AL FIRESTONE

Dr. Fitzhugh Mullan,
interviewer

Mullan: We're in Bernalillo, New Mexico, with Dr. Al Firestone. We will be in his office. At the moment we are in a restaurant nearby.

Why don't you tell me a little bit about your background, where you grew up and how you got into medicine.

Firestone: I grew up in Youngstown, Ohio, and my dad was a physician. His specialty was general internal medicine, and my uncle was a doc, and my grandfather was a doctor. So I was constantly exposed to medicine from the time I was a really small child. I used to hang out at my dad's office. Went away to high school for three years back East, and then when I came back--

Mullan: Where'd you go?

Firestone: Deerfield Academy, which is very preppy. The summer after I graduated, I went to work in the hospital in Youngstown as a lab technician, back in the days where you could just take somebody off the street and spend five minutes teaching them how to draw out blood and send them out in the wards to draw blood. So I did that all summer long, and then when I was in college, from time to time, they'd need me to fill in in Dad's office, draw blood and run labs there.

When I went to college at Oberlin, really my intention was not to go into medicine. I'd seen how hard my dad worked and the hours that he kept, and the demands made on him by patients, and

at that time really wasn't interested, and also I was fairly shy and had a lot of trouble relating to people on a one-to-one basis. So when I was at Oberlin, my interest was basically biology, looking at research.

In the summer after my junior year, I went out to UCLA on the Summer Institute of Space Biology with NASA, and we had all the med school professors, the physiology professors, the pharmacology professors, the anatomy professors, and covered a tremendous amount of material in a very short period of time. I realized that a lot of the science of biology was intimately connected with medicine. So I decided that while I was out there, I would go ahead and apply to medical school. When I was accepted about two months later, in October, that made for a very nice senior year in college.

Mullan: This was at UCLA?

Firestone: No, that was at Oberlin. UCLA in October of '68.

Mullan: You were born when?

Firestone: October 1948.

Anyway, so I worked the summer in a steel mill in Youngstown and then went out to UCLA. Loved the basic science stuff, and really was still thinking about going into research medicine. Then I hit the wards in the third year, and found that the thing that I really loved was dealing with patients, and would frequently be found sitting on a patient's bed talking to him at two o'clock in the morning. The role models at UCLA were all

tertiary-care specialists, and it drove me crazy looking at how they interacted with patients, how the lab values were much more important that what was going on with the patient, what the patient was complaining about and what the patient was going through. So by the end of third year, I had pretty much decided that what I did not want to do was to go into specialty medicine, and at that point I started looking at family practice.

The only primary care role model I had in all of medical school was the director of the USC Student Health Service (Dr. Addie Klotz). There was a rotation we could take at the USC Student Health Service, and it turned out that that was the last rotation I took in fourth year. So I pretty much had independently decided that I wanted to go into family practice, and we (my future wife and I) went out and toured around the country looking at family practice programs after junior year of medical school. At that point, I really wanted to get out of Los Angeles. It was too much of a big city and it was very uncomfortable for me. So we wound up in North Carolina in residency, in a community hospital in North Carolina.

Mullan: Where?

Firestone: Greensboro. The Moses H. Cone Memorial Hospital in Greensboro. That is loosely affiliated with the University of North Carolina (UNC) at Chapel Hill. So I guess the docs who ran the program had faculty privileges at UNC, much like the clinical staff privileges that we have when we teach medical students from UNM [University of New Mexico]. But the real ideal point about the program there was that there were maybe one or two internal

medicine residents, a couple of pediatric residents, and the rest of us were all family practice. The attendings were drawn in a large part from the community. There were only, I think, two docs who were on permanent staff with the training program, the rest of them were all from the community.

Mullan: What year was this?

Firestone: That was '73 to '76.

Mullan: Did classmates or faculty at UCLA take issue with you in going into family practice?

Firestone: Oh, yes. Marty Pops was a gastroenterologist who is, I guess, dean of students, and really felt like I was being an underachiever by looking at family practice program as opposed to pediatric cardiology or gastroenterology.

Mullan: Did any of your other classmates go into family practice?

Firestone: I think there were about two or three others. So this was a class of almost, I think it was 106. So it's probably 2 to 3 percent went into primary care. Everything about UCLA geared toward tertiary care. Actually, I think there were only about five of us who went out of state, too. Almost everybody else stayed in California.

Mullan: So how were the three years in Greensboro?

Firestone: Really challenging. I saw a tremendous amount of pathology, made unbelievably close friends with a lot of patients, and was sleep-deprived for about three years. You were on call every third night. The first two years we were in-house, and the last year we could take call from home. I figured out that at one point we were working about 108 hours a week.

Mullan: So what was your vision for the future? Where were you headed?

Firestone: Well, I knew I wanted to do primary care, family practice, and was thinking much more about small-town family practice rather than a big city. In December of '75, I started looking at National Health Service Corps as a means to get out and look at doing rural practice, without having to make the big monetary commitment of trying to set up a practice, and then after one or two years decide that that wasn't for me and I didn't like it. So we did the long-form application to the National Health Service Corps, in which they try and get a match with a community, and we applied to every region except for Region Six, which included Louisiana, Arkansas, Texas and New Mexico. They called me from Region Six and said, "How come you didn't list us?"

I said, "Because we really don't want to go to Louisiana or Arkansas."

They said, "Well, we've got some nice places in New Mexico and Texas," and proceeded to give me a list of a few of them along the Rio Grande and up the Rio Grande into New Mexico. We had already had one baby by cesarian section, and knew that if we

were going to have any other kids we'd need a C-section, so we didn't be too far away from someplace where that would be available, and we had friends in Albuquerque, so when the time came to look at sites, Bernalillo was one of the sites we came to look at. It looked real reasonable, I liked the people that I met here, and so we decided to come on out.

Mullan: What was here? What was happening?

Firestone: At that time, the same clinic building that we're in had a clinic that was run as Cooperative Health Services from St. Joseph and Presbyterian Hospitals in Albuquerque. They had had one physician, a surgeon from South America, who had been here for two years, then an internist who was American who was here for two years. Then the doctor who was here when we were looking, as I recall, he'd either graduated from Harvard and not taken even an internship, or had taken only an internship and no other postgraduate education. He was sort of a strange character that didn't fit in real well, and used to be very complete and ask eighty-five-year-old ladies with severe hypertension about their sex lives. He had essentially gotten down to the point where they were seeing about five to ten patients a day, and then finally things closed down in May of '76. By that time, we already committed to come out here, so we essentially started from scratch again in August of 1976.

