American Academy of Physician Assistants Oral History Project
Interview with E. Harvey Estes, M.D.
Conducted on July 22, 1998, by Brien R. Williams
at the home of Dr. Estes in Durham, North Carolina

BW: Dr. Estes, will you start by giving me a little bit of your own background?

EE: Sure. I was born and grew up in a town of two hundred fifty people in Georgia, about sixty miles outside of Atlanta, a farming community. My father ran a general store in the little town [Gay, Georgia], and I attended the high school across the street. Left high school not really having any clear notion of what I was going to do with my life, but then fell into a group of premedical students at Emory at Oxford, which was Emory's junior college, and later at Emory, and sort of got into medicine by association with a lot of other people who were planning to go into medicine.

Now, that was a kind of nascent career choice for me anyway, because there was an old general practitioner who was my doctor when I was growing up and sort of admired by everybody in town, so he was kind of a role model. But I would have clearly been a general practitioner in a small town had I not been sort of captured by a whole group of people who were brought to Emory by Gene Stead. Gene Stead was my . . . I've left out the part that I went to medical school, of course, and in medical school I came in contact with a new guy from Boston who had just come back to Atlanta—that was his home town—but he had come back to Atlanta to take over an ailing Department of Internal Medicine and rejuvenate it.

BW: At Emory?

EE: At Emory. And he brought a whole group of young people with him. This was during World War II and many people in the area were in the Armed Forces. Teachers and doctors in the teaching setting were hard to come by. He had a group of people and was doing research for the Armed Forces on the effects of plasma on shock. So this group of people was there teaching and at the same time doing research. This was the first group of people who were actually engaged in pushing back the frontiers of medicine. All the other teachers up to that point had been people who had moved into medicine as an art, an art form, learning from the past and bringing that to the patient's bedside. They were teachers by virtue of their skills as personal physicians.

But Stead and his group were different. They were known not necessarily for their care for patients—though they were all good physicians—but they were known for their knowledge of the scientific underpinnings of medicine. So, Gene Stead brought scientific underpinnings to Emory Medical School, and I was exposed very early to Stead and his group of young people.

When I was a senior medical student, I began to look around for places to go and went to Gene Stead for advice as to where to go, and he gave me some names of places to apply. I clearly by that time had as my model the young men who he brought in, and I wanted to be

a part of that and to be like them. So, I've been under the Gene Stead influence for a long, long time.

I applied to his Service at Grady Hospital in Atlanta as an intern and was accepted for a starting time in February of 1947. This was an odd time, but this was odd in other ways, because by that time World War II had ended and we were no longer attending school twelve months a year. We had a very tight, accelerated medical school curriculum up until about 1945 or so and at that point we sort of decompressed and we had a summer vacation for the first time. So we finished at an odd time and it was February of 1947.

Well, just before the end of 1946, Dr. Stead announced that he was leaving Emory and was coming to Duke as the Professor of Medicine, which was quite a blow because everybody looked up to him. I had looked forward to being a house officer under him. But he left a very strong department. His number two person, Dr. Paul Beeson, who later went to Yale, was left as the Chief of the Service. So I stayed there and was an intern and then later as a resident under Paul Beeson instead of Gene Stead, but with very close ties with the Duke group, who all came from there. He took about half the department with him and left about half there.

Well, after my first year of medical internship, which was really fifteen months because we got back on a July schedule, Dr. Beeson called a group of us in and said, "We have more of you applying next year than we can accommodate in the residency, but we are going to try something new. It's never been done here before. We have some funding that will

support two of you to take a year from out of your residency and learn to do some special things or to study some special things." So two of us elected to drop out for a year.

I worked with a young cardiologist there named Robert Grant and did some research on electrocardiography that next year, then came back into the residency, and then after another year of residency dropped out again for a second year of fellowship, learning to do cardiac catheterizations, which were then not a clinical tool at all but were a research tool. In that year I worked under Dr. James Warren and he is a very key figure in my career because he brought me to Duke directly under Gene Stead.

The story is that Jim Warren was the head of the Physiology Department at Emory when I had my year of fellowship under him. But during that year I was called up into the Navy and spent two years in the U.S. Navy. When I got out of the Navy, I found that Paul Beeson had departed Emory and taken the rest of the department with him to Yale, so the department there was no longer in place. But Jim Warren, with whom I had been working when I left to go in the Navy, had also departed Emory and had come to Duke to join Gene Stead. Jim Warren became the first Chief of the Medical Service at the new Veterans Administration Hospital here, across the street from Duke, and Jim Warren offered me the opportunity to come and finish my fellowship and to then consider a position on the faculty.

So, that's exactly what I did. I came back here and rejoined Jim Warren who, of course, was working very closely with Gene Stead across the street. It was Gene Stead's Department and Jim Warren ran one division of it at the Veterans Administration Hospital.

So, I came here as a result of Gene Stead indirectly, because he brought Jim here. I spent a year finishing up my fellowship and finishing up my residency requirements and then joined the faculty in July of 1953 here at Duke.

Now, at that time I became a cardiologist at the VA Hospital, then left, went across the street to Duke and joined the Private Diagnostic Clinic. Then in, I think it must have been the early 1960s, I became Chief of Medicine at the VA Hospital—the old Jim Warren job.

So I took that position and that was at about the time that the PA program was beginning to take root across the street at Duke so several of us became very active at that point. Gene Stead had been playing with several ideas in his head and we had been a part of watching them take place. One experiment that he did was to bring firemen, who worked a fairly loose schedule and had lots of free time, he brought these firemen in and gave them additional training in how to be technologists in the Cardiac Cath Lab. The experiment worked fairly well and so what this did was plant in his head the notion that people who were not trained primarily as medical people could be brought in and trained to do things and become highly useful in that set of skills.

There was another experiment that he did about that time. He was always thinking of other applications of people who were there already. He paid very little attention to tradition. [Chuckles] One of his friends and confidants was a very remarkable nurse who had some of the same attributes. Her name was Thelma Ingles. She was a professor in the School of Nursing. They began to talk about the fact that nurses really should do

more than they were doing at that time in hospitals. In fact, they could be key people in a health care team and around the hospital ward. So, the more they thought about it, the more they thought it would be a good thing to try.

So he and Thelma Ingles put together what was to be a master's level program to follow a standard nursing education. These nurses were to provide a special kind of care to hospitalized patients. This care was to be at a level between the standard nursing care and that that was given by the attending physicians. So, they brought a group of young nurses in—they selected them carefully—and they put them through this course of training, which was clinical in nature. It was not classroom. They were educated on the wards, taking care of patients. Quite successful.

They were extremely useful and respected, but the program ran into a major snag. In order to receive the master's level credit for the training, it needed the approval of the National League of Nursing, and the League of Nursing looked at the program and said, "Sorry, it won't pass muster," which came as quite a blow to Gene and Thelma and it really infuriated them. He thought, they both thought, it was very short-sighted. He immediately began to cast about for other ways of doing something similar to that and so he picked up an idea that a colleague of ours had developed in the wake of the firemen experiment.

This person was Henry MacIntosh, who was a cardiologist here. Henry MacIntosh had recruited some Navy corpsmen who were being mustered out of the Navy after having

spent time in the Norfolk Navy Hospital doing things similar to the cath process. He recruited some of those individuals into his laboratory and trained them to be high-level technical helpers in the Cardiac Cath Lab. He found them to be very useful. So he had had some experience with corpsmen. By that time the Vietnam veterans were beginning to come back and they were highly trained, highly skilled people who had been capable of independent assignments in the jungle and had done quite a bit. No place for their skills to be used, so the idea began to germinate that here's another substrate for another program like the nursing program.

But I think the piece of this that I think very few people understand is that, had the Stead-Ingles program been approved, there probably never would have been a PA program, because we would have started a nurse practitioner program at that moment in time and it would have gotten off the ground maybe three or four years ahead of the Henry Silver experiment in Colorado that started that program.

BW: Is that where nurse practitioners began, with Silver's program in Colorado?

EE: Yes, the pediatric nurse practitioner program. That was the first one. So, with all that as background, Gene Stead began to put together the framework for the PA program. You have to understand the peculiar position of the Department of Medicine at that time in Duke's history. Gene Stead was a powerful individual, one of four or five most respected and most influential people in the Medical School. He commanded probably the largest department in the Medical School. He had been *quite* successful in getting external

funding. People outside the area knew him well and knew that he did good work and they were willing to take a chance with what he proposed.

BW: He was head of, what was the title of his department?

EE: Department of Medicine. So, Gene Stead had enough clout to carry the day. If Gene wanted to do it, there were very few people that could stop him. So, he began to get the approval necessary to put the PA program into place. Did so, of course, with his influence in the Medical School and was able to go to his outside sources and get some funding for the program. So, he put it all together. He had a big enough department so that he could turn to his second tier of young physicians and say, "Okay, guys. This is what we're going to do, and go do it." [Chuckles] I was one of that crew who were assigned this task.

Well, this was in the mid 1960s and we put together in a fairly unscientific—not fairly but *very* unscientific—way a curriculum which we thought would be useful. It *was* based on what we *thought* would be useful, but it was not very scientifically based, and we began to teach people to do that. It was modeled pretty much after the Medical School curriculum. We had some basic stuff and then some experience on the wards, and at a point in time they were dubbed PAs. Now, this was the mid 1960s that the program really formally got started.

In 1966, Gene Stead announced that he was going to retire as Chairman of the Department of Medicine at the end of his twentieth year, which *was* 1966, and shortly before that he

had . . . there's another long series of stories leading up to this, but let me say that I had been asked in 1966 to form a new department at Duke which was to be called the Department of Community and Family Medicine. We were to specifically address the problems of medical access to care in communities. Our job was not to train surgeons or internists or obstetricians or pediatricians, but our job was to look at the problem of the community and say, "This community needs this kind of medical care and how are we going to do that?"

