Interview with Joel Alpert
Date: May 2, 1995
Interviewer: Fitzhugh Mullan

Mullan: The date is May 2, 1995. I'm with Joel J. Alpert, M.D., in his office at Boston City Hospital, and Boston University School of Medicine.

I am happy to be with you. I want to spend some time, before we talk about the present and primary care, discussing you and your background. Tell me a little bit about where you were born and grew up and your pre-medical school career.

Alpert: I was born in New Haven, Connecticut, May 9, 1930. My father was an accountant, my mother a housewife, although she helped my Dad in his small business for many years. I was an only child for nine years. My sister was born in 1939.

I went to public school (Hillhouse High School) in New Haven, Connecticut, and had a very successful high school career academically and extracurricularly. I was the editor-in-chief of the high school newspaper and had an outstanding academic record. Socially I had a small circle of close friends, like many of us did in those days. I went to Yale, which was my dream. My Dad had attended Yale. It was the only university to which I applied. I don't think I would apply to only one school today. I majored at Yale in economics, history, and sociology. This was a divisional major, and was a terrific way for a non-science person to accomplish pre-medical courses. While I always

wanted to be a physician, my interests were broad. After Yale, I went to Harvard Medical School.

Mullan: You knew you wanted to be a physician or you thought you wanted to be a physician during--

Alpert: To the degree that anyone believes they want to be a physician or that they know, I wanted to be a physician. I remember my parents talking of me becoming a physician. My father, while born in Russia, was really first generation here. Half of his brothers and sisters were born in this country and half were born in Russia. He came here when he was two. He attended Yale. Two of his brothers were physicians. His education was interrupted by the First World War. Two of his younger brothers become physicians. My Dad continued his education after the war by attending NYU and he became an accountant. His working helped my Uncles complete their education. I was exposed to the fact that my Uncle Sam and my Uncle Meyer were spectacular people and it was good to be a physician.

I also have a very rewarding memory of the family doctor who cared for our family. I had my share of minor illnesses when I was young. I learned a few years ago that a very distinguished pediatrician, Harold Harrison, who was the chief of pediatrics at Sinai Hospital (Baltimore) and a professor at [Johns] Hopkins [University], as a young pediatrician at Yale, saw me when I was

two and a half or three years old and I had petechia and Dr. Harrison told my parents that it was not anything dreaded and I was going to do fine. I did do fine. I'm glad he was right. I have these images of a physician being someone who helped people, and, that view became part of my makeup.

Mullan: Why did you not major in biology or chemistry then and science?

Alpert: I should have been prepared for this. You're asking me to look back on my decisionmaking. I cannot tell you for sure.

Mullan: It's an interesting issue, because I'm finding in a non-scientific way that many people who end up in primary care have at least divided allegiances or broader than as you might expect of always riveted on science. But what went into your thinking?

Alpert: If you remember, I said I was editor of the high school newspaper and I was involved in a range of extracurricular activities. When I started out in my freshman year in college, I think of my four courses, I had a language, I had math, inorganic chemistry, and English. The next year, I took two science courses. By the time I was halfway through my sophomore year, I remember very clearly thinking that if I had to major in science, I was probably not going to go to medical school. By science, I meant physics, chemistry especially organic chemistry. Organic

chemistry, of course, was the course that we were told determined whether you got into medical school or you didn't get into medical school. Although I did fine in my science courses, I was much more interested in literature, economics, English and writing.

Yale offered one divisional major, which was absolutely perfect for someone like me who hoped to go to medical school. To give you some flavor of my senior year, I took American literature, international relations, a writing course, and a course in religion. Perhaps this was good preparation for being a chairman rather than a scientist but I had no idea of what I would become. In the sense that classmates were turned on by biochemistry, I was not a science person. I remember thinking that if doing well in biochemistry or organic chemistry was what made a good doctor, then I was probably not going to be a good doctor.

Having made that decision, I was one of the most relaxed among my Yale classmates who were heading for medicine. Our class was about 1,000, and on the first day of our freshman year, there were probably 250 who said they hoped to go to medical school. Probably 125 ended up actually going to medical school, and what weeded them out were their science grades. It was, even in a collegial school, a fiercely competitive environment. I'm quite sure I did not take advantage of all that Yale offered but I know that the broader educational experience was far more enriching than had I been a science major.

Mullan: What would your vision had been at that time for your career? Do you have any recollection of what you thought about being?

Alpert: My memory tells me that I was influenced by my experiences, and I would go to medical school and become a physician, and being a physician meant being a practicing physician.

About the age of sixteen or seventeen, when I was a junior counselor at a summer camp in New Hampshire, I was counselor for a group of children from the Lexington School for the Deaf (New York). I thoroughly enjoyed children, that I made up my mind that children were going to be part of my experience. Earlier I mentioned my uncles who were in medicine. One was a general practitioner, a family physician in the Bronx, and the other was a general internist, who spent his career in the Veterans Administration (VA). He was an endocrinologist with an interest in diabetes. Both of them told me that you did not become a family doctor, that the career of a family doctor was not one to pursue.

Mullan: The second was a general internist working for the VA?

Alpert: Yes.

Mullan: But you said you learned from them not to become a general--

Alpert: Yes. Not to become a family doctor. The Uncle who was a general internist trained at Lincoln Hospital. He was house physician there for, I think, three years. Yes, I learned from them. Then, of course, when you went to medical school--

Mullan: I'm missing the point here. Their lesson was, don't do what we did; specialize?

Alpert: Yes.

Mullan: Said with bitterness or said with simple wisdom that medicine was changing?

Alpert: I think simple wisdom that medicine was changing. For example, the first uncle was too old to serve in the Second World War, whereas my younger Uncle was on active duty serving in North Africa and Italy. One of the pushes that was given to the development of specialization was the realization by those who went into medicine and served in the military that if you had a specialty, you had a better assignment in the military than if you were a generalist.

Mullan: So to the extent they counseled you, it was to pursue something more specialized than they had done.

Alpert: Correct.

Mullan: So they were role models in a sense, but at least their advice was to not follow them blindly.

Alpert: Yes, and I think that was certainly reinforced when you went to Harvard Medical School--I'm not certain any medical school would have been different in the fifties--that you had no generalist faculty role models to whom you were exposed. I remember in my third year of medical school, I was beginning to decide whether I really wanted to go into pediatrics, as that really was my dream, but thinking that pediatrics was too general a field and that it wasn't going to be intellectually challenging enough for me and that I really should go into internal medicine with a specialty. I remember walking down the street with a member of the Harvard faculty who was very supportive that it was okay to be a pediatrician because a pediatrician was a specialist.