Mullan: And were you the only person then, or were there others?

Firestone: I was out here for a month by myself and then was joined by a recent graduate Family Nurse Practitioner. Martha stayed with me for two years, and quit and married the druggist.

Mullan: What was the community understanding and expectation back then, and how has that developed?

Firestone: I think that at the time the feeling was they weren't really giving it much more than just the two-year commitment as far as what their expectations were. I don't think it was a situation where I came in and they immediately drew me into the community and figured I would be there for life. I think that they were concerned that I'd come, do two years, and then leave, and they didn't want to get their hopes up. I just found out recently that they had apparently been recruiting somebody before, had wined and dined him and had a big party for him, and the wife, who was a non-drinker, was handed a glass of clear fluid which she proceeded to try and drink, which turned out to be vodka, and things just didn't work out quite right. So I guess they were a little bit hesitant about the whole wining and dining scene. I think that at that time, I probably was enough of a loner and quiet person that they figured they would just let me slip in, fit in however things worked out, and see how things went.

Mullan: How were you accepted? It was you and your wife and child?

Firestone: Yes. There were really no problems.

Mullan: Did you find a place to live? Did they have a place for you?

Firestone: They went ahead and showed us a couple of areas that were possibilities when we came out to look at the site in January, and then once we made the match, and decided to come out, we just picked up a realtor and went out looking. So the community didn't get involved in the search for us as far as trying to find a home. I think that they basically left us on our own to go ahead and do things, which probably was good.

Mullan: How was the National Health Service Corps in providing orientation, support, guidance, or any of the above, none of the above?

Firestone: We had a couple of meetings. I guess there was a meeting in Dallas right after I got out, and before the practice got started. They had a lot of useful information. I remember that they had a consultant. Remember Les Fishbein [phonetic]? They gave a fair amount of help to the community, but, I think, still you basically wind up reinventing things on your own. I think it just always works out that way if it's going to work out well. But they were there for support, and start-up kits were really invaluable.

Mullan: Those were supplied by the National Health Service Corps?

Firestone: Yes, that was the big crates with everything in the world in them.

Mullan: Yes, and they were helpful?

Firestone: Yes, they were. We still use all of that stuff.

Mullan: There was a formal community board?

Firestone: Yes.

Mullan: What sort of relationship did they establish with you, and what did you expect to get from them?

Firestone: We had monthly meetings. The board was composed of--the initial board was the mayor; the public health nurse, who had provided really most of the medical care for Sandoval County for years, traveling all the way out to Cuba, sixty miles away; the pharmacist, someone who's very active in church activities; one of the guys from the public service company in New Mexico, so one of the businessmen; and I think one of the governors of one of the surrounding pueblos was also involved.

They pretty much said that from the start that their goal would be to go ahead and help with the business aspects of the practice, providing advice and counseling, and their intent was to stay out of any of the medical aspects of it and just let us deal with those on our own, which worked out very, very well, contrary to many of the other community boards in practices throughout the state that I was aware of.

Mullan: Did they put any money up? Was there an investment on the part of the community?

Firestone: I don't think so.

Mullan: So who owned the building?

Firestone: At that time it was just owned by a private--an entrepreneur who had built the building as an office building.

Mullan: The clinic had to pay rent for it?

Firestone: Yes. so basically, really, from the very beginning, we started out paying all of our expenses, with the exception of my salary, out of revenues. I don't remember any loans or any start-up funds or anything else to get us going.

Mullan: Let's pause for a minute on your story and talk a little bit about Bernalillo. Historically, the name is always--with Albuquerque being Bernalillo County, Bernalillo being in Sandoval County--

Firestone: And Sandoval being in Bernalillo County.

Mullan: Is that right?

Firestone: Yes.

Mullan: But it was an early important point on the Rio Grande River, is that right?

Firestone: It was a stopping place, a wintering-over place for Coronado in, I guess, 1560. There was an Indian pueblo, a fairly large pueblo on the other side of the Rio Grande that's now Coronado State Monument. I'm a little bit too asleep to try to think of what the name for the pueblo was.

Mullan: The tribe is gone?

Firestone: No, they're just sort of mixed in, and probably make up part of Santa Ana and Sandia pueblos. There have basically been Spanish who settled here and stayed put here from the 1560s on. I guess there was a time period where they sort of got run out by the Pueblo Revolt, but the families have stayed around and came back in. Two of the families, the Gurules, G-U-R-U-L-E, and Archibeques, A-R-C-H-I-B-E-Q-U-E, are basically descended from Frenchmen who were exploring the Mississippi Valley, got captured by the Indians, sold into slavery into Mexico, and brought up with the Spanish, and settled in this area.

Mullan: Liberated by the Spanish?

Firestone: I think they were sold into slavery to the Spanish.

Mullan: To the Spanish.

Firestone: I don't think they were liberated. So the areas remained permanently settled.

Mullan: Agricultural for the most part?

Firestone: Probably through the middle part of this century, agricultural. Now primarily people commute into Albuquerque where they have jobs in Albuquerque, or up to Santa Fe where they work for the state. There is still a little bit of agriculture, but not too much. Actually, it was a big grape-growing area up through Prohibition and the formation of the Middle Rio Grande Conservancy District, where they dropped the water table by creating some dams. But it was one of the few areas where the Old World stock of grapes would grow unaffected by--there's some sort of nematode that killed off all of the Old World grape stock, so that now I guess most of the European grapes are grown on American stock.

Mullan: The size of the town now?

Firestone: It's about 5,000 now. I think it was 3,500 when we moved out here.

Mullan: And the ethnic makeup?

Firestone: The ethnic makeup of Bernalillo itself was probably about 70 percent Hispanic and 25 to 29 percent Anglo, with a few Indians in Bernalillo. The county itself was 60 percent Hispanic, 30 percent Indian, and 10 percent Anglo when we moved

out here, with a population of 17,000. Now its grown tremendously. Rio Rancho, which is to the southwest of here, they must have 25,000 people in Rio Rancho.

Mullan: This is Albuquerque suburbs to the north?

Firestone: Yes, and it keeps growing out towards us. Bernalillo is isolated by having pueblos to the south of us, Sandia pueblo to the north of us, Santa Ana pueblo, and some Bureau of Land Management land to the east. Also to the east of us, Placitas, which had about 1,000 people when we moved out here, and was a mixture of retired military people who worked at the labs, and aging hippies, now is ultimate yuppyland and now has about 3,500 people.

