mike Hamilton. And Mike did a superb job. He turned the PA program around in a year in a fashion that I would not have thought possible. First of all, he learned what was required to write good educational objectives and get the faculty organized. He recruited Reginald Carter as educational director. Reg Carter was on the faculty at that time within the PA program. He recruited other faculty as well. He chose people not because they were the hottest young sensation, but because they were mature seasoned people who would follow an outline and knew why the outline was there, and were there to be helpful and teach what they needed to know. There was a constant danger in making that mistake over and over and over again and we had to continually remind ourselves that we are training people to do a job and we are not training them to be cardiologists or neuroendocrinologists, we are training them to be assistants to a primary care physician. That doesn't mean they can't be assistant to the neurophysiologist, but they have to learn that later. We are not going to teach this in our basic program. Well anyway that’s how the program I think matured and became much better under Mike's leadership and improved teaching and I think it has been going strong ever since. Now back to your original question.

JB: Was Dr. Hamilton under you?

HE: Yes. He was the head of the PA division in my department. We ended up with a department that had five divisions. We had a PA division under Mike Hamilton; we had an occupational medicine division; we had a family medicine division; we eventually got that last because it was obvious we couldn’t solve this problem without training generalist physicians, and we had to fight like hell to get that. We had a computer division, and a fifth one which was an oddity. It was the division that was supposed to pay our bills. That was the diet and fitness center. We had a program – it’s still going and is still profitable. It brings people from all over the country to Durham and teaches them to lose weight. It is a very good program. It is a resident program: patients come here and stay a month. They usually lose about 30 pounds. And they go home educated as to how they can maintain their weight loss. Many of them don’t maintain it, but they learn how. It brings them in. We bought an old Y[MCA] building in the middle of town and we still have it. It had a full basketball court, and a full Olympic size pool, and we

still got it. Patients lived across the street. It had a teaching kitchen, psychologists, and physiologists, and exercise therapists. We would show them how to shop in a grocery store and watch them fix a meal. We still do it. It's making a great deal of money; it's paid off its debt. But anyway, that was the fifth division. It was an interesting department. And the PA program has been, I think, been a superb program ever since. It still is, and it is going strong and the department is going strong. I left the department in 1985 as the chairman, stayed on for another five years as a geriatrician and did all kinds of things from geriatrics, to house calls, things of that sort. Ran several nursing homes using PAs and nurse practitioners very heavily. And then I retired in 1990, so I've been retired from the department and teaching functions ever since 1990, except I go over do some lectures for the PA program.

JB: On what you lecture?

HE: The history of the PA program, sort of. I also talk about how to stay out of professional trouble. I teach about medical organizations and how they get themselves into trouble. I believe that the American Medical Association is in deep, deep shit. The way it has gotten in there is predictable and almost stereotyped. What happens is that professional organizations hire staff. As expected they are good administrators and they eventually take over functions. They eventually eliminate the people who they represent and they become the organization; the organization becomes the administrators rather than the membership. So I advise our PAs to avoid that like the plague because it will kill your organization just as it killed the AMA. The PA's have thus far seemed to avoid it. They still have a pretty membership driven organization. I do not know how long this will last because it is an almost inevitable evolution. You hire good people, they become better, they demand more attention, more money and the membership gets lax; it becomes less involved. The average person in the AMA doesn't work for the AMA, they just belong and they expect the AMA staff to do it all. That is not the way it ought to be. Well anyway, that is another aside. And I do some workshops and things like that; nothing very important.

JB: Teaching is always important.

HE: Well, back to our involvement with the military: we were involved with military from the beginning in that we had contracts with the Coast Guard, and we may have had contracts with others too – I don 't remember how many, but I know the Coast Guard was involved. Every year we take a certain number of people from the Coast Guard. They selected them with our approval but they came and were treated just like anyone else and after graduation became PAs in the Coast Guard.

JB: What year did that start, sir, roughly?

HE: It started I would guess in the late sixties. In the first several classes, we had a Coast Guard member and they went back and became active Coast Guard members. Mike was making all these arrangements and I was one step removed, so this is why I don't know as much as Mike would know, or Bob Howard. The first head of the division, by the

way, was a guy named Bob Howard. Bob Howard is dead now. He was a family physician who came here and requested a job because he had heard about the PA program, and he says I believe in it and I think I can be helpful. And indeed he was. He was excellent. He was a very unique individual. He ran full tilt, and he left here after several years and became the head of the family medicine division at Mercer. He got into trouble, deep trouble at Mercer. He had some marital problems and got into drugs and he went downhill fast. He ended up dying in the federal pen, of cancer of the lung. But Bob was superb when he was here. Worked like a dog, and he worked with the AMA in setting up the accreditation mechanism. Then Mike Hamilton came. Then Reg Carter, and you know it from there. We were involved as consultants with the service many times. Bob Howard was involved and this is what made me think of him because he would go visit service training programs. I think it was in San Antonio that the Army had their program. But we also took students as I recall, from other branches of the service. We didn't treat them any different than anybody else. They went through just exactly as everybody else did. Nobody knew that they were Coast Guard, or Air Force, or Navy or whatever. We didn't coddle them or treat them any different fashion. I cannot tell you how many of them we took, or what became of them. I know that some did become military officers and many of our members have joined the armed forces and done a damn good job. I can't tell you which of those were Army or Navy before they came in, because I don't know. It wouldn't have made any difference. Well, anyway I've gotten you off on all kinds of tangents but I don't know whether I've answered your questions or not.

JB: yes, sir, for the most part. Just one question. How much of the initial curriculum did come from either the school in San Antonio or I have this interview with Mr. Mau and he was saying he and you went down and to Fort Bragg and looked at their program. I was wondering how much of the initial curriculum came from them.