Mullan: What was the environment and experience at Harvard like and how did it affect you in terms of your career direction?

Alpert: I was very fortunate to be at Harvard. Harvard was an extraordinary place. I'm not going to get into a debate as to whether there is such a thing as a best place. There are many very good places. But Harvard was the medical school that if you were accepted, you didn't go any other place. So that's as good a criteria as any.

I was surprised that I got into Harvard. I had done well at Yale. I'd continued my interest in extracurricular activities with our residential college newspaper, political union, and religious organization. There were many classmates who had better academic records than I had, and Harvard was the first choice for almost all of them. I remember classmates being accepted somewhere and then sending a note to Harvard and saying, "Well, are you going to take me or not take me?" and almost universally, Harvard wrote back and said, "No, we're not going to take you," or, "You'd better take your other choice." And so when I was accepted at Tufts and I had been accepted at two other schools, as well, I said, "I'm going to let my Harvard application ride." I pulled everything else out, and then I got into Harvard in early December.

I arrived at Harvard and I remember being told that no one should look around for the lower third of the class or ever worry about being in the lower third of the class because the lower third wasn't here; they'd gone someplace else. And indeed, it was a very relaxed environment. I actually found that my preparation, or lack of preparation or lack of investment, in

science courses, made the first two years more demanding for me than it seemed to be of some of my new classmates. Only 15 percent of us in the class had been non-science majors. I know a lot of percentages about my class, because I was the class historian and I wrote the class history for our yearbook. I can go back usually at reunion time and I can review what I wrote.

Medical school influenced me. It made me angry because compared to my senior year of college, the medical curriculum, taught in stop fashion, was like kindergarten. Harvard was supposed to be the best. It was not an issue of whether you were being taught about issues that were too specialized or too esoteric or irrelevant, but rather whether it was good teaching or not. Too much was poor teaching. I can tell you that to this day I can remember what in my experience would have been relatively irrelevant lectures. Thomas Welder, who won the Nobel Prize along with [Frederick] Robbins, and [John] Eiders gave a superb lecture on parasitology that I can recall to this day. There was a lot of poor lecturing and some good lecturing. I wrote in the class history that the first two years bordered on the unbearable, because we were being given the parts of the automobile without being taught how to drive it. Despite my frustration, I did okay in the first two years.

Early in the third year, there was an announcement made in preventive medicine lecture class that a volunteer program was being started at the Mass General Hospital called the Family Health Care Program. This was a program that was directed by

David Rutstein who was the head of the department. The pediatrician was Fred Blodgett; the internist Joe Stokes, Jr.

I was one of seven medical students volunteered--I was interviewed and was accepted in the program, and for my last two years of medical school I cared for a family, which in those days was revolutionary. Talk about informed consent; we were not told that we were part of an experiment that was eventually carried out comparing students, with those who did not take the course, to see what differences must result.

In my clinical years, I had confirmed my decision that I wanted to go into pediatrics. Now I was doing the Family Health Care Program, and I was very excited about what I was doing, and I had survived the first two years. My career decision also helped me to relax. At the two other medical schools (Tufts and Boston University), my friends were having a more difficult time at Harvard because of the enormous pressure on them to study for their exams and do well on their exams. This attitude at Harvard was, "There's only one way you can get out of here, and that's to graduate," and it was a very, very supportive place. I had more fun in medical school than I did at college.

Mullan: And your pediatric focus developed during the latter two years?

Alpert: My pediatric focus was confirmed. I did some volunteering in the second year at the local Boys Club, and so

then again my career decision was reinforced. I come to the wards at Children's Hospital in pediatrics in '54, and the summer of '55 was the next to the last major polio epidemic in Boston, and we were very, very much a part of that experience, and I spent most of my pediatrics at the Children's Hospital.

Mullan: That was '55?

Alpert: In '54-'55, I was a third-year medical student; '55-'56, a fourth-year medical student; and then, of course, in 1956 I began my internship, and then that was another polio epidemic that year. I went through two polio epidemics.

Mullan: The vaccine came out in '54?

Alpert: Yes, the Salk, activated vaccine. No, it was 1955. I'll tell you why it was '55, because it was just the fortieth year of the announcement at Michigan, so I think it was '55. But, of course, the vaccine came out too late. The epidemics had to run their course and the next generation would be protected.

Mullan: Then you decided to go on into pediatrics?

Alpert: Yes, I decided to go into pediatrics, still believing that I would be a practicing pediatrician. You talk about defining points, and I guess I've referred to a couple of them

already. Getting into Harvard Medical School was a defining point; not majoring in science was a defining point; doing the Family Health Care Program was a defining point and going to Children's Hospital was a defining point.

About two years ago, my wife found my match list and she looked at it and she couldn't believe what she saw; it didn't make any sense to her. The reason it didn't make any sense is, in those days, you could go into pediatrics either by way of general medicine or general pediatrics, and, in fact, my first choice for a training program was a combined program that Allen Butler at the Mass General was trying to put together. He was trying to combine a year of pediatrics and a year of medicine, and for whatever reason, that didn't come about. But I would have loved to have done that so I was still struggling with the family doctor bit. My match list had a pediatric program, by medicine, medicine, maybe a pediatric program, and was very varied in geography.

Children's was my first choice, and that was because if you went to Harvard Medical School and you thought you wanted to stay in Boston you went to Children's. There was no training program at Boston City, and the other programs were not seen as of the same standard as Children's, and so I came to Children's, which was another defining point, because I fought the Children's system for two years. Again, I did okay. I have some anecdotes that I could tell you that I'd rather not see them in print, I

had some conflicts during that time with some of the powers-that-be.

I was chairman of the committee to get the house staff a raise. We were being paid nothing in those days. We went in to see the general director. We thought we ought to get $25 a month. He said he would think about it, and he came back the next day or next week and said, "Yes, we can give you the raise, but the day rate is going to go from $37 to $39."

We said, "You mean you're going to charge patients more in order to give us $25 a month? We'll do without the $25 a month." We were pretty foolish. Fortunately, the residents at Boston City went on strike a few years later, and we all ended up in getting something.

Mullan: That is, get paid at all.

Alpert: We didn't get paid at all. Children's was the last hospital in the country to pay its residents. Clement Smith, M.D., a very distinguished professor, pediatrician and neonatologist, used to say that we should pay for the privilege of training at Children's.