I had accepted this job in 1966, just about the same time Gene Stead announced that he was departing. So at the end of 1966 Gene Stead was departing and I was brand new in my new job as head of this new department. So Gene by this time had his replacement identified and his replacement was Dr. James Wyngaarden, who was well known there, but he was primarily a research scientist whose strengths were in the bench laboratory. Gene Stead correctly predicted that training PAs would not be a major interest of Jim Wyngaarden and training PAs did fit into my activities because training a new cadre of medical practitioner who was going to be essential for under-served rural areas in particular, because we couldn't recruit doctors for that area.

So we arranged for the PA program fairly early in its being to be transferred as a unit of the Department of Medicine to the Department of Community and Family Medicine. I inherited direct responsibility for the program about late 1966, I guess, so it became mine [Chuckles] as an administrative responsibility. Gene Stead at that point took off for a year's sabbatical in New York, so he was not on the scene for a while. He was always

back on frequent weekends and things like that, so we could always talk to him; he was there and I called on him, but he was not physically in place most of the time.

The PA program by that time had been established, in the sense that it was going well, it was turning out a product and we were placing those products in various places, but training a new cadre of personnel requires lots of different layers of political activity. Gene Stead had accomplished the first, which was getting it started within the framework of Duke and getting a product through that process and out. But now we were faced with the problem of how do you get them out into the world, how do you make a place for them in the world, and how do you put them in place with the Medical Board, how do you enable them to practice within a legal structure? So, we had to do that.

We were all involved in that. Again Gene Stead had been able to get some National Institutes of Health assistance and so we put on a couple of major conferences about what are we going to do with the legal framework in which these people practice. So we began a series of conferences about that issue, bringing together legal scholars from all over the country and people in the state who were going to have to face this—the president of the Medical Society, the president of the Medical Board, the head of the Nurses' Association, some political figures in the state that were going to have to be a part of this process. We also hired a young woman named Martha Ballinger. Martha Ballinger was a lawyer. She had graduated at Duke and her husband was a physician. Martha began to work with the project as well. Over the next several years we sort of hammered out a framework of model legislation that could be suggested to legislatures for allowing PAs to practice.

At the same time there was a *lot* of external publicity about the program, because the program had been featured in some national magazines, *Look* magazine. It had caused some major rows with the nursing profession because this individual that was being graduated was touted as being "more than a nurse and less than a doctor," and the nurses took great umbrage at that. But that headline was what did it. It wasn't necessarily . . . I mean Gene Stead was at that moment sort of angry with the officialdom of nursing but by no means mad with nursing. But this was the activity at about that time: Getting it plugged into place in the state political and legal framework, and not only in this state but in other states.

Then the next stage was that of getting it plugged in somewhere in terms of the validity of the training itself. One of the things that's required . . . and we came upon this fairly quickly because there was a program that started in Atlanta that called itself a physician assistant program but it was about six weeks in length. [Chuckles] It was really a bare bones kind of thing and it was an attempt to capitalize on what was going to be a popular notion. It became fairly obvious that we needed a structural framework in which the profession of medicine could look at this thing and make sure that it was being done right.

We began a series of negotiations with the American Medical Association to put together an accreditation machinery that would be required for a program to be an accredited program. That required a lot of time and *very* prominent in that was Dr. Robert Howard, whose name you probably have run across already. But Bob Howard was here at that time. He was a family physician, a hard worker, a very innovative guy, and Bob sort of

took that as his project. He was at that time the Medical Director of the PA program and *very* influential in getting that process going. Traveled back and forth and tackled people that were important in that political machinery. It took several years to do but eventually we ended up with an Accreditation Board which had on there representatives from the College of Surgeons, the American College of Physicians, the Academy of Pediatrics, the Academy of Family Physicians, bodies of that sort. So it gave it some weight and gave it a machinery to . . .

[End Side A, Tape 1]

[Begin Side B, Tape 1]

EE: The upshot of all of this was to get an accreditation process for the program. By this time Bowman Gray, to our west, had a program that was going fairly strong and a good group of educators who were working with their program. They had some innovative stuff going on—a different kind of curriculum than we had—and they had the advantage over us in one respect in that they had the very active participation of professional educators who were more familiar with modern techniques of education than we were.

This leads to a sort of side story, I guess, about how we were kind of trapped in our own accreditation machine. [Chuckles] We were influential in getting this thing going and we came up fairly quickly as the first program for accreditation after this process had been started. The accreditation team contained some individuals who were from this more

educational school of thought. They paid much more attention to teaching techniques and to goals and objectives and things of this sort, testing.

So they came here and they found that our program, though it turned out good products, was severely lacking in some of these aspects of some testing, good objectives. They found that we were using highly skilled people to do our lectures, but they were tending to lecture about things that they liked rather than things that these individuals needed. We were leaning toward the training of people who were more specialized than the objectives that we had set out called for. So to our dismay [Chuckles], we were told that though we were turning out a product, that we were not meeting standards according to the body that we had helped set up. They gave us one year to correct that problem and they were going to come back and inspect us the following year. So, we had a lot of stuff to do. [Chuckles]

BW: And who was "they" in this case?

EE: This was the accrediting group from the American Medical Association.

BW: I lost the train of thought there, because you mentioned that at Bowman Gray they had emphasized the teaching.

EE: Yes.

BW: So they set the example which then they were saying, "Okay, now you should do the same that they do."

EE: Yes, yes, yes. And we at that time spent a huge amount of effort putting together a curriculum very similar to the Bowman Gray curriculum, and by a year we were ready to be reaccredited. We were successful and we've had no more trouble since then. But it was kind of interesting that we were . . . and they were *precisely* right.

We found that the process we were putting our students through was so much like the process we were putting our medical students through that we had some of the same effects. We were producing super competitive test-takers who compulsively were trying to learn every little bit that was put in front of them. It's impossible to do. Whereas after the institution of the Bowman Gray curriculum, which was team-teaching, non-competitive but with objectives that are laid out clearly ahead of time that must be met and if you meet them you pass, we found that our students were more relaxed, they were more congenial with one another, they were not cutting throats. [Chuckles] They were just better students, more socially active, and the product at the end was, if anything, better. So, we learned a lot from Bowman Gray. [Chuckles] And I think we learned things that the Medical School still hasn't learned.

Now, there are many aspects of medical-student teaching today at Duke that got there because it was tried first in the PA program. Quite a few things. I'm trying to think of a few of them. I can think of one thing, well, a couple. At a slightly later point, Bob

Howard had moved on and Dr. Michael Hamilton became the Medical Director of the PA program, a very innovative fellow.

Mike became concerned that our students were not adept enough with the examination of the female patient, particularly pelvic exams. He was aware of almost a folk movement in town in which a group of women became volunteers and offered themselves as patients to teach medical students and residents how to do a pelvic exam. Okay. That's kind of strange to think about, but a person who is undergoing that examination has a perspective that's damned important. [Laughs] Well, Mike Hamilton thought about that. He said, "Well, I wonder if we could get these women to become a formal part of our curriculum." So he went to them and they agreed to do so. This was by *far* a more, a superior way of teaching pelvic exam. The method was later picked up by the Medical School because they learned about it from PA students.

Another technique was suturing techniques. The PA program used simulated techniques of learning to do suturing using pigs' feet, which they would get from an abattoir. The pig's foot has tough, tough skin that's somewhat similar to human skin. So they began to use simulations of that sort—quite successful—before they were turned loose on a patient. Another kind of innovation: They began to use, at a very early point, some trained patients, people who were actors who were a standardized testing tool, if you want to use an inappropriate word for the examination. I mean, by using an actor who can give exactly the same story and react back to the instructor about whether the student asked the right question or not, you can standardize an exam. Well, this is widely used. There's a

whole laboratory at East Carolina now that uses actors for testing. But the PA program was using that a long time ago.

When you think about it, it makes a lot of sense, because a PA is trained in a two-year period of time and a medical student is four years plus three years of residency at least, so the concept-to-fruition time is much shorter with the PA than with the medical student. We don't know if it works or not with a medical student until ten years out, but you know in three years with the PA. Well, at any rate, we learned a lot.

The program became somewhat standardized and there were a lot more programs over the country. The programs in general followed the Duke model for training, with the Bowman Gray modifications, because we very quickly found that we liked that. Now, there were some other models, though. One model was developed at the University of Washington. This was very close on the heels of the Duke model back in the 1960s. This was a model called the MEDEX model that recruited young—well "young" is irrelevant—it recruited advanced-level medical corpsmen who had been trained for independent duty and it put them into an abbreviated program but one that was much more practice-oriented. They were essentially trained by going with one physician who trained them and hired them at the end of that process.

That MEDEX program operated for a while but as accreditation became more structured, the MEDEX program sort of evolved into a Duke model, because the initial three months or so of academic work was not quite enough to meet those accreditation standards and so

it stretched. The gold standard became kind of the Duke model, but it wasn't specifically addressed as the Duke model, and I've already indicated it had its downsides. But that structure of nine months of basic science training followed by twelve to fifteen months of clinical training became the national norm.

Now, an addendum here, which doesn't belong in the history but it's a prediction. I think we're running into some things now that are putting some stresses on PAs because PAs are coming out with the original model, and the original concept said the PA after two years is not a finished product. The PA at the end of two years is a generic, capable substrate for further learning on the job to be whatever the physician and PA together want that person to be.

But today's structure of medicine is a bit antithetical to that, because an HMO wants production the first day out and the economic incentives are not relaxed to the point or in the way they were back twenty years ago so that you could take thirty minutes at two or three times during the day and sit down with a new PA and explain a few things. There's just not thirty minutes to be spent! So what we are finding is that PAs that come out are having some difficulty becoming accomplished clinicians right out of the bandbox.

