HOLLY GERLAUGH

July 12, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: What is your date of birth?

Gerlaugh: 7/04/53.

Mullan: We're in the offices of the Maine Dartmouth Family Practice Residency Program, in Augusta, Maine. We're sitting actually in the office of Dan Onion [phonetic], who is the director of that program, who is on sabbatical currently in Oxford, Cambridge? England, somewhere.

Gerlaugh: In England.

Mullan: I'm with Holly Gerlaugh. It's the morning of the twelfth of July, 1996. It's partly cloudy and comfortably warm in the summer in Maine.

Miss Gerlaugh, tell me a bit about your background. I'd like to start with where you grew up, and how you got interested in life and the health sciences.

Gerlaugh: I spent the first eight years of my life in Ohio, outside Cincinnati, with my parents and my brother and sister. Then we moved to Florida with the Apollo Project. My father was

an engineer, and so we lived down there until the program stopped, when I was seventeen.

I first became interested in health in elementary school, actually. I was reading about Albert Schweitzer, and he became my idol. I wanted to go to a Third World country and be a doctor.

Mullan: And how did that develop? Tell me more. Were you interested in science?

Gerlaugh: Biology, probably. I was always interested in the living sciences and in people. I enjoyed working with people. So the combination of those two things.

Mullan: Was it a sense of humanism, or was there a religious side to it? If you can characterize what stimulated you back then, what was it?

Gerlaugh: It was probably the humanism. My mother was a dietician, but they were both very active in the church. It was the church that encouraged people to see the importance of being the best possible human being you could in your community, and caring about people in your community, and that got transmitted through my parents and through the church.

Mullan: What denomination?

Gerlaugh: It was a Unitarian Church. I got interested in the medical aspect of it, I think mostly through the readings that I did of people who were medical missionaries, and about the caring that they had for providing services for people who normally could not get those kinds of services. I did a fair amount of volunteer work in elementary through junior high, working with kids. The early Headstart, at that time I volunteered, it was a school right behind our house. I volunteered there for a while, did volunteer work mostly with children, working with different-age children, either through Girl Scouts and camping, or through Headstart and teaching, doing tutoring.

Mullan: So you were a Girl Scout?

Gerlaugh: Yes.

Mullan: This was in Florida?

Gerlaugh: Florida.

Mullan: And this was, I presume, interracially through either black kids or mixed?

Gerlaugh: Yes, it was mixed. Florida was very segregated in some ways. The blacks lived in one area, and the whites lived in another area, but the schools were already integrated. There

wasn't segregation in schools. There wasn't segregation in those kinds of areas.

Mullan: This was an area that was heavily impacted by the presence of federal programs, or not? This was Satellite Beach or one of those communities?

Gerlaugh: I don't remember a federal--

Mullan: I was just thinking with the Apollo Project.

Gerlaugh: Yes. This was far enough away from that, that we wouldn't have gotten those kind of funding. This was up in Daytona Beach area.

Mullan: This was just garden-variety Florida?

Gerlaugh: This was just garden-variety Florida, right.

Mullan: So you were there for high school as well, or that's when you moved again?

Gerlaugh: I moved when I was in my junior year. We moved up to Syracuse.

Mullan: And what did you think about, then, as you approached college?

Gerlaugh: That I was going to go into premed and be a doctor.

Mullan: And what did you do?

Gerlaugh: I went to premed.

Mullan: This was at Cornell?

Gerlaugh: This was at Cornell University. I got a bachelor's in arts.

Mullan: What did you major in?

Gerlaugh: In biology. I went there thinking I would be a doctor. During that time I worked, actually in high school and in college, I worked odd jobs, mostly working as an aide in nursing homes, and got a lot more experience in some of what the medical field was about. I worked in a large nursing home outside Syracuse for a couple of summers, and then worked in some smaller private ones that were less well maintained, managed. I had a sense of a range of care there. And did some work in a clinic right in Syracuse, a GYN clinic for the poor people, OB/GYN, as an aide.

Then in my junior year, I decided that it would be helpful to see a family doctor at that point because that's what I wanted to be. I had become a Quaker when I was in college. One of the Quaker men was a family practitioner out in the rural area,

worked at a practice most the time just single practice, and then had just recently got a partner in. So I spent some time that summer with him, to see what his practice was like, and what I thought about it, and was this what I wanted.

Mullan: This would have been early seventies?

Gerlaugh: This would have been 1974, because I graduated in '75. It was in Dresden, New York. He had a very rural practice, mostly farming communities. It was a very strong farming community, and his whole family, (he had children, he had a wife) was involved when they had started their practice out of their home. His wife had done the nurse care and the billing and all that. They saw patients out of their home, in the downstairs. It was one of those typical GP practices. Now he had a new medical building and things were much better, in terms of life, was a little easier for him, he wasn't on-call twenty-four hours a day.

But through that experience, I realized that family practice was really quite demanding, and that I needed to rethink through how much I was willing to devote to my job, my profession, versus the rest of my personal life, which I felt was a very important part, the religious part of my life, spiritual development, community care, (working in the community, doing volunteer work in the community), having my own life of both scholastic, I enjoy sports and family life. So I was concerned about how I was going

to integrate being a good family practitioner in a rural area, and still have a life outside of that.

It seemed harder at that point for a woman. It was one thing for a man to ask his wife and his kids to sort of be all a part of his profession, it's something else for a woman to say to a man, you know, "Help me out with being a practitioner. Cover the family and cover everything while I'm out here doing this." So I thought about making a change at that point. I still applied to medical schools that last year, but I started looking around for some other options. And that's when I found out about the nurse practitioner program, which would take people who had science background, already had a bachelor's in sciences, but would give them a master's in nursing, and give you nurse practitioner skills.

Mullan: This must have been a fairly early generation--

Gerlaugh: It was. We were second class to graduate from that program. Nurse practitioners had only been around for maybe 5 years before that.

Mullan: And that's at Pace University?

Gerlaugh: Yes. Pace University, at that time, had put together a program with New York Medical College to use their facilities, and to train, in a two-year program, family nurse practitioners.

Mullan: The Pace Program that you were in, in particular, was taking people who were not nurses, but had science background?

Gerlaugh: That's right.

Mullan: And preparing them at the master's level to be nurse practitioners.

Gerlaugh: That's right. There were only two other programs, I think, in the country that were doing it. Yale had a program, and out in Michigan, I'm not sure which school, they had a program out there that would do the same thing.

Mullan: And that has remained a fairly atypical model?

Gerlaugh: Yes.

Mullan: There are some around today, to my knowledge, but in general, that's atypical. Most nurse practitioner programs take people who already are registered Baccalaureate nurses and train them, even at master's level, for another couple of years.

Gerlaugh: That's right.

Mullan: Tell me just a word about Pace University. It's in the city itself?

Gerlaugh: It's outside the city. It's in Pleasantville, the home of *Reader's Digest*. It's in a suburban area of West Chester County.

Mullan: Is there not a Pace downtown?

Gerlaugh: There is also a campus downtown. I think their business school might be downtown.

Mullan: Right next to the Brooklyn Bridge, the Williamsburg Bridge.

Gerlaugh: They have campuses, I think, in a couple areas now. They've expanded more.

Mullan: But you were based in Pleasantville?

Gerlaugh: Yes.

Mullan: What a pleasant-- [Laughter]

Gerlaugh: It was very pleasant. We did our internships a lot in New York City. We'd take the trains in, or go in. We did most of our clinical work in the VA Hospitals there and Flower--Fifth Avenue, as far as hospital-type work.