I felt that I had experienced everything that Children's could offer me, and I really was having some difficulty in the emphasis on what we can now recognize as the unusual (tertiary care) in inpatient medicine. I also believed, and had been exposed to the idea, that you were a better doctor if you trained

at more than one place, and so I started to look at going to some of the other pediatric programs for my third year.

In those days, of course, we had an obligation to do military service. We had a plan called the Berry Plan, and you could not interrupt your training by choice, because if you interrupted your training by choice, you went into the military. Also, you didn't waver back in college in your idea that you were going to medical school, because if you wavered in that idea, you would be drafted and so go to Korea. The Korean War, which began in 1950 while ended by President Eisenhower (1957) was still a hot spot.

A mentor at Children's, Robert Schwartz, a pediatric endocrinologist, brought Barbara and I out to his home one night (I was married in July of 1957) and I was talking about my frustration with Children's and the fact that I knew I was going into the Army the year after that, and I wanted to go someplace else. He said, "Why don't you go to England?" because Children's Hospital had at the time an exchange program between St. Mary's Medical School organized by Reginald Lightwood, a very distinguished British consultant pediatrician, and Charlie Janeway, who, of course, was the chief at Children's I revered.

I said, "Gee, do you think I've done well enough to go there?"

He said, "Sure, you have."

I went in and I saw Dr. Janeway, who I still call Dr. Janeway. He told me years later, as a faculty member to call him

Charlie, but I still talk about him with such reverence that he'll always be Dr. Janeway. I went in to see him, and he said, "You know, people only go for six months."

I was so unhappy at Children's, I said, "I'm not going if I can't stay the whole year." No one else had applied that year and he had no choice, and so I went for the full year.

Mullan: This was your third year?

Alpert: My third year of training. Dr. Janeway was quite concerned about spending a full year in the UK. He wasn't sure that I would get the same intense experience at St. Mary's as I would at Children's. But I went, and I was introduced to outpatient medicine. St. Mary's was a community hospital and the esoteric, not that we didn't see the unusual, by and large, went to Great Ormand Street, where the consultants also had their wards. If you were good enough and became a consultant, one day you could practice medicine in the outpatient department.

I was the registrar for one consultant pediatrician, the important man for me, Tom Stapleton, I was exposed to the wonder of practice away from the hospital ward, and I became convinced, still thinking that I was going into practice, that I wanted to be in the community and not be hospital-based.

Alex Nadas, a very distinguished pediatric cardiologist, offered me a fellowship in pediatric cardiology, and I said I would think about it. Bob Haggerty had come to Children's in

1955; he was the chief resident the six months before I became an intern, and he had developed a family care program for students and residents at the Children's. Both of those programs, the one at Mass General and the one Children's, were supported by the Commonwealth Fund. Bob asked me if I would come back after my two years in the Army and spend time with him.

I go to Fort Leavenworth, Kansas. I spent two years in basically a college community, because Fort Leavenworth housed the Staff and Command College of the U.S. Army. I practiced pediatrics and loved it knowing that that was what I wanted to do. But there was a family geographic pressure that was on us--namely, my wife came from Columbus, Ohio, and I came from New Haven, Connecticut. We had our second son at that time, and my wife had had a significant illness. We never understood the etiology of it; it was pulmonary and it was life-threatening. Neither one of us were ready to go back to a community where both of our families were, and here was Bob Haggerty's offer to come back and then, lo and behold, came a letter from Dr. Janeway asking me if I'd be chief resident. I said, "Wow," and then I thought about it. Being chief resident was not really what I wanted to do because that was in-patient. I negotiated and became chief resident for the outpatient department while I was a special fellow in the Harvard School of Public Health, and worked with Bob Haggerty. I I then spent a second year doing that. Remember now, there were no formal fellowship programs in the

area of what we would call general academic pediatrics today. That was then 1962, and I started applying for jobs.

Bob was funded by the Commonwealth Fund to study the health outcomes of the families who were receiving care from the Family Care Program, and asked me if I would stay with him as the clinical director. Here was another defining point. I remember him saying to me, "No one knows how long they're going to be in some place, and obviously you could go somewhere else." I had been offered the job as director of the outpatient department at two hospitals, one in Columbus, one in Pittsburgh. He said, "Why don't you stay with me five years, and then after five years, then you can go. Gee whiz, you'll be able to write your own ticket."

The opportunity to be associated with Bob and Charlie Janeway, this extraordinary man who was, on one hand, so very much a bench scientist and on the other an internationalist and humanist, supporting the Family Care Program. His umbrella was protective of all of us so that without much hesitation, Barbara and I said, "Yes, let's stay." So we joined the Family Health Care Program, and I became an instructor in the Harvard Medical School.

Mullan: Which was based still at General?

Alpert: Still at Children's.

Mullan: This was '62 on, then?

Alpert: This was '62 on. The work went extremely well. Bob and I, primarily Bob, recruited a marvelous gentleman, John Kosa, who trained formally as a psychologist, but was an exemplary medical sociologist or a health services person well ahead of his time.

Mullan: This was for the measurement side?

Alpert: This was for the measurement side.

Mullan: This is for patient outcomes?

Alpert: For patient outcomes.

Mullan: The Family Health Care Program at Children's was focused exclusively on children?

Alpert: And families. We called it family-focused care. We still had the limiting factor that Children's was a specialized hospital. The Peter Brigham was an adult hospital and the Boston Hospital for Women owned the pregnant woman. It was not a simple environment for putting the family together, but we tried.

Mullan: But this would also seem to have been an early effort at trying to think through the broader concepts of primary medicine or primary care medicine.

Alpert: Absolutely. You're familiar with the monograph that Evan Charney and I wrote.

Mullan: But that's a decade later.

Alpert: That's a decade later, and if you look at the chapter in that book on the history of medical education programs at the undergraduate or medical school level for primary care, you will find that the Family Health Care Programs at Harvard, Children's, Mass General, Yale, Case Western Reserve, were very much in this model, and I think that's exactly what they were.

Mullan: What was your thinking at the time? Was there an analysis that spoke to the steady fragmentation of the medical model or was the growing concept of family medicine appealing? What was the basis of your thinking?

Alpert: I think the driving force was the fragmentation. Joel Alpert, in his heart, was still a family physician. Bob Haggerty, in his heart, was a family physician. His grandfather was a family physician in upstate New York. I will assume that you're going to talk to Bob about his experiences. His father

was a pharmacist. When he came to Cornell, he was told that if he became a family doctor, he'd be throwing away his education, and he will tell you more about that. But we were a very special island in a sea of specialism. But, you know, we were respected, because we played the game by the rules. We were good, we were scientific, we were independently funded. It was just that the field was different.

