JOHN C. ANDERSON

August 10, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Anderson: May 31, 1946.

Mullan: We are in Cle Elum, Washington, which I am told means--

Anderson: "Rushing Water" in Yakima Indian.

Mullan: We're in the house of Dr. Anderson on a beautiful, clear Saturday in August, August 10, 1996. I'd like to ask you just to tell me a little bit about where you were born, where you grew up. You come from Washington?

Anderson: Yes. I've been in Washington almost all my life. I was born in a small town up in northern Washington, Chewelah. Just lived there briefly. My father found employment in the Tri-Cities at the Hanford Atomic Products Reservation.

Mullan: Tri-Cities?

Anderson: Tri-Cities is Richland, Pasco, and Kennewick. It's way southeastern Washington. In fact, that's where he had been born. That's where my mother had been born, also. So it was a

born. That's where my mother had been born, also. So it was a natural move back for them. I grew up there from the time I was three months old to the time I left high school.

Mullan: What was it like?

Anderson: Very much small-town environment. It was enlarging cities. The Hanford Reservation and then the Columbia Basin agricultural development brought a lot of industry and hiring to the area. So it was a growing area, but still had basically rural atmosphere.

Mullan: With the nuclear contribution the town, which we've read about much in recent years, what was it like to grow up around that?

Anderson: Well, the athletics teams in Richland are named the Richland Bombers. The school symbol is the atomic nucleus in electron orbits. During kindergarten, I remember having air-raid drills, going under the table for protection whenever the siren sounded. It was something that I took for granted and we didn't develop a fear of. I actually worked one month at the Hanford Reservation on the radioactive waste disposal crew. There were these big tanks of radioactive waste out there that you might hear about. I helped load some of the liquid out of the areas to leak out through those tanks. I got some radiation exposure.

They assured me it was minor, and I haven't had any problems from it, so I suspect it was okay.

Mullan: This was when you were in high school?

Anderson: Just after high school, yes.

Mullan: So that there was a kind of coexistence with the nuclear, both the actuality and the theory of the nuclear, of the bomb.

Anderson: We knew that that's where the jobs came from in the area, so there was a pretty easy acceptance of it.

Mullan: Looking back on it now, the radioactive level remains pretty good?

Anderson: Yes. I think a lot of the down-winder study concerns have been exaggerated. The people who have claimed injury from the radiation exposure are families that I certainly don't recognize the name of from growing up there. I suspect there has been a fair amount of invention of symptoms. I think there are some real concerns, but our knowledge of radiation risks were pretty immature then, and I don't think anything was done with intent to cause risk. I think it was more ignorance, if anything.

Mullan: In terms of the existence of the waste and the clean-up costs, how do you feel about that?

Anderson: It certainly was not a far-sighted effort, as far as containing waste there. Ironically, the economic benefit to the area of the clean-up probably will exceed the economic benefit to the area of atomic products manufacture.

Mullan: Fascinating. They'll be going for some years, I guess.

Anderson: Yes, certainly. I think they're projecting it into the year 2010 currently, and I'm sure with technical overruns, it will go beyond that.

Mullan: Tell me about your family life. What actually did your dad do and what was that like?

Anderson: He was a industrial chemist. He specifically was a spectroscopist, measured the radiation, light-wave radiation spectrum to analyze solid materials. So he was involved in that for probably fifteen, twenty years before his retirement. His work was in Richland, and we lived in Pasco on a small piece of land just out of town, kind of similar to what we're on here, although it was desert there instead of forest. Mother did not work outside the home until later. She took training as an L.P.N. and worked at that briefly before her death. She died of breast cancer in 1965, the year after I graduated from high

school. Father survived about nine years after that, but he eventually died of pancreatic cancer, which is fairly common for industrial chemists, primarily chemical agents rather than atomic-type stuff.

Mullan: Any sense that that was related to his work?

Anderson: Yes. I am almost certain he was involved in some fairly dirty chemical industries prior to the time my parents got married. He was employed by some industrial chemistry outfits back in New Jersey and described a lot of exposure there.

Mullan: How did he feel about that when he was dying?

Anderson: He accepted it. He was also a smoker, he didn't blame anyone else, and that wasn't his nature.

Mullan: As you look back on it, was it a good youth? Was it fun?

Anderson: Very much so, yes. We were out of town, we had animals. I raised chickens, we had a garden, about four blocks into town. I had friends. They were all very positive. We were a very conservative family, church-going. Church has always been a very important part of my life and was certainly so back then.

Mullan: Which denomination?

Anderson: Lutheran.

Mullan: As you think about it back then in particular, what sort of values did it build or emphasize for you?

Anderson: Certainly very conservative, people-oriented values and service-oriented values, the belief that I had an obligation to be of help to other people.

Mullan: Religion doesn't always come off that way. In the world, obviously there's individualism in terms of what it does for the person, what the person feels about an after-life. Was there something about the denomination, Lutheranism, or the church, or your particular experience that emphasized service in particular?

Anderson: I'd have to say it was maybe more family orientation; I'm full-blooded Norwegian and proud of the heritage; we were raised to believe that Norwegians were responsible, stubborn, and basically capable people. We grew up knowing that a lot was expected of us.

Mullan: How about medical influences in your youth? Were there doctors that [unclear] from your family or what were [unclear] ?

Anderson: No physicians. We had a family physician, but he visited infrequently. We didn't have very much money, so we took

care of most things on our own. There were two pharmacists in the family, one aunt and one uncle, and they interested me in health care a little bit. And my mother took her training in nursing, which also raised my interest a little bit in health care.

Mullan: What did you do about college?

Anderson: I went fifty miles away to Whitman College in Walla Walla (which also means "Rushing Waters"), and I spent three years there. I started out into pre-medicine, but I saw the pre-medical crowd there and I figured out in a hurry this was a group I couldn't run with. I changed from thinking about medicine to an interest in chemistry, which had started in high school and looked at going into academic chemistry as a career. Spent about two years working at that. The second year, I became increasingly interested in biochemistry as it related to some of the other sciences, but I did not do well in organic chemistry because I was also in a fraternity and having a lot of fun.

Mullan: Why did you feel that you couldn't run with the pre-medical crowd?

Anderson: They was very competitive, had a quite a reputation for being cut-throat, for doing anything to get a better grade than the next guy. Just not a congenial group of people.

Mullan: So it was more a qualitative issue than it was [unclear] intellectually to be.

Anderson: Right. I felt I probably could have competed. I wasn't motivated, though. I think I had about a 2.4 grade average the first two years, if I remember right. The folks that did go through the pre-med program there ended up going into urology and orthopedics and neurosurgery. There was not the kind of values there that favored primary care. In retrospect, I think I was probably right, but I didn't feel comfortable with it].