HE: They tried. I think Mau and Stead went down and looked at how they trained corpsman. At that time when they went down I don't think they had a formal PA program. It was just training corpsman, so they did go down and look at that so that they would know what they were getting when they got these people. But I don't think it influenced the early curriculum very much. Jim Mau, you have interviewed somebody who I think was very important back then.

JB: I will interview him on Thursday, sir. I haven't talked to him yet.

HE: Oh, you haven't yet. Well, Jim was very influential, he was Gene Stead's right arm. He was his administrator, and Jim Mau was assigned the duty of finding a spot for all these people. Getting all of the administrative details lined up — great guy. Gene Stead depended on him and he depended on Gene Stead. They worked as a really wonderful team. I am glad you are talking to him.

JB: I think it will be a very valuable conversation.

HE: I think it will.

JB: One of the things that was mentioned in one of the Fort Bragg interviews, anyway, was that Dr. Stead tried to hire some people from the military who were training corpsmen to come up to Duke. I was wondering if you knew anything about that.

HE: I didn't know that.

JB: I have one source that says that.

HE: I do not know that. He may have been trying to recruit them into the program. And I suspect he was. Why don't you come up to Duke and we'll put you through the course.

JB: Make an officer out of you.

HE: I suspect he did that. But as far as I know he didn't try to recruit any teachers. Because he really had all he could use with his department. That's interesting. But it may not be true.

JB: I was hoping to corroborate it with someone up here. I guess more generally, how do you see the PA today against the initial vision of 1965?

HE: Very different.

JB: In a positive way?

HE: Very positive. I think none of us at that point would have envisioned a PA going out and deliberately taking over a clinic and running it, which many of them are doing now, and doing this removed many miles from their supervising physicians. That would have been actively opposed. Many people would have voted it down if they thought that this was going to be the outcome. I think that's great and I think that the PA is probably going to be the primary care provider of the future countrywide. Because I think doctors have become too expensive; they have become too over-trained; they've become too enamored of making a lot of money. I don't think it's to anybody's advantage to encourage more doctors of that sort when you can push PAs. I think nurse practitioners are evolving in the same direction. But unfortunately the nurse practitioner who started very close to the PA in practical training is going to be more and more marginalized. [interruption] I think they are becoming more and more isolated from the medical profession by their own choice, or rather, by their leaders' choice, not the individual nurse practitioners. In fact they come out…but this is one problem that I am seeing in other venues: PAs and nurse practitioners are going out into practice and we are forgetting one important fact that PAs always understood in the early years and that's that the new PA graduate is an unfinished product. The PA has been trained to appreciate and understand many things. But the PA is not a fully trained assistant to anybody when they leave here. They are assumed to be employed by a physician who is going to be aware of that fact, and is going to be willing to train them in the knowledge and skills that he or she has, and to watch them and to be a mentor in their further development. We see over

and over again a doctor who will hire a PA from right out of school at Duke and say, "you are in charge of this clinic and I am going to be over here 20 miles away. If you have any questions call me." Now that is the doctor's fault. It's also the PA's fault for taking a job like that and thinking that they can handle it without having some bobbles along the way. But that understanding that the PA, and the nurse practitioner too, are unfinished products as they emerge from their training program is being forgotten. Now, they become very good after they have been seasoned by good, solid practitioners who are their trainers and mentors. That's my only fear. I think trained in the proper way by a mentor, by the first or two mentors who can teach them caution; teach them practical knowledge; teach them to be honest and say, "I don't know. I need to find out." And how to refer. If we can avoid that mistake, then I think the PA and nurse practitioner can be a solid basis for the primary care system that will be to everybody's advantage.

JB: So if PAs take over the primary care, do you think in the future it would be possible for veteran PAs to be able to train the novices or will they still have to go through an MD?

HE: I think they could train them and they largely do now. Many doctors turn their new PA over to the old PA to train. That requires constant feedback. Is it breaking down? That's another potential mistake that we can make is to forget that feedback. That if we have PAs training PAs, we must make sure that those PAs understand the connection with medicine. Because the work that a PA does today in a practice has evolved from a cutting edge medical practice of five years ago or ten years ago. Techniques of practice evolve and change. It is said that half life of everything you learned in medical school is about five years. Every five years you wash out half of what you learned – it's been replaced by something else so you've got to constantly go back and replenish yourself at the well. Well, if you are a PA and you don't replenish yourself at the medical well then you are going to be in bad shape. And if the teacher of that PA is nothing but a teacher of that PA and doesn't himself replenish at the medical well, he is going to be 50% as good in five years as he was at the beginning; 25% is good at 10 years; 12 and ½ percent and so forth. In time he is going to washout and no good at all. That connection has got to be maintained – you can't divorce yourself from the medical profession. You have got to be a part of it. Now I am very proud of something that I had a responsibility for in North Carolina in that I introduced a measure in our state medical society permitting us to accept PAs as members of the medical society. They are members of the medical society now, and doctors have accepted them as such. We tried to do the same thing for nurse practitioners but we were turned down.

JB: Is that pretty common with state medical society here?

HE: There are several now who do it, but it's not real common. We are not the only ones now, but we were the first ones.

JB: What year was that sir?

HE: Oh I don't remember. Probably 10 years ago. That's my guess. It's been a long time, and we tried to do it with nurse practitioners but that was defeated by our house of delegates at the medical society. They didn't want to bring nurses in. The antipathy is on both sides. There is a great deal of distrust which I think is doing nobody any good. Well, anything else I can tell you?

JB: Is there anything else you wanted to add about the story, sir?

HE: I can't think of anything. Well if you think of anything, give me a call.

JB: Yes, sir. Thank you very much. I appreciate it.

HE: you are welcome.

-- end of interview --