And then Bob, who had had a number of job offers given to him, in 1965 was offered and accepted, the position of Professor and Chairman of Pediatrics at Rochester, and I was called in by Charlie Janeway. Bob had recommended that I take over the experiment and the program, and Charlie Janeway said that he wanted me to continue as director. I was very flattered and accepted, and I got a $1,000 raise, which took me from $10,500 to $11,500.

I was moonlighting at the time. Moonlighting meant practicing pediatrics. I would go out to a suburban office two nights a week and every other weekend, and I developed a practice of about 700 families. You notice I use the term "families." Again, I set my limits as a pediatrician, but, by golly, in the counseling that I was doing and in the viral and occasional bacterial illnesses the children had that their parents had, I didn't set any limits on what I would do. That was an important part of that next period, and my practice continued until 1971-1972, when we went to England on sabbatical.

Mullan: This was from when to '72?

Alpert: Yes, from 1965 until '72. We had definitely moved in the family medicine direction. We began to refer to the program as a family medicine program. We offered a fellowship for men and women who were general practitioners--it turned out they were mostly men--who had been in practice, who would come and spend a year tooling up for the academic community--incidentally, reassuring them that they knew their stuff. People like Lynn Carmichael, Jim Burdette, Tony Bowers, Nick Zervanos, are some of the names that leap to my mind, Whitney Brown, came and spent a year or two years with us while that experiment that I described earlier was going on, which was a randomized control clinical trial of the care that we were delivering.

Mullan: This training was to broaden their scope of practice?

Alpert: Well, as it turned out, this was to confirm for them--and we were very correct on this--that their practices didn't need much retooling. What they needed was the confidence that they could survive in the academic environment and they could run programs and they knew just as much as the people did in academia, if, in many cases, not more. And as you know, a number of them who I've just mentioned went on to chair family medicine departments.

Mullan: They were pediatricians?

Alpert: No, family physicians. Our family medicine program, with Charlie Janeway's support, started a family medicine residency, and this was prior to the boards in family practice. You know when people say, "Virginia, is there a Santa Claus?" and someone says, "When is Harvard going to have a family medicine program?" Harvard had a family medicine program. You spent one year at Children's, you spent one year at the Brigham, you spent your third year in the Family Health Care Program as a fellowship. You could sit for either your pediatric or your internal medicine boards if you did a fourth year. Some people did two years of medicine and one year of pediatrics and one year of family health. Some people did two years of pediatrics, one year of medicine, and one year of family health.

But as we were moving into that--this starts somewhere around '68--we actually got some money from the American Academy of General Practice renamed the Academy of Family Practice and their Family Health Foundation. The family medicine boards were formalized in 1969. I think it's either '68 or '69, and it became a three-year program.

We were on thin ice in terms of the new requirements, because the OB piece was one that we had never been able to fit in easily. I left the Family Health Care Program in '72. My successor was not able to stand the onslaught, and the residency was not accredited, based primarily on our failure to incorporate

OB into the training program and the new requirements of the Board of Family Medicine.

During that time period, I was a member of a planning group that started the Society for Teachers of Family Medicine. During that time period, I personally was overjoyed to be on the circuit. I think I spoke more at annual meetings of the Academy of Family Practice than I did the American Academy of Pediatrics. We felt like we were on the cutting edge.

In the family medicine world, there are some people who are in retrospect real giants. In fact, Fitz, a man named Amos Johnson from North Carolina came up to me one day and said, "What would you do if we got millions of dollars in training money family practice?" To shorten that story, Amos was so politically well connected and he succeed. That was the actual beginning of funds for Title VII, where I got involved later on with title VII. But this man and his colleagues, Ned Burdet from Kansas City, the two of them did the homework, and started laying the groundwork for support for family medicine on the federal level.

Mullan: A quick word on the environment before you go on which we should do in time. In the environment in the sixties, when you were involved in these fascinating interdisciplinary efforts both in pediatrics and in the broader community in Harvard and Boston was there tolerance, was there enthusiasm? What did they see growing in terms of this generalist outcrop?

Alpert: Remember now that President [John F.] Kennedy is assassinated in '61. [Lyndon B.] Johnson becomes president. Vietnam is still fairly quiet, but the War on Poverty begins right in the middle of this decade. Count Gibson and Jack Geiger at Tufts established the Columbia Point Health Center, so the OEO impact is coming.

What was going on in Boston, as in every other urban community, was this excitement of community-initiated efforts, the recognition that a lot of people were not getting serviced, were not receiving care. The community movement gets reborn. In many ways, I've always said that the Health Center was invented in Boston and New York around the turn of the century in the Settlement House and Health Center concept, and then it gets rediscovered in the mid-sixties and put into an up-to-date version. So that what was once called the Bromley Heath Child Health Station becomes the Martha Elliott Health Center; the East Boston Relief Station becomes the East Boston Neighborhood Health Center; and very rapidly in Boston community programs are developed under model cities programs and a lot is happening.

Mullan: So the developments were community oriented.

Alpert: Right, but in Boston not to generalism.

Mullan: And yet there was a kernel of generalism going on, at least in your shop.

Alpert: Oh, yes.

Mullan: And it was tolerated because it wasn't seen as a focal issue of tension. It was just happening in--

Alpert: It was no threat to anyone. And remember, the tradition at Harvard is every tub finds its own bottom. In 1970 we became the first endowed family medicine program in the country because we were awarded almost a million dollars. IRS rules had changed, and if a foundation didn't give away a certain amount of money, it was in big trouble. It would lose its tax-free status. So a Philadelphia named the Theodore Schultz Foundation, had grown to about a million dollars, and we competed for that and we got it. That was to endow the Family Health Care Program, and that took place just before I went to England for my sabbatical. You must ask how did we get Philadelphia money to Boston. There was a Harvard connection but most important, Charlie Janeway had some years before been awarded a modest sum ($5,000) and told me how he kept the Foundation . He said no matter what the size of the gift, you made a fuss and thanked the donors.

Mullan: So it got recognition because it was financially self-supporting. It wasn't taking or challenging anybody else.