Mullan: [unclear]?

Anderson: I spent a third year there, but I thought I'd probably be better going into education, so I took education courses that year to become a high school science teacher. Enjoyed that greatly, had a wonderful education professor. Again, good, clean values. really nurtured my interest in being a teacher. I was all ready to continue on with my fourth year. I also recognized I wasn't being too successful at Whitman in fitting my needs. Connie had been at PLU in Tacoma, her college, and I decided to join her there, so I got all the arrangements made to move over and continue my education training there.

Mullan: That's in Seattle?

Anderson: In Tacoma, which is south of SeaTac Airport.

Mullan: Connie--you had met on the way?

Anderson: We had met between our junior and senior years in high school and had been going together pretty much steadily since then. She was from Kennewick, I was from Pasco. We took a summer enrichment program in biology. We met carrying butterfly nets along the Yakima River.

Mullan: That's romantic. How [unclear]?

Anderson: Well, something happened before I got there. I had spent previous summer as an engineering aide for the Forest Service in a small town in Idaho, which was a job I had happened to pick up. I was going back for the second summer of that, got kind of bored on weekends. I walked into the local hospital and asked if they had something I could do on weekends, and the local administrator talked with me for a little while and he said, "We'll take you on". I'll bring in my old whites and you can wear those and mop floors and take care of patients, but I'm also going to see if I can get you interested in medicine." I worked with him, I worked with the local doctors, an outstanding group of doctors there, and the nurses. I got to watch an appendectomy, got to mop up after deliveries. I figured out about three weeks into that that I could do that and I wanted to do that.

Mullan: What was the town again?

Anderson: McCall, right in the center of Idaho, about halfway between Boise and Lewiston, up in the mountains, beautiful area.

Having had that experience, I went back to Whitman, asked a pre-med advisor there who I'd also had as a research advisor, asked him what he thought of me going into medicine. He wrote back, "I think you should stick with teaching high school chemistry." So I wrote to the pre-med advisor at Pacific Lutheran University and he said that, "Your record is not too promising, but come on and talk to me when you get here and we'll see what your chances are."

I was really motivated now. That was a most nurturing environment. Instead of the 2.8 that I had at Whitman, I got a 3.9 there at PLU. Got involved in pre-medical activities and continued in chemistry, but didn't have a long enough record to apply for medical school. I did take the MCAT's and did well. So I got the number-one recommendation out of PLU, but it was too late to apply for the next year of medical school.

I went over to Washington State University, got accepted into their biochemistry graduate program. So I did a year of biochemistry graduate work there, some research assisting. It was also the Vietnam years, and I had a lousy draft number. In fact, I had gone through my induction physical, and they had me scheduled to be on the train for induction, but one of the professors at WSU found that they needed a full-time teaching assistant in chemistry for that year. That would keep me from

being a point-man in Vietnam and kept me out of the draft until I could get into medical school.

Applied to U of W, checked out other schools, got accepted at the U of W, University of Colorado, and ultimately chose U of W.

Mullan: Which year are we at now?

Anderson: This is 1969. Connie and I were married after we graduated from college, so we had a year of low stress at Washington State University to get ourselves settled for medical school, which was very nice. Took my pilot's training there, too.

Mullan: As you entered medical school, what sense did you have of what kind of doctor you wanted to be, or did you have a sense?

Anderson: Yes. I just wanted to be a rural doctor and practice in a town similar to where I'd gotten my inspiration and something similar to where I grew up. I kept that orientation, talked to the advisors, and all they knew about primary care for rural areas was primary care internal medicine. So I kind of committed to that and had an advisor, spent some time talking to him, didn't feel quite right, 'til my second year they opened the Department of Family Practice. Ted Phillips came in and the first time I talked to him, I knew that that's where I belonged.

Mullan: This is when you were a second-year medical student?

Anderson: Second-year student.

Mullan: How was medical school? How were those first two years?

Anderson: First two years were intensive, really, and I found out how I could do. I found out that I was really quite a good student, able to run with them. [Laughter] I didn't especially enjoy the first two years, it was too much book work, but I got through it okay. Then the third year when I started the clerkships, that's really when I blossomed. I found that I was very good at working with people, that I enjoyed the interaction with people, being nurturing, and enjoying the relationship with my patients. By then we had a primary practice clerkship rotation set up in rural areas, and I went out and did that my third year, and it was an outstanding experience.

Mullan: How did you like Seattle?

Anderson: It's a nice city. I knew from the start that I wouldn't want to stay there.

Mullan: A classic quandary of medical education is recruiting people from rural backgrounds who get to the city and never leave. In fact, that does happen. Didn't happen to you. Any thoughts why not?

Anderson: Both Connie and I had rural roots, rural traditions in our families. We enjoyed the city resources, but didn't like being around that many people, didn't enjoy that concentration of people, and did not want to think about raising our kids in that kind of environment. So it was a pretty easy choice to go back to rural.

Mullan: For your residency, what then did you do?

Anderson: Went back to Rochester, New York. Ted Phillips had a series of us going back there. He'd done a teaching fellowship there before he came out to Seattle to prepare himself for an academic career. He sent two or three others from the university back to Rochester before me, two of us went my year, and then it stopped after that.

Mullan: This now was '72?

Anderson: '73. I interviewed twelve places. Ranked five. My second choice was University of Maryland in Baltimore, which was just an outstanding program, but an ugly place.

Mullan: This was in family medicine?

Anderson: Right. That's all I interviewed for. Third was Flemington, New Jersey. St. Paul, Minnesota and Wesley in Wichita. Outstanding programs, but--

Mullan: Did you have some notion of wanting to go back East?

Anderson: Yes. Connie and I both wanted to experience a different environment for a while, both for medical training and just for life experiences.

Mullan: How was Rochester?

Anderson: Nice town, very nice, very small-town atmosphere, kind of similar to Spokane in Washington. It's a relatively big city, but very much small-town ideals and attitudes. Good, clean industry. They had just come out of their race riots, so there was still a tension there that was very interesting, which we dealt with and it was a part of a lot of relationships there.

Mullan: Do you want to say about that and how the race relations affected the place?

Anderson: Yes. Growing up in the Tri-Cities, there was some racial issues. Pasco was probably the closest to being racially integrated, although it did have definite places where the blacks lived and definite places where the whites lived. I grew up hearing my family refer to blacks as "niggers" and grew up with some initial attitudes that probably would have led me to be racist if I hadn't had some extraneous experiences. But I did have friends in high school who were black, and became more comfortable with it as more people were doing at that time.