Mullan: And you were under the aegis of New York Medical College for that?

Gerlaugh: Right.

Mullan: What was your class like? How many and who were your colleagues?

Gerlaugh: I can't remember how many there were. I guess there was about twenty of us. We ranged in age quite a bit. As you can imagine, a number of these were people who'd gone back to school after they had families. It was almost all women. They ranged with people who had literature degrees, to people who were like myself, who had a fairly heavy medical science background. But pretty uniformly, they were interested in working with people as opposed to research or anything. They were interested in clinical work.

A lot of us really didn't quite know what a nurse practitioner was, frankly. You get into something, and you don't always know. I suppose it's like getting married, you don't know what you're getting into till you're actually there. I had an idea or idealistic idea of what nurse practitioners might be, but I really didn't know. And frankly, the people that were teaching us didn't know either, because there hadn't been a lot of people out there yet doing this. There had just been a start. The majority of nurse practitioners are trained to go into primary care. So there was a lot of emphasis on family dynamics,

preventative care, patient education, counseling, as well as the medical side of differential diagnosis and medical conditions and that sort of thing.

Mullan: And these qualities of nurse practitioner training were present in your program?

Gerlaugh: Yes.

Mullan: More prevention, primary care, education oriented?

Gerlaugh: Yes.

Mullan: Did you consider physician's assistant training at that time?

Gerlaugh: I hadn't even heard of it. I didn't know it existed until I went to Pace. There was a PA working at Roosevelt Island long-term facility for severely handicapped. There was actually no nurse practitioner role models in a lot of these places, either.

Mullan: Because you were close to the first generations.

Gerlaugh: That's right.

Mullan: At the time, and looking back in retrospect, what would your thoughts be about the nature of your program, not bringing in people who were nurses? How would it have been different, or how is it different, as you reflected on it, from programs that start with nurses and produce nurse practitioners, whereas your program which started with bachelor's, graduates in general, and produce nurse practitioners?

Gerlaugh: It's a good question. I think that what's important is that people have a fairly strong background in health care fields somehow.

Mullan: But you said there were people who were--

Gerlaugh: There are people who, in terms of their educational training, were not at all in the medical science field or health care field, but in terms of experience and jobs, had worked in the heath care. A lot of people were chosen because they'd already worked a year or two years as EMTs or had done nurse's aides stuff.

Mullan: Either they had education, or they had experience in the health care, and, yet, they didn't have indemnity. They didn't have breeding as nurses.

Gerlaugh: Exactly. That is probably the biggest difference, is that until I hit the graduate program, I had never been exposed

to a mentality, I guess, in terms of training and in terms of working, I think at that time nursing had. It was a real shock for me to go from being at Cornell, where you're expected to be the best and the brightest, and you're expected to excel and be an individual, to a place where there was still a sense of hierarchy, of the doctor being the doctor, that nurses would still get up and give a chair to the doctor, because the doctor was there. In the training, as well as in the programs where we were working, we were in that system still where the nurses were to do the doctor's beckoning and the doctor's orders, that we were following doctor's orders.

Of the people who were training us, there was only a few who were actually nurse practitioners. The rest had doctorates in nursing, some of them. They were very well educated, and had had training and experience in different areas, but this whole new role was something that they were still trying to figure out. We were at not only the cutting edge of starting a new role, but we, as students, were also questioning our teachers as far as, "But why should we have this relationship with physicians this way?" We were in the position of giving medical orders. We were beginning to develop our roles as we were learning.

Mullan: I'm unclear as to the precise point you're making. I understand the general point. Are you saying that because this was an early example of a nurse practitioner program, the level of independent thinking that your faculty had was fairly primitive, compared to later years, that being that they either

were nurses with traditional training and traditional attitudes, for better for worse, or they were nurse practitioners who hadn't really experienced the workplace, or hadn't really developed their own sense of independence, so that they were more dependent in their thinking than you as students were?

Gerlaugh: Yes. I think that the model of teaching in nursing schools and for that matter in most pre-college education is structured to follow instructions, memorize information fed to you but not as much to stimulating people to think for themselves and generating ideas, and figuring out things for themselves.

Mullan: And they brought that with them to this curriculum?

Gerlaugh: Right. So here they were teaching people to be independent thinkers, to start to be in the independent role of managing things, and yet they were teaching in a model of hierarchy, memorizing. "You should memorize this, this, and what we say is the way, it is." But also in the clinical field, that when a doctor says this, that you do what he ways, and not going back to begin and say, "Wait a minute, we're independent thinkers here. We could be colleagues in this. We could help each other. We have things to offer, too." And that there's a way of working with doctors as colleagues. And they still didn't have that kind of idea, of the collegial relationship that I think has developed over the years. That was a transition piece, I think, that was hard for me.

They (Pace University Nurse Practitioner Program faculty) viewed diagnosis as either "nursing" or "medical." If the NP (Nurse Practitioner) stayed within the nursing diagnosis, then he/she was within the realm of their nursing license. If the NP used medically based diagnoses, the NP's work required medical supervision or oversight.

Im not sure if this distinction was drawn by them to carve out a new NP profession or perhaps was intended to side step legal/economic issues of NP licensing. But for myself, this distinction as confusing.

So, to arrive at a diagnosis and treatment plan, we were asked (on the one hand) to use decision making skills with all the complexity inherent in a differential diagnosis but on the other hand, to work by protocol dictated by our supervising physician.

Once we worked in the "real world" especially in family/primary care, those earlier protocols weren't relevant. Also even if a supervising physician wanted to develop the volumes of protocols necessary to cover all the potential diagnoses in the NP's everyday work, protocols take the art, the finess, and the intuition out of medicine and leave a dry, potentially poor substitute.

Mullan: Back to my original question, and apologies for posing on this, because I think your experience is so rich, having been in a number of different aspects of the interface between physicians and nurses and committees, so my question, again, is

for a group coming in who are non-nurses, you spoke personally that this kind of hierarchical thinking was new and somewhat unpleasant to you, or inclement to you. If you and others had been coming out of a nursing background and been through nursing school, is your point that that probably would have been less eye-opening or less of note to you?

Gerlaugh: I think so. The way that the faculty, at that time, characterized the two classes that had gone through, the class before us and our class, was that we were extremely rebellious students. They perceived us as rebellious, compared to what they'd been used to when they'd been teaching bachelor students. This was the first time they'd been teaching, I think, graduate-level students. Because we were constantly questioning, if we wanted to learn more about something, we'd say, "We need more information here. We want more of this, we want more of that," and were asking a lot, really. There was something different about what we were doing. We weren't settling. We really weren't settling for certain levels. We'd say, "No, this is not what we need to know." If somebody started teaching an area, we'd say, "We don't need to know this part. We really need to know this area." And there wasn't a lot of flexibility there to listen to that, which I think it needed, because this was a new program in a new area. I think it needed to be fairly flexible as it developed its program.

Mullan: As you approached the end of your training, what did you have in mind? What did you foresee doing?

Gerlaugh: I wanted to work in a health center. I started looking for jobs in a health center. I figured that I eventually wanted work in a more rural area, but I knew initially that the only place to find jobs, I needed to have on-the-job training, because the internship that they provide was only a three-month actual internship. I knew that I was going to be spending the next couple of years learning more. So I wanted to be in a place where there was people who had been in practice for a while, and people in a setting where I was going to get a fair amount of feedback.