Mullan: What is the medical tradition in town? Were there doctors in town in earlier years?

Firestone: Over the years there have been some osteopaths who practice in town. Dr. Butler was here for a long time, had a small five- or six-room hospital, and was known to step over somebody bleeding in the street if he hadn't paid his bill.

Mullan: What year would this have been?

Firestone: I think that it's probably through the early fifties, through maybe the mid-fifties. Then a guy named Ken Warren, who is also a DO, was out here for a while and then went down in Albuquerque. There was one other DO, Art Wershaw, who had been

out here for a few years and then went into Albuquerque. So there had not been really anybody who'd been in stable practice for probably about ten to fifteen years when we came.

Mullan: So picking up on your story then, you arrived at-- [Tape recorder turned off.]

We're talking about when you got started here, what your expectations were. You had a two-year commitment, presumably?

Firestone: It was a two-year commitment because I didn't have an obligation to the Corps, I was strictly volunteer, and had managed to get out of residency without any loans or any obligations, so that I was viewing it primarily as a means to go ahead and try rural practice and see if I liked it, without having the real financial obligations that trying to set up a practice entail. So coming out was with the idea that, let's look at the two years and see how things went and see if I liked it.

The community had, as far as the range of patients, the old Hispanics who'd been in the area for hundreds of years, the Mexicans who'd just come across the Rio Grande and had gone to work on the local dairy, the Anglo professionals who work at the labs, the people who are still living on communes up in Placitas, it was just a fascinating mix of people. As far as the medical aspects, the range of patients that we saw, the type of diseases that people had, the fact that care was pretty much cradle-to-grave care, delivering babies and following patients all the way into their nineties, made it fascinating.

Mullan: Did the people come?

Firestone: Yes, it was slow. Things started off fairly slow, with seeing fifteen to eighteen patients a day for the first few years, which was fine with me because I'm not a speed demon in terms of seeing patients, particularly not in those days. As a resident, I'd frequently come out of seeing my last patient and find all the lights out and everybody gone and the door's locked. So it was good for it to start out slowly, and I think that it was a good idea that it started out slowly. I think that a lot of the people in the area were concerned about really committing to the new doc, because they'd had doctors who'd come in, spent two years, left, doctors who'd come in, spent two years left, and so that they really didn't want to transfer their care from the physician in Albuquerque until they had a chance to get some idea of what I was about.

The other thing is that in those years, when I started practicing in Bernalillo, I was twenty-seven and looked like I was eighteen, and had pretty long hair and a beard, so that I think also slowed down people developing a trust. It did take a while to go ahead and earn the trust. I think that's good, because I think otherwise people get false hopes about what to expect. So this way they started out expecting not very much, and then got very comfortable over the years.

Mullan: What happened over time to your commitment and to the practice?

Firestone: I think that as far as my commitment, the more time I spent here, the more interested I got in the area and the more I began to view the people in the practice and the people in the community as being more like my family. Being in a small town, being the only doctor, sort of means that you're never really off call and never really out of the role. On the other hand, if you're comfortable with the role and don't feel like you're being strait-jacketed by the people in the community, don't mind being a little bit in a goldfish bowl, and view being on call all the time sort of in the same way that you view being on call for your kids, only in this case, we're looking at having 17,000 kids, it becomes not disturbing to be sitting at lunch and eating, and somebody comes up and starts talking to you about their hernia, or the fact that they've had diarrhea for four or five days; it just doesn't bother you. I think that as long as you're able to go ahead and maintain a separate identity that's not disturbed by being interrupted, then I think you do okay.

I think that if you need absolute private time where nobody bothers you, number one, you ought never to have children, and number two, you probably would have trouble functioning in a situation like this. I think that a lot of docs seem to need that absolute space away from the practice, and so they get in big call groups where they're on call once every three weekends, or four weekends, or five weekends, and work like crazy during that time, and never get home during that time when they're on call, but when they're off call, they're completely off and really unreachable.

I found it's much easier for me to be on call all the time, but the call's not bad. So two or three phone calls in an

evening, maybe getting called out away from home once in a week, but having to make sure that on Saturday you get down and do rounds, and that you're never too far away from a phone. I get away with playing soccer and playing chamber music, and going out to whatever the kids are doing, and just with a combination of having the beeper with me and having access to a phone someplace, I've managed to do real well as far as keeping a life that is somewhat independent from the practice. My wife might not agree with that, though.

Mullan: I do want to ask about that. In terms of hospitalization, you referenced deliveries and making rounds. How have you handled that?

Firestone: I did OB for eleven years, so all the time when I was in the Corps, I did OB. Once I got out of the Corps, it would have been a question of having to pay for malpractice insurance about the same amount of money that we had generated from all of our prenatal care, labor deliveries, postpartum care and newborn care. In the last year that we did OB, we averaged $200 per prenatal care delivery, postpartum, and neonatal care combined.

Mullan: That would be set against what, like 800 or 900 in the commercial market or more? A lot more than that.

Firestone: Maybe about 900 or 1,000 in a commercial market in those days, I guess now probably about 1,700 or so.

Mullan: Where did you go to do the deliveries?

Firestone: I was doing deliveries at Heights General Hospital, which was the osteopathic hospital. The reason I did that was that they did not have a specific requirement as far as postgraduate OB training. The other hospitals had a rule, they wanted six months of postgraduate OB training, and I had four months, plus all of the deliveries I did during the residency, so that I never really looked into try and get privileges at Presbyterian or St. Joseph. So I just did my deliveries at Heights, but did most of my medical hospitalizations at St. Joseph's Hospital and Presbyterian Hospital.

Mullan: Did you have patients in the hospital most of the time, or do you?

Firestone: In the early days we might have somebody in the hospital one week out of three or four. Now it's more like there will be two or three days a month when we don't have somebody in the hospital, and our hospital census probably averages about three patients in at any one time.

The closest hospital when I came was eighteen miles, and that was either main St. Joe's, or main Pres. Then Heights General moved to Montgomery, so that was fifteen miles, and then Presbyterian opened the Presbyterian North Side Hospital about ten miles from here, which was open for about five years, reached a point where we were seeing a fair number of patients, and then they closed it down. It sort of corresponded to the time when DRGs and respective payments were coming in, and the numbers of patients in the hospital dropped, and so the powers-that-be withdrew their support from the outlying hospitals.