Again, I think my basic attitudes that I had been raised with were that I would value people, and it became apparent that that included people of other ethnic backgrounds.

At the same time, Kennewick, across the river, was almost entirely and exclusively segregated. There were no blacks or Orientals living in the entire city of four thousand people, and it was explicit that none were allowed. That's changed.

Going through college, going through medical school, certainly I had increasing exposure to some very nice and capable people of various racial backgrounds, and became increasingly comfortable and had a lot of friends of diverse background.

So in residency, going into that situation of still racial tension, I was able to relate to a good variety of people and actually included in my practice, in the family practice center there, some of the people who had been leaders in the race riots, and got to talk with them a lot about the attitudes that were there and how things were changing and what still needed to be done. Very enlightening experience. I enjoyed it greatly.

Mullan: How was the residency itself? This was early years of family practice, wasn't it? What was it like?

Anderson: Some of us refer to those as the Camelot years at Rochester. We had Gene Farley , Jack Froom, Don Treat. We had visiting professors, Jack Medalie, Hiram Curry. It was just a highly stimulating environment. We did the grunge work. We did our eighty-hour weeks during internship. Had arrogant, hostile

internal medicine attendings, OB attendings, but we dealt with those, put up with them, worked around them, and had very much a community spirit in the Family Practice Center, very supportive both socially and professionally. It was painful when residents got into problems. One got into problems with cocaine dependency, another one got into troubles with divorce, another one just tried to quit, but we supported everyone through it.

We got outstanding educations as family physicians, but we also were indoctrinated into the philosophy of family practice; what it meant to be a family doctor, what the ideals were, how we could nurture the future of family practice through research and through academics, and just had an outstanding experience.

Mullan: The attitude of the medical center, in this case, a prestigious research learning medical center and some of the physicians, faculty and otherwise, toward this new thing, this warmed-over general practitioner, tell me about that. Was that uphill or was that okay?

Anderson: Blatantly ambivalent. They enjoyed the prestige and attention it brought to the school, but they also didn't want to let it get out of control. They kept it as a Division of Community Health. They refused to give any kind of faculty status or prestige to the faculty, and did everything they could to keep it from becoming a significant force within the university or in the medical school.

Mullan: How did your faculty deal with that?

Anderson: It was very open. They did what they had to do to get the rotations, to get the funding. They'd fall back on reminding the leaders of the prestige that they were bringing to the school and the prospect of federal funding. The leadership reluctantly continued to allow the department to do whatever it wanted to, without giving much institutional support.

Mullan: In terms of students and young people at Rochester, how did they respond to the presence of family practice?

Anderson: The students were very receptive. They enjoyed the family practice rotations. They were very excited by what was going on there. They saw that primary care was going to become a bigger thing, and a lot of them chose it because of that. Those that didn't choose to go into primary care, I think were more knowledgeable, sensitive specialists because of it. It didn't sell well as far as the number of University of Rochester medical graduates that went into primary care. They were still highly specialty dominated.

Mullan: You were there then for three years?

Anderson: Correct. I wanted to get back to Washington State. I didn't have much money. We had a son by then, and we wanted to get established someplace without much financial risk or

financial investment, at which time I heard about the National Health Service Corps from a friend. He wanted to go into Van Buren, Arkansas, but he already had two partners chosen, that was Larry Green, one of my residency partners; he told me who to contact.

Then a friend from medical school called from Walsenburg, Colorado, and said, "I've been out here for a year, and I'd sure like you to come out and join us," and I went out and interviewed there. They had just about the whole town come out to a get-together at the country club to recruit us. It was exciting, and I signed, and about a month later, got a letter my friend saying, "Well, I hope you have a good time here, but I'm going back to the Northwest." We would have had just nobody there that we knew and be a long way from home still, and so we backed out of that one.

I called out to Washington to see what kind of opportunities there were out here, and ended up talking to Roger Rosenblatt. I'd met him in medical school. He was in the first group of University of Washington family practice residents; I had worked a little bit with them. He put me on to a place up north called Torosket, and I went there and interviewed. It was a great experience, a great setting. It's still an active practice that grew out of that Corps site. But they chose somebody else.

So I got back on the phone with Roger. He said, "There's a place called Cle Elum. It's going through some tough times, but if you want to look at it, you can." I came out. It looked like a place we could be for two years. I signed and we started.

Mullan: Why was the NHSC important for you as a vehicle to get you here?

Anderson: Mostly as a low-risk way of getting here. I had no obligation, no scholarship, and it just seemed like a good way to get into a situation without too much personal investment or risk, and something that would support me for a while until I found out what I really wanted to do out here. It was a stepping stone. That was my initial direction in the Corps.

Mullan: So what was Cle Elum like when you arrived, both medically and in general?

Anderson: Well, it was awfully slow. The emergency room was awfully busy. People would come there instead of to the clinic, and they had at that time a whole lot of dirt-bikers coming around here during the summer. They'd come over from Seattle, they'd zip up and down the slog sites from the old coal mines, they'd crash, they'd get all kinds of injuries, and most of them would need extensive cleaning before we could find their injuries.

Mullan: What had been the history of practices in Cle Elum?

Anderson: There had been several medical practices back when the coal mines were working, when there was a good economic base, and when the population was fairly high. There were as many as eight

doctors at a time and the hospital stayed full. After the coal mines closed down--

Mullan: Which was when?

Anderson: About 1962. Most of the physicians left. The one who remained retired with heart trouble and alcoholism. From '62 on through 'til the time I started in '76, there had been something in the range of thirty-six to forty doctors that had come and gone.

Mullan: What sort of town and size? Where are we exactly?

Anderson: The population declined from about 12,000 people in the upper county area to 1,800 in Cle Elum, 400 in Roslyn, and a total area population of about 4,000. The economic base was way down. The employment base was mostly logging, a little bit of manufacturing, and a little bit of tourism, but the coal mines were no longer an economic factor.

Mullan: We're about 100 miles southeast of Seattle?

Anderson: About 85 miles a little bit south, more east.

Mullan: So what sort of reception did you get when you arrived?

Anderson: They were glad to have another doctor. There had been a National Health Service Corps assignee here for a year at that time who had done an internship back at Cooperstown. Very bright guy, very rural oriented, but he just wanted to have a local practice, no hospital care, and wanted to have a fairly easygoing lifestyle where he didn't have to do too much. So he was here. He really had established modern medicine here. I give him a lot of credit.

Mullan: What was his name?

