THOMAS S. NIGHSWANDER

August 4, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: We're sitting on Dr. Nighswander's back porch, I guess, bedroom porch, in Anchorage, Alaska. The date is the fourth of August, 1996. Everything at the moment is very green, a variety of evergreen and deciduous trees. I suppose it isn't this green all year 'round.

Nighswander: Oh, generally, end of September, it's all yellows and oranges and the leaves are gone and it turns to white. Actually, you can see the mountains. During the wintertime you really get a much better view of the mountains. You get nestled in here in the summertime.

Mullan: There are no moose and there are no pussycats at the moment, or no rabbits, all that inhabit these environs, I'm told.

Nighswander: That's exactly right.

Mullan: Pussycats and rabbits I've seen.

Nighswander: And if you're lucky, we'll get a moose that'll come on down.

Mullan: You didn't start here. Why don't you tell me about where you came from.

Nighswander: I've got to include Ruth a little bit in this story, because she's very much a part of it. Ruth and I actually went to high school together back in Kent, Ohio, and for some reason, we went to several universities. I went to Kent State long before it became famous, and Ruth went down to Wittenberg in Springfield, Ohio. Even though we'd gone to high school, in fact, dated in our senior year, we went off to separate universities, but kept corresponding.

Later on in college, the relationship developed further and further, and finally in our senior year we decided we were going to go in the Peace Corps. I don't know why, but I'd always wanted to go to Africa before I ever went to Europe. We'd never traveled. My dad had worked for the city of Akron in the water department for thirty years, as had my grandfather, so there was sixty years of working in the water works. In fact, I've worked for the city of Akron water department in the summertime during college. So we kind of came out of that background. Dad nor my mother had gone onto college, nor had Ruth's parents, for that matter. Her parents came from Germany when they were in their twenties, so Ruth is first-generation American. But anyway, for some reason I'd gotten real interested in going to Africa, I guess from something I'd read. I remember once meeting a missionary who had been in Africa, talking about Africa drumming at night, and it sounded fascinating.

Neither of us had ever considered health as a career at all. I had an undergraduate degree in sociology and philosophy, and Ruth was an elementary schoolteacher with credentials for teaching German at the secondary level. So we applied for the Peace Corps, and we decided that if we got accepted to the Peace Corps, we'd get married, and if we didn't, we wouldn't. We would wait. [Laughter] Those decisions were easy at those times. We'd wait. But anyway, we got accepted into the Peace Corps, and we thought we'd probably be teaching. It's much easier to place couples in teaching positions than any other activity. But some GS-5 clerk, I've always suspected, had our applications, and when they decided which pile to toss it in, they tossed it in this pile that said "tuberculosis public health, Nyasaland."

Mullan: Nyasaland.

Nighswander: Which was the prior name of Malawi. Malawi became independent in 1964.

Mullan: It was French?

Nighswander: It was a foreign British colony, south of Tanzania, nestled in between Mozambique and then Northern Rhodesia, now Zambia. But the toss of the pile went to Nyasaland in public health. This is 1964. We got married on a Sunday, a week after I graduated from college. Ruthie had gotten out a semester earlier and was teaching in Cleveland at the time, in fact, was

teaching German. We got married on a Sunday, and on Monday morning we were off for Peace Corps training, the first six weeks at Harvard, and the second six weeks at Chapel Hill, with a guy by the name of Dr. John Castle.

Mullan: This was at Harvard?

Nighswander: Castle was chair of the Department of Epidemiology, Chapel Hill. His name soon will be familiar to you as you connect with this. I'll jump ahead in this story and say that there were 40 of us on this project, tuberculosis/public health, in Malawi. Malawi becomes independent in October of 19--I'm sorry, while we were in training. While we were in training, we started training in June, and actually, Malawi became independent from Britain in that July, so July 6, 1964 is their Independence Day in Malawi. So henceforth will be known as Malawi.

To jump ahead a little bit, but out of the forty of us on that project, all of us were what we called at those times BA generalists those years.

Mullan: Did you actually call yourselves that?

Nighswander: Well, that was the name that the Peace Corps had given to us. Today, out of the group, there's six physicians, two dentists, a quarter of the group have master's in public health. [Laughter] It was one of those life-defining events for many of us. In fact, we had a sense of it while we were there.

Well, Dr. John Castle and Dr. Cecil Sloan had very interesting backgrounds. They had worked in South Africa in a small group who was led by Sidney Clark. In fact, I don't know if you know Clark's early story, but maybe you know him better than I do. Have you ever met him and talked to him?

Mullan: Yes. I mean, if it's relevant to the story.

Nighswander: Yes. Right. It's relevant to the story. The issue was that they got assigned to work in South Africa, and one of the issues was to get the kids immunized. They had to get the women together, and they started a nutrition group with the women. This was community development work around health. The bottom line is it became so successful, the kids started to live and they all got kicked out of South Africa. This group, Kark, Castle and Sloan, and there were several others, were the founding fathers of Community Oriented Primary Health Care. Anyway, Castle and Sloan were the ones that really were the ones behind this Peace Corps project.

So our introduction to medicine, a field that I had never considered--(I graduated from college with 15 hours of geology, that was my entire science background)--resulted from a toss into this pile that says "tuberculosis/public health." It turns out these folks really did the original thinking and writing about community health and medicine, and it obviously had an influence on all of us. The project worked within the communities to help

identify and treat tuberculosis in out-hospital settings in Malawi.

About two-thirds of the way through that experience in Malawi, I started thinking about medicine as pretty interesting stuff, what we were doing was akin to some of the stuff in sociology: working with groups, trying to figure out what motivates groups of people in communities and so forth.

Mullan: Tuberculosis was the focus?

Nighswander: Yes, TB was the focus, exactly right. The principle clearly was the same.

Mullan: TB was endemic?

Nighswander: It was widespread and, God, it's even gotten worse recently. We went back to Malawi in '84. That's later in the story, but, yes, it's awful, because of AIDS and its association with TB.

Mullan: Tell me, before we go ahead, let's go back for a moment. Tell me a little more about your rearing in Kent. You were born in Kent?