So I looked at big-city health centers, and I ended up in Rochester. I applied mostly in upstate New York area, ended up in Rochester, which seemed to fulfill that. It had other nurse practitioners who'd been there for a while, and it had a fairly good system of providing care, in terms of integrated with social workers, with outreach workers. The only thing that was a problem was that I had to decide whether I was going to go into pediatrics or internal medicine, because they didn't have family nurse practitioners, so I ended up working with internal medicine.

Mullan: This was based not on your training, but on your preferences, and then you were slotted into that part of the health center?

Gerlaugh: I think it was because at that time, that was what the opening was in. It was in the internal medicine side, and so that's what I applied for.

Mullan: This was the Anthony L. Jordan Health Center?

Gerlaugh: Right.

Mullan: What sort of center was it? What sort of community? What was the job like?

Gerlaugh: The Center was built in the late sixties. It was right smack in the middle of the so-called inner city. It was actually slightly outside the inner city. But it was in the middle of a ghetto, what you call a ghetto. It was a housing project area that had been built. It had been set up, when somebody had looked at why are we getting hundreds of people coming to the ERs for sniffles and earaches and urinary tract infections, and they looked at where these people were coming from, and a huge number were coming from this one section, a poor section in these projects. It turned out there was no doctors, no health care at all in those areas, and so people had nowhere to go. So they decided to set up a health center in the middle of that.

They were also interested in providing jobs, job opportunity for people in that area, because there wasn't a lot of opportunity there. People were mostly unemployed. So the OEO

[Office of Equal Opportunity] got involved. Don't know a lot about how that all mixed, but the OEO funded a large part of this thing. They hired mostly people from the community, and those people were hired to be techs, lab techs; medical assistants; outreach workers, who were like mini social workers, but sort of social worker assistant, if you want to say. They developed teams that would divide up the population so that every team that you're in had one physician, one nurse practitioner, an outreach worker, and then we shared a social worker.

Mullan: This was the halcyon days of the community health center?

Gerlaugh: Oh, it was incredible facility, amazing. It had pediatrics, OB/GYN. It had a psychiatric center. It had dental laboratory, pharmacy. Everything was right there.

Mullan: How did it function?

Gerlaugh: It certainly provided good health care. As you can imagine, a massive health center like that, it has its own growing pains. There were a lot of people to see. It was incredibly busy.

The other piece of the OEO money was to train people very quickly, get everybody with high school educations who was working, get them into training for lab tech or whatever they

were going to be going into. They trained a number of people to become nurses from the community.

Mullan: And how were you seen? Did people know what a nurse practitioner was?

Gerlaugh: There were already nurse practitioners there. It was a part of their model. There were four teams in internal medicine, and each team had a nurse practitioner, that was already there functioning. So when I got there, there was a role model for me, finally.

Mullan: And how did you feel in terms of your own competency?

Gerlaugh: I think the first year was difficult. There was a lot to learn. I started out working very much like a cookbook, in by what we call protocol, almost. I worked very closely with the physician from Pakistan--Farohk-- Foroozosh, his name was--and he worked with me. I worked with a number of the other physicians at times, but he was the main one that I worked with. I also worked with another nurse practitioner who helped me. It was a year of internship training, basically.

I learned the ropes of basic internal medicine from an outpatient point of view. The physician and I would work together, in that he would refer cases of things that were routine, somebody who just needs to come back in for their every-three-month blood pressure check, and I would do the diabetic

teaching for him. I'd see the call-ins, people who were acutely ill, I'd see most of those acutely ill people for him, and then refer them to him. And he saw most of the diagnostic dilemmas oftentimes. I would end up referring people who were out of control back to him.

Over a period, I was there for three and a half years, I developed sort of my own practice, and he had his own practice, but periodically, we would throw them back at each other, as people either got out of control. I would send somebody in with heart failure, maybe, for him to monitor more carefully, or somebody who I was working up and couldn't figure out what was wrong, I'd shift them over to him.

Mullan: And that worked comfortably? He was accepting of that?

Gerlaugh: Yes, he liked that, actually. It worked well for him.

Mullan: How about from the patient perspective?

Gerlaugh: I think it worked very well, because our styles were a little different, but we respected each other's styles.

Mullan: Did people ever say, "I came to see the doctor. Why am I seeing you?"

Gerlaugh: I don't remember getting that. No, I don't remember getting that much.

Mullan: So even back then, the nurse practitioner was fairly readily accepted?

Gerlaugh: Yes.

Mullan: How did you explain yourself, or introduce yourself, at that point? I presume these were people that never heard of or seen a nurse acting as a principal stethoscope-carrying caregiver. Did it require any special explanation or not?

Gerlaugh: I think some of that occurred when people got their appointments. That they were told that there was an opening with the nurse practitioner, or if they weren't going to be seeing the doctor, and they were used to seeing the doctor, and the people were given the choice on whether they wanted to see them or not. So it wasn't something that usually came as a surprise at that point. I have a sense that the office staff tended to field more of those questions if people were unsure about what that meant or had any problem, because I don't remember getting a lot of it. It's hard for me to remember back that far, but occasionally people would ask about my training, what I'd done before.

Mullan: But they were accepting?

Gerlaugh: Yes.

Mullan: How did you like the work? Had you achieved what you had wanted to in terms of your earlier ambitions for health care?

Gerlaugh: I enjoyed the people I worked with, and I enjoyed the patients. It was very satisfying, because you, in some ways, have a chance. People in poorer neighborhoods are pretty sick and usually don't have a lot of access to someone to take them through a system that could be a very difficult system. I think nurse practitioners, particularly, are good at that, and holding people's hands through it, explaining what's going to happen, helping them go through a complicated system when that needs to be done, and also helping them make connections when they need to, to fit into other parts of the systems so that they can access services. I think that we did a good job of that and that people were appreciative of it. I got a lot of satisfaction out of seeing people make changes, get healthier, getting care that I thought was pretty good care that was offered there at the Health Center. We did home visits also, the nurse practitioners. It was a pretty small community in terms of area. We covered a small area, because it was quite densely populated.

Mullan: Ethnically?

Gerlaugh: It was very mixed, more heavily black, but also a large Puerto Rican population. There was some Southeast Asian. I don't remember a lot about that at all. I don't remember that being a large part.

Mullan: Tell me more about certification or credentialing at that point. When you graduated from the nurse practitioner program, did that confer a certificate that said you were a nurse practitioner?

Gerlaugh: They gave us a certificate. The school gave us a certificate, saying that we were family nurse practitioners. At that point there was a national certification process that had just started again. It started the year before we graduated.

Mullan: This was state-based or national?

Gerlaugh: It was national. National certification exams through the same program that developed the registered nurse program.

Mullan: Did you get an RN? Did you have to take the exam?

Gerlaugh: We had to take the nursing boards, and that's conferred through states.

Mullan: The Boards being the RN--

Gerlaugh: RN Boards. We had to become a registered nurse. We took the boards at the end of our two years. Our program had a 100 percent passing. There was a little problem politically at that time because it was a new program. As you can imagine, these are non-RNs taking the RN program who'd only gone through

two years, and there was a little bit of kind of political shuffling at that time. New York State, where I took my boards, there had been some concern about whether they were going to drop the credentialing of Pace as being able to be a school that could send their students for boards, but they had a hard time pushing that too far, because our students were, you know, 100 percent of them were passing this, as compared to other schools. So they didn't have a lot to stand on at that point. But that was sort of a little shuffle that was happening at that time.