Alpert: We had relatively little impact on the environment around us. Each year we would have approximately thirty-two to thirty-

five, which is about a quarter of the class of Harvard Medical School students, spend their third year in continuity caring for a family. We had family medicine preceptors, because these men who'd come out of practice were preceptors, as well as general internists, general pediatrician, and a psychiatrist, social worker and public health nurse. To this day, path crosses with former Harvard students who are well-established in their specialty careers and they remind me of those very heady days teaching family medicine to third-year medical students at Harvard.

Mullan: In '72, you went back to England.

Alpert: In '72, I go to England. Coincidentally, Evan Charney was there at the time. I was supported by the Division of Medicine and National Center for Health Services Research. I am very proud of this support. My grant received a 100 priority score. Gene Carmody was in the National Center for Health Services Research and Development, and the other half, you were not called the Bureau of Health Professions, but it was the Bureau of Health Manpower and the Division of Medicine. My application went to Health Services, but the Bureau of Health Manpower kicked in another five grand on the contract, so Evan and I had support for the monograph.

Mullan: In England?

Alpert: In England. Just as we are leaving for England, I am offered the chairmanship at Boston University and Boston City Hospital. I had been interviewed for a number of places to go and be chairman of pediatrics. The job at Boston City and Boston University--was a terrible job; the best thing that could be said about it is that the population that it served and its service responsibilities matched my educational goals. I didn't have to sell my house and our family didn't have to move. The BU team had interviewed me in September but had not offered me the job. And so that kind of petered through the year, and then two weeks before we went to England, something like that, they offered me the job, and I had to decide in the next two or three or four weeks whether I would in fact not return to Harvard but come to Boston University.

Returning to Charlie Janeway, who never gave people direct advice, but helped them make up their own minds. One day he said to me, as I'd been to see him a second or third time, "You know, Joel, I'm going to be stepping down in a couple of years. I'm going to put you and Dr. So-and-so in for tenure."

I had succeeded by all the rules. I had published over sixty papers by that time, thanks to John Kosa and all those wonderful folks and the fellows in Family Health. "I'm going to put you in for tenure, and you're going to be able to spend your career here, and I think that's terrific. I would like you to be responsible for family health and the outpatient department. So your choice is very straightforward. If you stay at Harvard, you

will teach the people who will teach." Charlie also, with all that humanism and all that broad experience, was a comfortable elitist. He also said, "If you go to Boston University, you'll teach the people who will do."

So now it was decision time. I came home to Barbara that day and I said, "How can you possibly teach the people who will teach if you've never taught the people who will do?" And I came in the next day and I accepted the BUSM position, and I never looked back, because I've been here as, as I said, chairman twenty-one years, and it's been two years since I've stepped down as chairman.

Mullan: This was just before you departed for England?

Alpert: Right.

Mullan: So they gave you the time off. You were able to go to England anyway and write the monograph.

Alpert: Well, who gave me the time off? First I had to go and check with Harvard, because, to take a sabbatical and not return to your institution was not ethical behavior. Charlie Janeway again helped me with this one. He said, "Joel, you're not costing Harvard a nickel, because you've got this wonderful grant." If I had not gotten the grant, then I would have been getting money from the Department of Pediatrics. I think I would

have made a very different decision and would have returned to Harvard.

Alpert: So that he said, "Yes, you can do that." And I saw the dean of Harvard Medical School, Bob Ebert. A couple of things had occurred with regard to Harvard. Bob Ebert had become Dean. He was starting the Harvard Community Health Plan.

Remember I said to you how proud I was that the Family Health Care Program could fund its teaching and its research activities. It was very difficult to fund service activities. Medicaid had come in in 1965. A lot of people were uncovered, not as many as today, interestingly enough. I said to Dean Ebert, "Would it be possible for the Family Health Care Program to become a teaching unit for the new Harvard Community Health Plan?" He said no for a number of reasons. I think the two most salient ones were, one, he wanted the Harvard Community Health Plan to be his creation, his contribution to the Harvard community; and secondly, he was worried whether the Harvard Community Health Plan was going to make it or not and didn't want to be burdened by teaching.

I remember going back to Dr. Janeway very disappointed and his being somewhat philosophical about that, that if we hung in there, eventually we could become part of the new Harvard Plan, but I had to understand these limitations, and I realized that I needed to go to someplace else to try out my ideas. The Boston University people wanted me to start immediately, i.e., in July.

The Chairman of the Search Committee had come to my house the week before they offered me the job and said, "Are you irrevocably committed to going to England?"

I said, "Why are you asking me that?"

"We want to know that before we offer you a job."

I said, "Well, I don't know until you offer me the job."

So they offered me the job. We had been to England, we'd bought a car, our kids were in school. I said, "We're irrevocably committed."

And so then they had to go back and they had to figure out would they wait eleven months for me. Boston University School of Medicine had a new dean. The new dean was a wise man who said, "Twenty years from today, what difference does it make whether Joel, or whoever we recruit, comes on June 1st or comes on the next June 1st?" So I shortened my sabbatical by a month, and it all worked out.

Mullan: Tell me about the primary care monograph, and let's wind that forward by talking about the use of the word "primary care" or "primary medicine" or "primary physician." Were you using that in the sixties? When do you first recall that word being packaged in that way, and what brought you to write about it in 1972?

Alpert: Remember, I had gone for my third year of training in '58-'59 to England, but that was as a third-year pediatric

resident. We had established a number of friendships there. Bob Haggerty had also been to England, and through a combination of the people I met, I was introduced to primary care--one of the things that Bob did when I joined him was put me on a circuit, and I went and met with George Silver, who had just written about the family medicine experiment at Montefiore. I met Kerr White. I'd been privileged to meet John Fry, Archie Cochrane (Wales), and Frye and Kerr White, I think probably Kerr White's article in the *New England Journal of Medicine*--was an important introduction to primary care.

Mullan: In '61.

Alpert: The term "primary care" probably originates from a British White Paper in the thirties that talked about the need to regionalize health services and referred to primary, secondary, and tertiary care. You know, it's kind of hard to trace back and be confident of when the term is first used, but I think that in a contemporary sense we give Kerr White and John Fry credit for the terminology.

Mullan: You were using it by the early seventies to the point that you chose to write about it.

Alpert: We were using it in our teaching in the sixties. Now, it was almost a strategic use of the term, because "primary care"

had pizazz. We had enough sense; after all, if you look at the history of the terminology, terminology changes, but the function never does. General practice had some. Look at the academic world. Richmond at Hopkins--and I know this because I think about this a lot and I've written about it a lot--talked about "the whole person." You can go back to Charlie Janeway's grandfather around the turn of the century talking about medical school education, and Osler saying the same thing, that in turning over education to a full-time faculty that the clinician and the generalist were going to lose out. You can find quotes in the 1900s, early, about specialism taking over.