Mullan: Tell me about the growth of the practice, the relationship with the Corps, and give me a history through the eighties.

Firestone: Well, after the first two years with the nurse practitioner, then we got a Corps-provided physician's assistant. Ken Pickard was with me for five years, four of which were with the Corps, and then the last year, he was private hire.

One of the problems was that right about the time that Ken had completed his civil service with the Corps, and they weren't going to renew him for civil service, that was the same years that the Corps was expecting repayment for the preceding years, the net reimbursable cost for the position. So we found ourselves trying to pay back money for his previous year's salary, my previous year's salary, and pay for his current year's salary, and so at that time we were very rapidly eating into any money which we'd managed to save over the preceding seven years. Ken very wisely, at that point, got a little bit nervous, and when a job came up with the VA [Veterans Administration], he moved to the VA.

At that point, we were probably averaging about twenty-five to thirty patients a day. We went about, I guess, three months or so without another provider, and then got another PA who came down from one of the other outlying clinics in El Rito. He was with me for a year, but that one didn't work out. That's really the only relationship that I've had where I was not real comfortable with the practitioner we had. So by sort of mutual consent, he moved on at the end of that year.

I spent a long time looking for our next PA, and after about five months of being completely solo, found a young woman, May Goldenberg, who had finished at the PA program at Baylor, and we hired her. She actually moved into the community in Bernalillo and stayed with me full-time practice for five years, and then after getting married, and when she was about to have her kid, then she left the practice.

We got a husband and wife team from UNM, each of them worked half time, so one week on, one week off. So we were paying perks for two people, and malpractice for two people, but getting one practitioner, but, in general, that worked out pretty well.

Mullan: They were again PAs, or physicians?

Firestone: No, they were physicians. They were family practice, having completed family practice residency at UNM. That worked out pretty well. They were here for three years, and then they left here and went to Lovelace, down in town.

By the time they left, we were seeing, averaging probably thirty to thirty-five patients a day, and had reached a point where we were generating enough revenue to pay their salaries, but still were requiring some money from the state, which we got as a grant. [Tape recorder turned off.]

Mullan: We'll take a diversion and talk about school systems and kids.

Firestone: One of the things moving into a rural area is that you always worry about what's the school system like, because

you've got kids that you would ideally like to see go on in academics and be able to do graduate school if they want to, and have the same kinds of learning experiences that you've had. In a rural community, you can get really good schools or you can get really bad schools. Bernalillo just happens to have a school system which in the grade schools is not too bad, but in the middle schools and high school, the academics are really not very good. There's a tremendous amount of pressure not to perform, not to do work, and even the kids who are good students then have problems when they get to college, to where the valedictorian of one of the Bernalillo classes, maybe about six years ago or eight years ago, went down to UNM and had to take remedial math and remedial English. That was a pretty scary prospect.

Having gone to a private school, I felt pretty strongly that I wanted the kids to go to public schools, because I thought it was really appropriate and good experience to learn to deal with lots of different types of kids and still manage to go ahead and learn how to do the work that needs to be done. My wife felt very strongly that it was not a good idea, and so our kids went through public school up until through fifth grade in the local school, and then went into Albuquerque to a private school from sixth grade on. That's worked out pretty well. It means a lot of commuting, but they've gotten good educations.

Mullan: Fortunately, you're close enough you can do it.

Firestone: Yes. That's a funny thing about Bernalillo as far as how it functions as a rural community. In some ways its very rural as far as the population mix and the types of things that I

see in the practice, and a lot of the attitudes of patients. On the other hand, it's very close to Albuquerque, it's a local phone call as far as talking to consultants, and it's fifteen minutes for patients to get down from the office down to get X-rays done or to go down to the hospital or to go see a consultant, twenty minutes down to the hospital, so that it's got a lot of the benefits of being in a city, but a lot of the benefits of being in a rural area also. It's an ideal situation.

Mullan: We were talking about the financial basis of the clinic, and you talked about the variety of people you had work with you. The Corps for a number of years supported you and then began to make payback requirements, I gather?

Firestone: Yes.

Mullan: At some point the state began to provide some kind of support?

Firestone: Well, the state grants came out at about the same time that I got out of the Corps. After I'd been here for eleven years, the National Health Service Corps suddenly realized that they had been supporting me in the same clinic for eleven years, and gave me a "move or get out" ultimatum. Actually, about five years before that, as there began to be some reductions in force in the Corps, I began to look at the reenlistment bonus, and one of the things about the reenlistment bonus was that if they said, "Move," you moved, or you lost a lot of lump sum benefits and lump sum leave time, accrued leave time, things like that.

So I talked to Herman Martinez, who was the regional project officer, something like that, for New Mexico, and said, "What are the chances that they're going to move me?"

"Oh, no, no problem. Don't worry about it. You go ahead and take the bonus."

Well, I decided not to, and about three days later Herman called and said, "Hey, Al, we're going to move you to Colfax, Louisiana."

I said, "No. No, you're not. I didn't take the bonus." So they basically left me alone. But at eleven years they decided that they'd give me a move or get out ultimatum.

I asked the people in the Corps, "Well, if I leave, who are you going to replace me with?"

That was at a time when the numbers of people in the National Health Service Corps had dropped down, the scholarships had dropped way down, and basically they said, "Well, there's nobody in the pipeline."

So with seeing 7,000 or 8,000 patient visits a year, providing medical care for 10,000, 15,000 people in the area around Bernalillo, they basically said that I had to move and they weren't going to replace me with anyone. So at that point I went ahead and resigned from the Corps and just went into practice in the same office, working with the same community board, but as private hire, and that's worked out real well. I have not had any problems with that at all.

Mullan: Were they and were the clinic revenues able to maintain your salary at the same level or improve it?

Firestone: Well, I don't know. I've taken about a 20 or 30 percent pay cut when I quit taking a bonus, and then when I switched over to private hire, I think the salary was probably pretty comparable, but a lot of the salary was taxable, whereas before it had not been. But what helped us was that right at the time when I was getting out, the state began offering some rural primary care grant money, which basically allowed us, with the revenues that we were generating, it made up the difference between what we were generating and what we absolutely needed. Those grants have grown over the years.

Mullan: As you went through these various stages, you were obviously taking personal income hits, and yet choosing, at some personal sacrifice, to stay. What motivated you? What was your view of what you were doing and where you were headed?