We are starting in North Carolina this year, and it starts next month, a new program which is an internship for PAs in which PAs and, by the way, nurse practitioners as well, the same problem, but both PAs and nurse practitioners are accepted into the program and they spend approximately three months in four different clinical disciplines, to the point that

they become fairly skilled clinicians. They spend time with a pediatrician, they spend time with a general internist, time with an emergency room physician, because that's an area of insecurity, and some time with a family physician. But we're training them specifically to be rural PAs and nurse practitioners, working semi-autonomously with a doctor some miles away. My prediction is that that's going to rapidly increase, and I think that we will see PA training as two years plus a clinical experience maybe of one year's duration.

Well, back to the story. PA programs in general have become somewhat not stereotyped but the model has become pretty well fixed. The training has been done so many times that it's fairly routine and the product has done well, and I think that the sky is the limit. It's kind of unbelievable to me that this program in the 1960s that was such a hypothetical thing now has twenty, thirty thousand practitioners who are out there and doing quite well and making their own way in the world, but still doing pretty much the job that was envisioned, though a much expanded job.

I think the PAs are able to do anything they wish to do and anything they can, but I think there's little genius in the original Steadean concept, which is there is nothing fixed about education. Education is a matter, a process of layering skills and education on top of previous skills and education, and the best education is education that's immediately used. The concept that an individual with less than four years of medical school can become a skilled operating room technician, can become literally a surgeon, with practice and good instruction given over a period of weeks or months, but technically that person can be as

skilled as the best surgeon out there. Now, yes, if that surgeon starts with maybe a couple of more layers of hypothetical knowledge, but anyone can get that.

It's a bit of an artificial device to put an MD degree on one and a PA degree on another or a nursing degree on another. It's basically human intelligence and good instruction and good practice and insisting on getting it right and doing it correctly. But there are no degrees that give skill. It's earned, and it can be earned by PAs as well as MDs. The acceptance of that notion is quite a jump. [Chuckles] And Stead made that jump many years ago; mid 1960s he already had it. But there are physicians, for example, who get up on the floor of the House of Delegates of the AMA and say, "No one but an MD can do that." Clearly they are wrong. [Chuckles]

Now, clearly there must be standards and there have to be checks and balances, but a PA is capable of doing anything or a nurse practitioner can do anything. It's a matter of how they get the instruction, how they use it, and do they know when they have run out of skill and need help. We as physicians have the same problem. [Chuckles] We run out of skill and we have to refer. But it's the same process in medicine as between PAs and MDs.

BW: When you refer to members of the House of Delegates getting up and saying only physicians can do something, are you referring to something that still goes on today, or was that in the past?

EE: Oh, yes. Oh, yes. I can show you . . . in fact I've got a copy of *AMA Medical News* that came yesterday and on the front page is a picture of a member of the Board of Trustees. The quote under him has to do with nurse practitioners and PAs exceeding their limits. [Chuckles] So it's very current. Still there. Now, to be sure, the article a little later on says that PAs can do a lot and the quote is in there—in fact I'll get it and give it to you— the quote is in there that the house is divided. [Chuckles] The medical house is divided. There are those who say PAs can do a lot and there are those who say PAs shouldn't be allowed to do anything and I've run into that more than once.

We have been *very* fortunate in this state—and this is something I'm kind of proud of—because when we ran across attitudes of that sort in the state, we've gotten physicians to come forth in numbers and to stand up and say, "PAs can do a *lot* and we want them, we value them, we need them." And when they say that, the other camp generally backs down.

BW: Now, you talked about the Bowman Gray accreditation and whatnot, and that came up in, what, about 1970, something in there?

EE: I would guess 1970.

BW: And you took over the program in 1966.

EE: Yes.

BW: Now, after accreditation, at what point did you leave the program?

EE: I left as Department Chair in 1985. I stayed in the Department but not directly connected with the PA program at all from 1985 to 1990, and I retired in 1990 from the faculty at Duke.

BW: Okay. So, now after accreditation until 1985, what were some of the battles you were fighting or the issues that were being addressed?

EE: Not a great number of battles. I mean, things were fixed, the position of PAs was pretty well fixed. We occasionally ran into problems with nursing and my activity at that point was political activity with the nursing profession and with medicine itself.

In, I guess, the early 1980s, we had a period of time in which nurse practitioners were a bit antithetical to PAs and attempted to get independence and autonomy for themselves and attempted to get ahead of PAs in a political sense. The center of this was the Medical Board here in the state. This was state politics entirely. Every state's different, but the Medical Board was . . . well, essentially the nurses were trying to get out from under medical supervision, and the PAs—the difference between PAs and nurse practitioners, politically the two were the same, they have the same rights and privileges, same supervision, but the Board of Nursing has additional responsibilities for nurse practitioners. The nurse practitioner answers to two bosses: The Medical Board and the

Nursing Board. The Nursing Board is first, the Medical Board is second. The nursing profession tried to get the Medical Board out of the picture. They were only responsible to nurses. And they used as their take-off for that process some rules that the Medical Board had imposed that were felt to be prejudicial to them.

So, I began to work politically to parry that and the way it came out is somewhat different than I had expected. My intention at the beginning was to parry the nursing thrust by keeping the Medical Board in place. We ended up . . . I got myself appointed as the medical representative or one medical representative in a joint group to look at the rules that were governing nurse practitioners. These were not bad folks. They were not trying to do anything. It turned out that they were pointing to some process issues that were present in their process of getting accredited as nurse practitioners that were awkward and difficult and should be changed. [Chuckles] So we helped them get the changes that they were trying to get under the Medical Board. We didn't change anything, but we made the Medical Board more adaptive.

In the course of that, we insisted that the PAs and nurse practitioners needed to stay together and so we liberalized nurse practitioner rules and we liberalized PA rules in parallel. The nurses appreciated that and felt that they had gotten something out of this, working with PAs and doctors together and to this day the nursing profession in this state views us as friends. We're not enemies in this state. [Chuckles] And I think I'm sort of responsible [Chuckles], because they . . . and it was nothing that I did and it was nothing I intended to do.

By virtue of getting together and talking about the problems and looking at it in a systematic way and trying to honestly solve the problem that these people had, we solved some problems not only for nurses but for PAs as well and, to some extent, for the Medical Board as well. The Medical Board is far more streamlined in its process now, has given the Nursing Board much more authority than it had before, has never regretted it [Chuckles], and it has done it with good feeling on both sides.

BW: Now, is that typical of most states?

EE: No.

BW: Talk about that for a bit.

EE: In some states—New York being probably the best example—nurses, physicians, PAs are at each other's throats. What one proposes the other opposes, and there is no harmony in the camp at all. I think it works here because we have sat around conference tables for literally days working through problems, and we know each other, we respect one another. If a Nursing Board person calls and says, "We have a problem," then we honestly look at it. Now, that process is *very* difficult and it has to start somewhere, but I think we started [Chuckles] and it's been very useful. I think to some extent it has to be . . . I'm not a confrontive person, and I think sometimes people come in with a chip on the shoulder, and when that happens, things get off on the wrong foot.

We went through a process with nursing, just as an example of this, two years ago, three years ago. We looked at an issue that has been present in most states: Nurses don't like the term "supervision." They're supervised by physicians, but they rail a bit. Most of them don't give a damn really, but it's the profession and it's the leaders and it's the ones that sit around and worry about things like that that are concerned. But the word "supervision" to them means subservience, and "subservient we don't want to be. We have our own field of expertise, we have our own knowledge, and Medicine doesn't have that. So, we're nurses first. We're not subservient to any damn body out there in that field. In the medical field, we may be, but we are not subservient. We are nurse practitioners."

So we got together to talk about that and not only that, but we have a rapidly increasing number of nurses who are not nurse practitioners but who are something called nurse clinicians who work with branches of medicine in various ways. There are some that deal with neonatal wards, some who deal with cancer, some who deal with psychiatry. There are nurse specialists in almost every corner of medicine. These are nurses. Most of them are trained as master's level nurses and they believe that they have the right to practice. So, we got together to talk about that, between medicine and nursing, and we came out with something we both agreed with, a statement on collaborative practice. Instead of supervision, it's collaboration.

[End Side B, Tape 1]

[Begin Side A, Tape 2]

BW: . . . a statement of collaborative . . .

EE: Collaborative practice.

BW: Practice. Okay, pick it up from there.

EE: We started a process of talking about how we work together as doctors and nurses. We had nurse practitioners, we had nurse anesthetists, we had clinical nurse specialists of various kinds, and we came out at the end with a statement of collaborative practice that we all agreed with which was noncontroversial and said everybody has their areas of expertise. In the course of taking good care of patients, which *should* be why we're here, we should use whatever expertise we have and we should recognize our limitations. If a doctor wants to do something that a nurse knows more about, then he turns to her as the expert. Makes good sense.

It made such good sense it passed both of our representative Houses in our professions here in this state. We were instructed to take this statement to our national organizations and propose it as a statement of action nationally. We did this about a year and a half ago and nursing had no problem with it, because it's what they've wanted all along. But when we took it to the AMA, we were practically tarred and feathered. [Laughs] We had to

withdraw the resolution, because it would have been modified in such a way that would have been *de*structive rather than *con*structive. So, we were literally roasted by our colleagues, from Georgia mainly, who believed this is a terribly important issue and one in which medicine and nursing, that medicine must preempt its role and if we don't, then it's going to lose prerogatives in the future. And Georgia *clearly* had support to win. So we had to withdraw it and ignominiously come back [Chuckles] and say, "Look. We tried." The nurses understood. But they also understand one other thing, and that's that what the AMA does, does not govern what North Carolina does. So, the fact that the AMA passes a rule that says nurses here act in a subservient way doesn't mean we have to do that here, and they trust us in that. So we're fine. [Chuckles]

BW: And in the development of this notion of collaborative practice, the doctors were an equal player in that community.

EE: Yes.

BW: It wasn't just PAs and nurse practitioners.