Then we got our degree at the end of two years, and we had the option of going and getting certified with the nurse practitioner certification exam at the national level. At that time I had heard from the people who graduated the year before us, that they'd taken the exam, and it was ridiculous. They said it had nothing to do with being a nurse practitioner, it was like taking the nursing boards again. And so I said, "Well, I'm not going to participate in something that is a farce," and so I refused to take the certification exam. At that point, because it was just a new thing, it was optional, nobody was really pushing it. They didn't require it anywhere for a job. Most of the nurse practitioners I worked with, who'd already been in practice, had not taken the certification exam, and so I never did. And to this day, I've not taken it.

Mullan: Did Pace confer an academic degree, a master's?

Gerlaugh: Master's in science in nursing, and family nurse practitioner certification.

Mullan: So you spent several years in Rochester?

Gerlaugh: Three and a half years.

Mullan: What happened then?

Gerlaugh: The funding, as you can imagine, began to get tighter. And when funding gets tighter, they watch a little a more carefully how money is being spent, and they wanted you to see more patients. So they started printing out how many patients everybody was seeing every month. There was a lot of pressure to see a lot of people, and it became much more of a mill than I was comfortable with. I felt like patient care was beginning to suffer when you asked that people be seen quickly and sort of overlook some of the social issues that were causing the medical conditions. I was able to do less home visiting, and in a situation like that, you really need to know what's happening in the home in order to sometimes understand why someone's diabetes isn't under control, why somebody with a huge ulcer is just not getting it healed.

The pressure was very strong. I was burning out. So I started looking around for a job. And at that point, when they heard I was unhappy, they encouraged me. I was also having a hard time with the physician I was working with.

Mullan: Same physician?

Gerlaugh: Same physician. A pleasant fellow. A very pleasant fellow, very nice with patients, but as I was, I think, sprouting my own wings, and beginning not to work by protocol, but much more making those kind of decisions, or when you begin to have your own opinions about things, it might be a little bit different, it was running into flak. And I needed to work with somebody who I felt like would be willing to listen to an opinion I had. And so they offered that I change physicians, which I did for a year.

I worked with Isaac Dombo, who was from, then, Rhodesia, and had left during the wars and come over here to work and was about to go back again, but couldn't get into the country because of politics. These were mostly foreign doctors, by the way, that worked in internal medicine at Jordan.

Mullan: Doctor Dombo was black?

Gerlaugh: He was black. I worked with him for another year, and that was very nice. He was very good with patients. I enjoyed the way that he worked with patients. He was a good teacher to me. He taught me a lot more about medicine, too.

But I still wanted to leave. I was ready to leave the big city, and wanted to do something different, wanted to work in a more rural area, which was more what my long-term goals were.

At that time, I found about this job through a person who had graduated with me through Pace, who had gotten the job directly here at Maine Dartmouth. She had called me up and said she knew I'd been looking for a job the year before, and was I still interested. They had a job opening here, and that's when I came up here. That was in February of '81.

Mullan: Catch me up with the personal side. Were you married at the time? You had a notion about protecting your life somewhat from the rigors and hassles of solo practice. Had that been a good decision? Had your personal life progressed?

Gerlaugh: Yes. I had a life outside of work, let's say. I was not worried about being married to my profession. I was very active in the community at that time, and was editor of a small paper.

Mullan: What sort of paper?

Gerlaugh: It was called the *Empty Closet*. It was for gay people. It was the main paper for the Rochester group of both gay men and women.

Mullan: Good name, *Empty Closet*.

Gerlaugh: The *Empty Closet*.

Mullan: It took me a moment.

Gerlaugh: And I did that. I also was president of the gay association there. My partner at that time was also a nurse practitioner and got involved in politics, and so I also got involved somewhat in politics there with her. We set up a number of different programs trying to increase the--at that time there was some problems with the police in the gay community, and so we tried to resolve, mediate complaints and problems, and try to develop better relations with the gay community and the police. We were also active in setting up a chorus, singing groups, and were active with the women's Take Back the Night activities of trying to make aware the problems that women face in the neighborhoods and the streets.

And we worked with the prostitutes. There was a group of prostitutes, and their name I'm going to forget, I think it's Coyote, a very politically active group, and we worked also with them. There was a number of gay prostitutes, both men and women, and worked with that group. So that was some of my outside activities. I was also active in the Quaker Meeting in Rochester.

Mullan: So considering moving to a much more rural setting, that felt comfortable at that time? You had had it with the city? Or you were at least looking for some different living setting?

Gerlaugh: I loved the city. I was pleasantly surprised. Rochester has some wonderful communities, and you get the small-town community feeling from living in the communities within Rochester, but I really am a more rural person. So I was looking for a rural job. My concern was as I saw people who were working and practicing in medicine in rural areas, that there's a real danger in getting out of date, not having colleagues to pass things by, and to constantly be updating yourself with those people who kind of question you when you've done something, as well as people who you go to for that kind of curbside counsel. When I observed or talked with physicians working in rural areas, it was a danger that they ran into. I wanted someplace that was rural, but would still allow me to stay up to date.

Mullan: So this met that?

Gerlaugh: Sure did.

Mullan: You came here. What was it like?

Gerlaugh: We were in the small offices here, an old nurses' dormitory that had been converted into a little health care center. And we were very crowded. One dorm room would fit ten residents and myself, maybe, who would be seeing patients. No, it wouldn't be that many. Seven. It was noisy, but it was what people called funky.

Mullan: You were the only nurse practitioner at the time?

Gerlaugh: The other nurse practitioner, who was B.J. Beck, who was my colleague, worked on one team upstairs, and I worked on the downstairs team with a group of residents. We were divided up so that there was half the residents in each team. Then the faculty was divided, also. At that time, there was only two family practitioners on the faculty, all the rest were internal medicine. Alex McPhedran was the director, and he was a neurologist, but both those two people, Dan Onion as the internal medicine person, and Alex McPhedran had gone back and taken their family practice boards, but there was only two other family docs at that time, and they were divided between the two teams, also. So there was really a family doc, a nurse practitioner, and then the residents. There were three residents of each class.

Mullan: And what was the role then, and, for that matter, now, of a practicing nonphysician provider in amidst the residents?

Gerlaugh: We basically worked closely with the second-year residents the most, to start with. Second-year residents were the ones who were managing. They had three to four times a year, (three to four months a year), they were in charge of managing the outpatient practice, covering the outpatient practice, and the inpatient practice for the FMI, the outpatient part of our the residency program. So any admissions that came in, they were responsible for. Anybody who was sick and came over and needed

to be seen, and their resident was off doing another rotation, they were responsible for.

We divided up those patients, basically. I would either see the patient as a call-in, or they would see them, depending on who had a schedule. We both also had our own practices. So there was our own ongoing practice, as well as managing and covering for everybody else who wasn't there. So we worked fairly closely together. Every month there would be a different resident who I'd work with. It was a interesting relationship, because I was both in a teaching role, as well as a colleague role, as well a nurse role. So it was kind of a blend of all these things.

Mullan: It must be a little schizophrenic, or more. I can think of your initial pair of hands to sort of buffer the unpredictable flow of patients. So you're a service provider. You're potentially a mentor. You're also potentially someone who would consult a physician under certain circumstances. How did, and does, that sort out in terms of your variable teacher/student/colleagueness?

Gerlaugh: It was very dependent on the personalities. It was very personality-dependent with the residents.

Mullan: Yours being fixed and the residents being variable.

Gerlaugh: Well, my personality can go up and down, too. [Laughter]

Mullan: You need a certain chameleon quality, I think, to play this role.

Gerlaugh: You do. You have to be very--I like to think of the word "flexible."