Firestone: It wasn't anything really altruistic or anything, it was just the fact that I really enjoyed what I was doing and felt like I could survive on less income. So I felt as long as I wasn't hurting my children, hurting my family, and as long as I could go ahead and continue doing what I enjoyed doing, then I didn't care too much about what the money was. It was still more than what anybody else in town was making doing farming or ranching, or working for the city, or working for the small machine parts manufacturer in town. I always felt guilty about the money that I made. I guess I still do. I sure feel guilty about the amount that you have to charge to go ahead and provide medical care.

Mullan: What did happen and has happened over the years on the charge side of your practice, and how do you handle folks with no money?

Firestone: Over the years, the charges have risen from probably an average charge of $10 to $15 for an office visit up to an average charge per patient encounter around $45, by the time you work in everything like lab and EKG and suturing, or taking off warts and moles and things. I think our average charge for patient encounter is around $45.

We've always used a sliding-fee scale discounts that were set up when we first got here. So basically, someone with an income that's below 200 percent of the poverty level qualifies for some form of sliding-fee discount. There is a minimum charge that we do, which I think is about $10 per office visit. In theory, they're supposed to pay for that at the time of the office visit.

[Begin Tape 1, Side 2]

Mullan: On side two, continued.

Firestone: There is basically always a little bit of tension between the providers and the front desk staff, with the front desk staff trying to collect money, and the providers trying to provide care without any charges. I think that probably sounds familiar. So that our goal is that if somebody comes in and needs to be seen, our intention is to go ahead and see them.

Every once in a while, somebody will have trouble fighting their way through the front door, but not very often.

Mullan: You have, I presume, Medicare, Medicaid, and some private insured patients?

Firestone: Medicare, Medicaid, make up probably 30 percent of the practice, about 30 percent is now HMOs, and the other 40 percent is made up of a combination of a few private insurance plans, and a lot of what my friend Bob Lynn refers to as "Arrangements of Omaha." And probably about half of that 40 percent group is on sliding-fee scale.

Mullan: It sounds like you have a fair number of patients that have an insurance engine to provide some kind of support.

Firestone: It's a lot better now than it was in the early eighties. In the early eighties, we had our 30 percent that was Medicare and Medicaid, and not very much beyond that. There were a lot of people with no insurance and no money in the early eighties. Things have gotten significantly better, and now probably about 75 percent of the patients that we see have got some source of revenue, whether it be private pay or one of the HMOs or Medicare or Medicaid, but there's still always 15 to 20 percent that really have some trouble in terms of buying medical care. I don't think that that's going to go away. New Mexico has, I think, traditionally been sitting about 20 to 25 percent uninsured.

Mullan: The highest in the country in general.

Firestone: Yes. Yes.

Mullan: And Bernalillo must reflect that, I would guess.

Firestone: Yes, Bernalillo tends to be probably even higher than that sometimes. Frequently they're the people that need the health care the most. Someone who comes in with--well, a recent one was a thirty-year-old who had just moved up here from Mexico, I guess her husband was working at the dairy, and she's got an advanced breast cancer with matted positive nodes. So she has no insurance and doesn't qualify for Medicaid or Medicare. So then that becomes a problem with beginning to work out with a surgeon, with an oncologist, and with a hospital to try and arrange for her to get the care that she needs. I will admit that there are roadblocks to getting things done, but I've never had patients refused by doctors and rarely by hospitals.

Mullan: Is that right? When you call up and broker it for them?

Firestone: When I call up and run interference, we can usually get things done. With this young woman, we got a surgeon and got an oncologist, and oncology is terrible because of the expense of the medications, but the oncologist has got a deal with the drug companies for just this kind of patient, where they can go ahead and get free medications. But it's difficult and it puts a stress on the system, because it used to be that revenues for insured people were enough that they allowed for the free care.

Now with repayments from Medicare, repayments from Medicaid, repayments from insurances and HMOs being much tighter, it--

Mullan: You can't cost-shift like they used to.

Firestone: Yes, you don't have enough room to cost-shift. So it does take a commitment on the part of the people that you're referring to.

Mullan: Let's talk a little bit about primary care as a concept. You've been a practitioner of primary care over a long and changing period.

Firestone: A long and checkered career.

Mullan: But a period that classically is described as the sort of formation of the primary care concept, when you first took your residency, and family medicine was a new contribution of that, and people began to talk about primary care. Then a period of a sort of slide through the eighties where primary care was of not great prestige or pay, and now a period in the nineties where primary care is occupying a more central place in the system, with a varied reputation ranging from "the wave of the future" towards "the terrible gatekeeper that stands between me and what I want." So I'm interested in your observations as a front-line purveyor of generalist services, what you've seen over that time, what you've experienced.

Firestone: I think one of the interesting things is when you start looking at some of the figures that get generated by the HMOs as far as family practitioners as gatekeepers. Assuming that all of us have been honest in terms of not altering how we deal with patients and how we do referrals, when we refer, then probably the family practitioners provide one of the most cost effective and effective styles of medical practice.

We consistently, when we look at numbers, tend not to refer very much, and tend to do as much as possible on site. I think that the care our patients get by being less fragmented can be, in a lot of respects, a lot better than what they get by going to seven or eight different styles of specialists. I think that a patient who presents to a family practitioner, or just to a generalist, for a headache is far more likely to get a discussion of what stressors are going on in their life, far less likely to get an MRI or a CT scan the first time they come in complaining of headache. I think that maybe the specialists feel like they need to because if they don't and something does come up, then they feel like they'd be too liable for malpractice.

Mullan: But you don't feel that?

Firestone: No. I think that's part of having a relationship with somebody over a fifteen-, twenty-year period. When somebody comes in with headaches and you know the stressors that are in their life, you know how they've responded to previous stresses, you know how their mother and their sister respond to stress in their life, and it all fits a pattern, you're far less likely to go ahead and go chasing zebras.

On the other hand, if you see someone absolutely isolated, and they come in and tell you they're having the worst headache they've ever had in their life, your first response is to go ahead and get a CT scan or an MRI.

A recent patient described her chest pain as being ten out of ten, and promptly got admitted to the ICU for rule out MI by the emergency room physician. When I got down there and talked to her, I knew that if she stubs her toe, that's ten out of ten, and an hour later it would be a seven out of ten, and I also, in poking around at her chest wall, found that her pectoralis muscles were exquisitely tender and she said, "Yes, that's the pain I was having." So if she had not presented at the emergency with it, she would have been seen in an office, given something appropriate for the muscle pain and sent home. As it is, she wound up with a $2,000 hospital bill.