Nighswander: Yes--I, my dad, and grandfather were all born in Akron, Ohio. Kent is about 10 miles from Akron. I was raised with an older sister and younger brother, with a very modest

income. I guess maybe we were poor. Maybe, I don't know. I didn't feel like it. Well, Dad was a city employee, and Mom worked various and sundry jobs off and on. Both Ruth and I were blessed with very supportive, helpful families, and we had a wonderful childhood, basically.

Mullan: Any doctors in your youth at all?

Nighswander: No. None whatsoever. There were not any really role models. I can't even remember the names of my early physicians. I remember all my schoolteachers, but I can't remember the names of any physicians at all, not from that period. That's interesting.

Mullan: How about religious background?

Nighswander: Yes. We were real involved. I was a member of the First Christian Church of Kent, considered the seminary, of course. The first time I heard of Africa, I think, was probably at a church camp. That's where that medical missionary was. I used to substitute preach in the summer when the minister was gone. I started that in high school. I did it in college a few times.

Mullan: Did you consider the ministry?

Nighswander: Actually, during college, about my junior year or so, I actually visited the seminary at Oberlin and considered it briefly, not really seriously. I, fortunately, woke up to my senses. [Laughter] But actually had considered it. The church was real important in my youth, and then continues to be off and on. Our spiritual journey led us to became Unitarian. Right at the moment because of their religious education program, we are Episcopalians, but once you're a Unitarian, you can be anything. You can kind of go with the flow, so it's a lot easier. Likewise, Ruth's had a very similar experience, too, because she was real involved with the church. She was a camp counselor in church, at her church camp, and obviously became very active with Lutherans. This is a big Lutheran country. The Alaska Nation Medical Center is a big Lutheran country, too.

Mullan: Were religious values important to you?

Nighswander: Yes. Well, there are a couple of issues, I think, concepts. One is this idea of this world community, where you have some responsibility for others beyond yourself. I think that was real important. I think the "dignity of man" kind of issue, that was one that was really inculcated by my parents. No matter who you were or what kind of work you did, a human being was a human being, and they deserved respect and value and dignity. I'm still real comfortable walking into a group of beer-drinking, blue-collared workers. That's real easy for me to sit down and communicate with them. I feel real comfortable in

those kind of settings. That's the way I was raised. I worked on a farm part of time growing up, a large farm, and then the work with the city workers. You get used to it. Civil service is in my genes, I guess, working for the government. My Dad and Grandfather worked for the City of Akron for a combined total of 60 years.

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Mullan: In the City of Akron of the United States.

Nighswander: That's right.

Mullan: All government.

Nighswander: All government including the Peace Corps. That's all government, all the same. That clearly has been real influential, although in fairness, I think that a lot of us who joined the Peace Corps in those years were responding to the call from [John F.] Kennedy. But there's some altruism there, and there's some real practical things. I mean, it sound like a great way to go travel and see the world, and a real adventure, and along the way, in a modest way, if you could help others, that would be great, too.

Mullan: What was the experience like?

Nighswander: The day-to-day experience was very positive for us. Ruth and I were stationed in the north part of the country, Nkata Bay, on Lake Malawi. It's one of those great lakes that fill up the rift valley of Africa (Lake Tanzania, Lake Victoria, and Lake Malawi) which stretches for a few hundred miles.

Mullan: Nkata is the same as the Nkata Freedom Party of South Africa notoriety?

Nighswander: Yes. But this is among the Tonga Tribe, which is kind of an outcast. Not an outcast, it was a separate tribe which was considered somewhat haughty and arrogant.

Mullan: Within Malawi.

Nighswander: Yes, within Malawi. Beautiful setting. We were there right at the end of the colonial period. Lived for a while in the DC's house.

Mullan: DC?

Nighswander: District commissioner, and next to the OC (the Officer in Charge of the police). This is the old colonial days. I had tea at four o'clock at the OC's house with his wife, which was delivered by white-gloved houseboys and so on and so forth. In my second coming, I want to come back as a British colonial. I mean, they had a great life, in 1930 or so. We arrived just as

the British Civil Service was disappearing, being replaced by a Malawian Civil Service. For a long time at Nkata Bay after the office in charge of the police, (the Webbs) left, Ruth and I were basically the only folks (white Europeans) the only Europeans there. All the rest were Malawians.

There were two aspects of experience. We really started our marriage there. It was a situation where we were both obviously well known in Kent, had been reared there. We were plucked out, went to Africa where we had to establish our own identity. We were trained to do the equal work and giving the TB skin test, basically, is what we did, taking X-rays, and actually reading X-rays, then handing out INH by the bucketsful. But we were trained to do it, so we had to work out this relationship, how we were going to work together. Twenty-four hours a day, I mean, that was it.

Mullan: How was it?

Nighswander: We went through some interesting times. It wasn't anything that was going to blow apart our marriage or anything like that, but I think the strength of our marriage has been that start. Where you got away from friends and family, and you're on your own, and you had to figure it out how you're going to do it. Some couples didn't make it. You would see it happen when vacation time, holiday would come, they'd start taking separate holidays. The first tell tale sign. [Laughter]

The idea, then and now with the Peace Corps (because we obviously stayed in contact with the Peace Corps), was to train host-country nationals. It's the concept that's still used. So we had local folks we were working side by side with and passing on the skills that we had, modest as they were. We felt very good about our experience, and many people in Malawi (the Peace Corps in Malawi), I think, felt that our being so isolated, and up where we were led to a pretty ideal experience. We felt that way about it.

Many of the Malawians that we were in contact with in 1964, we're still in contact with, and were able to reestablish our contacts in 1984. When we were back in D.C., in 1996,.we had the Malawian Ambassador over for dinner. We have a Malawian here in Anchorage who housesat for us last month while we were gone. So we've stayed in real close contact with Malawi. So I think that not only our personal kind of experience and what it meant to us at the time and in the future were significant. The contributions--what contributions we did make were quite modest.

Mullan: That is a question I wanted to ask, because it's so often been said of the Peace Corps and other such experiences that while they fly under the banner of transfer of technology, or altruism, or white man's contribution, or whatever, in fact, they do more for the participant than they do for the recipient country.

Nighswander: Clearly.

Mullan: Is it clear? I've always felt a little ambivalent about it.