Mullan: Agile. [Laughter]

Gerlaugh: And have to be able to adapt to all the different personalities and problems and quirks that a resident brings, a resident being under probably the most stress that they're ever going to deal with in a long time, and not always sure of themselves, and yet needing to be sure of themselves, because they're in the role of having to call the shots. So they're in a difficult position, and people respond differently to that stress. Sometimes we would have people who had never been there in their first year, would take on a new second-year. We had a first-year resident who left. We'd have some new second-years who didn't know me at all, hadn't worked with me at all the first year, hadn't worked in our system, and now they're suddenly in charge. So it was difficult for them. For myself, I think I enjoyed it, because I liked that kind of challenge of working with people and different personalities. To me, it's a challenge more than anything else.

[Begin Tape 1, Side 2]

Mullan: Side two of tape one, with Holly Gerlaugh, continued.

Gerlaugh: I enjoyed working with those challenges. Sometimes it was difficult, and other times it was pure pleasure. The residents, in general, we have a very dedicated group of people, who, particularly in the early eighties, were very idealistic about wanting to be family docs, out there, rural, on the front lines. Being a GP is really what a lot of the people--what they want, what they called the granola group, the people who were the idealists about family practice, and really were putting that first.

Mullan: Has that changed?

Gerlaugh: We talk about it a lot. We tend to think it's changing, although we don't know whether the students are changing or whether we're changing. Sometimes we think it's because we're getting older that we're seeing things differently, and other times we wonder if the groups that are coming through are different. There seemed to be a real change somewhere in the late eighties, where it seemed as if there was a much more, I hate to generalize, but we were generalizing, wondering if we were getting more of the "me" generation. the people more interested in their own lives as primary, first, and the profession as secondary. So to ask people to put out that extra,

that before was sort of an expectation, that when you're a resident, you have to back up, and sometimes have to come in more, you have to stay up longer, sometimes you'll have to see a patient, squeeze him in here and there. But there's a lot more anger involved when that happened, when they were asked to do that.

Mullan: How's that now? Is that continued that you're still questioning the "me" generation, versus the granola group? We're getting larger numbers of residents.

Gerlaugh: Yes. There's been a lot of shifts that happened all at once. One was around 1990. I would have to look back at the years of what group was here. There was a concern that we weren't going to get enough applicants. We were wondering if family practice was going by the wayside as more and more specialists were being trained. More and more people coming out of medical school were interested in going into research and other things, and making a lot of money. So these people weren't going into family practice. The people who were interested in family practice were interested in large cities, or not in working in a kind of setting like we would have here. So we were concerned.

Mullan: Early nineties was kind of a nadir in terms of applicants.

Gerlaugh: Yes. And we were worried. We were wondering where we were going to go with it. And then, suddenly, at the same time, all sorts of hell broke loose, which you know more about than I do, understanding what all happened.

Mullan: In terms of interest in family medicine?

Gerlaugh: Family medicine, payment. All the whole payment schedule changed in terms of, now, as they're trying to go to diagnostic DRGs and all those kind of payment things, where they were beginning to try to even out. You know, a surgeon gets paid the same amount as a family doc does when they do the same procedure. Well, that was just, to me, totally revolutionary. And that was the ideal. I realized that that ideal has not necessarily come to--you know, there's still some problem there, but I think that that had some change, too.

But for whatever reason that it might have happened, around that same time that we were worried about not getting enough, and, indeed, there was a year where, for the first time, we didn't match that, that was the first year that we took foreign graduates. We took two foreign graduates that year. Within a matter of two years, we swung in the opposite direction very quickly. We were suddenly, and up to this year, being deluded, really, with applicants.

Mullan: Has your role changed over the years, or has it continued in this variable student/colleague/mentor?

Gerlaugh: It's changed. Within about five years, because of the changes in the way they began to define nurse practitioners and PAs, the mid-level practitioners as they call them in this state, they got regulated, too, but it was required that I could no longer have a second-year sign my charts, and those were the people I was working most with. So I had to start having either a third-year or a faculty member sign my charts. And very quickly it became more that it had to be at least a supervising physician, which turned out to have to be the faculty.

So as that happened, from a practical point of view, it became more difficult. I wasn't really working as closely, the second-year residents didn't know what I was doing so much, which is, in some ways, one way that they learned how to work with the nurse practitioners, they saw what I was doing. They saw what kind of work I was putting out and what I was capable of doing. So they were, at least indirectly, if not directly, watching what I was doing, learned how to work with me, and what I can do and what I can't do, what my limits were. As they stopped seeing my charts, and stopped working in terms of if we stop splitting up the number of patients, I didn't work as directly with them, I think that the role changed somewhat.

The relationship with the residents, I wasn't working as closely with the residents. I became more of an advisor for them to come to, in terms of instead of seeing, necessarily, patients, and working with them together, as I might with somebody like I did back in the Jordan Health Center, where we saw patients, the same caseload of patients and shared them, I had my caseload,

they had their caseload, but they would come to me for questions. I guess I was used more as a preceptor. And my relationship changed in terms of being much a preceptor as opposed to wanting to go to them for advice.

As I became more experienced and realized these people have so little experience, it was hard for me to go to them for advice. I was tending to go more and more to my supervising physician.

Mullan: So you feel there's been a learning curve for you that has continued.

Gerlaugh: Yes. And also referring my patients. Before, when I was referring patients back and forth for the physician, it became less likely to refer a patient to a resident for advice. If I had a dilemma and I didn't know what to do, I wasn't necessarily going to send them to a resident, because I didn't have as much confidence that they would be the best step for the patient.

Mullan: It sounds to me like that would have been a product of your seasoning and your experience, more than a product of the change and the signing regulations.

Gerlaugh: It's hard for me to sort out, but it did happen around the same time.

Mullan: Was that a state or a federal?

Gerlaugh: It was state, at the state level. They changed the regulations here twice. Well, two major regulation changes since I've been here. Back in the mid-eighties, and when they had all the nurse practitioners and PAs going to the same mid-level guidelines. When nurse practitioners had to also be countersigned, have counter signatures on their charts. Before that, I didn't have to have a counter signature by a supervising physician. So that's how they could get away with having just a resident on the charts. We didn't need them. But then when they went though the change, it was obligated that I had a--

Mullan: A third-year resident or attending.

Gerlaugh: Right.

Mullan: Then the second change was more recently?

Gerlaugh: The recent one was a year ago. The nurse practitioners, two years ago, had a very strong lobby to have the Nurse Practice Act change, where the nurse practitioners would be able to practice independently, independently meaning what they called collaborative work. They wanted to able to have midwives who did not have to, before they could practice, find an OB/GYN who would work with them. That would be an example of that new

law. They wanted to be able to order, get an order on something that they didn't have to go through a physician for orders.

So that went through the legislature with a lot of fury on both sides. The Maine Medical Association was against it and lobbied quite strongly against it. The legislature, in their wisdom, said, "You guys go out and duke this out. You figure it out and you come back to us," which I think was wonderful. And there was a lot of good talk that went on between--I say Maine Medical Association, but they were representative of that group, and the nursing association, the Nurse Practitioner Association, working to try to hammer out something that they both could agree on.

And like all things, when you try to work with a nebulous group of people, some people would be at a meeting, get things worked out, hashed out, would understand and feel comfortable with each other as working members, and then the next meeting somebody else might show up who hadn't heard the whole discussion and would sort of throw the whole thing into a big ball of wax again. So it was a very difficult process.