Mullan: So you think there is something to be said for the continuity of relationship that a primary care physician can provide. Because there are those in the interview I just did who felt that's greatly overrated, that the ability to know families is rarely helpful, and most diseases, most morbidities are unique, the term was silo, it was a silo disease, and you could treat it like a single silo, unrelated, not completely related to other family members or other episodes of disease.

Firestone: I think that people's response to illness tends to be fairly stereotypical or maybe idiosyncratic, so that one person is going to respond to a cold and sinus congestion with one set of complaints, and somebody else is going to ignore them

completely. I think that by knowing somebody longitudinally over a period of many years, you get a better sense for what they're like. You can, maybe even starting at age three or four months, begin to get a feel for how somebody responds to their environment, and twenty years later when they come in for a problem, their response to that problem is still going to be based on everything that's happened since birth. If you've watched that, then you've got a much better sense of how to handle it.

Sure, if somebody comes in and says, "I've been having some pain in my chest, I've smoked for twenty years, and gee, my eye's drooping," without any other knowledge of the patient, you can begin to start thinking about a Pancoast tumor. But most of medicine doesn't work that way. Most of medicine is the usual set of illnesses that you see on a day-to-day basis and how that person responds to them--back pain, headaches, viral respiratory infections. The other side of that is somebody who comes in and is complaining of swelling, and you look at them, they're swelling a little bit, their pressure's up some, and you know that they have three siblings, all of whom have lupus, it tends to help you make a diagnosis easier. So that knowing what's in the community, knowing what's in the family, does make a big difference.

I think that we, as primary care providers, frequently have a special relationship with our patients that does not exist with the broken-up specialty-oriented care. So if someone gets a stomachache and they go to the gastroenterologist who sees them for that stomachache and never sees them again, after having scoped them from both ends, and then three months later they have

headache, or they have hot flashes, or they have chest pain, and they wind up seeing a different specialist, I don't think that you can provide good care to that person with care that fragmented. There's definitely a need for the specialist, and there's definitely a place for using the specialist, but I don't think that it should be done without the presence of the primary care physicians.

Mullan: What do people in Bernalillo do? Who comes to you? Is it the whole town, or is it certain folks who find by reasons of finance or continuity, you attractive, others zip right down to Albuquerque for their specialists without stopping?

Firestone: I think it tends to be self-selective. I think some people demand and want the specialist care, want to see the neurologist for their headache, want to see the ENT doctor because they've got some allergic rhinitis. Other people are very happy just staying put and coming to us for everything. Some people refuse to go to doctors in town. I think that, fortunately for us, it's not everybody in town who comes here, so that we're not overwhelmed. I think that it allows for different styles. People ask for different styles. They may go into Albuquerque to go see another generalist. They may want to go into Albuquerque to see a doctor who's going to go ahead and give the penicillin for their cold and Valium for their nervousness. So those patients will self-select also.

Mullan: How about the problem that many have cited about the field of generalism, that with the advance of medical knowledge,

one person can't be expected to be competent across the spectrum? How do you experience that?

Firestone: I think you can be competent across the spectrum. I think you can have a tremendous breadth of knowledge, and when someone comes in with a problem that doesn't make sense to you, you just need to know when to go ahead and call and ask, and which questions to ask, but I think that you can't know everything about everything, but you can know a lot about a huge amount, a huge variety of medicine. Then just don't hesitate to hit the books, and don't hesitate to get on the phone to call. If you remember you read something, I think I remember I read something about, oh, gee, somebody with back pain may--there's something in my mind about retro-peritoneal fibrosis. Well, you can't know everything about it, but if you know that something exists, you can then make a call to the specialist and pick his brain about it.

Mullan: Have you found that it's become more difficult over the years as knowledge has changed and grown?

Firestone: No. No. I think that there's still a tremendous amount which is dependent upon someone's judgment as far as, is this patient sick, is this patient not sick. If they're sick, is it something typical, or does this not sort of fit with what you've seen in the last twenty years? I think that somebody fresh out of residency going into practice in an isolated area, I think that they're very insecure, and I think that's a real problem, because you don't have the depth of knowledge.

I think the ideal situation is when someone who's a recent graduate from a primary care program goes out into practice with somebody who's got a lot of experience. You then have a balance between the new information and the judgment. I think that a period of apprenticeship is a good idea, and works out very well. I think it's hard to go out like I did into a relative vacuum, and I think that you have to be able to accept a certain amount of insecurity and be able to accept dealing with a lot of grey areas in terms of what you're seeing and what you do. You need to be able to yell for help, really.

Mullan: Have you been able to mentor others, either as students or residents or docs in practice? Has that been part of what you've done?

Firestone: I'm glad you asked that. When I first got out here in '76, I started precepting in the residency program, going down and spending Thursday afternoons at the university in the clinic. I did that for about two years, and then began getting medical students in their fourth year out with me in Bernalillo. Then a couple of years later when UNM started their primary care curriculum, I started getting first-year medical students in primary care who would spend four months with me. I've also had some National Health Service Corps Scholarship students come out in between third and fourth year and spend two months in the summer. That was a great program. I'm still extremely close to several of the students who came out here during that time.

But I've had probably three to five students a year plus teaching what was the introduction to the patient, and is now

clinical skills block, at UNM. So I've had contact with probably 15 percent of the medical students who graduated here in the last twenty years. That's great, because it provides a stimulus to you to continue studying, because you constantly have a student going, "Why do you do that?" If you can't justify it to yourself, how do you expect to be able to justify it to a student? So that's helped a lot. I think it's made me feel far less isolated.

Mullan: Any of them want to come back and go into practice with you?

Firestone: Actually, several of them. Unfortunately, a lot just seem to be just out of step as far as when I have somebody that I need. This has happened a couple of times. Most recently, Joe Pope just finished his residency about two years ago, and about a year after my other partners had left and Carmen Rodriguez had started working with me. So Joe's up in Farmington now. But Joe Pope, Karen McCarney Brown [phonetic], I've got two students right now who are graduating this year, one of whom I think would love to come out and practice in Bernalillo. So it's always been fun, but timing is everything on that.

Mullan: With coverage of rural health and rural primary care being so problematic nationally, and with programs like the National Health Service Corps indicating that at best they provide temporary solutions, or at least individual position is only a temporary solution, to what do you attribute your

monumental contribution to this community and your ability to stay on?