Anderson: Gary Pomerantz. So when I came, there was him, there was another general practitioner here who had been kind of a drifter, and then when he heard that they'd signed me, he figured out that there wouldn't be enough salary for him. So with two days' notice, he left town, took one of the local nurses with him. That was kind of inauspicious. They had also closed the hospital three months before I came. So things were very much in a depressed state.

So when I came to town, it was with the idea of continuing to provide service to a declining population without much financial promise, but I could stay as long as I could get support. Mostly they wanted emergency services, not community care.

Mullan: Who was "they"?

Anderson: The hospital board, the board of commissioners for the public hospital district. They had had the foresight when the hospital closed to commit to maintaining emergency services, and they wanted to foster a local medical clinic so that the older people would have a place to go for their care, but their attitude was that hospital care should be done by doctors in Ellensburg and the doctors should mostly be available for emergencies and routine care for the people that couldn't easily go out of town for their care. So they kept the ambulance service for getting people out of town for care when they needed it.

Mullan: So what was it like getting started?

Anderson: [Laughter] Very different from what I'd imagined. There were not attitudes of primary comprehensive care here. People really believed that they needed a specialist for everything. They came in for colds, for injuries, and really did not have too much interest in comprehensive care.

Mullan: Why was that?

Anderson: Just the exposure over ten years of not having local primary care.

Mullan: So as much a disbelief in the ability of anyone to provide primary care as it was a belief in specialty care? Let me not put words in your mouth.

Anderson: I think it was a little bit of both. Specialty care back then had all the prestige. That's what people perceived as saving lives and doing the dramatic things. So certainly if you wanted the best care, you had to go to the best specialists. The Virginia Mason Hospital Center had been the miners' hospital. It has always been entirely specialty, and that was the ideal for the people who were going to the Mason Clinic.

Mullan: This gets ahead of our story, but since we're at it, let's talk about it. I would presume that over a period of years, local attitudes have changed and there's been a reeducation process, or at least a change, in regard to their attitudes towards primary care. Can you develop that a little bit? How did it happen? Why did it happen? Where does it stand today?

Anderson: Yes. That's been almost entirely one patient at a time. When they come in for their cold or for their broken fingers, I'd ask them if they were up to date on regular checkups, if they'd had their tetanus booster, if they had a regular doctor, and offered to see them back for a regular exam and develop a baseline of information about them, and kind of taught them that everybody should have a primary care physician

who has comprehensive knowledge of them, and who can work with any other doctors they need to see. We didn't do it by articles in the newspaper. People didn't read the newspaper much. We tried some community education sessions. The most we ever got to attend one of those was five people.

So it was almost entirely just one person at a time and them talking to their family and friends. Developing a reputation for dealing with illnesses appropriately, and year by year going a little more comprehensive on their care, taking care of their illnesses, developing credibility and replacing the instability that they had had previously with being able to trust that their doctors were going to stay and continue taking care of their needs.

Mullan: If a certain individual was converted to you, did that make a difference in terms of ripple effect?

Anderson: Absolutely. Yes.

Mullan: Trendsetters?

Anderson: Yes.

Mullan: What kind of people were those?

Anderson: There's the man who was a local county commissioner. He's a political leader, he and his wife had a local business,

and they came in to me pretty early. They had some significant health problems, and I did the right things for them, and they've been my patients ever since. I've delivered their grandchildren and have taken care of the entire extended family. Several like that, the newspaper publisher, who at the time was also the hospital district administrator. He invested his care with me. I care for some of the teaching community, other local professionals, attorneys, dentists, and a lot of the agricultural leaders. I've had a good rapport with them.

So it wasn't just one group, but it was many different individuals who then brought their families in. Likewise, there are families with whom I didn't get along, who thought I was being a little too uppity trying to establish primary care in the local area. Their attitudes were so entrenched that they thought I was doing wrong by them by trying to do their care instead of being just a source of referral to specialists. There are families now who still will not come into the clinic for their care because of being offended that we weren't the kind of doctor they wanted.

Mullan: A significant part of the population?

Anderson: Probably a fifth of the population goes out of town for their care because they don't believe that it's possible for them to get good care here. These are also the same people that go out of town for everything else and who vote against any development in the community. They're the depressed segment of

the population who are here because they think they're stuck here and can't make it anywhere else.

Mullan: Are those the same who go out of town for their care?

Anderson: Correct. They won't invest in local care, they won't trust anybody local to be good.

Mullan: Are these insured people or uninsured?

Anderson: A lot of them are insured. They're working, they're employed. Some people who are considered to be leaders in the community even are in that category.

Mullan: I'm going to turn the tape.

[Begin Tape 1 Side 2]

Mullan: This is John Anderson, tape one, side two.

Tell me then how your practice developed. You were here at the outset with another National Health Service doc who left after a year.

Anderson: Right, left after a year then went into an ophthalmology residency. Paul Schmitt started back then. He had done an internship at Swedish Hospital in Seattle after medical school at the University of Michigan. He grew up in Detroit, and

he'd done two years down at the Indian Health Service down in Shiprock, New Mexico, which was, in essence, a family practice residency at the time. They had residency-type rotations, even though they were employed full time to serve the population. They had an active education program, very supportive group of people there. One person that was down there at the time was Dan Ostergaard. He's one of the leaders of the Academy now. He (Paul) had a very good experience down there and came to Cle Elum with what I considered to be essentially residency training and high-quality patient care.

Mullan: Sent by the Corps?

Anderson: Yes. We also had a half-time salaried position who was a graduate of the Providence family practice program in Seattle, joined us, did half-time with us, half-time with the migrant clinic in Wenatchee. His passion was flying. He makes John Geyman look like a casual pilot. He eventually retired from medicine and is flying full-time down in Florida flying charters to the Bahamas and towing aerial banners. He was a very good physician. He was with us for four years. We started transitioning from the Corps to a private partnership, and at the point where he is going to be taking responsibility for private practice business, he decided to leave.

Mullan: Tell me a little bit about the Corps in terms of its support. You're a federal position [unclear] private community,

with certain kinds of supports, but also the open expectation you will put down roots and convert to private. Tell me about how that went. Was it hard?

Anderson: I think I've said before, the first year I found several occasions when it would be easier to leave, and even looked at some other places.

Mullan: Tell me more about that.

Anderson: When it didn't look like the community was going to support an expanded practice and my partners were not supportive of me establishing a hospital practice twenty-five miles down the road in Ellensburg, and it didn't look like there was the potential for growth and improvement there that I had hoped for. I sought advice from the Corps people and they said they'd keep working with us. Roger Rosenblatt was very good at intervening in some of the disputes that we had. Dr. Ted Phillips again, with the university, I ran into him at a meeting, told him about our troubles, and he suggested that I hang in there for a while longer, which I did.