EE: Yes, yes. In fact, it was just doctors and nurses. PAs were not involved. PAs knew about it, because we told them about it at all stages. Deliberately they were not there, because this was not—I mean, we had no problems with the way PAs—PAs have always adopted the stance that they work under the supervision of a physician. This is a declared tenet of the group. But not so with nursing.

BW: Having seen the nurses obtain this, there was then not a ground swell for PAs to deal with the same issue?

EE: PAs stayed more relaxed about it, which is fine. I think the rank and file is relaxed about it. There are some PAs who, I'm sure, feel exactly the same way. We deal with that in an individual way and I'll mention an example. I have dealt with this over the past twenty years as it comes up. The Medical Board in this state will, for example, get very uptight about something that happened in a given community, and sometimes the PAs will call on me to go and give an opinion as to whether this is something that the Medical Board should worry about or not. I usually do it and I usually come back and say what I think, and usually, the Board usually goes along, because they respect somebody that looks at it fairly objectively, and I think I do.

One of them was a PA—and this is a good example—a PA in a city in this state who ran an Urgent Care Center. He began working with a doctor, but the doctor wanted out of this enterprise so the PA bought the doctor's interest. He became the proprietor of this professional enterprise. Well, technically the doctor is the one who has the professional responsibility and the laws are written that the doctor has to have that responsibility. There *is* a way to do it and the lawyers can figure out any way. The way is the PA owns the business but the doctor owns the practice, and the business can hire the doctor. [Chuckles] So, it can work. This PA had arranged it with a good lawyer, so he met all

the requirements of the law, but in reality he owned the practice and he went out and hired a doctor to come in and work with him.

He hired a doctor from another state, who came here. The doctor was quite good, the doctor was quite happy doing that. He was an older physician who came here to get a little time with his grandchildren. He wanted to come and work a limited number of hours and the PA allowed him to do that in this Urgent Care Center. He did a good job of supervising, he did a good job of reviewing charts, he did everything that was supposed to be done.

The Medical Board was fretting over this issue. So I went down and wrote a report, pages in length, went over everything, told them what I found, and they looked at it and brought it to their lawyer. My opinion was he was doing everything he was supposed to do and their lawyer agreed, so they had to let him keep going. They didn't like it [Chuckles], but . . .

In another situation we had a PA who was an ex-military PA and this group is a little unusual in that many of the military PAs operate with a lot of autonomy. Many of them operated under battlefield situations and they don't take as easily to supervision as some of their civilian counterparts, but it varies widely with the individual. What this was, an ex-military corpsman who was working with a physician and the physician became disabled, and I mean disabled. He was in the Intensive Care Unit and the PA was still technically working under him. [Laughs] This physician obviously couldn't supervise what he was doing. Though the PA was technically taking his charts and discussing

patients, it obviously wasn't happening because the physician wasn't capable of doing it. We had to sort of call that one.

So, I guess I'm the, I've sort of fallen into a role as the person within medical officialdom that can be called on by the PA profession and can advise them as a friend and give them advice, and I think it's worked well.

BW: That is not an official capacity.

EE: No.

BW: You're asked to do this on a voluntary or consultative basis?

EE: Well, actually I'm on their Medical Advisory Board, but it doesn't meet very often, and I'm the only one they call on. [Laughs] Now, yes, they have other people on their Medical Advisory Board and they will occasionally call on them when something official has to be done, but I usually am the only one.

BW: And the reason you're called on probably is because you are able to see things from both sides fairly.

EE: Yes, yes, and I've been around and I know where the stumps are sometimes that are under the surface of the water and you run into trouble there.

BW: And your standing is as solid with other physicians in the state as it is with PAs.

EE: Yes. Well, anyway, that works.

BW: Right.

EE: So, that's kind of been my role for the past ten or twenty years. Again, I left my official role with the PA program, having any administrative responsibility for it, back in 1985. I can say that there was a period of time in the early 1980s when we were under fairly severe stress to cut the PA program back because it was a time when there was a thought that there was going to be an excess of doctors and there was certainly going to be no need for PAs. If I had to say today, I'd say there's going to be a greater need for PAs than there is doctors, because they can deliver good quality medical care under the structure that they're utilized for at a cost that's far less than that of an MD. I think it is possible for an MD to work with their PAs and to produce good quality medical care at a very reasonable price, and I think that's going to be increasingly called on. I think the doctor's role in the future will change and the PA may be the front line.

BW: That's fascinating. Do you see this already happening?

EE: Yes. Yes. Several places. We often . . . my job for the past ten years has been to, I've worked for the Medical Society Foundation and I have, as my tools in my corner I have

money. I can help a physician get started in a community by helping him pay his medical educational loans or supplement his salary or whatever, but I can also supplement a PA's salary or a nurse practitioner's salary.

So, what we have done is to go about . . . my job is to go around the state and look at areas that need medical practitioners and do what's necessary to bring that practice there. It may be a physician, it may be a PA, it may be a nurse practitioner, or whatever. But we work with troubled medical communities, troubled for two reasons: One is the community is poor, and that's the usual reason. It can't afford a doctor, but it still needs a doctor. The second reason is that there is some medical dysfunction, malfunction, and many times this is the medical practice itself. The doctor may be a poor doctor. He may not be able to attract a partner because of his personality or whatever. He may not know how to work with other people. He may be a loner. All of those occur.

My job has been to go in and sort of help diagnose the problem. I work with other people in other organizations and we work as a team. We go there and make a diagnosis and see what we've got and how we can apply it and try to solve the problem. *Many* times we recommend that your next step is to hire a PA. You can't afford another MD but you can afford a PA. We recommend that often.

There are some situations in the state, and I'll mention this one because I think this is going to occur more often, and actually this one didn't work out but this is what we recommended. Two older doctors, sixty and seventy years of age, who had been in this

town for twenty and thirty years, they had been trying for years to recruit partners. They recruited five or six but for various reasons, mostly life style, they've not been able to hold on to these people. They've come there and they've spent one or two years and the wife is not happy or the younger physician is having to work too often.

Well, it looked for a while as though we were not going to be able to get medical practitioners there to work with these two guys. Our recommendation was that they hire four PAs. They had one but they were not using this one correctly. So we counseled them about that. It was our recommendation that they hire four and the four PAs would work a regular schedule, the same as the doctors had been working. The doctors had been working every other night, taking lots of calls, killing themselves at the ages of sixty and seventy, and they couldn't take it any more.

Well, our idea was hire four PAs and let them work every fourth night and you are working every other night as back-up for them. The only reason you are called is if it is something that exceeds their skill. Well, they looked at that for a while and they were ready to do it, but they finally hit a bonanza some other place and they got medical partners. They still hired other PAs and those are working well. I think the PAs are a more flexible part of the system than the physician many times and can be placed when a doctor can't be afforded.

BW: Flexible in what sense?

EE: They can work in a hospital. They can work in an outpatient clinic. They can work by themselves. They can work in an office with a doctor. There are more of them. You can get two for the price of one doctor. It can just cover more hours, it can cover more. The other situation is the situation where we've got a widely separated county. Let's say we've got a county seat in the middle with ten thousand people and we've got two or three towns of a thousand people each. Well, a PA can staff one of those towns as a peripheral site with the doctor coming there maybe twice a week, but the PA is there all the time. That's feasible. With a hub and spoke system, they can close, except for the central hub, at night and on weekends, they can close all the spokes and contract to the hub on holidays so that everybody knows where they can get care ten miles away. But five days a week or six days a week there's a PA in my local community that I can go to. That's a pretty flexible system. And you can have four or five doctors working in that central location, maybe in a community hospital, doing the hospitalizations for the whole system, doing the consultations for the whole system, doing the supervision for all of these outlying places.

BW: Now, are current PA training programs designed to produce this kind of a PA who could work at the spoke, not the spoke but at the satellite.

EE: That's a spoke.

BW: And deal with the full range of—[Background buzzing noise.]

EE: That's a weather alert. That's a thunder storm.

BW: I thought maybe it was a roll call that you had to go to.

EE: No. It's the weather. It's the NOAA [National Oceanic and Aerospace Administration] Weather Alert and it scares the hell out of me, but it's one we bought since tornadoes have been prevalent.

BW: So now this tells us that one is nearby?

EE: There's a thunderstorm in the four or five county area somewhere that is noteworthy, but I think it would be rumbling if it were close by.

BW: The question I have is, I guess, to what degree are PAs graduating from programs that can handle a whole smorgasbord, or how do you deal with that situation?

EE: Okay. Now, that's an important topic, because I don't think that most people understand that all PAs are trained to be generalists. There are a couple of exceptions to that statement. There are a couple of surgical PA training programs, one at Alabama and one at one other place. But those programs are so close to the generalists' program that they make it past the accreditation without any difficulty. All of the programs are set up to train people generally. I now go back to the Bowman Gray plan, which I want to give credit to because Bowman Gray said, "Okay, now, generalist physician, the operating plan here should be that they are trained to do what most people need. Let's take the top one

hundred conditions that come into primary care physicians' offices and let's train all PAs to do those one hundred things." So they designed a curriculum based on the one hundred most commonly encountered problems.

Now that's still going on and I think that's the right and proper thing to do. I wish medical schools did. The specialty can come later. All PAs are trained as generalists in the sense that they're trained to do the hundred most common things. Now, when they finish, they're not finished clinicians. And back to the program I interjected a minute ago, the idea was that every physician hiring a PA was going to spend the first couple of years teaching that person how *he* wanted to do things. But that aspect is being left in the economic wake now. [Chuckles] That's what's necessary to replace, I think, by some additional clinical training.

Now, to give the PA training program some credit, PAs are trained at least nine months and most often it's twelve and fifteen months, in a clinical setting doing things. They have an awful lot of hours under their belt when they leave—far more than the nurse practitioners, by the way. They are experienced clinicians comparatively, but still not to the extent that a doctor would be after three years of residency, for example. That's what the residency does for the physician. The PA doesn't have that in a standard program, but I think it's going to be a requirement in the future. Every PA is technically a generalist, but they're not trained to be omnipotent. [Chuckles] They can't cover every detail. They've got to have some additional seasoning and training.