Nighswander: In our situation, I think that was clear. It might have been different in 1984 when we were back for the year, when we were more highly skilled. We'll get to that period. I think in '84, it turns out that Ruth probably made a more significant contribution than I did. I was on a World Bank Health Planning Project and basically you don't do health planning in a dictatorship. But Ruth was teaching at the Community College of Nursing, and I think that probably was important.

Mullan: With the INH you dispensed, and with the--

Nighswander: For individual, fair enough. For the individual patients that we took care of, you betcha. I think on a one-to-one and the number--and I don't remember what the number is now--in terms of people that were diagnosed and treated in the villages, yes, that worked. The problem is that even that system that we had, that we developed and experimented with, was too expensive for a very poor country to maintain. Even in 1984, Malawi ran out of petrol three times, the police don't even have gasoline to get around. Just even getting drugs out to the local communities--90 percent of that country is rural--is almost an impossible feat. Here we had two people dedicated just to one disease traveling by motorcycle down village paths. Not sustainable in that kind of an environment because of the nature

of the infrastructure. What makes sense to us here, and I'm sure I don't need to tell you this, just doesn't work in a lot of these developing countries. It's apples and oranges.

Mullan: Yes. Yours was a medical care intervention in that situation, where even public health was absolutely rudimentary.

Nighswander: Absolutely. Absolutely. I'll give you the '84 story, talking about oral rehydration therapy. There was a conference that CDC [Centers for Disease Control] had in Malawi in '84. Some of the people attending it said, "Listen, why are we hydrating? We don't have water." There was a drought in some parts of Africa at that time. Having water available or water that was drinkable was just not possible, regardless of trying to get the oral rehydration salts delivered, which is another issue. But just the basic drinkable water was not available.

Mullan: Salt and water.

Nighswander: Yes. That's exactly right.

Mullan: It was a seminal experience for you, I would gather, both in terms of your ongoing connection to Malawi and also in terms of thinking about what you wanted to do with yourself when you came back. Tell me about that.

Nighswander: The decision came down to this. I didn't know anything about medicine whatsoever, except the exposure we'd had. Dr. Bill Peck was the in-host country director of this project. He was employed by the University of North Carolina. I think he was on the faculty of the University of North Carolina at the time. He's been an old TB guy from around the U.S. , and Bill was probably at the time in his mid- or late fifties, and although John Castle and Cecil Sloan would come over from time to time, Bill was the one that did that in-country medical support, read a lot of our X-rays and whatnot, and told me one time after we'd gone through an X-ray session, he said, "You know, Tom, I bet you could become a physician."

Well, I remember some sleepless nights. That's because I knew that I was a modest student. I wasn't a stellar student at Kent State in terms of grades. If I were interested in medicine, I'd have to go back to undergraduate school and do some pre-medical sciences, number one, and I didn't know how I'd do with that. But it came down to if I didn't give it a try, in 15 years, on a bad day in another career, I'd really kick myself in the pants and say, "Yes, why didn't you give it a try?" The worst-case scenario was I'd go back t undergraduate school, it wouldn't work out, or I wasn't capable, and fifteen years later I'd be able to say, "Well, at least I gave it a try." I'm in another career, having a bad day. I would ask, "God, why didn't I go into medicine?" I'd say to myself, "Well, I tried that, it didn't work." Basically, that was how I made basic decision. If I didn't give it a try, I'd really kick myself in the future.

Mullan: What did you do?

Nighswander: So what I did was, I came home. I enrolled back in Kent State University. I was able to do that by mail. I had enough contacts there. Two weeks after I got out back in the country, I went to see a guy by the name of Dr. Jack Coy at Case Western Reserve University. Jack was a legend in his own time. He's still living at 96. Dr. Coy was the "admissions committee" at Western Reserve and had been for many years. This was in the sixties, and I told Coy I wanted to go to medical school. He said, "Well, that's interesting. Let's see how you do." [Laughter]

In the meantime, I had written to some other schools at the same time, including Chapel Hill.

Mullan: You were taking all the sciences, blitzing them?

Nighswander: Well, I hadn't started yet. I was getting ready to start. We got home in July of '66 now, and I saw Dr. Coy right as soon as I got back. I wrote to Chapel Hill, and I never even got a letter back from them. Western Reserve was obviously the only school that was ever going to be interested. I went back, yes, and I took physics, chemistry, and biology. In December--it was a quarter system--I got a four-point. I sent the grades up to Dr. Coy, and Dr. Coy said, "You keep on like this, I'll guarantee you admission. Maybe not this year, but I can in the following year." I had showed him how I could meet Western

Reserve's minimal requirements in a year or summer. Second quarter I did well, and the beginning of the summer they had someone drop out of the Fall class and I got in. So I went a year and a summer--

Mullan: You took organic during the summer?

Nighswander: I took organic during the second summer. Within the following year of leaving the Peace Corps, I was in first-year medical school, Western Reserve because of Jack Coy, clearly.

Mullan: How did you feel about the sciences? How was that year?

Nighswander: It was a rugged year. God, it was tough. I mean, here's a sociology major with 15 hours of Geology, and I struggled. I struggled that first year in medical school. I remember that as a real heavy year. I think I might have even flunked the first exam. I felt bad, and Coy was real encouraging. Basically, I had a very positive experience in medical school. Just had our twenty-fifth medical school reunion about three weeks ago, saw a lot of old classmates. But Western Reserve was well known for "bent arrows, . Coy had an uncanny--he really liked a lot of varieties in his classes, so he picked these oddballs. Jack Geiger [phonetic] graduated with me. Geiger was another one of Coy's guys. And Dave Sacher [phonetic]. Dave was a year ahead of me, kind of interesting

background. We were called his bent arrows. There were straight arrows and bent arrows. [Laughter] He was just interesting in someone that was a great soccer player or was a great musician. That was the Western Reserve tradition and, in fact, still is. Except now they've got a big admissions committee, and just as an aside, I'm on the admissions committee at the University of Washington, and we spend more faculty time admitting students to the University of Washington than we do teaching them. I mean, the admissions, I'm a drone interviewer. The real power's in the executive committee. There's hours and hours of faculty time that goes into admissions, and Jack Coy did it all and obviously did very well with it.

Mullan: How was the medical school experience?