But at the end of it all, I think the end result of it was that the people who were regulating the rules and regulations for nurse practitioners and PAs at the level of the Board of Medicine, said, "Let's make some changes here. Let's loosen up some of this stuff, because it seems like we need to get rid of some things that just don't make sense in terms in the way people are practicing in Maine, nurse practitioners." And what they got rid of was the requirement that a supervising physician was

required to sign charts after five days, that within five days you have their chart signed, and that all charts have to be countersigned, all orders have to countersigned.

You can imagine in a rural area, this is very difficult to have a physician be looking over every single one of these things. They liberalized the rules and regulations to say something to the effect of, "Your supervising physician and you will work out an agreement, a statement, of how you will work together, be supervised, and then give guidelines in terms that it has to be sure that the care of the patient is not compromised, that's it's the best care that can be given, and that the supervising physician has oversight in the practice."

Mullan: So it's a step, a major step toward independent practice.

Gerlaugh: Yes, it was.

Mullan: Did the Maine Medical Association accept that, or was it passed over their protests?

Gerlaugh: No, that change in the rules and regulations was accepted, and that was separate from what they working on in terms of this Nurse Practice Act. The Nurse Practice Act never went through legislation. But I think because that happened, it made this other change occur in the rules and regulations, this was a whole legislative change.

Mullan: So what did happen was within the regulatory structure, and it modified the sign-off procedures to give them more independence, but the actual legislative change, then didn't go through.

Gerlaugh: Did not go through.

Mullan: At some point along the way, you decided to become a physician assistant.

Gerlaugh: Right.

Mullan: What did that mean in terms of what did you have to do, and why did you do it?

Gerlaugh: It was around '84. In New York state, when I was working in New York state, there was some difference in the PAs and nurse practitioners, in terms of what they could and couldn't do. It was minor at times, and it would change depending on the politics. I wasn't very involved in it, but I was aware that there were some changes happening. When I came to Maine, there was some stirring about whether or not Medicare was going to reimburse the PAs, but not nurse practitioners. And I said, "This is a bunch of baloney. We're both doing the same job. The PAs and nurse practitioners often are in the same jobs." It just didn't make any sense.

And so I didn't really want to get involved with fighting those things, because they were more national. Things like Medicare reimbursement was national issues. So I wanted to avoid the whole issue. Quite frankly, I said, "Well, shoot, then let me get certified as a PA. If I'm doing the same thing, then let me get certified in both things."

That was the other thing that pushed me, it was the last year that you could be grandfathered in. You didn't have to go through a PA program to take their certification exam in '84. In '85, I think, you did. You had to have gone through a certification or a certified program. So I could go through another program, but do comparable work, and you had to meet other guidelines, in terms of having done so many years of comparable work and have comparable training. And I did that. I met those guidelines, and I took the exam. I was in the 99 percentile of that. So I felt like, "There. I've done it. I'm certified. If anybody questions whether they're going to reimburse me at one level, I can be either."

Mullan: So it was largely to keep all your bases covered. It was not any kind of dissatisfaction with being a nurse practitioner.

Gerlaugh: There was some dissatisfaction with being a nurse practitioner.

Mullan: Tell me about that. Because your identity, now, your formal identity on your name tag and on the plaque out front is as a PA.

Gerlaugh: Right. I was unhappy with nursing, in general, in terms of at the level of the nurses. I like the approach of the nurse practitioner approach, in terms of the emphasis on the person, the patient education, and the counseling, and the primary care aspect. I was not happy with nurses seem to do a lot of infighting. At the national level, there seemed to be a lot of emphasis on what our role was. People were always talking about the role of the nurse practitioner. We couldn't make a medical diagnosis, we had to make it a nursing diagnosis. I said, "You know, this is just a bunch of rhetoric so that we can avoid dealing with the fact at the state level when rules and regs say that, I'm not allowed to be making medical diagnoses." So the nurses say, "Well, then it's really a nursing diagnosis, what you're doing." You know that that's baloney. It's just not true.

They were still trying to make everything sound like it was a nursing diagnosis. I said, "We need to take the bull by the horns, and say that's not what we're doing. We really are practicing medicine here."

And they were saying, "Well, we're practicing medicine." I thought that their approach, the whole way in developing the nurse practitioner role, was wrong, that instead of trying to make it a separate role from physicians and medicine, that we

should be collaborating, and working in a way that we have certain strengths that we can work well with physicians, and that we should be developing that, but not saying that we're somehow totally different. And so I think it was my frustration.

Mullan: These discussions you had in terms of your ongoing political, or quasi-political role, were with colleagues or within the context of the State Nursing Association? Other than your head, where were these discussions taking place?

Gerlaugh: It had started back in the graduate school. These were the kinds of arguments that we were having with the faculty at that time. They wanted us to do nursing diagnosis, and trying to always put everything into a nursing diagnosis. And we'd say, "What the heck is a nursing diagnosis?" Well, it's everything that's not medical, that's for sure. It can't be medical. To me it was very difficult to figure out what it was. It was nebulous. It made no sense. But anyway, it started there.

Then as I still had a contact with the school, and they would want me to take nursing students to do internships with, and I would have these arguments with the teachers then, saying, "This is what I do here. This is the kind of role model that I would provide." And it was also happening at the political level, at the state level, the Board of Nursing and the Board of Medicine. The Board of Nursing really had no idea what nurse practitioners were. So here we're regulated by a Board of Nursing who doesn't know what a nurse practitioner was really

doing. And the PAs were much better politically organized. They knew what they were doing, and they went out and protected PAs from whatever, making sure that they were reimbursed properly, and that they had good working relationships with the physicians.

Mullan: This was in New York?

Gerlaugh: Here in Maine. It was through all that discussion with the Board, here, as I saw the politics. The PAs were much better organized and were really going in the direction I thought was going to be in the long run. They made sure that they didn't get left out when it came to reimbursement, e.g.,when it came to making sure that we could write orders for physical therapy.

Mullan: And their message is clearer, and I observed this as I've watched these debates, but their numbers are small. The nurses have a lot more political clout because of their numbers. How does that tie up?

Gerlaugh: The nurse practitioners don't. I think nurse practitioners, aren't they fairly comparable?

Mullan: In terms of numbers, yes. When the politician looks about to whom they're going to kowtow, or to whom they're going to listen, the Nursing Association comes in representing one and a half million nurses, nationally, and there are 30,000 PAs. There are 30,000, roughly speaking, PAs, 30,000 NPs, but they're

approaching 2 million nurses. So the political muscle of nursing exercises nationally and on a state level is much greater than PAs, not withstanding the PA message is far better organized, say, than the nursing message of the nurse practitioner message within nurse.

Gerlaugh: I think that in this state of what I've seen is that the PAs had gotten their message very clearly through, were very politically active and very politically powerful, and that still remains true, between them and the nurse practitioners. Only recently with this new bill that the nurse practitioners had been working on, had they become much more politically active and are starting get themselves organized.

Mullan: And those changes you described in the regulations pertain to both nurse practitioners and PAs?

Gerlaugh: Yes. Because that was the first change that happened back around '84, in that time period, early eighties.

Mullan: But the more recent one, also, the liberalization, pertains to both nurse practitioners and PAs?

Gerlaugh: That's right.

Mullan: Why does nursing have this rhetorical doublespeak and everything that flows from it? I know well of what you speak. Why does the culture of nursing create and perpetuate this?