BW: Let's look at it from the other perspective. To what extent are doctors in a program like here at Duke prepared for dealing with PAs when they get out into their own practice?

EE: Another important question, because they many times are not. Gene Stead said from the beginning, "It is as much an educational process for the doctor as it is for the PA." The doctor must explore what that person knows as an individual, because no two PAs are alike either. He must know the personality, he must know the strengths, the weaknesses, the preferences—all of that is part of the doctor's learning process. He must validate all of those skills and be sure that he wants his patients to be subjected to that. I think that in many medical schools, medical students are trained with PAs and I think that's good. Most medical students know what a PA is. Most residents know what a PA is. At Duke at least, every department has a whole bunch of PAs around and many of those PAs actually teach MDs about specific things. They may be very specialized at very esoteric things, but they nevertheless are quite good.

But the doctor has got to learn what the PA . . . and I don't think most doctors are trained about two or three aspects of the job. One of them is their responsibility. Everything that I do and everything that that PA does, I'm responsible for. It is my responsibility to know what that PA is capable of and is doing. Now, that's quickly overcome in most office practices, because the doctor learns that that PA does a damned good job—may do it better than I'd do it. There are lots of offices that delegate all of the suturing, for example, to the PA, because the PA does it better. Doctors need to know that it's their responsibility, they need to know that it's their responsibility to check the skills of the PA, it's their

responsibility to validate it, and it's their responsibility to delegate it and to let them fly, and I don't think that's done well. There are a lot of doctors who pick that up *very* quickly because they recognize that this individual can do as well as they can. You can point to offices all over the state where PAs are working *very* effectively and the doctors trust them. They give them lots of responsibility and they wouldn't do without them.

BW: Okay. We've gone from Dr. Stead coming across the street and saying, "Here, I have an idea you might be interested in," to your being the justice of the peace traveling around North Carolina putting water on fires.

EE: Yes, yes.

BW: Is there any major area that we have not touched on over that period before I go back and ask you some follow-up questions of my own?

EE: I don't believe so. Not that I recall at the moment.

BW: Where I'd like to pick up a thread is with your becoming the Chair of the Department of Community and Family Life.

EE: Family Medicine.

BW: When you did that, was that an emerging field or was that already well established and you were just plugging in to something there that you knew all the ropes? That was also a creative process?

EE: Brand new.

BW: Brand new. Okay, talk about that.

EE: And naive. [Chuckles] In retrospect, I learned some politics that I didn't know before I went in. Back in 1964 and 1965, there was a growing movement in the country called family practice. Duke didn't have family practice. There was a faculty member, though, who attached himself to some of the early leaders in the field and they were in this state. I'll mention a name, because it's an important name. Bill Demaria, D-e-m-a-r-i-a.

Bill Demaria was a pediatrician on the faculty at Duke. Bill was the pediatrician for most of the Medical staff. I mean, everybody's kids went to Bill. [Chuckles] He was the doctors' doctor. Bill Demaria became enamored of family medicine and he said, "Well, family medicine is coming and we'd better prepare for it and we'd better adopt it." Bill went about the Medical School asking other people to help him get that started. They had a proposal. He went to a member of the Department of Medicine and got an ally, an infectious disease expert named D. T. Smith , and they began to petition the Dean for a Department of Family Practice.

Well, the Dean was a surgeon. Didn't know quite how to do this. Didn't know whether it was an important thing or not. So he did what any Dean does: Appointed a faculty committee to study it. Well, he put an obstetrician in charge and they formed a program to study family medicine. They quickly deduced that the major problem, the major impetus for the formation of family medicine was a lack of doctors in many communities. The primary-care physician in many small communities was gone. The problem was really the community that was demanding a replacement for somebody that could no longer be replaced.

The committee came up with the notion of starting a Department of Community Medicine. The problem was not training a generalist physician; the problem is the community. I was asked to head a department to use economics, to use PAs, to use computers, to use any other thing that would help bring medical care to the community in a more economic and . . .

[End Side A, Tape 2]

[Begin Side B, Tape 2]

EE: I took the job on the recommendation of Gene Stead. [Chuckles] He called me in and said, "I think this is a challenging area and I think you'd do well in it. The committee would like to offer you the position as the first Chair of this new department." Well, I took the job, meager budget, meager office space, almost no facilities. Immediately they began

to toss everything that nobody else wanted into that department, so I had to fight off a lot of things.

But it became as apparent as the nose on your face that there *was* a need for a generalist physician, that we were not producing that new kind of breed, and no matter we worked very hard on computer-based medical care, telemedicine. We had telemedicine back then before it was even thought of. We had self-administered medical histories and computer-based medical care and we sent faculty members to work with IBM in New York in 1970 [Laughs] to put together computer-based medical records. We had a division of computer medicine by 1970.

Well, but it was also apparent that there was a *very* crucial missing piece and that was a generalist physician. So we began to petition for a new family medicine program. Well, I didn't know it when I went in but in effect our new program was proposed by that faculty committee as a means of fighting off Bill Demaria's idea of family medicine. [Laughs] And there I was coming back four years later proposing family medicine within that new department.

By 1972 we had a Department with Family Medicine, a *Division* of Family Medicine within our department, and the name changed to Community and Family Medicine. But the Family Medicine Division was at the community hospital, not at Duke. Duke continued to hold off Family Medicine until the 1990s. [Laughs] That's another chapter. That's why I left my Chair.

Family Medicine did well. Family Medicine quickly rose to be the largest provider of care under the early HMO plans in this state and by virtue of that they began to take patients away from the mother house to the community hospital. Two other departments, Medicine and Surgery, began to promote doing away with the department because it was competing with them. The Dean appointed an external study by Lewin and Company of Washington, D.C., to come in the state and look at the state, the need, the local environment, and to advise. He advised that they swallow hard and say family medicine is part of us and we're going to bring it back into the University and make it work for us instead of agin us. But they elected not to do that and announced, to my utter dismay, in 1985, on May 5, [Chuckles] that they were going to eliminate Family Medicine from the Department and it was going to be Community and Family Medicine, I mean Community Health Sciences again [Chuckles], at which point I announced my resignation from the Chair and my determination to fight it.

Well, it didn't last long. By June they had to take it back [Laughs] and Family Medicine is now a full partner at the University Hospital and running most of the stuff that's really important, like getting out into other communities. There are still some departments that don't know its importance [Chuckles], but things have changed quite a bit. The price for me was giving up the chairmanship and fighting it from outside and, fortunately, fighting it effectively and fighting it at a political level in the state. They got three or four hundred letters from all over the country pointing out that "we'll never send you another patient."

[Laughs] And it worked. So, they didn't realize that they were dependent on that and that the super-specialty orientation depended on a broad base of primary care.

BW: So you were being a pathfinder in that area as well as in the PA.

EE: Yes. Yes.

BW: So why do you give all the credit for creativity to Dr. Stead?

EE: [Chuckles] Well, the Department has had a lot of, we had five divisions, all of them I think very good divisions and all of them have been successful: The PA program; Family Medicine; we had an Occupational Medicine Division which went out and did occupational medicine all over the state and still does; and we had a Division of Medical Infomatics Computers, Medical Information. We've had our own computer-based system since the 1960s. We also had a strange division, which was our money-maker, a division called the Diet and Fitness Center, which was very successful. Operated and still operates.

BW: Diet?

EE: Diet and Fitness. It brings people in who have a weight problem and treats them very intensively and very well—the best medical care, the best psychological care, the best training (they're trained to shop, they're trained to . . .) and an exercise program to go with

it. They come here and stay for periods of two months and lose fifty pounds while they're at it. But it also makes money. It produces a million bucks a year for the Department. The Department of Medicine, our competitor department, my old, own department, Dr. Stead's own department, started one at the same time but based on rehabilitation of cardiac patients. That program has lost money and ours has made money. Ours has been pristine pure weight loss, weight loss, and ours has made a million bucks a year, and theirs has lost money. [Laughs]

BW: How many of these five divisions existed when you took over the chairmanship?

EE: None. I had one desk, one secretary, and fifty thousand dollars a year for salaries.

BW: So in the expectations of the authorities, what were you supposed to do? Go to lunch with the secretary every day?

EE: That was my point, that my objective was to build and to solve, and in 1985 the solution was build Family Medicine, build Primary Care, build Infomatics, build Occupational Medicine, which we did. The success of the Family Medicine program in the managed care business led to that attempt to extrude us, because we were a bit early.

BW: And in these other areas, you didn't have models to build on much either.

EE: No. Well, I think the Department has done well. The Department has grown steadily. My second-in-command took over when I resigned, and everything went merrily on. They made some mistakes, some mistakes that ten years later are having to be redone. We started a very cooperative program with the community hospital. Right after I left the Chair, two departments decided to sever the relationship, which was very warm and very firm, over an issue that was political. They decreed that there should be no cardiac surgery at the community hospital. [Chuckles] "We want all that back home, and if you start a cardiac surgery program, we're going to withdraw our medical and our surgical residents." They did and they did and they withdrew, and a month ago Duke took over the responsibility for running the community hospital. [Laughs] Now, we've got to go back and reestablish what we could have had for free ten years ago.

BW: Now, during this period of time that you were involved in, I would assume a lot of administrative responsibility and pedagogical, were you also continuing your own research or areas of professional activity or not?

EE: Very little in the way of—some clinical research. I continued clinical research for about twenty years after I took over the Department. What I took up was working with a very good pathologist who was doing stuff that could be done of a nonclinical sort. Most of my time was, I would devote one-half day; Saturday mornings were research time. I would go over and spend time with Don Hackel and we did work with coronary circulation which could be done in a laboratory. But I've done no research with patients since I became Chair in 1966.