Firestone: I think it takes somebody who's flexible, whose goals can be adapted to the community. I think that if you go into a community with a set of ideas about what you want to do, how you want the practice to run, and how you would like to go ahead and raise the community up to your standards, it won't work. If you can go into a community and see how you fit in, and sort of settle into a niche that exists in the community, and are willing to adapt yourself to the needs of the community, I think things work.

Mullan: What in the values or the makeup of Al Firestone has enabled you to stay here this long?

Firestone: I think the biggest thing is my own curiosity and my own enjoyment of dealing with the problems and the people that I find here. The thing that's allowed me to stay here is the fact that I really enjoy it. I really enjoy the people, I really enjoy the intellectual challenge, and I found things to do here that make me happy. I've got people in the community that I play music with. I've got people in the community I play soccer with. I've got easy access to Albuquerque, which gives me a little bit more--

Mullan: I think that must be a help.

Firestone: I think it helps a lot.

Mullan: Because if you take the same community and put it 100 miles from Albuquerque, without the ability to have your kids in school or your wife working there--

Firestone: I think it puts stress on it, and I think that would be a real test as far as how adaptable am I really. I think it would probably work for me, just based on my knowledge of how I am.

We haven't talked about the whole question of rural practice and the spouse, and that's always a real issue. Either someone who's not married goes into a community, or someone who's married and whose wife doesn't really fit in, or doesn't want to fit in, or has different values, that can be a real problem. I remember when you were chief medical officer for the Corps back in Les Fishbein's era, we had a meeting in San Antonio. I think it was Les and Larry Lyons (both well over six feet) and I went to the Spurs game or something. I really felt dwarfed. But there was a woman who was in one of the border towns down along the Rio Grande. The clinic hadn't opened up yet. She'd been down there three months, they still weren't seeing patients, because they didn't have a facility set up yet. She was probably the only unmarried female over the age of about eighteen in the entire town, and she was one of the most depressed people I've ever seen in my life. She felt totally isolated.

Mullan: So the family ability to adjust to it makes a big difference.

Firestone: I think they have to be able to adapt.

Mullan: At the risk of leading, let me try an idea on you. What about sixties' values?

Firestone: Yes, I think that helped. I think that we came out of the sixties and I graduated from Oberlin with a feeling that we could really change the world and make the world a better place, and that things that were of value in life were not making lots of money, and not having the sharpest car and the nicest clothes, but rather trying to make the world a better place. I think our expectations of what things in life would make us feel gratified may have been a little bit different. I think that maybe that's where the altruism is.

When I say that being here and doing this makes me happy, it may be that part of that is because the things that make me happy are not having a Porsche and not having the fanciest house, and not having a six-figure income, but rather doing the kinds of things that are intellectually gratifying and doing something that makes me feel socially useful. Because those things make me happy, it makes it more likely that I would fit in doing this.

So, yes, sixties values probably do come into it a lot. I don't think that any of these things are done consciously. I don't think that I sat down and said, "I really want to do some good for the world, and I think that the best thing I could do would be to go into a small community that hasn't had a physician staying there for many years." I don't think it works on that level.

Mullan: What about your reflections on the National Health Service Corps?

Firestone: I'm really grateful the National Health Service Corps for the time that it did support me, because it allowed me to go ahead and get settled in and practice in an area that I might not otherwise have looked at, and really provided the financial support that was necessary for us to go ahead and stay functioning during those early years. I think that the theory of the Corps was wonderful. I think that the goal in our years was to go ahead and get somebody who would fit in and stay forever. I'm one of the examples of people who did that. But I think that there was a lesser goal, which was to get doctors into an area that were underserved, and even if they only stayed for two years, at least that was providing service that would not otherwise have been provided. I think that it's certainly not the ideal outcome from the Corps placement, but it was certainly one that was necessary.

Mullan: And better than nothing.

Firestone: I think that what you do is you try several docs until you finally get one who fits, and there are some places that you're never going to get somebody who wants to stay, like Lordsburg, NM, and Lordsburg continues to be a problem. On the other hand, there are a lot of communities that are isolated where there is someone out there who worked it in. I think the Corps provided a means for a lot of them to get to those sites. So I think the Corps was a great idea, and I'll be forever grateful for the time that I spent in the Corps.

Mullan: A question on the nurse practitioner or physician's assistant. You had the opportunity to work with several of both. I guess two areas of questions. One, what is the optimal relationship between the primary care physician and the non-physician provider, and, secondly, are there differences between NPs and PAs?

Firestone: My gut reaction is, yes, there are. I think that my experience with the PAs has been that because of their background, they tend to have a little bit more physician-like qualities, in terms of the things that they're interested in and in terms of how they approach problems.

Mullan: How would you characterize physician-like qualities?

Firestone: Oh, it's going to be hard to put into words. I've gotten into trouble trying to do this before, too. Let me sort of skip the other way and talk about the nurse practitioners. Nurse practitioners that I've worked with, the two nurse practitioners, had both had extensive time as a nurse before they went into nurse practitioner school. They seemed to be a little bit less self-reliant and more tentative, to lean more heavily on the physician. As far as clinical skills, I think they're very comparable. I think the nurse practitioners have got a lot of experience as far as patient care, patient education, and direct patient-handling skills that are real important, and we definitely tend to utilize those when we're working with the nurse practitioners.

I think the PAs maybe have less of those skills as far as how to go ahead and get patients to do their own care, how to teach them to do the dressing changes, how to teach them about general care issues. Maybe that's why I say physician-like, in the sense of it's more on an intellectual level rather than getting down and dealing with, "This is how you do the dressing change, and this is how you do the breast self-exam." So I think probably what I'm saying is the nurse practitioners are probably better on patient education skills.

The PAs, and again the ones that I've worked with have been post-baccalaureate students who've then gone back and done the PA school, they tend to approach problems more in the way that medical students in their late years of training or residents would. Then once one of the mid-levels been in the practice for two or three years, they basically just fit in and they are essentially a partner, and the difference at that point may be in terms of depth of knowledge, but that's about it. The mid-levels in the practice always function much more as a partner than as an employee or as someone in a subordinate role.

Mullan: Is that the way you function? That is, your NP or PA sees patients independently?

Firestone: Yes. If they've got questions, they'll go ahead and grab me and we'll go over the question, go over the physical findings, talk about management, review cases at the end of the day, much of the same way I would do with just one of the other docs or a medical student in the practice.