We had technical advisors from the Corps, were very good as far as practice management, setting up our accounting system, working on facility planning. We had good consultations arranged by the Corps for our new facility. And of course, they continued paying our salaries so that we did not have to rely on the community for that. So overall, the Corps was good enough that,

indeed, we decided to stay with them for four years instead of just two. But after four years, it became financially feasible for us to move over to a private practice basis, which has been reasonably successful ever since then.

Mullan: Did you have to change the nature of the patients that you saw in order to financially make ends meet once you weren't federally employed?

Anderson: No. It was a smooth transition as far as that. We did not feel pressure to see more patients. We had been seeing the number of patients we were comfortable with, right from the start, as many as would come in, and as the practice built we just gradually started seeing more patients, like starting with four or five a day on up to the present of fifteen to twenty a day. We always maintained our community-oriented attitude. We've never excluded any patient from care because of finances. We have made ourselves available to serve all the needs of the community and have not restricted our care either under the Corps or under private practice. So the ideals, I think, were the same. That's why we were comfortable with the Corps for the first four years. Their ideals, their goals were the same as ours, to have a stable practice here and to enjoy the work that we did.

Mullan: In many, many communities, the Corps has placed competent physicians for two years or four years, and they have

not, in fact, stayed, have not been able or been willing to convert to private practice. I appreciate the [unclear] communities in this country, but as a senior observer of transitions, do you have any sense of why you could make a successful transition and many others have not been able to?

Anderson: Certainly the length of time we took, the four years that we took to make the transition, was key, having the continued support through that time so we could take a careful look at it and really take time to develop the practice. That was useful. Our own orientations, as far as wanting a community we could live in and raise our families in, that was probably the most important aspect of the entire thing. We came here wanting a small town to continue to live in for a long time. That's a tough thing to nurture and to promote in a person, but that was probably a key item. And then the community responding to us where we saw the potential for a satisfying, continuing practice.

Mullan: Tell me more about how the practice developed. There are very impressive comprehensive practices today, but that's been [unclear]. Sketch in the developments over the years.

Anderson: After the half-time physician left, we were just the two of us for about six months. We recruited in Elizabeth Wise. She had done her residency in San Diego, done medical school at Harvard, undergraduate at M.I.T., just impeccable credentials. She had grown up in Chicago. So again, my two partners do not

reflect the traditional desirable rural origin, but certainly they were family-oriented people with family values. She had been raised traditional Jewish. He'd been raised traditional Catholic. So again, very fundamental, traditional, religious backgrounds also, which make for very rural-appropriate qualities.

Once we had the three of us established, we periodically sat down and looked at our goals for the future. We've always had long-term planning as an explicit part of our discussions. We have changed our chart work to reflect a desire for more comprehensive care, as far as the database that we acquire on patients, prompters for preventive-care items, and just generally mutual expectations for the level of care that we are going to offer patients, expecting that each of us will inquire of patients as they come in about their routine care, immunization status, talking about mammography. I've given tetanus boosters for people who have come in with sprained fingers. Older people, certainly promoting preventive items with them as well, immunizations, routine exams, mammography, estrogen use for women. We take opportunities to talk with them when they come in for episodic care. Like I said, it's just continued developing so that more and more patients are buying into what we're selling. Currently, I'd say, 70 percent of the patients that we see in a day are people for whom we have a comprehensive care role.

Mullan: Obstetrics. Tell me a little bit about the ebbing and flowing of that.

Anderson: [Laughter] I loved obstetrics right from medical school. I was able to do an elective in obstetrics. My as a third-year clerkship. I went out of town to Boise for that. I was the first student to have the opportunity to go there. Instead of a traditional university hospital experience of maybe two or three hands-on deliveries, I did sixty deliveries, first assisted on eight or ten C-sections, assisted in surgery, and was the primary care provider for a home for unwed mothers. I had just an outstanding experience in medical school.

Residency, I continued having an interest in that I attracted a lot of OB patients to my practice. Because I was going to an area possibly without OB backup, in my third year I did three months every-other-night call on the high-risk OB service at the university hospital. That was really a dumb thing to do, but an outstanding experience. I became comfortable with C-sections, vacuum deliveries, forceps deliveries, management of preeclampsia, premature labor, just a very good experience which prepared me comfortably to do just about anything out in a rural area. Had C-section privileges my first year at Ellensburg. Paul had been doing deliveries, too, but didn't enjoy it as much, not as much volume. Liz has been doing obstetrics all along, but she does only low-risk OB. Paul stopped doing OB about ten years ago. I continue doing it including C-sections. Liz has continued the low-risk ones, and each of do about twenty a year,

which is comfortable. I've done as many as forty deliveries in a year, but it's slacked off now that there are more OB providers in the county.

Mullan: You did them initially at the office?

Anderson: Up at the birthing room at the family medicine center.

Mullan: Since then at the hospital in Ellensburg?

Anderson: At the hospital. If it's a complicated labor, I'll do as many as three or four trips down and back in a day to do the management. There are other providers down there, but sharing OB coverage with providers outside the practice disorganizes the management, doesn't work out well. So I'd rather occasionally make frequent trips during office time and manage the patient to the best of my ability, rather than asking others down there to cover for me.

Mullan: You're twenty years in, almost, at the twenty-year point. Characterize the practice now, both in terms of its numbers and in terms of your feelings about it.

Anderson: The practice is staying at about a twenty-patient-a-day level. I'm seeing proportionately more stable patients in my population than I've been seeing for, five to twenty years, and consequently less new patients. I still see two to three or four

new patients a week who are coming into our practice. That makes up for the patients who either die or leave the area. So at twenty years, it's a much more stable population. I know my patients better. I know their family status. I know the stresses that they go through, and when they come in with worse back pain, I know to ask them if their husband is employed right now. That's pertinent. It's challenging, because as I get to know them better, they get to know me better, and sometimes try to manipulate me, but that's not a problem. It's mostly on the plus side with my patients.

It's a little bit uncomfortable when I am not available to them, but they know not to call me at home when I'm not on call. They know that I'm just going to tell them that, "You'd better talk to my partner about this, and see if something needs to be done." So they are courteous and very respectful, but I also feel badly if I'm out of town and they have a crisis. I feel like I've missed out on an important part of my relationship with them.

Mullan: How has it turned out being a small-town doc? Has it turned out the way you thought it would be or what's different?

Anderson: It's been a more intensive experience than I could have could have anticipated, just being part of people's lives like this, their births, their deaths, their marriages, their divorces, emotionally very challenging, but also very rewarding. If I had it to do over again, I would certainly choose to do what

I've done. I would not make a change. It's been the most satisfying, gratifying thing I could have ever imagined having done.