BW: Were you aware that Robert Young died, I guess, yesterday?

EE: No.

BW: Who used to play Marcus Welby, MD, on television—I just heard that on the radio this morning—and just for the record here and for my own information, distinguish between the family medicine practice as you were teaching it and the old family doctor model which you mentioned right at the very beginning in terms of the man in town.

EE: Okay. Right. The concept of family medicine came out of some studies that were done in the mid 1960s, at about the same time as the PA program started, for the same reason, by the way: Inability to supply doctors to under-served communities. It was clearly recognized that the old pattern . . . by the way, the old pattern was four years of medical school and one year of internship spent in four rotations: Surgery, pediatrics, OB, and medicine. That was the old pattern. The residency tradition didn't start until after World War II, when people started coming back from overseas. There were specialists before World War II but very few. After World War II, the old internship disappeared and merged into the residency. Well, by 1966, the pattern was clearly established that the residency, for three years, four years, five years, was the pattern, not rotating internship.

Well, we needed generalist physicians. The generalist physician should train no less than the generalist internist and the general pediatrician and the general surgeon. So, we

wanted to make the training three years. Rotation is through medicine, through pediatrics, through psychiatry, through emergency room, some formal three years of experience in something that looked like a doctor's office.

The distinguishing feature was the fact that there was a model family practice clinic and the faculty ran a clinic, an outpatient clinic, and took care of a population of patients. The resident worked with the faculty as an outpatient physician and in addition rotated through inpatient experience in medicine, pediatrics, OB, so forth, and so forth. Well, that pattern was established in 1966 and we were one of the first departments to start a Department of Family Practice. Ours started in 1972. That's what Bill Demaria wanted the school to do in 1966. [Laughs]

BW: In 1966, I was in Berkeley, California, trying to understand the hippie movement. And to what extent did that spirit of the times impact on you all here or wasn't that an issue?

EE: Yes, it was an issue. For example, I was on the Academic Faculty Council at that time as part of what many places have called Academic Senate or whatever. Students invaded the president's home and captured the registrar in his office and tried to burn the records and things of that sort. Yes, there was ferment, a lot of it. Terry Sanford was brought in as president about that time with a background as a paratrooper and a governor and an FBI agent and quite skillful in dealing with students and sort of stayed the Philistines at the door. But, yes, that was very much a part of the campus environment. Not very much in the Medical School. Very little in the Medical School.

BW: Now, in my experience at Berkeley, a lot of my colleagues became attracted to the Peace Corps as one way of expressing social conscience and whatnot. Now, I would think the kinds of programs that you were heading up would have the same kind of appeal.

EE: Family medicine has many roots of that sort. The young people who went into family medicine at the beginning were largely the rebels who were reacting against becoming a left-toe specialist or a left eardrum specialist. A whole person. We welcomed women. In fact, one year eleven of thirteen of our residents were women. Didn't have to dress to the teeth and, you know, a lot of stuff that was very similar to the Peace Corps. A lot of that stuff in there along with it.

We viewed ourselves in somewhat the same way as the blacks at the same time. Nobody liked family medicine. It was over there in the outhouse and nobody allowed us to come in the big house and do things. To get family doctors admitted to the community hospital to do OB, for example, was kind of big, because the obstetricians wouldn't let us in. Had to fight it. Everything was a fight. The surgeons didn't like us to learn to do surgery. The medicine people didn't like us to learn to listen to hearts. Had to fight to get in, usually by finding one or two people that would do it. Very much of that sort of feeling at the same time.

BW: So in a way you have been a professional rebel.

EE: Sort of. Sort of. Not in the sense of getting a gun and going to the door, but in a much more subtle way, injecting change into the system and feeding the change and watching the change change the system.

BW: And do you feel you took some heavy hits because of that within the University or within the profession?

EE: Yes. To be booted out of your Department [Laughs], that was pretty heavy stuff.

There's one other incident I want to tell you about, because I think it's highly significant. This was 1967, very early, before family medicine. One of our first efforts was to say the secret of getting out into communities is to encourage group practices—group practices, where you can bring a critical mass of internists and pediatricians and obstetricians and surgeons together. To do that, we wanted to form in this community of Durham a model group practice that could be used to train people to work together as pediatricians and internists and obstetricians. We recruited a group of two internists, three internists, to be the first physicians to start this. We got some money to start it. We got a building. The building was a leased building that was built by an entrepreneur here in town for our purposes.

The first objection we had was from members of my own Department of Medicine, who said, "You are hiring three of our trainees to go into town and to compete with us," and they went to the Dean to ask him to forbid us to do this. He came to me to say, "What are you

going to do about this?" You've got members of a very strong Department who had convinced Jim Wyngaarden (Jim Wyngaarden was Gene Stead's successor) to take this cause and to take it to the Dean. Well, what do I do about that? Here's the most powerful department in the school and we're the youngest department. We didn't have but three people and they were the three people that were going to do this, and they were going to forbid us from doing it.

Well, I got on a plane from Washington, D.C., back to Durham, and happened to sit next to Evelyn Stead, who you'll meet tomorrow. Evelyn Stead said, "Well, you know, Gene is coming home tonight." (This was a Friday night.) "And he'll be here tomorrow." They were to have an extraordinary meeting of the medical private diagnostic clinic on Sunday morning at nine o'clock where they would consider this issue and we were to make our case to the Department of Medicine as to why we should be allowed to do this. She said, "I'm going to tell Gene about this and he'll call you when he gets here." And he did. I told him what was up and he says, "I'll come with you on Sunday morning."

Nobody expected him. [Laughs] And here was the old man, the Chief, that everybody admired and everybody looked up to, came in and he said, "Let me handle it." He stood up and he says, "How dare you?! The newest Department! Your own trainees! They have nothing, not even a pot to pee on, and you've got all of these resources, and you've got all of these specialties, and you're going to tell them that they are doing an unfair thing by competing with you, who are so well established, and all of you are renowned in your fields and so forth. How *dare* you say that to them?" They voted to let it pass and to approve it.

[Laughs] Well, Gene Stead has helped me at some critical times. It would never have passed had he not gotten up and said that.

BW: He did have clout.

EE: He had clout. So this tells you why I'm so fond of that guy. There are other times, too, politically and otherwise.

BW: I want to just go through a few quick questions. You got your BA at Emory as well.

EE: Yes.

BW: And that was in biology?

EE: It was in premedical sciences, sort of biologic things.

BW: Okay. Now, there's no order to this. When you were . . . Let me stop the tape for a moment.

[End Side B, Tape 2]

[Begin Side A, Tape 3]

BW: Okay. We want to cover the curricular problems.

EE: Yes. In the earliest days there were meetings in which various people got together to talk about what we're going to teach these guys. I mean, they're coming. Now what are we going to do with them? We gravitated toward *things* rather than—well, there were some obvious things. You've got to teach them anatomy, you've got to teach them physiology. But you also need to teach them specifics. We began to teach them how to do electrocardiograms, how to do suturing, how to draw blood, things that today look kind of simplistic and have proved to be just sort of inconsequential details, but essentially we came out with teaching them things that those who were around at that time thought were important. This was not the systematic look at the situation that I described earlier from the Bowman Gray program, in which you looked at one hundred diseases and looked at what anatomy do you need in order to handle those one hundred diseases, what physiology do you need, what biochemistry do you need, what pharmacology do you need. Now that's the part that we just missed entirely. I think the early criticisms of our curriculum were exactly on the mark. We were trying to teach them to be young physicians rather than young physician assistants, and there's a difference.

BW: Were there other problems that you recall from that stage in the development?

EE: No problems. I think things went reasonably smoothly as far as the teaching went. I mean, we had young people who were bright and they picked up what they needed.

BW: Your teachers?

EE: Yes, and the students as well.

BW: How did you select the teachers? And did you have to beg some or did they step forward quite willingly?

EE: Well, at that time it was very simple. Gene Stead said, "You will do it." We didn't argue with Gene Stead. We did it. That was the beginning. And there was a person who was very important at that point and this was Jim Mau, M-a-u, whose name has probably come up before because he was the interface between Gene Stead and the program. Gene Stead depended on Jim Mau as an administrator to get things done. We all knew that Jim Mau spoke with the voice of authority of Gene Stead behind him, and so Jim Mau got things done.

BW: Now, very rapidly, you had another problem and that was how to limit the enrollment, right? Because this caught fire very quickly.

EE: Caught fire quite quickly. I forget how long it took us to get up to forty, but it got there fairly fast. At first it was four or five, then seven or eight, and then all of a sudden it was forty. And we stopped at forty because that's as big as a classroom would hold. It turned out that we could have done it with twice that number but forty looked like a nice classroom full.

BW: How long did forty remain the limit?

EE: It's still kind of the limit. Now it would go over at times, but I think Reggie [Dr. Reginald Carter] tells me that forty is still the basic number. Now, we do have some students at some peripheral places that are taught electronically (teleconferencing), but they are in addition to the forty. Forty is generally the number. It's just a nice sized class.

BW: I mentioned this matter of cogermination, that other PA-type programs were developing about the same time.

EE: Yes.

BW: Speak about this.

EE: Yes. Why did the PA program catch on? I point out that the PA program started at the same time that family medicine was also starting and that the nurse practitioner movement was also starting, and the MEDEX program and everything was going on at the same time. My conjecture is that they all arise from the same basic problem and that was the lack of generalist physicians out there in the country at large.

I think my way of putting it together goes like this: At the beginning of World War II, let's say in 1940, 1941, every doctor out there was, not *every* doctor but the majority, the vast

majority of all doctors were generalists. They were trained under the old system of four years of medical school and a year of rotating internship. Some few went ahead and got some specialties, but they were all generalists and they had distributed themselves widely over the country. They went into the service. They quickly learned that there was an advantage in being a specialist. They were given the GI Bill benefits as a result of their service and many of them came back and used their GI Bill in order to get a specialty. One that I can think of was a general practitioner. Came back and became an otorhinolaryngologist by using his residency, his GI Bill sponsorship, in order to get that. Well, that was common.