Nighswander: Medical school was a very positive experience. I realized, well, that's the late sixties, and Western Reserve was kind of a little place, people were protesting the war and so on and so forth. But good friends. It was an excellent faculty. At Western Reserve, you don't enter medical school, you enter the medical profession, and you're told that from day one when you walk in. "If you don't make it in four years, it's our fault. It's the medical school's fault. We admitted you, and damn it, you are going to graduate." So it wasn't any of this stuff--the old days--where you count down four, and they'll be gone at the end of the year. Western Reserve was very good. I always felt very positive about that.

Mullan: It was a political time. Were you involved in the politics at all?

Nighswander: Not really. I had a lot of classmates who were. There was a big black bag protest--Lilly. We all turned in our black bags because Lilly Drug Company was trying to buy us off with black bags and stethoscopes. So there was a big black bag protest. But more importantly, all the stuff was going on in Vietnam at the time, and we were pretty much out of that, except that the draft board was down my neck and paying real close attention to what I was doing, where I was going. But I wasn't the activist. It wasn't, and hasn't been, really my nature to be the active protester, more behind the scenes.

Mullan: How about the community medicine side of it?

Nighswander: Yes, the community medicine stuff. Again, Western Reserve, by tradition, had been real involved with that. We were assigned, in day one basically, to an inner-city black family in which the woman was pregnant, and you followed her pregnancy, generally, the first year of the child's life. I got involved with that family all four years. Although in terms of the community stuff, I really worked pretty hard in medical school academically and didn't spend a lot of other time outside.

Mullan: How did it square with your Third World experience? Quite different?

Nighswander: Yes. It was different. Of course, this was all new, and it was real hard, frankly, to fit it kind of altogether, because of the amount of the resources that we were using in Cleveland. I become more and more aware of where the emphasis should be later on when I was able to digest that whole experience. These were pretty monumental changes for me, in retrospect, not having thought about medicine at all, and with no really exposure whatsoever, and then coming in the door of medicine through this community health perspective.

Western Reserve at the time, even though they had this community piece, was really a hotbed of internal medicine and specialty training. I do remember looking around, and this did bother me, and trying to see physicians on faculty that I thought had the kind of lifestyle and doing the kinds of things that I was interested in, and I didn't find them. Most were pretty focused on academic careers. I remember distinctly a very popular obstetrician/gynecologist faculty member, well known for his research and patient care. He committed suicide. It turns out his professional life was doing very well, loved by his faculty, loved by his students and patients, and his personal life was in shambles. That's what did him in. I remember that well.

Mullan: In terms of identifying with--

Nighswander: Yes. You're trying to pick out models, and, really, the guy that was the most exciting at the time was Dr.

John Castle. As a matter of fact, for the two medical school summer projects, for the summers we had to do a project, kind of a senior projects, I went back to Chapel Hill and Jim Castle worked in Claxton, Georgia, with Dr. Curtis Haines. I don't know if you know Curtis Haines. You know about him? The reason he's familiar is the American Academy of Family Practice now has this award "Dr. Curtis Haines Award." It turns out he's a generalist physician in Claxton, Georgia, doing various community-based research. So Ruth and I were down with Curtis Haines between our first and second summers in Claxton, George. It's a project sponsored in collaboration with the Department of Epidemiology at Chapel Hill, the Claxton, Georgia, Heart Research Study.

Mullan: You had a sense of not having role models on the faculty, or having trouble finding them?

Nighswander: Yes.

Mullan: Did you have a developing sense, or any kind of sense of what you wanted to do?

Nighswander: Yes. The orientation we had gotten at the Peace Corps from Castle and Kark. Basically, I knew what really made sense to me was community ownership, when the community owns their own health, then things can happen. The question is what kind of role does community ownership play. Kark wrote an early

book called *The Social Practice of Medicine*. I've got it. I don't know if you've ever seen it or not.

Mullan: I don't think so.

Nighswander: It's a 1952 book. I just looked for it downstairs. I thought you'd be interested. I think I've got it at the office, as a matter of fact. You didn't find that at Western Reserve, and the closest person that I knew that could talk about that, and had actually had experience with community medicine and developed work around that was Castle. Did you ever meet him at all?

Mullan: I never did.

Nighswander: We had a Peace Corps reunion last summer.

Mullan: He died several years ago.

Nighswander: He died. Yes, he had lymphoma, Hogkins. He died in the late seventies. We met up again through the Clinical Scholars Program in 1975. He was on the board for that. Actually, we stayed in contact. But it was Castle. At our Peace Corps reunion, 25 of us were discussing John. It was Castle who was my model, everybody was inspired by him.

Mullan: Twenty-five was--

Nighswander: Our Peace Corps volunteer group--that group from Malawi IV. It was clear that it was Castle who WAS an inspiration,, and we all felt uniquely treated by him. It turns out we weren't unique. He treated everyone that way.

Mullan: How many of you were there?

Nighswander: There were 40 of us in the project in '64, and there were about 25 of us that got together. That was a 30-year reunion. It was '94 was when we got together.

Mullan: Again, the numbers of physicians?

Nighswander: We had six physicians, one dentist, and a quarter of the group have master's in public health. Isn't that amazing? When you think about it, there's something intuitive about it when a community owns their own problems. They can make things happen.

Mullan: As you went through medical school, was your family supportive? What sort of attitude did they take? This is quite different than the Akron Water Works.

Nighswander: Oh. Oh, well, gosh. Yes. It turns out all of us graduated from college, the three kids. Sue, my older sister, she went on to graduate school, and I went to medical school. My parents couldn't have been happier. They were delighted.

Mullan: How about finances?

Nighswander: We did it on our own. We weren't supported by the family at all. Ruth was teaching at the time. We took out some loans, but she also went back and got a master's degree while I was in medical school. We don't remember how we did it, but we didn't get any help from the family. As soon as we left the Peace Corps, we had some money in the bank. We had two or three thousand in the bank.

Mullan: Scholarship?

Nighswander: There was some scholarship money and there was some no-interest loans, and that's how we did it.

Mullan: You're reaching the end of school, and now it comes time to translate going into action.