Mullan: In terms of your role now, not so much with the practice, but your role in town and with the town, what is it and what is it like?

Anderson: It's been variable over the years. Small towns are very easy places to get involved and receive jobs to do. The first few years I was here, I was on the board of directors of the Chamber of Commerce, went on to be president of the Chamber of Commerce. I think my fifth year here I was president of the local Kiwanis. Very easy to get involved. During those same years I did my committee chair positions down at the hospital and was chief of staff down there. My role in the community has been decreasing. I did chair the second campaign for the levy for a new school building, and when that failed, I felt let down by the community and decided to start putting my energies elsewhere. So overall, my formal community activity level has decreased, but I still continue to go to community events, get around talk to people, talk about local concerns. Informally involved, but not in a formal aspect anymore.

Mullan: What about the visibility and prominence? How does that play for you? Is that difficult, is that fun?

Anderson: As far as being a visible person in the community?

Mullan: Right, and knowing a lot about people in the community. As many people said to me, "You're one of the biggest buildings in town. Everybody's always looking at the doctor."

Anderson: It's an explicit schizoid nature of living in a small town. You separate out what goes on in the exam room and the emergency room from your relationships with people elsewhere. Some of our closest social contacts are people who are also my patients, but when we are playing pinochle or at dances, we don't talk about anything that has to do with their health care or my career. We talk about family, we'll talk about local activities and concerns, fairly clearly divided out. Once in a while somebody will approach me at Safeway with a question about something medical, and unless I'm able to deal with it just immediately with one short sentence answer, I'll say, "Well, maybe we better talk about that over at clinic." They're generally very good, not persistent. So as far as being in the community, I feel that I can be out there as an individual, as a person, and not necessarily as "the doctor."

Mullan: Have you been part of the health apparatus in the county or state? How does that work?

Anderson: For the county, not so much. We have a good strong health department structure here. I have been involved in

strategic planning committees for the hospital and currently involved with the independent physicians' association for the county and involved in setting up a health care plan we're working on for the communities along with the hospital. So to that extent I've been involved in health care planning, but as far as an overall health care planning effort, at times we've tried to get that going, I've tried to instigate a couple of efforts there, but it's faded because of lack of interest and lack of leadership other than myself developing.

Mullan: It's often said that clinical medicine is one agenda and public health is another and they're not related. As the health system changes, as public health departments enjoy less support in some cases, there's increasing worry about who will superintend the public's health. In your particular town and corner of the world, how do you see that developing? Are those real issues or not?

Anderson: The public health activities of personal health care are being moved into the private sector fairly well in this state. We have health insurance programs, both Medicaid and subsidized health insurance plans that have made health insurance accessible for just about everybody, and, therefore, have made it cost-effective for private practices to do a lot of the indigent services that the public health department used to do with immunizations and so forth.

As far as overall surveillance of population, private practice is certainly not going to do that. We have every good intent of serving the health care needs of the population, but there's going to be a lot of things that go beyond what a private practice is going to be able to attend to. There's no reimbursement for it and there's no other reinforcement for us doing it. It's just not an expectation and it's awfully hard to do. So we need to have some continuing structure for surveillance, and I think that's going to be the new health department function.

Mullan: You've been part of the Family Medicine Movement since its early days. How do you feel about it now?

Anderson: I'm tickled with the way it's developing. It's becoming more respected. It's recruiting more and more medical students now as compared to past years, and the emphasis in the profession is for more comprehensive care, a higher level of responsibility for family physicians doing well what family physicians are able to do. I think it's very good, very strong.

Mullan: You've also had the opportunity to participate in the National Health Service Corps and at some distance watch it over the years. Your reflections and commentary on it as an instrument of social policy and medical policy?

Anderson: It certainly continues having a mission. The attractive communities where private practices can easily take root are already served. The Corps has met its mission in an awful lot of communities, but there continue to be communities which do not easily suit themselves to a continuity practice, and the Corps' role now is increasingly to be staffing those places with possibly rotating physicians, certainly subsidizing those practices and giving what support it's able to, maybe continuing in certain places, establishing practices that would be viable with changing from federal to local or state support. The changes in health care funding I think are favorable, and I think we'll make that possible more places as we go along.

Mullan: Do you precept or work with [unclear] sites or federal efforts round about at all?

Anderson: I haven't had any involvement. Most of the acquaintance that I continue having is just talking with the Corps people, Ken Bahm in Seattle especially.

Mullan: How about teaching? Do students or residents rotate with you all?

Anderson: We're actively involved. We take one or two medical students a summer. It's called the Rural Underserved Opportunities Program with the University of Washington. It's a program I helped develop some years ago, and they send medical

students out to rural practices between their first and second years of school. It gives them an intensive exposure being immersed in the practice and seeing what family physicians do.

Mullan: You also lived through a time when the number of physicians graduating and available to rural practices has steadily risen.

Anderson: Yes.

Mullan: Specialists in particularly, generalists as well. How have you observed that? How has that been recorded or sensed in Cle Elum, Ellensburg, in this area in general? What has it meant?

Anderson: Our county is doing rather well at attracting family physicians. Right now we have sixteen family physicians in the county for a population of 28,000, which is pretty close to the ideal ratio, and two-thirds of the physicians in the county are family physicians or primary care. So we've really done very well here. But it's an attractive area and economically stable, a very attractive place for people to live, so we have to be grateful for the resources we have.

Overall, probably the most encouraging trend is the difficulty that pathologists and some other specialists are having finding jobs out of training, that they really are having to recognize that they're saturating the market, and at the same

time the number of family practice residency choice among graduates of U.S. schools has been increasing. I see those as positive. Pediatrics, and general internal medicine, whatever that is, are also seeing the same. So the trends are appropriate. We do need some mechanism for allocating training slots. I don't know what that's going to be. ACGME says it's not that. I think it has to be something to do with federal funding that makes it less advantageous for programs to maintain training programs for unessential specialties.

Mullan: You've described increase in generalists in the county. What about specialists?

Anderson: We have just about what we need.

Mullan: Has that changed? What was it like when you came? What's it like now?

Anderson: When I came, there were two internists, a pediatrician, an OB/GYN, and a general surgeon. We now have two general surgeons, two orthopedic surgeons, who are really good for the hospital because of they bring a lot of money into the hospital, three very good general internists who do a lot of cardiology support. Three pediatricians. We have an ophthalmologist now who's excellent. We do not have urology or ENT in the county on a full-time basis, which is just fine, and we don't have any sub-specialists. Everybody continues asking

why we can't get people to come in and make specialty consultations where available. My personal response is the same as in "Fiddler on the Roof." The students come to the rabbi and ask, "Rabbi, tell us what the appropriate blessings for the Czar would be." The Rabbi says, "May the Lord bless and keep him--far, far away." That's how I feel about sub-specialists. It would be convenient for them to have office hours in Ellensburg occasionally, but they do not serve an essential function. The infrequency for which they are really needed, justifies having people travel farther to see them.