Gerlaugh: I'm probably the last person who'd be able to speak to that, because I didn't go through that culture. I think I get nurses angry at me, trying to interpret what's going on, and I really wasn't a nurse. I didn't work in the nursing field, other than as a nursing assistant. So I don't know. I'm hoping things are changing. But my concern is that we're getting away from the professional nurse, at least here at our hospital. The concern is we go away from professional nurses and start replacing professional nurses who are well trained, with medical assistants or LPNs. There's something major happening within the nursing profession. I don't know enough about it.

Mullan: Let me propose a theory to you, and you tell me whether you think I'm on the right track or not. Nursing has a long, honorable, and ambiguous history in the shadow of medicine, a history which is impacted by not only a subordination in a professional hierarchy, but also a profound gender difference, which is less pronounced today as medicine becomes more clearly coeducational, while nursing remains 95 percent a female profession. But the roots of nursing, as nursing began to professionalize itself and began to identify itself as a more independent profession, were built along academic lines with strong traditionalist academic emphasis, the kind of emphasis you

described a bit. I mean, academic in a somewhat more scholastic and rigid, rather than free-thinking form, scholarly form.

So that there was a great emphasis on the hierarchy of professional degrees and getting higher degrees. Educational upgrading was very important. So higher emphasis on baccalaureate training and master's preparation and doctorate preparation. But in the practice domain, it was still pegged on a nurse practice arena in which nurses were in charge, but they were in charge of their part of the hierarchy only.

Nurse practitioners represented, at once, the flower, or the wildest wishes, of nurses over the years who wanted to get out from under the wing of, and out from under the shadow of physicians, because they were now functioning like physicians in many ways. And yet to the extent that they also wanted to maintain control over the definition and domain of nurse practitioners, it had to be defined under the Nurse Practice Act, which had all this secondary rhetoric that was defining, trying to define, medical and clinical phenomena under a nursing rubric, which doesn't hold up intellectually very well, I don't think, never has, and yet was elevated to kind of big league status as they tried to take on medicine, while still maintaining a nursing definition.

I think that remains operative even today. Today it's a powerful ambiguity that nursing struggles with. Medicine is, to be sure, turfish and is ambivalent itself about these nurses who are practicing medicine. But it befuddles sensible policy-making, because you've got a lot of other agendas playing here,

desire for professional independence, a desire for gender independence. I think there's a kind of pride that nursing has of being a women's profession that's kind of come into its own, but a little bit like some proud women's colleges that have actually suffered in the era of coeducation. Whatever did happen to Radcliffe? And how does a Radcliffe graduate feel about now being told she's a Harvard graduate twenty years later? I mean, it's a difficult area of gender interplay and historical rewrite, as well as an active area, professional interplay today. That's my thinking about it, which is less clearer sometimes than I'd like it to be, but I think those are the factors that play in it. Does that resonate with your experience?

Gerlaugh: Yes. It resonates both on a personal level and political, what I've seen happen. You say it more clearly than I do.

Mullan: I just wanted to know if it was on base or not on base. Is anything off base with that?

Gerlaugh: You've been studying this, and I can't seem to put together how I actually feel about--let me start again. You take nurses, a nurse in the emergency room. You start at a level of somebody who's basically only doing the biding of the ordering physicians a LPN or 2-year nurse might do. Then there is a person who's a Bachelor or Masters level who can make their own judgments about a lot of situations. They anticipate what's

going to be needed. They begin to form their own decisions. They're making triageing decisions. They can start to do more procedures. Pretty soon a person's role develops as they develop experience and so it seems silly, in some ways, to say that they can't do something because it's "practicing medicine." Certainly they can learn all kinds of skills that have traditionally been medicines domain.

I think we need to come to grips, and I think that's what some of this legislation has been doing in Maine, is trying to come to grips with saying, "Let's get rid of all this confusion about who can practice medicine. Let's really talk about what we're doing. Are we competent or not?"

What makes somebody competent to practice medicine? What kind of training do they need, or their background? When is a physician not competent anymore? All these issues came to a head, and I think that they're important things to think about. I'm not sure that I know what the answer is. I worry about any profession, including nurse practitioner profession, that aren't stringent in maintaining a competent group within their ranks.

Mullan: Let me ask you about your future as you see it. What do you think is going to happen twenty years down the road, for example? Are we going to continue to have two educational and cultural streams, PAs and NPs that function clinically in terms of practice and largely the same domain, but they've got these different traditions and different icons and different language, or not?

Gerlaugh: I'm hoping that they're basically going to merge much like DOs and MDs merged, in terms of PAs and NPs, that they may still have some difference in terms of their training, but there may still be different training programs, but that they're seen more and more as variations of a theme. As we have gone and started here at the residency have come to understand that DOs are not three-eyed monsters or different or weird in some way. I think that it took a long time for the medical community, the hospital community, the medical, to understand that DOs had a legitimate place within the medical community.

Mullan: And a set of competencies that were very similar on their own.

Gerlaugh: That were similar. You had a different perspective and that that training had some difference, but that basically we're talking about the same animal. I think that NPs and PAs, that that's eventually going to happen. That same process of understanding we're the same animal, I think it's going to happen, too. I see the change having to happen with the nursing. The nursing part of it is going to have to let go of a little bit more of their stronghold on the definition, and that's going to be a hard one.

Mullan: What about the future of what I will call the "mid-level provider" vis-a-vis, the physician provider? We've had a period, obviously, of physician shortage, where there was a market

opening for an increased number of non-physicians. Now as the availability of physicians become much greater, and as managed care somewhat restricts the number of physicians that are required, or the number of clinicians that are required, first of all, are you feeling in your own experience, or that you hear from others, any dampening of the market? And what about the future? How will things sort out in terms of non-physician providers vis-a-vis physician providers?

Gerlaugh: My sense in watching what's happened in nursing, (where they've gone from RNs to Med Assts. because of budgeting, in a market economy), is that HMOs/the managed care is moving in the same direction. The primary direction right now is still looking at a market. So whatever's going to be marketable, whatever is going to save the most money is the direction it's going to go.

If NPs, PAs, midwives can show that they basically can still provide, as you'd say, in a market economy, a product at a lower price, I think that they're going to become very marketable. I personally am chagrined at that kind of approach to medicine. I just find it very sad to start looking at this as providing health care from purely being driven by market, and I'm concerned about that. As I see that changing my practice and how things are changing, I'm worried about it. But from a purely selfish point of view, in terms of how marketable NPs or PAs are going to be, I think we're going to be very marketable.

Already, in this community, where we started out, there was only us two nurse practitioners here in Augusta, and there was a PA down in Richmond. Now I'd hate to try to guess how many nurse practitioners and PAs are on the medical staff here. There must be at least three just out of the ER. Almost every practice now has at least one PA or nurse practitioner, and we were the only ones before.

Mullan: Do you have any idea how many are practicing in Maine, either NP or PA?

Gerlaugh: No, I don't know. I can find out for you.

Mullan: But for the moment your sense is the market is good for the mid-level provider?

Gerlaugh: Very good.

Mullan: And the future, you think, will continue to be so, provided their cost-effectiveness is demonstrated or perceived?

Gerlaugh: And we continue to go in this direction of market-driven health care.

Mullan: Salaries for NPs and PAs continue to increase, which begins to diminish their cost-effectiveness. At least that's

been the national concern. Any reflections on how that might play itself out?

Gerlaugh: You're asking me things that have to do with things outside my practice that I'm only speculating on. But I think they're still at least a third to half the price of a physician. If they can put out 80 percent of--

Mullan: What do NPs and PAs make in Maine?

Gerlaugh: The average, I think nationwide, is $48,000.

Mullan: For both, either?

Gerlaugh: I think they're pretty comparable right now.