Nighswander: Well, the problem is was I was coming up against these people who were going into internships with second-night call or better even every-night call so you don't lose half the good cases and all that kind of stuff. I didn't want that. Then there was this community medicine piece. I looked around the country and got real interested in Kaiser. They were only in California--very interesting program, trying to keep people healthy, and out of the acute care system. I started my

internship with Kaiser on Gary Boulevard, one of the premier prototype HMOs.

Mullan: That's San Francisco.

Nighswander: San Francisco. And I had another enjoyable time. All my medical training I enjoyed. We were busy, but we lived in interesting places with interesting people, and Kaiser had a lot of physicians on staff whom I could relate to.

Mullan: Hold on a second.

Mullan: This is Dr. Nighswander, tape one, side two, continued.

Nighswander: Not only relate to medically, but they were interested in lifestyle issues. Not that they were doing the kind of medicine I was interested in necessarily, but the family was always important. Ruth and I (by this time, we were married seven years), we didn't have kids. But spending time with her and having a life of your own, I have outside interests, and so did the Kaiser physicians. They didn't have the community medicine piece as such, but certainly lifestyle issues were important to them.

My big deal was the draft board. The draft board is now getting very interested in what I was doing. This was 1971-72, and they were very interested in what I'm going to do after my first year of internship. I was on the old rotating internship.

I started looking around for alternatives, and one of the alternatives was obviously the Public Health Service. There was this new program. As soon as [Richard M.] Nixon had signed authorization for the National Health Service Corps (I think it was about December or January of '72), I was on the horn, and called. I called Washington and applied, because it was either Vietnam or the Public Health Service. I had already taken an induction physical to go to Vietnam. I got this telegram from David Kindig, and it was Arkansas and the NHSC. Oh, God! I started making phone calls, and there was a potential NHSC program in Alaska. I called the regional health director, Dave Johnson, as a matter of fact.

Mullan: In Seattle?

Nighswander: In Seattle. And another guy who was the medical director, a cardiologist named Willard Johnson. I had also heard from the Indian Health Service, and there was a "good" place in Harlem, Montana. I remember I called up there and the current physician said, "Ought to be a great clinical experience." [Laughter] And I thought, "That sounds suspicious." I asked him more, and they were underfunded. In fact, I called Willard Johnson after that. I remember this well. Willard said, "Tom, you don't want to go to Harlem. It is underfunded, understaffed. We've got something brewing up in Alaska you might be interested in." It was this Alaska Health Manpower Corporation. He said,

"We want to try start some mid-level practitioner programs in Alaska."

Mullan: This is Dave Johnson, the Regional Director?

Nighswander: This was Willard Johnson. Willard was a cardiologist. He was one of Dave's deputies.

Mullan: This was Public Health Service?

Nighswander: Public Health Service, absolutely, out of Seattle. He said, "You might want to make a few calls up there and see." Boy, this was probably June now, because I'd had held off on the National Service Corps' first offer. They'd sent me another option in Florida. But once I heard about something in Alaska, Alaska did sound really interesting.

Mullan: Had you ever been to Alaska?

Nighswander: No. But, you know, it sounded like great country, interesting, new frontier, last frontier, whatever it was.

Mullan: Can I just before we pursue Alaska, a couple of things on the internship. Now the health maintenance organization and graduate medical education are a big and controversial issue. Kaiser of Northern California is a place that medical education has gone on within an HMO for many years. What in 1971 was one's

perspective on an HMO or managed care, both in general and as an intern?

Nighswander: I think that Kaiser was clearly a successful program. It had gone through an early phase in California where Kaiser physicians were not only renegades but obviously second-class citizens and Communists. What is this? Hospital staff being salaried physicians. Even in the early seventies, especially on the East Coast, I think a lot of my colleagues, and even the faculty at Western Reserve thought that I had jumped ship. I mean, they really thought they made a mistake with this one, my going out and do that. Particularly, this idea of capitation, physicians (this became controversial later on) received incentives to keep people healthy. The Permanente Medical Group, received capitate dollars to take care of patients, and if they didn't use all those dollars, they got a bonus at the end of the year.

The training program was excellent. These were a group of physicians who were pretty cost-conscious. You made judicious use of procedures and the laboratory. Obviously, there was no incentive for them to do big expensive cases. Busy, lots of patients, a lot of common stuff. There was general surgery in high volume, so you got to do lots of things.

Mullan: Did you have a sense that you were seeing a vision of the future, or you were seeing an interesting sideshow?

Nighswander: It was an interesting sideshow at the time. I mean, it was a way of practicing medicine, though, that made sense to me. I guess there were great features of it. One was the group practice. I just couldn't envision myself being a solo practitioner. That was number one. Number two, my family had always been salaried. I couldn't imagine, even then, of charging anybody for what I did. This like fee-for-service kind of thing--

Mullan: It was comfortable.

Nighswander: It was comfortable. Philosophically, I thought it was the way to do it, and I thought that I saw really excellent care at a real reasonable price, and enjoyed the physicians, the way they talked about patients, the way they talk about medicine. They obviously were not in it for the big bucks, although money was really never an issue for us. So it was a group of physicians that I liked and had a lifestyle that I liked, too. They clearly had a life beyond medicine.

Mullan: Did you at all consider, if it hadn't been for Vietnam, would you have stayed on in that system?

Nighswander: Yes. Yes, I did. In fact, it was unclear whether NHSC in Alaska was going to come through now we're into June of that year. The work is over the first of July, and I applied for a California license, in fact, had made arrangements. They had

said, "We'd be happy to have you stay on." So that was a real honest alternative and
option.

Mullan: It turned out Alaska was looming.

Nighswander: Yes, but Alaska was looming. There was this new organization up here called the Alaska Health Manpower Corporation. Its purpose was to get together all the various and sundry agencies in 1972 in Alaska who were involved with education, health careers, and also do some experimental work in developing mid-level practitioner clinics. Mid-level practitioners were, in 1972, physician assistants. They were brand new on the scene. That first PA program was at Duke and started in the early sixties.

There was a new training program at the University of Washington, run by a guy by the name of Dave Lawrence. I don't know if you know David or not. Dave ran the Medex program that had just gotten started. It had been started by Dick Smith, who's out in Hawaii now. When Dave had taken over for Dick, in fact, they had seven students here in Alaska in 1972 who needed to have some coordination work done. Even though the assignment for National Health Service Corps to the Alaska Health Manpower Corporation was to develop three remote community mid-level practitioner sites somewhere in the State, the Medex program from the University of Washington was other duties as assigned.