But at the end of World War II, we were no longer training generalists, I remember, because in 1966 I looked at it as part of my new assignment and my new department. There was something like two hundred residencies for general practice available in the country that were labeled that. There were lots of people, not *lots,* but a few people who went and got one year of medicine and one year of pediatrics and one year of OB and maybe six months of surgery and put it together themselves. But there were two hundred out of all the residencies in the U.S. that were designated for family medicine or for general practice. Those were half unfilled. Of those that were filled, the majority were people from other countries who were coming in and moving in to soft spots where they could get in without difficulty. So, everybody was moving in the direction of specialization.

Now, this doesn't have its impact immediately, but essentially from 1945, at the end of World War II, until 1966, we had not trained any generalists, and the doctors that were

there were beginning to retire and beginning to die and beginning to need replacement. As these doctors went back to medical schools to find their replacements, there were none. This was true all over North Carolina. I remember the calls of desperation that came to our new department, because everybody said, "Ah hah! We've got this new department that's supposed to solve these problems. We'll give you a telephone number to call."

So we got a call from a doctor in the eastern part of the state named Ernest Furgurson, who became a good friend, and we sent our first PA to him, by the way. Ernest Furgurson , seventy years old, in an eastern North Carolina town says, "Send me a doctor. Please." "We don't have a doctor, Dr. Furgurson." "But I'm seventy years old. I can't stand every other night. My partner is older than I am." "But we don't have one." Well, we sent him Craig Bruno , one of our first graduates, who stuck with him until he [Furgurson] died.

Well, that problem was there all over the country in spades, and out of that problem came the PA program, the nurse practitioner program, and the family practice program, and lots of other programs. [Chuckles] The problem is still with us. It's still there in 1998. The same damned problem that I am tackling every week when I go to work. But it's the basis for all of the interest in the programs.

BW: Why did the generalists lose allure so quickly and so permanently?

EE: Medicine is a complex process. There was no family medicine program at that time. People that were training general internists were training them like themselves, to be . . .

the people that were training general internal medicine at Duke were cardiologists and gastroenterologists and endocrinologists. That was the glamour, in the subspecialties. If you were anybody at all, you wanted to be a subspecialist like those models that trained you. In my day, twenty years earlier, Gene Stead, John Hickam, Jim Warren were first of all good general internists who were beginning to pick up some specialty training. But the initial training was general internal medicine, twenty years earlier.

There is another thread that feeds in here and it goes back to the same era of 1945 and there's another piece of it and it's one that I ought to mention. It was 1950 when we began to see the National Institutes of Health come on the scene. By 1955, the National Institutes were beginning to pour money into medical schools for research and out of that research came lots of information: New knowledge, new techniques, new machines, transplantation, cardiac catheterization, angiography. You could name dozens of things out of every field that came out of the investment that the federal government made in the 1950s and 1960s. All of the output of that investment was beginning to be apparent by 1966.

So, we were fighting powerful forces. It was only the rebels that wanted to be rebels and to go back and be generalists in order to do what these old GPs did.

BW: So the program at the University of Washington sprung forth.

EE: Yes.

BW: Silver in Colorado sprung forth.

EE: Right.

BW: What about Bowman Gray? How did that come about?

EE: Well, it joined with the Duke program as one of the earliest PA programs and became strongly entrenched in its own local community and has continued to produce forty PAs a year. I mean, the number forty keeps coming up. Bowman Gray until fairly recently was the other program in our state that took forty a year. So, we were sister programs within one state.

BW: But Duke also spawned programs in other parts of the country, like with Bill Stanhope, who went to Oklahoma and so forth.

EE: Right. There were people who were in the early programs who became the gurus of the new profession—the Bill Stanhopes, who went forth and became the teachers and leaders that got the profession started and got the Academy started, put together the internal machinery that made the profession a profession.

BW: So there's no question in your mind that Duke occupies a very preeminent place in the . . .

EE: Yes. And I think we fought some of the early battles with . . . I think almost every state has adopted this model legislation in one form or another that we put together back there. That's become kind of a standard.

BW: We breezed past that, but actually that took up a lot of your time, didn't it?

EE: A lot of time, yes.

BW: And not only in terms of writing but also . . .

EE: Conferencing.

BW: And meeting with politicians.

EE: Right.

BW: And did you use Stead as your mentor on that or did you quickly come to understand the political situation in the state?

EE: Well, Gene sort of dropped out of the political situation after he left as Chair but was a trusted advisor and behind-the-scenes person, but sort of left the daily battles up to Bob Howard and me and other people that were out there doing the more daily battles.

BW: I think being effective politically requires a whole bunch of skills that you must have learned growing up in Georgia or something.

EE: Yes. Must have. [Laughs]

BW: My note here says we were going to touch on the AMA role.

EE: Right. Now, back in the 1960s—I'm sort of leading up to it but it's indirect but it has to be—back in the 1960s there was a new federal legislation called the Regional Medical Program that came into being. This was about the time our new department started. The Regional Medical Program was to get the benefits of heart disease, cancer, and stroke research out to the medical community at large in a more effective and a quicker way. So, as the Chair of this new department, the Dean said, "Look, you are Duke's representative on the Regional Medical Program because, I mean, that's your departmental responsibility."

So I became the Chair of the Regional Medical Program for the state, which was all three medical schools at that time plus a federal machine that was created to carry out the mandates of that new piece of legislation which had to do with medical teaching. But it itself spawned a few things, such as the University of North Carolina established an air force to carry its teachers around to do teaching as part of the Regional Medical Program. We funded that and they now have five airplanes that carry people around. The early cancer programs in the state were all done with Regional Medical Program money.

But any way, I became, in this new role, very active with the state of North Carolina's outlying doctors—very unique at Duke, because very few people at Duke had had that opportunity of going out and meeting their counterparts in other places.

Well, I became very active in the local medical society. I went up through the ranks as an officer in the County Medical Society and was proposed as an officer in the State Medical Society, and I went up through the ranks there and eventually became president of the Medical Society in Raleigh. That took from 1966 until roughly 1978, where I became president and have remained active ever since and somewhere along the line became active in the AMA, because this is kind of the progression. I became a delegate to the AMA and became an alternate delegate, then a delegate, and served as a delegate for nine or ten years. After you get known, you become chair of committees and so I became a member of the Council on Scientific Affairs and eventually its Chair. So, yes, I've been very active in the AMA, and now retired, thank God [Laughs], because it took a lot of time.

BW: I want to ask you your observations on who goes into the PA program. Over time has that changed and who is doing it now?

EE: It has not changed *that* much but it has changed some. In the early days it was a lot of returning corpsmen—bright people who had been active in the Armed Forces, mainly males—but as time went on we had a more diverse group; oddly enough, but not odd when you think about it, some nurses, who said, "Look, I want to be a PA. I don't want to be a

nurse any more." So they went in this route instead of becoming a nurse practitioner. And that's still the case.

But mixed in with that are a group of people who had become music majors, French majors, economics majors, who have said to themselves, "My God. I've always wanted to be an MD, I've always wanted to be involved, and I didn't know that there was any route other than to become a physician and to spend five years or ten years doing it to do that." For some reason they learn about this and they say, "Well, that's *exactly* what I want to do." So you find a huge number of those people who have done something else in their lives. They've been teachers, they've been lab techs, they've been economists, they've been everything, and they have decided that "that's exactly what I want to do."

Now, we put a barrier in their way here and, I think, most places, in that we say, "You've got to have some hands-on experience working with patients." So, many of those take time out of their lives in order to get that experience in order to get the two years of PA training. So, it's a group of people who have done something else but who have always had a nagging feeling that they wanted to do this, and that feeling is strong enough that they want to really change their lives and do this.

It's a *fascinating* group of people. They have a social conscience. They don't want to do things the standard way. They question things. They don't let you get away with things. [Chuckles] I think everybody who lectures PAs and medical students will say they're different. I'd rather lecture the PAs, most of them, because they question things. It's a

different group. The medical students, many of them, are lock-step. They've been competing from the time they were twelve to be the first in the class and to be the top of their class and they've not done anything else. The PA group is different. Many of them are older. They're more challenging.

BW: Describe the requirement that they have had service before they enter the program. What does that entail?

EE: Well, this was from the beginning and it came from the second year, as I recall. In the second year the class admitted, or to the class was admitted a young woman who wanted to be a PA but who had never taken care of patients. She had been a lab tech, as I recall. She had worked with the lab things but she had never had the responsibility of taking care of patients. She dropped out because she didn't like taking care of patients.

Well, Gene Stead said at that point, "Okay. That's it. We're going to require that people have hands-on experience. They have got to get dirty. They've got to be vomited upon. They've got to have an experience of responsibility as a care-giver that's going to help us separate those who are repelled—and I can't use any other word—from the business of serving in a very close way a person who is sick and dependent and calls on you to hold his head while he pukes. That is not for everybody. So, from the beginning, from *that* beginning, we have required that there be one year of experience in hands-on patient care. Now, we've had lots of people who have taken a year and become patient aides or have become volunteers in emergency rooms or something of that sort in order to get that kind of

experience. I think it *is* a screening device that gets rid of those who are not damned serious.

BW: So if I apply, the program tells me, "Go get your year of service in your community," and doesn't define precisely what that is. I come up with it and then I document that I've been there and been puked upon and so forth and so on.

EE: Yes. Yes.

BW: So that actually in a sense adds a year, although maybe this could be a part-time volunteer.

EE: It could be a part-time volunteer job and often is. People who are thinking about it go ahead and get that as a part of their preparation for it. Many of them take a chemistry course or whatever is necessary in order to make it, and this is a fairly competitive game now.