Mullan: The growth of specialists, I would gather that happened step-wise, the surgeon, an OB and so forth, and you say it's about right now. How would you characterize "about right"? What's the formula to know that it's "about right"?

Anderson: That the specialists that are in the area are doing mostly specialty work and not doing much that's outside of their area of expertise. They're not doing much general practice.

Mullan: How about on the other side? It's fine for you to say as a family physician, "I don't want more competition." It's not the way you put it, but it could be argued, "I don't want more competition by some specialist who will look over my shoulder and share and steal my patients." Some make the argument, "It would be awfully nice to have a urologist available here and not have to travel." Where do you have to travel to get a urologist?

Anderson: Either Yakima or Seattle.

Mullan: What's your argument to someone who says, "I'd sure like to have those services available in the county"?

Anderson: The main argument is that it has to be economically feasible, and I don't have anything against them coming in. I don't think patients are going to suffer extensively and take care to them that I should be delivering. But in order for them to support themselves, they have to have a certain volume of patients so that they can pay the rent, and the hospital, in order to have a urologist on staff, needs probably fifteen to twenty thousand dollars' worth of new operating equipment that they don't currently have to have. So there has to be a justification for that expenditure, and so far that justifiability has not been there.

Mullan: Do you have any segments in the community or population that are not well cared for? Is there an underclass in the county? What county are we talking about, by the way?

Anderson: This is Kittitog.

Mullan: Of the residents of Kittitog, how do you constitute a medical underclass?

Anderson: The working poor, the ones who, for various reasons, do not have health care insurance. They are welcome to be seen, we pursue collection with them, but not too vigorously, but they tend not to come in. They tend to neglect their care.

Mullan: The nurse practitioner and PA has been a phenomenon in recent years as well. Are there any working round about and how do you see their role and the growth of their numbers in [unclear]?

Anderson: They are three active nurse practitioners and two physician assistants down in Ellensburg. Two of them are with private clinics, the rest are with the Student Health Service at the college. We will be employing a physician assistant here starting this fall when our part-time doctor leaves, and we'll be using him probably three days a week, mostly to see patients in the clinic. He's a fellow that was the operating room supervisor down at the Ellensburg hospital, went into the Medex PA program, did his preceptorship with us for six months last year, a person we're very comfortable with, and we are looking forward to having him working with us.

Mullan: How do you see the role of non-physicians practicing family medicine?

Anderson: They're limited. They need a niche into which to fit. Andy, for instance, our physician assistant, has not had a whole

lot of training in emergency room care, and as a physician assistant when he's on call, one of us will need to be on back-up call with him. So the question arises whether it's economical for us to pay him twenty-five dollars an hour to see six patients in sixteen hours when we could do that without salary cost to us. But certainly a higher-volume setting like the office during the daytime, we can very easily justify having him do that. He doesn't do flexible sigmoidoscopies, he doesn't do complex lacerations, he doesn't do fracture reductions yet. So he's limited compared to what a fully trained family physician can do. That's why we're not recruiting for two more physician assistants for next year. We will be recruiting for a family physician.

Mullan: Any feeling about physician assistants versus nurse practitioners?

Anderson: Not much. As long as they function the same way, I have absolutely no problem. In this state, we somehow gave nurse practitioners independent practice legislation a few years back. Theoretically, a patient can go see a nurse practitioner and be referred to a specialty nurse practitioner and never see a physician, or see a generalist nurse practitioner and be referred to an MD specialist or sub-specialist, never seeing a generalist physician. That worries me because they cannot in their years of training acquire the same set of skills and capabilities that a family physician can in eleven years of training from high school on, and they are billing themselves as the equivalent. They do

not have the flexibility, the overall level of evaluation skills, and the formulation capabilities that a physician has, and I think they are over-billing themselves. I think that experience will show that generalist nurse practitioners who are not working in cooperation with generalist physicians result in a higher cost of care because of the higher level of use of specialty consultations.

Mullan: Your religion was important to you as a young person. Has it remained so? Does it impact your practice in any particular ways?

Anderson: We're continuing to be active in the church. There's no Lutheran church of our flavor up here, so we go to Ellensburg for church activities. We're not as active as we'd like to be. As far as impact on the practice, I do relate very well to the variety of people. There are some people, more Fundamental Christians, to whom it is more valuable to have a Christian physician. I have that credential. It's probably not critical, but it's a useful way for me to have influence in their lives.

Mullan: Does that mean they would be disinclined to go to Dr. Wise?

Anderson: Yes.

Mullan: Are they up front about that?

Anderson: The community is traditionally very strongly Roman Catholic. The fact that Paul is not an active practicing Catholic is not as important as the fact that he was raised Catholic.

Mullan: Got those baseline [unclear].

Anderson: Yes.

Mullan: Tell me a little bit more about your family. We didn't hear much about Connie's early days and children.

Anderson: Connie teaches. She taught while I was in medical school, taught for another year while I was in residency and did some graduate work in environmental studies, then stopped teaching for a few years to get the kids started. As soon as the kids were in school, she started doing preschool teaching again and then eventually got on with the public school as a science teacher and enrichment program teacher for the highly capable. She has continued doing that. She has always been an activist. Her first four years of teaching, she became a member of the negotiating team for a large district and has continued being involved in teacher leadership in this district. Very much outspoken and very much a positive person for the educational association here. She likes to let people know how she feels about things.

Mullan: The children?

Anderson: Joseph was born in Rochester during residency. Very bright kid, was a National Merit Scholar, has been going to PLU for three years now and is starting his fourth year majoring in computer science with a minor in religion. This summer he has been working at a church camp over in Idaho, enjoying that greatly, and it remains somewhat mysterious to us what he's going to do after college, whether he's going to go on to computer graduate work or just what he thinks he's going to do, or whether he's going to go more towards the ministry. We don't know yet.

Cammy was born in Ellensburg, lived here all of her life, graduated from high school this past year, also a National Merit Scholar. Proud of her. She's going to go to PLU this fall. She had thought about sports medicine and physical therapy, but her real love is music and she would like to go into music education. Plays trombone, piano, does vocal. Very talented in that and a bunch of other things.

Mullan: How has your work impacted the family?