Mullan: This was a National Health Service Corps position?

Nighswander: This was a National Health Service Corps position. Early days, lots of flexibility. It's one thing I've learned about new programs. If you get in early, you've got a lot more flexibility than later on.

Gosh, to get the position, I talked to the Public Health Director of Alaska at the time, who's long ago retired, the new director of the Alaska Health Manpower Corporation, a guy by the name of Bill Deak, a genius and controversial. In July 1972 he was in California at the time, and actually on his way to Alaska, stopped in San Francisco to interview me. Time was marching. I was done with my internship. I still didn't know what I was going to do, but it took with Bill, and up we came.

Mullan: He was in the Public Health Service, too?

Nighswander: He was not. The Alaska Health Manpower Corporation was a consortium. Money came from the Regional Medical Program's Bill was hired by--this RMP project. So up we come with this background and I started going out and visiting communities and these little community boards.

Mullan: You moved to Anchorage?

Nighswander: Yes, we came to Anchorage. We came up to Anchorage that August 1972, site unseen. I was assigned to an old

apartment building on Eighth Avenue with this Alaska Health Manpower Corporation. The board included the Hospital Association and the Mental Health Association, the State Medical Society. This was a town with 70,000, that's what Anchorage was in 1972. Within a month, after an internship, I was down talking to the little health board in Craig, Alaska, across from Ketchikan, on Prince William Islands. Then I went to Yakutat, which you flew over on the way up there. Eventually I went to Galena, which is up on the Yukon River, and talked to--well, I was going to talk to the mayor, but the day I got there, when I was coming in town, this was in December, the mayor had just mushed out of town for his trap line. Roger Huntington was the mayor at the time.

So I'm going around and talking to these community-based health boards. Well, they weren't called health boards. There were two or three people in these communities who were interested in improving the health of the community with some kind of a practitioner. You had to explain what a PA was at the time, and most of them had community health aides. I went out the Aleutian chain to Unalaska, which is 800 miles out on the chain. They were interested. I had the time to go back again and again. By this time, in Alaska, these villages had been used to consultants flying in and flying out, and never be heard from again. But I actually did go back. I had the wherewithal to go back again.

Mullan: Where were you going to get mid-level practitioners from?

Nighswander: That I didn't know. I just knew there was a few programs around.

Mullan: You were trafficking the idea.

Nighswander: Yes, I was marketing the idea. We didn't have an idea, but somehow we could put it together. But in the meantime, I was also helping arrange for and monitor the preceptorship of the seven PAs who were up here in 1972. One you're going to see is John. I remember distinctly the first bite we got from a community. I was really discouraged. I had been up here six months and nothing was happening. I said, "Well, honey, we'll see. We'll stay here for two years, and I gave it the best shot. Enough of that." Because I was expecting people just to hop right on the bandwagon, and go ahead and buy it by hook, line, and sinker. It turns out working with communities doesn't work that way.

Anyway, gee, in January that year, Yakutat called me back, "We are interested. In fact, we've talked to the legislature, and we think we can get a new health facility down here." The first bite was Yakutat, and the first program that got going.

I'll jump ahead of the story. Three mid-level practitioner programs got developed by community boards in Yakutat, Galena and Unalaska. They're still in existence today. And they are owned by and run by the community. Remember Roger Huntington, who leaves Galena on the dog team to go out mushing the first time I arrived, I was best man at his wedding in 1979. Larry and

Carolyn Powell, the mayor at Yakutat at the time, eventually became close personal friends.

The work was what you and I believe in. There were three or four people in these communities who were interested in health issues, about the health of their community, and were willing to take it on. What it reinforced was this idea of "We've looked at the enemy, it's us, and what are we going to do about it?" I mean, that's an epiphany in a community when that happens. To a greater and lesser extent, it happened in all three communities, and many, many more communities in different circumstances.

With the National Service Corps, we had some resources to provide, but what I've learned over time, what's made those programs successful, is the community ownership piece. You must give the program away. It's not your program. The National Service Corps resources help jump start it, but now their programs are independently funded.

Mullan: So that was '72, '73.

Nighswander: That was '72, '73, '74. Three years. I'd say the third year things really got rolling. I stayed a third year.

Mullan: Besides getting those programs started you were you doing other things?

Nighswander: Yes.

Mullan: You were the class coordinator for the Medex Program?

Nighswander: Yes, the Medex Program. That's how I got tied in with Dave Lawrence.

Mullan: They were rotating students up from Seattle.

Nighswander: They were rotating students up. I was doing the coordination and got involved with a lot of health things. It was a small state at the time, well, still is. I was involved with the State Medical Society. Rod Wilson, who you're going to meet tomorrow, Rod was president of the State Medical Society at the time. So I first met Rod and did some stuff with them. He was a young Turk. But it's just amazing that the group of us are all still involved in it.

Then I was on the auxiliary faculty at the Alaska Native Medical Center helping with the community health, teaching the community health aid program.

Mullan: Were you practicing at all?

Nighswander: No, I was really weak clinically, even though I was a supervisor for these mid-level practitioners. I did see patients over at the Alaska Native Medical Center on a part-time basis. Then after I went out and helped established these three community-based programs, I was the supervising physician for the physician assistants who were out there.

Mullan: So you were doing more teaching and community organizing than practicing.

Nighswander: Yes. Really. Yes.

Mullan: You had some instinct that you needed to go in public medicine?

Nighswander: Yes. There was no question about that. Well, I wanted two things. I wanted clinical medicine and I really wanted a master's in public health. I wanted some more background in epidemiology. Dr. Ted Phillips came up. Actually, Ted was on the advisory committee of the Clinical Scholars Program. Well, I didn't know at the time. He came up and he wanted to meet me. By this time the Regional Medical Program was based in Seattle. People had heard about these three community programs, and I was able to get them started, and they were ongoing and functioning. So I was getting decent press. Ted came up and had lunch, and talked about a fellowship program that they were starting at the University of Washington. Again, it was going to be the first year of a new program. They were looking for interesting people and although I didn't quite fit because they were really interested in people who had a residency training, Ted thought I might be able to work something out. I said, "Gee, I'd be interested."