Mullan: What about their scope of practice? Do you assign certain patients to the mid-levels knowing that the level of care is going to be more appropriate?

Firestone: Probably not. Probably not. To a certain extent, patients, when they call make an appointment, they may specifically request one or the other providers. Some may want to see the nurse practitioner, and some may want to see my partner, Carmen Rodriguez, and some may want to see me. I think a lot of that winds up being which style of practice they're comfortable with.

Mullan: Do you see pretty good acceptance, or do you see examples where there's non-acceptance of mid-levels?

Firestone: I see examples, but they're fairly rare. Most people are pretty comfortable seeing mid-levels.

Mullan: What about the tussle that goes on politically both in Washington and probably in Santa Fe about formal legal scopes of practice and levels of independence and supervision? I mean, are there tensions that you experience in the workplace, or is that largely posturing at a distance?

Firestone: I think it's mostly posturing at a distance. Most of the mid-levels I've worked with would probably not feel real comfortable in a completely independent practice. I think that they would like to have somebody to bounce ideas off of when they have someone that they feel uncomfortable with. I guess I'm not

uncomfortable with having a PA practicing up at Haven Springs [phonetic] and being in touch once a week, or having direct supervision once a week, but being on the phone whenever necessary. I don't have a problem with that. I think completely independent practice without being able to touch bases, without feeling completely at ease about touching bases with questions and problems, I'm not comfortable with that, because I think that the experience and the depth of the training is not enough to throw somebody out in the world and not have them in at least a reasonable proximity to a supervising physician. That's just too much.

Mullan: As you've seen the system change over the last four or five years, with a strong emphasis on a competitive market and managed care, what has that meant for you in your practice?

Firestone: Fortunately, it hasn't affected us too much. We've been having to deal with the HMOs for about, I guess, eight or ten years now, and a lot of the paperwork involved has been a real nuisance. I think primary care has been given more and more of a controlling interest in this, at least as far as lip service. What it really means is that we get to do much more of the paperwork involved in getting patients seen. The increase in paperwork over twenty years has been unbelievable. I get probably twenty or thirty bits of mail a day that require a signature or written justification for why I want a patient to get oxygen, or why should this patient have a wheelchair and a walker, and can you justify this, or the school nurse wants us to okay a swallowing study for somebody.

So we as primary care docs, I don't think our role has changed in terms of being gatekeepers, I think we've always wound up being gatekeepers, but now there's just so much paperwork involved in doing it that it becomes really burdensome. So you get paid essentially the same, or on a percentage basis maybe a little bit less than what we used to be, because you get paid 85 percent of what your usual fee was. But then on top of that, they say, "Okay, but here, do this additional hour's worth of paperwork, too." It's difficult.

I think that as reimbursement stuff changes and doctors try and crank through more patients, it may mean that they refer out at a little bit earlier stage to some of the specialists, rather than taking additional time to go ahead and work through the problem themselves, and that's a problem. I think that if we allow that to happen, then what some people are saying as far as primary docs being glorified mid-levels, may eventually become true, because you're no long hospitalizing and you're no longer working up complex problems by yourself, then in referring out very, very early, then it may be true, you may be functioning as a mid-level. I don't think it necessarily needs to be that way.

I think that as primary care providers give up more of the complicated problems and become less involved with the inpatient care of their patients, I think they begin to lose a lot of the skills that they had, as far as the medical skills. I think that they then rely much more on the people skills that they have and that they're strongest with. I wouldn't like to see that happen.

I think that a mixture of both the humanitarian side of medicine, being able to run interference for patients and their families, with the specialists, I think it is extremely

important. I think it's important to be able to sit down with families and be able to work through when is enough enough, when is it appropriate to call it quits, when is it appropriate to go ahead and have the patient stay at home. You can have patients stay at home with cardiogenic shock, because they didn't want to go in the hospital, and they didn't want to go ahead and be resuscitated, and if you're not going to be resuscitated, why go to the hospital?

I had a little old lady with bad COPD and angina stay at home with a heart attack, when her blood pressure was sixty over forty. So they sort of gathered everybody together and they said goodbye, and the following morning her pressure was 120 over 80, and her urine output was kicking up again. So I think that if you immediately react on a reflex level every time something is the least bit complicated and refer it, I think that you do a disservice both to patients and family.

Mullan: Tell me a word about the future. Do you have any sense of what the practice of primary care rural medicine will be like twenty years from now? Will Al Firestone still be in Bernalillo, or will Al Firestone, Jr., be here?

Firestone: Well, I think that in the same way that things have changed a tremendous amount in the last twenty years, I think they're going to change even more. I think that we're beginning to see a little bit of it in terms of telemedicine with high-resolution cameras and being able to essentially go over patients with someone who's 3,000 miles a way. The military is doing some of this now, having telemedicine from a general medical officer

on an isolated ship being able to communicate with someone at the medical center.

Mullan: Are there going to be independent physician practitioners or will it all be done by large groups?

Firestone: That's a real question, and I think part of the thing is again, it gets back to almost the same reason for why I wound up in the National Health Service Corps in Bernalillo, as opposed to just going into practice for myself in Bernalillo, and that is that it takes so much money to get started in practice, that a lot of people feel that they need to go ahead and go out as an employee, as a physician employee. That seems to be the future of certainly primary care medical practice in the cities is that very few people are going to go out into independent practice, and most will want to go ahead and sign on and be an employee, because the pay is going to be better initially, it'll help them pay off some of their student loans, but it will make for less independence.

As far as what will happen in the rural areas, I think the rural areas are still going to have the same sorts of problems getting physicians to come out that they always had, in that training occurs in a tertiary care center and so that people are very uneasy about going out and practicing medicine when they don't have the equipment and the lab and the inpatient hospital stuff that they did when they were in training.

Mullan: More mid-levels, less mid-levels, will the mid-levels capture the field?

Firestone: I don't think they'll ever completely capture the field, but I think that there'll be a lot more of them out in the rural areas. That's always been the goal. Unfortunately, many of the mid-levels get sucked up by the big practices in the cities, too, because the pay's better, the hours are better, there's less responsibility.

Mullan: Any parting thoughts?

Firestone: I think that there's always going to be a place for docs to go into rural areas. I think that there's a huge need for docs in the rural areas, and I think it's tremendously gratifying. I think that there's not much you can do with your life that can be as interesting and as continually challenging and as gratifying as practicing medicine in a rural area.

Mullan: Good. A good place to stop.

[End of interview]

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