We certainly were aware of the crisis, the shortage of specialists, the imbalance that was occurring, where do you get a family doctor. Richards talked about the whole patient. George Rezder at Cornell talked about comprehensive care. Kerr and Hammond at Colorado talked about comprehensive care. Case Western Reserve had a Family Health Care Program, and all of these programs were experiments in medical education, but they were describing a function, and the function is generalism, and the pizazz term in the 1960s was "primary care."

And so we wrote and talked about primary care. When Evan and I realized we were both going to be in the U.K., I enlisted Evan to write the monograph. It was my idea, and that's why my name is first author, not just alphabetical. But in terms of the definition, for example, Evan made more of a contribution to that than I did. I was the reactor; he was the developer of the

definition. We talked about primary care, and it was indeed primary care.

And then the word "generalist" or "generalism" returned in the late seventies and "community" has now come back in, and we're going to continue to recycle words. As an aside, that's why I've always been opposed to changing the name of the Ambulatory Pediatric Association, because whatever popular word of the day you want to use, you can name your society by that name.

Mullan: As you wrote the monograph and as it was received and read, first the writing side and second on the reading side, what did you have in mind its contribution would be and what was its contribution as you got reaction to it and have continued to?

Alpert: I told you that I had done a little history in college, so I've always been a bit of an amateur historian. I felt there was a story to be told of how we had got to where we were. There was a need to pull together all of the experiments in medical education. Let me illustrate that point by discussing preceptorships. Most full-time academic faculty, they turn their noses up at preceptorships. Every report of preceptorships in the literature, show that they are with reasonable evaluations, astonishingly successful. Yet preceptorships have not been incorporated into the mainstream of medical education. So there was a reason to write about preceptorships.

We also consciously wanted a report which would be directed at graduate education. For the undergraduate piece, we said, "Hey, guys, it's all here, and we're pulling it together in one place." At the graduate education level, we really felt, being very comfortable about pediatrics, that we should applaud family medicine as a new endeavor, and spank internal medicine. In those days, the percentage of outpatient time in the majority of internal medicine programs in this country was not 5 percent, was not 10 percent, it was zero. We had a prescription for graduate education. We drew on our experience in the U.K. as to how to educate people on the graduate level.

The first chapter in the book, the definition, was done to let people know what we were talking about. I think the long-term staying power of our monograph has, in fact, not been the history, has not been the menu for graduate education, but has been the definition. Bob Knouss was then head of the Division of Medicine, and, based on the monograph, offered a contract program, the first three programs of which our BUSM/BCH program was one, and then Bob's Division funded another three. You should have in your archives who the six programs were. Bob had six contracts awarded before Title VII passed and used those six programs and a lot of politicking to get the support for Title VII. I am very proud of the role that I played in Title VII, because I was the key contact with Senator [Edward M.] Kennedy and we had a contact with Senator [Jacob] Javits, and therefore we had both sides. Paul Rogers was the key person in the House,

and Steve Laughton was his legislative person. The result was Title VII was in the health professions legislation of '76.

This was the first time that I really entered the political process on a national level. Both the House and the Senate passed the bill. For the training in general internal medicine, pediatrics, and family medicine, the House appropriated zero, and the Senate appropriated $20 million. The compromise was $10 million the first year. I remember thinking, "Is that the way it always works? I mean, is it really true that numbers get split?" What was also remarkable about the compromise was that funding began in the first year due to large part to the previously awarded contracts.

Mullan: But you saw this as operationalizing the concepts.

Alpert: Yes, we operationalized the definition, yes, and I think our monograph played a very, very important part in Title VII.

Mullan: Let's move forward quickly, in the interest of time. Let's first pick up just on your experience as a pediatrician and a department chairman and moving forward from the early seventies to the early nineties. How did you see the evolution of pediatrics during that time vis-à-vis generalism both here and in the country?

Alpert: Pediatrics has always been in a funny position. Pediatrics is the first specialty in this country that does not

begin with a technology, not with a procedure, not with an organ definition, but with an age definition; if you will, a social menu. So it's not at all surprising that you find as my pediatric career begins in the 1950s, the then-editor of *Pediatrics*, Charles May, wrote about the dissatisfied pediatrician. He asked can new pediatrics be practiced? The immunizing agents, the antibiotics and nutritional advances had effectively revolutionized pediatric practice. Without consciously realizing it, pediatrics was becoming an outpatient specialty. It was to be practiced in the community.

Pediatrics did not accept this consciously or easily. This is what the Family Care Program was doing at Harvard. This is what we've done in the Department of Pediatrics at BCH/BUSM. But you find this theme being echoed throughout this whole period, and certainly when I become a chairman of pediatrics and joined the chairmen's organization, AMSPDC, the American Medical School of Pediatric Department Chairmen, I would say of the 100 to 120 chairmen--the number grew as the new medical schools came, so by 1990 we were about 125 members--there would be about a dozen of us who would have legitimate credentials as a generalist, and the rest would have come to their chairmanships by the specialty route (endocrinology, neonatology, cardiology) whatever it would be.

Mullan: It's 100-125 specialists and whatever, is that what you're saying?

Alpert: Yes, of the 125 pediatric chairmen, 110-15 would be specialists.

Mullan: When I was at AMSPDC last year or the year before, I counted in the program, and you're not far off. The numbers were included Canadian medical schools, as well?

Alpert: I eliminated the Canadian medical schools.

Mullan: I got about 15 out of 140. It was down around 10 percent.

Alpert: If you add the Canadian schools, it's about 140, that's right.

I developed a reputation at AMSPDC that I would be the guy at the back of the hall that, as the meeting would end and we would have finished with the NIH [National Institutes of Health] and finished with NICHD, and I would get up and I would say, "But Title VII is in trouble." And I remember an enormous debate that went on, where the majority of the chairmen wanted to turn Title VII into a capitation program so that each pediatric program would be paid so many dollars per head of resident for primary care. I went bonkers because I wanted it very much to be a competitive program. I said, "We would not have a center in the management of cystic fibrosis at Boston City Hospital, but we sure as hell had a center regarding primary care."

There have been a number of pediatricians who have been at the forefront of the primary care movement. Look at the first three Pew Awards, two of the three went to pediatricians--Barbara Starfield for research and Bob Haggerty in education. But of academic pediatrics, as a discipline, has kind of gone along with the flow and as least as far as the chairmen were concerned primary care was not the mainstream.