Mullan: Maine?

Gerlaugh: Maine is probably similar to the national right now.

Mullan: Let me ask a question about your future. You've done this now for fifteen years. You have to be one of the most seasoned clinician/educator/practitioners.

Gerlaugh: Actually nineteen years.

Mullan: Nineteen years. I meant the actual place, right here. Do you foresee staying in this kind of practice? Do you have ambitions to do other kinds of practice? Where do you see yourself headed?

Gerlaugh: At this point I see pretty much staying here. I'm very lucky in working with a wonderful group of physicians. It's a stable practice here. We don't have large turnovers of the faculty. We're growing more, we're adding more people, but we haven't had a turnover. The people we get are high quality. The residents are good-quality residents. I have a lot of flexibility here. So I see myself staying. I don't see myself leaving at all.

Mullan: How about your life outside of work? How has the move to Maine been these last fifteen years?

Gerlaugh: It's a nice place to live. I've become active in other activities. I have enjoyed being in a rural area, and it's easier to be a part of a community in a rural area for me. And I have a family. I have a family life.

Mullan: Tell me about that.

Gerlaugh: I have a little fourteen-month-old. I have a husband, and live out on a farm out of town, and it's very pleasant here. It's a wonderful place to raise a kid and to just even be a

single person here. I've enjoyed it over the past fifteen years. I've been very active still in politics. Through the church, I've joined the Council of Churches.

Mullan: Which church here?

Gerlaugh: The Quaker Meeting, but through the Meeting, I've been active in politics. The Council of Churches has a legislative group that watches all the legislation that comes before the state, and we review it from the point of view of the churches, what their interests are, which is basically in the people who have no voice, the poor, the mentally ill, the mentally retarded, children, elderly, so we review all the legislation. I'm no longer on that committee. I was active in that, I enjoyed that, being able to do that little piece of it.

I've been very active in Central American politics, and that's when I went down to Nicaragua for a while, for a year. I took a year off from here. We had no sabbatical policy then at that point, so I asked for a leave of absence, and went down there to do my Third World medicine, something I always wanted to do.

Mullan: You got your Schweitzer itch scratched.

Gerlaugh: So I got to do that. I saw what it was like, socialized medicine in Nicaragua, saw how it works and how it doesn't work. Nothing works when you have no money, that one

thing I learned. But it was a very good experience for me to see what was happening, what could be made to work almost on a shoestring. You know, you talk about running health care with a bake sale, that's about what was going on. So that was a good experience for me, and it certainly let me know in terms of the "Schweitzer itching" that in order to make a change in any community, you have to stay. You can't go somewhere for two weeks, two months, or two years; you have to be in it and be a part of the process and be willing to help make a community change.

And they told me that. They said, "Go back to your own community. You've got a lot of work to do back there." That was their main message. "Do the work in your own community. Make the changes there, because that's where it needs to happen in order to help us down here, that you all need to do, making the changes." So there was, for me, personally, a lot of growth, and professionally in that year.

Mullan: You were active in gay politics and the gay community before. Has that represented a gender preference change for you?

Gerlaugh: Yes, it was. It was a major change when I came to Maine at some point here, and that was a whole community change, too. It's interesting. That's a whole other subject, is communities. There's a very active gay community here in Maine, and rural. Rural active is very different, I found, than city active, but still, nonetheless, very active. And we've had a

number of gay people, residents, come through the residency and have been become part, a very strong part of our community here, have stayed on and become physicians in the community, and that has been really a nice thing to see, to see how a fairly conservative community can deal with all that.

Mullan: And that's been, other than painful, I gather that's been good, positive?

Gerlaugh: I think it's been, yes. I think it's been very positive. The community, I think that's it's been very positive. The gay community in Maine continues to be quite active in many different ways.

Mullan: How do you like motherhood?

Gerlaugh: I love it. I'd do it again if I could. But I'm forty-three.

Mullan: A brave undertaking.

Gerlaugh: Right. I don't know if I'm going to have another chance at it, but it's just been delightful.

Mullan: And in terms of going back to your earliest notions about your career, how do you feel about how your career's developed? Do you think you made the right choices?

Gerlaugh: I think in looking back at it, if I'd been exposed to more role models of women in family practice, of all the variation that people can do, I think it probably would have worked out fine to go either direction, as far as to become a physician or to go ahead with the track I took. In some ways I don't know how much a difference it would have made. Women have come into family practice and can develop a practice that is children-friendly and family-friendly. Here at the residency, we keep hoping that we are modeling different styles of practice in terms of the people who work part time, where people can job-share.

So we try to model that in a number of different ways, and we've tried to do that throughout the time we've been here. The people at the faculty, at the residency, are concerned: are we modeling a style of practice that's healthy for an individual? So that's been a piece of the whole, talking as far as at the faculty level.

How are we going to encourage it? Early on, when I first came here, there was only two women. Well, let me see, how many women in that whole class? There might have been two women in the class I first came in, and we constantly said, "How are we going to encourage more women to apply here?" And it had to be because we provide an alternative here for women. We took on a couple, and we allowed them to job-share as residents. For one year, one was working and the other was home, and then the next year they shifted, and it took them four years to get through the program instead of three. And we did another one where let

somebody work part time. We did it another way, where we've had people take leave of absences when they needed to. That kind of stuff, I think, has to be a part of the residency training and modeling.

If I had that kind of modeling, I think, back when I was in college, I think that it would have been okay for me to continue on my path, and I was headed towards upstate New York Medical Center, as far as going to medical school, a fairly family-practice-friendly medical school, and I think it would have worked out okay. But I don't regret it at all. I think what I'm doing now, I've ended up in the same place I think I would have ended up before, and I love it, it's really a lot of fun.

Mullan: You make a case of the kind of convergence of clinical activities, whether with interests and values, as you started with, you kind of ended up at the same place. Whatever the banner you're carrying, you're carrying a couple of them, PA and NP both, but it does seem to be an example of how we are rethinking and resorting the clinical challenges. The somewhat rigid thinking, rooted in the past, isn't going to serve very well. Now, whether it endures or not, speaks a little bit to political clout and the obstinacy of some of the players on all sides, but it seems to me in the future, as I write about and practice and talk about primary care, the notion of at least five disciplines providing primary care--internal medicine, pediatrics, family medicine, NPs and PAs--

Gerlaugh: OB/GYN. They just passed that here in Maine. Did you hear about that?

Mullan: No.

Gerlaugh: They've passed it at the legislative level, that they can provide primary care in these HMOs, where you have declare a primary care person, that they can. That they also have it so at the HMO level, that you're legislatively allowed now to have your health care, your one-time visit for GYN through a gynecologist. What does that do with trying to provide comprehensive health care? It's very difficult.

Mullan: But somehow the definition functionally has to be simplified and codified, and I don't envision how that's going to come to pass, since the players have stakes in it. But if the notion of primary care is going to undergird, it seems to me, the health system of the future, it ought to be simplified and regularized, and not have these various players whose clinical reality is tethered to historical circumstance, and doesn't serve as well as it might, the current circumstances.

Mullan: I think we have to start working more collaboratively together, and understanding, being able to work together. We already work fairly well in these small communities, together, and the surgeons, and the OB/GYNs, so as a community we work, but the politics sometimes drives us apart.

Mullan: Anything else you'd like to enter into the record? It's been a wonderful interview and very generous of you.

Gerlaugh: I can't think of anything. There's all sorts of things to say, but I don't know anything that might be useful to you.

Mullan: Why don't we stop at that. Thank you.

[End of interview]

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