Mullan: Say more, just for the record, about the Clinical Scholars Program.

Nighswander: It is a program sponsored by Robert Johnson Foundation in which, as it has evolved, clinicians who have been interested in issues beyond clinical medicine--beyond pure one-to-one patient encounters--interested in issues related to health policy, medical education, or community health or university-based research, are given an opportunity for a two-year fellowship program to explore some of those issues with discipline. The early clinical scholars have pursued careers in these areas very successfully.

Mullan: But you went into it for two years. You went back to Seattle?

Nighswander: Went back to Seattle for two years. A real busy two years, because I worked on a MPH and worked in a residency program. They gave me some clinical credit for being up here, and in the clinical scholarship program. So we stayed down for two years and did it all.

Mullan: You both did clinical training and an MPH?

Nighswander: In the School of Public Health.

Mullan: How was it?

Nighswander: We had a delightful time. I've been blessed. Wonderful people.

Mullan: The clinical time was in family medicine?

Nighswander: The clinical time was in family medicine.

Mullan: By that time you had come to identify yourself as a Family Practitioner?

Nighswander: Yes. It was clear from the work that I had done up here, and if I were interested in coming back. My inclination and interest was in being a generalist physician. Family practice was the most appropriate specialty for me, even though I hadn't really identified what I was going to do afterwards. That's where my clinical interests were. It fit well.

The other piece of it was this policy stuff and how that might fit. The two people who were real heavily involved with me at the time was Gil Oman. I don't know if you know Gil at all. Then Dave Rogers, the Foundation President. The Foundation, incidentally, was relatively new at the time. Robert Johnson Foundation was relatively new.

Mullan: Was that the first class of clinical scholars?

Nighswander: Yes. That was the first class of clinical scholars. Although Dave Rogers told me that he was interested in

clinical scholars going into a clinical academic career path, he would not at all be disappointed if a few of us migrated and did other kinds of things.

Mullan: The real world.

Nighswander: Yes. There were a few dineros [phonetic] around, I guess. I never thought of it--the dinero routine. Gil's real intense.

Mullan: What was he doing then?

Nighswander: At the time, Gil was the director of the Clinical Scholars Program for the University of Washington and on the genetics faculty. He went back and served in the [Jimmy] Carter White House. For two years he was there, he was on Carter's science staff. I think Gil wanted me to stay, as we approached the end of the two years, in some kind of academic family practice. Although, others like Dave Rogers thought it was clearly appropriate if I wanted to come back to Alaska and do something up here. The possibility that was open up in Alaska was the development of a family practice setting at the Alaska native Medical Center, which was a new idea.

Mullan: Family practice setting as in training?

Nighswander: No.

Mullan: Practicing?

Nighswander: Practicing.

Mullan: Organizing appropriate services around a family practice model.

Nighswander: Yes, a family practice model. The Alaska Native Medical Center had a typical out-patient department that also was responsible for the emergency room, and for health aides phone consultation in about forty-some villages around south central Alaska, south of the Alaska Range, out the Aleutian Chain, down Kodiak Island, up in Mat Valley.

Mullan: Health aides are Native people, trained?

Nighswander: Usually women, 16 weeks of training, traditionally over about a three-year period of time, in every Native community in the state that's over 100 people. They are the primary care providers, start IVs if necessary, do suturing. They really are the primary care provider in these communities. We have them, as I said, throughout the state. It's a well-established program. There are four different training centers. If the health aid is overwhelmed with a medical issue, the patient will be transferred by air to their local hospital. For example, the hospital in Nome Kotzebue, or Bethel. If the patient needs additional care,

they'll fly into Anchorage, which is really a tertiary care center.

Mullan: "We" being the Alaska--

Nighswander: The Alaskan Native Medical Center. So even yesterday, I was on the phone to Nenilchick, which is actually on the Kenai Peninsula, with a patient. When you work in the emergency room, which we do, we supervise, provide medical backup support all the way out the Aleutian chain to Atka, which is 1,200 miles out, with a village of 180 people out there. So that was the program, when I returned in '77--

Mullan: What year--

Nighswander: '75 to '77 down in Seattle in the Clinical Scholars Program.

Mullan: In '77 you re-entered the Public Health Service?

Nighswander: Correct. Exactly. I wasn't sponsored by PHS in the Clinical Scholars Program. Who did I talk do? I probably talked to Ed Martin by that time. I talked to him about getting some sponsorship and staying in the Public Health Service, and doing a clinical scholar, but it was cumbersome. So I deactivated my commission in 1975.

Mullan: When you come back in '77, you were in the Indian Health Service?

Nighswander: Yes. So back in '77, I come back in '77 in the Indian Health Service. The hospital, the Alaska Native Medical Center, was willing to put more resources into the out-patient department, to develop a kind of family practice clinic. It was unclear what they wanted to do unless they had more resources. So I brought four people with me, brand-new physicians, and we had a core group with that.

Mullan: Family practitioners?

Nighswander: Well, they were all family practice oriented. At the time we didn't have that many family practitioners around. One was family practice; one had generalist with pediatric training, who had been at the CDC, wanted to get back in clinical training; two other guys who were general practice folks who had some work experience. I think that was the original group that we had.

We had a core group to do something with this unmanageable out-patient department, which also ran the emergency room, and serviced these forty-some villages, with not only with phone calls, but village visits.

It's at about the same time that the WAMI program was starting-- Washington, Alaska, Montana, Idaho--where they wanted to do community-based training, outside of the University of

Washington for medical students. We were in very early discussions in '77 or '78 with that group, even some discussions about actually developing a family practice residency in the state of Alaska, which in 1997 is going to happen. Our first residents get admitted next July.

Anyway, over the time period that I was as chief of family practice here, we put all those pieces together, did a training program, organized a Family Practice Department. In addition to the classic out-patient department, we tried to change walk-in patients to appointment patients using a family practice model. This WAS to be done within a hospital that had developed along university lines, with subspecialty medicine, a pediatric department, OB/GYN, etc.

We were blessed here, and always have been, with a very senior staff , very stable staff. As opposed to a lot of the Indian Health Service settings, we had people who were here for the long term, and worked together, so that has always worked out very well.