Mullan: From '72, from your early days as a chairman through your late days as a chairman, would you say that from your early days to your late days the forces in pediatrics in terms of what was acceptable and what was valued in terms of teaching, in terms of specialism versus generalism, evolved, and if so, how? That is, do they become stronger and then weaker? Did they become steadily stronger? And was general pediatrics marginalized over the time?

Let me just add, from my perspective as a pediatrician trained in the early seventies, the notion of general pediatrics seems redundant, because essentially even at that point, pediatrics was generalism and there were a few specialties, or subspecialties, they were called. By the 1980s, one was referring to general pediatrics in contradistinction to the way much of pediatrics was going, or at least tending to go.

Alpert: I agree with your point, but I think not your conclusion. First, I think you're right that the issue of the

conflict between generalism and specialization, while there was a tension within pediatrics, that pediatrics as a discipline recognized that clinically it was a generalist discipline. That occurred twenty years before internal medicine. In fact, if our pediatric voices were lonely, let me tell you, the internists were hermits. Pediatrics was challenged by family medicine. Were family physicians in this country taking care of children? The American Academy of Pediatrics says 85 percent of its members are generalist pediatricians.

Pediatrics, still is struggling with the gap that exists between formal training and clinical practice; that is, the nature of childhood diseases in the community and the reasons that children end up in the hospital, increasingly are at variance. Hospitals deal with low-prevalence events while the high-prevalence events go on in the average pediatric practice. I still think that you would find a tension today were you to ask pediatricians, "How are you prepared for practice?" "Were you well prepared to deal with the school problems, learning disabilities, failure to thrive, abuses and neglect, the adolescent behaviors, sexuality?" There's a broad menu. The answer would still be that there is a gap that exists between what goes on in training and what is out there in practice.

During my residency training, I did over 400 exchange transfusions and not one pelvic. Our pediatricians at Boston City Hospital know their adolescent GYN and have done hundreds of pelvic examinations and very few exchange transfusions.

There have been a number of reports about the educational gap. The Task Force Report on Pediatric Education (1978) is typical. This report presented a menu of general pediatrics, the nature of what pediatric training ought to be. Then you look at the follow-up as to whether education changed or not after the report. The report was largely ignored. But change is coming. There was a set of residency requirement regulations that appeared out in the mid-seventies that emphasize the teaching of subspecialties in contradistinction to what we're talking about today. But the latest regulations (1995) emphasize adolescent medicine, continuity, the very broadest menu, and have achieved, I think, a proper balance for the specialties.

You are right when you say there has been a recognition, then there was a weakening, and then there's a strengthening, but why did I say I disagree with your conclusion? There has been this gap between most of us who spent our careers, in academia and those who are out there in the practice world where there has been this gap. Once the pediatrician got out into the practice world, he or she either adapted and knew that there was a different morbidity that they had to deal with. Bob Haggerty coined the term "new morbidity." I talk about "changing morbidity" or a "social morbidity," that if you didn't become skillful in dealing with, you were going to have a rough time in pediatric practice.

Mullan: How has the experience at Boston City been for you?

Alpert: I have two external measurements, and I hope when you translate the tape to words that you'll recognize I am smiling. We talk about outcome measures today. I came here thinking that the state of children would improve and that we would produce more primary care physicians. If I look at national outcomes, I have been a miserable failure. Children are worse off today than they were twenty years ago; not, of course, in a 50-year chunk or a 100-year chunk, but in these twenty years, things are worse off. Immunization levels are down, poverty is up, all those things, Fitz, that you know better than I do. And certainly the shortage of primary care/generalist' has gotten worse, and even though we've had the blip in training in the last two years, continues to get worse. In that sense, my work here has been a failure.

In a very different sense, if I focus myself on this institution, I think that ours has been a department here that is vibrant and vital, that is scholarly, whose scholarship menu is directed at the high-prevalence events of inner-city children, and that we have succeeded. I came here because, "The service responsibilities match my educational goals," and I've been very blessed in this environment. This is a "because of" and "in spite of" institution. Because of the value and the mission of a municipal hospital, we've been able to do the things that we wanted to do, but it's in spite of, because it's a dysfunctional system--the incompetence, the ties to City Hall that we have dealt with through the years. Certainly there are many, many

good people who have struggled to make this system work, but I think for public hospitals to succeed, they have to be separated from the politics of City Hall. But to take it a step further, we have a brand new hospital a block and a half over which is there because of City Hall. So we are a "because of" and an "in spite of" institution.

Mullan: A question on MCH. This goes a little afield of the primary care story. Well, maybe not. I've watched MCH as a phenomenon both from the federal perspective and the states' perspective; that is, the culture of federally funded, state-mediated maternal and child health programs deriving as they do from the Children's Bureau, etc. They have always seemed to me to be fairly insular and, for better and for worse, targeted in a fairly specific way, with, until recently, anyway, relatively little bridge-building. I mean, if you take Healthy Start as a requirement to build bridges in more directions or different directions, it would seem like at least a somewhat different approach. But without getting any more editorial than that, which I really didn't mean to, how have you seen the MCH program integrating with the growth of generalist pediatrics? Or does it?

Alpert: Again I agree with your observation, but not necessarily your interpretation. If you look at the history of MCH which

starts with the Children's Bureau, the great names, Martha Elliott, Arthur Lesser, Title V, that's a marvelous story.

Do you know that as a pediatrician in a general hospital I have to subscribe to "separate and equal"? I mean, just think about that. If I open up my doors and invite everyone in, the children lose. If you ask people about my reputation in this institution, the ones who like me will tell you I'm a bulldog; the ones who don't like me will tell you I'm a pit bull. The message is, I am a fighter, and I have been a fighter for children here. I've had to have separate waiting rooms. I've had to have separate trained technicians. You have to have pediatric nurses. And it goes on and on and on.

I think the MCH, the bureau, has this same mentality, that the women and the children have to be carved out, and it's almost like circling the wagons. It's necessary to do that to survive. You pay a price for it, and you pay a price for it in that the people who are on the outside looking in sometimes think that you are too isolated and that you don't build bridges. I don't have an answer to how to do it otherwise. It is a very interesting and important observation.

Mullan: If you look at the theme in your own life of the sort of early development of a generalist practice that reached out to the rest of the family and all that's followed from that, that does seem like quite a different mind-set, a different world view than the far more kamikaze-like MCH approach.