Anderson: I've missed out on some things. I haven't had the time to spend with my family that a lot of fathers do. I haven't done as much outdoor activity as some fathers do with them, but I've always nurtured their interests, gone on hiking and camping trips. I've always taken two or three weeks a year vacation as a family. It's been a different experience. I've been able to

offer them a financial security that other fathers can't and an ability to choose their college without regard to finances. There's pluses and minuses. I've, I think, served as a good, positive role image to them, and I think they've enjoyed having a father who was respected in the community.

Mullan: Has either one indicated an interest in medicine?

Anderson: Cammy, with her interest in sports medicine, but not something she's decided to pursue. They both think that I work too hard, and they don't have a full sense of the rewards that I feel from what I do.

Mullan: The future. Where do you see yourself going and your practice going and family medicine going?

Anderson: I'm certainly going to stay here for the next fifteen years. I've going to retire when I'm sixty-five and do something else medically. I've put an absolute limit of doing what I'm doing for fifteen more years. I expect the practice to continue growing. I expect us to go to five physicians within the next few years, and within ten years I expect to have an in-patient facility here, and I expect us to be working in very close partnership more with the Ellensburg physicians, and continuing to provide good primary care services, not have any--

[Begin Tape 2, Side 1]

Mullan: This is Dr. Anderson, tape two, side one.

Anderson: And continuing such that our practices be a primary source of comprehensive care for the community.

Mullan: Final question. As you look back on your practice, are there particular patients or episodes that stand out in your mind? Obviously in a community of individuals, I'm sure many difficult social circumstances have passed through your ministering hands, but is there anything that stands out that were you to step back and say it was a particularly important patient or particularly important episode of care, individual, family, community, or for bad. What would you say?

Anderson: There's been so many of them, but there's a few that stand out. There's one man who was a leader in the local fire department in promoting first aid training for the community and CPR training for the fire department members. He came under my care. He was older and he was diabetic. He came in one day, seemed to have bronchitis and he was sick enough to be hospitalized, didn't seem especially acutely ill. I put him on antibiotics and just not a high intensity of service. And he died. I was at a Kiwanis meeting and somebody came in with the message and I had to leave the meeting and go talk to his wife and daughter at home, tell them what had happened. Devastating. He had had a pneumonia that I hadn't recognized and symptoms were masked by the diabetes, and I hadn't recognized quite how ill he

was. That was a tough one to go through. I continue to acknowledge that if I had taken a little more time and evaluated him more thoroughly that I probably could have recognized that he was more ill and been more aggressive, put him in intensive care, and he probably would have lived five years longer. So that was a prominent person that I probably didn't serve as well as I could.

Certainly others I've recognized appropriately what was going on. Recently the wife of one of our hospital district commissioners who was new to town who hadn't established care, she came into the ER and was having difficulty with her breathing. A very healthy fifty-five year old woman but was progressively having more difficulty. I was able to establish that she had critical aortic valve insufficiency, symptoms very consistent with coronary artery insufficiency, and she hadn't had a Pap smear for five years and had had diagnosis of cervical cancer previously. So I got all of those covered, told her what she needed to have done, did the Pap smear which turned out fine. Did basically a complete exam which brought her up to date on care from the previous seven years that she'd been neglecting her care. She's a stubborn German. I told her that she probably needed an aortic valve replacement and coronary artery bypass grafting, which she proceeded to have done in Seattle and is back under my care, and is telling people that I'm wonderful.

So there's experiences on both sides. Just remarkable people around here. I've enjoyed working with them and the episodes of care become more of a continuum than isolated

experiences. You save a person and then they find something else to die of later on. So the episodes end up taking less importance than just the continuity of care to the individual throughout their life path.

Mullan: Any dramatic or unexpected kinds of happenings in the practice, or local rural medicine?

Anderson: We've certainly gotten our share of recognition here. We had the National Advisory Committee for the Office of Health Policy come out. I do think it was more to visit the filming site of "Northern Exposure" instead of our practice, but we had a luncheon for them and showed them through our building and talked to them about our perspective on rural health care. A legislative committee from the AARP visited us. We showed them around a nursing home and showed them how geriatric care is conducted in a rural area and talked about the care program we had going for the elderly in our population. Very nice visit with them.

Mullan: We've touched on a lot of things. Is there anything that we haven't touched on, in regard to your experiences, that you'd like to add?

Anderson: One of the advantages of being here, compared to Tonosket someplace like that, has been that it is fairly close to the city and I've been able to have a higher level of involvement

in organizational medicine than if I was more rural, more isolated location. I've been able to serve as president of our State Academy of Family Physicians, I've done a lot of committee work with the Rural Health Association and the State Medical Association. I serve on the admissions committee at the university, which I've found a lot of fun. Currently I'm getting a little more involved in some of the national organizational stuff. It is my third year now on the Residency Review Committee for family practice, which I'm finding very exciting, a great opportunity to expand the role of family practice and its level of quality assurance.

Mullan: So that means you get good access to the airport is important to you?

Anderson: Yes.

Mullan: You travel fairly often on a professional--

Anderson: On the average of five to six out-of-state medical meetings a year.

Mullan: That's an interesting add-on. I'd not thought to ask you about your impressive set of professional engagements. You've done lots. Anything else you'd like to add?

Anderson: My relationship with my partners has been critical. We are about as different as three people can be, but we've always been able to come to agreement on the important things. We respect each other. We don't do much socially together. I think that's probably an important thing in a small town, is that if you are going to have an enduring relationship in a small town, you have to have social contacts beyond your associates.

Mullan: That's because it's taxing or redundant if you do them with your associates?

Anderson: I think you get tired of each other. We get stale on each other. Our friends are the manager of a local manufacturing plant and his wife, very nice people, very much similar interests in the community. A cabinetmaker and his wife are good friends. A Forest Service employee, his wife is a bank teller. Before they moved out of the area, they were very close friends of ours. Just a variety of social contacts I think is important for personal support, and nurturance.

Mullan: The stability of your relationship with your partners, as you pointed out, is one element of the success of the practice in the town or the medical care in the area. Other than the happenstance of chemistry of three people who are fairly mature and stable and work together, is there any wisdom or formula or comment as to why that's worked and thrived?

Anderson: Just agreeing to make it work, and to not let differences become more important than the shared vision.

Mullan: Do you have any kind of structure, a staff meeting, [unclear] group? How do you deal with each other?

Anderson: We have a weekly practice meeting. The three of us meet with our office manager and talk about what our issues are and how we're going to deal with them. Nothing other than that.

Mullan: Good. Thank you, John.

Anderson: Thank you.

[End of Interview]

Index