BW: What about demographically? What generalizations could you make about PAs?

EE: Many more women. Older people who have done other things.

BW: Ethnically?

EE: Unfortunately there has not been as many from ethnic minorities as I would like to see. Now, there are reasons for that, I think. When you put more and more barriers there, in terms of educational requirements and other requirements, then you very quickly filter out some ethnic minorities who should be there.

Now, we've had some ethnic successes of a sort that I had not expected, because many of the young black men and women who have entered the program in the very early days went ahead very quickly and applied for medical school and are now medical practitioners. This gave them enough confidence to go back and apply to medical school.

But as far as PAs, we are *searching* for ways to do it and Reggie [Carter] has got some very bright ideas now that have to do with keeping the training in local communities. He's got a program in Lumberton dealing with a biracial group of minorities, Indians and blacks, that I think has some promise. They're actually taking the program to them so that they don't have to leave home.

BW: And does distance learning factor into that?

EE: Yes, it will. That's going to be a bigger part of it, and it is now to some extent.

BW: What about economic status? Is there any observation you'd make there?

EE: Many people are earning their own way and I'd say that most are, that most of them are people who have gotten responsibility for their own payment and very few have . . . and this is causing a problem because many of them finish PA programs with debts that are in the 50K range that become a problem, unless they go to an under-served area. We've been able to help some repay those. That's about half of the debt that MDs end with, but it's still a lot.

BW: And what kind of salary do they expect in their first couple of years of practice?

EE: Fifty thousand to sixty thousand right now. The going price is about half that for MDs. It has consistently been that.

BW: So they parallel one another in a way.

EE: They parallel one another.

BW: I wanted to get your observations on why the word "physician's assistant" was selected.

EE: Okay. That has been a bone of contention from the beginning. At the beginning the word "physician assistant" was probably okay. That's the one that Gene Stead put upon them. But there was very quickly a thought that there should be, that this is a bit demeaning to be called a physician assistant. There should be a better word, and there have been several attempts at that. The word "physician associate" had a time of

popularity and there were some attempts to change names of programs to physician's associate, but that didn't stick. And there have been some strange names that have been thought up, such as "syniatrist," things that are kind of off the wall. They would imply that this is a different breed and it doesn't really assist physicians in that sense. There's been no satisfactory answer. I think that the profession has drifted with the term "physician assistant" without *anyone* having any feeling that this is the perfect term and that someday somebody will come along with it and at that point everybody will change.

BW: But it was Dr. Stead who said, "This is what we're going to call these folks."

EE: Yes, that's right. And MEDEX, I mean, that was a coined word but it didn't stick for the field as a whole.

BW: Now if I told you I was going to be interviewing Bob Howard tomorrow, what would you say?

EE: Bob is an interesting guy for whom I have the greatest affection and respect. He has had a troubled life in some ways, but Bob was wound tight and I think one would predict that he would either spend himself or burn out at some point. He could put more time and energy into a task than anybody I've ever known before or since. Worked day and night. Worked *effectively* day and night, and had good ideas. And I think he burned out here.

[End Side A, Tape 3]

[Begin Side B, Tape 3]

BW: What were the circumstances of his departure?

EE: He decided to go elsewhere, to take another position and be a program director. I'm sure money had something to do with it and autonomy had something to do with it. I think he thought he was ready for something else. As I recall, he went from here to Florida to start a new program there, a responsible job, and he did that. So, he left here in good stead and in good repute and did an effective job where he went. But he did have some problems later that were, I think, a consequence of his being the person he was. But he was exactly what we needed and produced effectively.

BW: Did you say you hired him?

EE: Yes.

BW: And his being here for those four years was critical.

EE: Critical. He would travel back and forth, and he would argue and he would persist, and he would nag and everything else. He brought in with him somebody that he had worked with in his past named David Lewis. Dave eventually became the program director at Florida after Bob left. Dave had come from a strange background. He had been a band

director. [Laughs] But he and Bob became a team. Dave was the administrative person and Bob became the front person who did all the travel and cajoling.

BW: So their role was mainly public relations?

EE: Dave had the job of curriculum, learning objectives, making the transition over to the new model rather than the old Duke model.

BW: And Howard's?

EE: Howard had to do with, he was here at the time when we were trying to get the AMA to cooperate and things of that sort.

BW: Dick, is it Scheele?

EE: Scheele. Dick was one of the early graduates of the program, sort of a model person who became a leader of the PAs who were graduates. Went into practice here in town and tragically died suddenly of a massive coronary. Would have been a leader somewhere. He was charismatic, *very* intelligent, very looked up to by other people as a leader, and he was *very* influential in getting the organizational unit started that became the AAPA.

BW: Do you recall what drew him here? How he arrived?

EE: Well, he came to Duke among our applicants early, and I don't know why he came here. I guess, I mean, he was a corpsman, he was out of the military. But why? I guess we were the only game in town at that point.

BW: And was there anything special about the program he entered here in town? Special because someone got a job out of the program, right? A person that appeared on the panel that I observed in the literature from about 1990, the 25th anniversary, Katherine Andreoli.

EE: Andreoli.

BW: Andreoli.

EE: Kay Andreoli was important at the point where the PA program was starting. She was the head nurse on the coronary care unit here at Duke. Kay was married. At that time she was married to a physician who was on the faculty as well. She worked for Andy Wallace, whose name probably will come up lots of times. Andy Wallace, along with me and several others, had the task of teaching these young people, and he taught them a lot of cardiology. Part of the teaching had to do with learning electrocardiography and learning resuscitative techniques and things of this sort, and Kay Andreoli was a part of that. So Kay became an early instructor in the program and became one of the early supporters of the program within nursing. She left here to go elsewhere as a leader within nursing, but at the early phases of the program she was a key person as an instructor, as an ally within a political structure that was hostile. She later wrote a book with Andy Wallace about

interpretation of the electrocardiogram for the coronary care nurse. So, she went on to another field. She was at Alabama for a long time.

BW: So she's never, when she left Duke, she didn't return to Duke?

EE: She did not return. She is now a vice president at the University of Chicago, I think, or Northwestern, right now. She is a very prominent person in nursing in Chicago right now, and a good friend. I think Kay has been a friend [within nursing] since she was here. But she knew it back then from inside.

BW: Now the nurse that worked with Stead in the early days, Louise?

EE: Thelma Ingles.

BW: Thelma. I knew it was either Thelma or Louise. Once things didn't go with their collaboration, she didn't reenter the program in any way?

EE: No. In fact, Thelma went overseas. She became an emissary of the Rockefeller Foundation and she became a staff member with that Foundation and traveled. She left the scene.

BW: You mentioned Jim Mau.

EE: Jim is still around, though he is retired. His health has been poor. He remained as the administrative chief in the Department of Medicine for many years. When the program moved over to us, he sort of dropped his role with the program but remained a supporter and a friend of the program from there until now. He was certainly an important individual early in the program.

BW: From what standpoint?

EE: Whatever you needed. You needed a classroom, you needed a few thousand dollars to do this, you needed, some hurdle to get over, then Jim Mau was the person to go talk to. Resources mainly. Physical resources, space resources. He could generally find it for you. He had lots of irons in lots of fires and he was owed a lot of nickels by a lot of people who could get things done.

BW: What do you consider your legacy to be in all of this?

EE: Well, clearly it's Gene Stead's idea and Gene got it started. But I think my legacy is fighting it through some of the next battles, the next stages, and getting it on a level playing field. I think I've saved it a few times from being eliminated at Duke by standing up and saying, "I think this belongs here." On the state scene, I think I've been crucial in some of the battles that the profession has had to fight in the state and so I think I've kept it moving. [Chuckles] I hope I've been friendly every time, to help the profession get over some of the tough spots, to get it introduced at a few places where it needed to be introduced. So, I

think that's been my role: To sort of take it from the germ of an idea and keep it on the path to the point where it could survive on its own.

BW: Do you remember the day that Stead called you, or dropped by your office, or had you come to his office and said, "Hey, I have this idea."

EE: I don't remember specifically the day. It sort of grew, because we clearly talked about his nursing program before. We talked about the firemen before. We talked with . . . I remember talking with Henry MacIntosh many times about that. But I don't remember any specific—I don't think there was one. I think it grew like Topsy.

BW: It's interesting how some people's lives take a direction that becomes so defining.

EE: Yes.

BW: Sort of without—I mean, if anyone had said to you when you were at Emory, "We need physicians' assistants and you're the guy to bring this profession into being," you would have said, "What's that all about?"

EE: And really it was—when you think back upon it, there was no reason to say that I had to accept that. It would probably have disappeared at that time, had I not accepted it, because Jim Wyngaarden would have not been interested at all. He would have said, "As far as I'm concerned, it can disappear tomorrow," and he would have been just as happy.

BW: Under those circumstances and as a young person in the field at the time, what stopped you from being sort of capitulatory?

EE: I viewed it as something crucially important to the roles of my new department. I really believed that and I still do. Just as surely as I believe that family medicine was important, just as surely as I believe that those things were *essential* for the role of my new department, I believed it. I didn't do it because anybody wanted me to do it.

BW: Now you say in terms of your department, but surely you also mean in terms of a much larger . . .

EE: Yes, I think so. I think so, because I took my role as a new department Chair because I believed that the University and the Medical School should play a role which I'm gradually seeing take place, after I've left. But I think some day somebody will say, "Well, maybe he had something to do with it." [Laughs]

BW: I think that's quite clear. I think this proves it.

EE: But I guess that's the legacy, because nobody made me do anything.

BW: Are we leaving anything unsaid today?

EE: We've covered a lot more ground than I believed existed, but I don't know of anything.

BW: It's been a wonderful interview. It's been a privilege to sit here and hear the story.

EE: Well, I've enjoyed it.

BW: Good.

[End Side B, Tape 3]