Alpert: Yes, but, you know, if you look at my own career, I was much more outreach as you've described and, let's say, had much more less fixed boundaries.

Mullan: Or cosmopolitan.

Alpert: Or cosmopolitan in the Family Health Care Program than I would have had, or have had, here at Boston City Hospital and Boston University, where I've had to protect, if you will, the pediatric turf. So at the same time that I have reached out, we've had to protect the boundaries. There are people here who would tell you that I was fiercely partisan and fiercely insular as far as the pediatrics are concerned.

Let me then take you to another area. I feel we've done an injustice to the last twenty-five years, and you've seduced me, because, you know, what a wonderful opportunity to talk about yourself. I still have a dream about the model of family medicine in this country which is both pragmatically and programmatically driven. The pragmatic part of it is, the turf cannot be owned by any single division of our profession, because for better or worse, no one can now produce sufficient numbers of generalists to provide the services that everyone needs, and every American ought to have access, without a financial barrier, to a clinician who is that individual and family's primary care physician. So it's family physicians, it's general internists, and it's family physicians.

I will step on some toes on this one, but if I had a blackboard, given the nature of urban settings and more specialized environment, the rural environment and where we are, I would have a generalist for young families who would come out of the pediatric track. Once you teach pediatricians gynecologic skills, there's no reason they cannot take care of young families. I would have an adult side model, a converse of that, who would have much more geriatrics in their experience, and I think that that's a real need because the geriatric population is very special. The family physician would in general, clearly not always, be much more of a rural model. I have three kinds of family physicians: the one who cares for young families and whose expertise in the hospital, with children; I would have an internist whose expertise is much more with the adult and the elderly; and then I have a generalist who is the family doctor, who really probably does do OB, and does that in a more rural setting.

If I had an absolute blackboard and we could have anything we wanted, I would probably go with the family physician model as it exists in the U.K., with the caveat being that in the UK children would appear--and I don't necessarily have the data to support this--but would appear not to get the attention that they need in that system. It's much more of a sick-care system, so that if you want your immunizations or you want counseling, you go to the local health authority or the health visitor. It's not that straightforward a network.

But to go back to my pediatric commitment and pediatric model, I would like to see the pediatrician, the general pediatrician, really function as a family physician for young families.

Mullan: And your view of the future vis-à-vis generalism (pediatrics), where we're looking ten or twenty years down the road, how do you think this will shake out with respect to generalism?

Alpert: If you go backwards in history, we will not reverse what has happened, because we have not made a commitment to a generalist system in this country, and the words will turn out to be the same rhetoric that in my career I heard in the fifties, the sixties, the seventies, the eighties, and I must confess with actually more noise in the seventies, and now again more noise in the nineties. However, I don't think things are going to stay on the same course, because I think that the delivery system, the financial barrier, the absence of national health coverage in this country, is going to create such a crisis that it could well be that generalism will end up being the kingpin, the foundation, the basis, of medical practice in this country. So I have a combination of optimism, which I hope that it does happen, and a little guarding, because it has in the past been rhetoric.

Something else that's different now is there are powerful economic forces out there that appear to be moving in a different

direction, but the powerful economic forces in the past were historically on the side of specialism, and they are not now. But I don't know whether that is short term or not.

Mullan: The non-physician provider in general and vis-à-vis pediatrics, will the non-physician provider replace significant portions of the physician work force or the pediatric--

Alpert: I'm much more comfortable in that prediction. My answer is no; that is, the non-physician provider will not replace the physician. I don't think the non-physician provider was ever intended to replace, although in the minds of some of our articulate nursing colleagues, there are 400,000 of them coming down the highway, and we physicians better watch out. And I have my own baggage on this issue. After all, I trained as a physician and I've been primarily training physicians. But I think that our nursing colleagues and other non-physician providers have their own areas of skill, do things better than we do in many areas, but they will succeed because they're part of the modern medical model umbrella, and that it is a collegial relationship and a partnership that will work, but not a replacement.

Nothing would please many of our specialty and nursing colleagues more for us to keep doing things as we're doing them now, because they would say we had defaulted on the contract and they will take it over. But if we did see that happen, we would

be the only country in industrialized society, where that would in fact have occurred. Of course, we are the only industrialized country that doesn't have national health insurance, so I suppose we could succeed in that area.

But I think the numbers game, let alone my own view of what a physician ought to be and the issue of what medicine is about, has history on its side. Talk about history, medicine has a 5,000-year-old history.

I mentioned earlier I've got some data that we're putting together. We have studied urban emergency-room utilization over a 30-year period. In the 1960s, 35/40 percent of the families who came to our emergency rooms were basically no pay. In the seventies, when we repeated the study, the percentage, with the introduction of Medicaid, had dropped to about 31. It's now up to 58%. That's a window before Medicaid managed-care. This inequality will ultimately force the system to revisit major health care reform with universal health insurance as a goal.

I don't think the educational piece of this, where I've invested most of my life, is going to have much to say about the outcome. We are going to follow. Dan Funkensteen's data (forty years' old) says that medical students' career choices reflect the values of the society. If society values having a personal primary care physician and choice of physician then medical students will choose generalist careers long before academia changes.

Mullan: Any parting thoughts about the evolution of generalism as you've seen it in general or from your IOM [Institute of Medicine] primary care committee perspective or other?

Alpert: Primary care has never gone away. The name has changed. There have been times when primary care has been stronger, and we may well be entering into a time period when primary care is stronger. The fact that primary care has been in a roller-coaster and that it cycles and that it has its ups and downs is because we do not have a societal commitment. We do not have a defined primary care service. And so long as we don't have a defined service for primary care, it will cycle. Like the stock market, it will have its ups and its downs.

Mullan: I used to think that the Canadian system, with its single kind of primary care provider, the family physician, was certainly simpler, but also stronger. For reasons I don't entirely understand, nurse practitioners are being developed rather rapidly in Canada, which will begin to take it out of focus.

Alpert: You now have added something new to my knowledge base. I was not aware this was occurring. I do know that the nurse practitioner in Canada, except for some of the isolated areas, was basically zero. So it may be, Fitz, that what's happening is they're going from having nothing to a little bit.

Mullan: Apparently it's coming on fairly strong. The Canadian system, which I know only a bit, is in more flux than we often ascribe it as being.

Alpert: But everyone still has coverage and people don't worry about getting hurt when they're ill.

Mullan: I very much appreciate your taking the time.

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