We started the WAMI training program here. We started Introduction to Family Practice as a catalog course at the medical school. It's one of the required rotations. There were two family practice curriculums in the state, one here and the other one in Ketchikan. Did very well for that program. That program grew, and, of course, the number of patients grew, and so forth. I stayed in that position until 1984.

Mullan: This was Chief of Family Practice?

Nighswander: Chief of Family Practice.

Mullan: This was a kind of developmental mission.

Nighswander: Developmental mission with pretty close university ties to the University of Washington. I stayed involved with medical politics in the State, on various and sundry committees with the State Medical Society.

Then I got a call from Management Science for Health out of Boston, to whom I had sent a CV some years before. There was a World Bank Health Project in Malawi, and they needed someone to go to Africa, '84. So they called, and I was thinking of other names of people I knew who might be interested. They said, "No, we're interested in you."

I said, "Well, there's no way." Ruth was a community health nurse at the time. She was a community health rehab nurse at the time, and the kids were in school.

Mullan: Had Ruth gone back to nursing school?

Nighswander: Oh, yes. Because of Malawi, she ended up becoming a nurse.

Mullan: When was that?

Nighswander: When she got up here in '72. She went back to AMU, Alaska Methodist University. Ruthie had taught back in

Cleveland and in Kent when I was in medical school. She got a master's degree in education, before coming up here in '72. When we arrived here, she thought she might be interested in nursing but didn't want to spend that much time in school. So she goes over to Alaska Methodist University and said, "Gee, how about the two-year program?"

They said, "You have enough credits. I bet you in two years you could get a four-year degree." So that's what she did, she ended up getting a four-year degree.

In the meantime, personally, we got into kids after ten years of marriage. For some reason couldn't have any genetic kids, so we got into adoption. So our daughter's Alaska Native. You probably don't even know that.

Mullan: No.

Nighswander: Well, half Native and half English lawyer. She was just on the phone. She's down at Pacific Lutheran University right now. She's 21. We adopted her before the Indian Child Welfare Act.

Mullan: Which proscribes? Prohibits?

Nighswander: Yes, basically. It corrects what many felt were inappropriate adoptions, especially in the Lower 48. It gives the tribe the first choice to place the child. We adopted Heather in 1974 when she was two months old. Heather was with us

in Seattle. She was born late November of '74, and we got her in February of '75.

Mullan: How many children have you got?

Nighswander: We've got two, Heather and Sam. Sammy's also adopted.

The phone call came from Management Science for Health in '84, and they wanted us to consider going to Malawi. Ruth and I went out backpacking that next weekend and started talking about it. The more we talked about it, we said, "We probably could do it." Interesting opportunity, and we had stayed in contact with Malawi.

I called back. It was early in '84. Actually, they had filled the position when I called back the following Monday. So it was out of the question, except the person for the position didn't work out, and about two months later they called again and said, "Would you consider going? The project was helping develop a ten-year national health plan for Malawi. It was being required by the World Bank for them to get additional funding. They need a deputy chief of party."

I said, "Sure." So I inactivated my commission again. At the time Everett Rhodes was Director of IHS and Everett called and said, "Gee, don't inactivate your commission. We'll figure out some way to do this, putting people on loan."

Remember that era. I don't know who all abused it, but it was enough people so that they were putting restrictions on loaning people. [Laughter] They had to squelch it, and there was just no way to do it quickly. So I inactivated.

We went to Malawi for that year with a group led by a Brit, a British guy. Very good. It was a terribly frustrating few months, because we were all fired real soon after we got there. The bottom line, the short story is, you just don't do health planning in a dictatorship. I mean, you sit down with the principals, the principal secretary for the Ministry of Health, and all the deputies, and you think you get a decision, and nothing happens.

The project blew up in November 19985, and I was taking a year off, and I didn't want to come home. So Ruth started working in Kamazu Community College of Nursing, on the faculty. I rejoined the Peace Corps, actually, in country working for the Peace Corps Director. This is a side story. Scott Faulkner, who was a political appointee, was the Peace Corps Director in Malawi. He had worked in the [Ronald] Reagan transition team. Professional Republican, right? We get a franked envelope from him last December, and he's back. "Hear you might come back to D.C., Tom. Look me up." "I work for Newt Gingrich." [Laughter]

Mullan: I'm confused.

Nighswander: Scott Faulkner was Peace Corps Director in Malawi in 1984, and I worked for him. He's a very conservative Republican.

Mullan: He now works for Newt Gingrich?

Nighswander: And now works for Newt Gingrich. He's the Chief Administrative Officer for the House. So on the House side of Congress, he runs everything from flowers, to all the concessions, to the members-only dining room, all the furniture, and a $40 million budget.

The reason I wore my tux back in D.C., in the last six months, was Scott Faulkner, some of the stuff that Scott got us into, it was just one of the things.

Mullan: What did you do in '84?

Nighswander: Initially I did some Peace Corps clinical, medical work for the few months that I worked for him full time, and then some planning activities to develop health programs for Peace Corps volunteers.

The last three months I was there, I worked as a pediatrician in the government hospital. That's real Third world medicine. Sixty beds, 180 kids, and I think we had about 40 kids die in the few months I was there. We were right in the middle of meningitis season. Every child prophylactically gets

phenobarbital to prevent seizures. They have meningitis, but the whole country ran out of phenobarbital. There wasn't any. It's one of these impossible situations that it would be useful for everyone to do. Really, it's incredible.

Mullan: Pause on that for a minute. Your reflections on your second time in Malawi. Had things prospered, and did you make any different kind of difference?

Nighswander: No. It was interesting. We went back to some of the same villages we worked in 20 years prior to that, 1964, as a matter of fact. Went back to Nkata Bay. We were remembered, and met some of or old clinical officers. That country is run by clinical officers who are not physicians. They have four years of training after secondary school, and they run the hospital system. They're called clinical officers, not medical officers. They do C-sections. They've done special training for some opthamology skills, so they do eye surgery, I mean they do marvelous work. Some of those senior clinical officers, we made contact with them again.

But going back to the villages, in many ways the villages were worse off. The British Civil Service had been replaced now fully by Malawian Civil Service who were really disenchanted with working in a dictatorship. The Life President of the country, a banned physician in the colonial days, who led them to independence in 1964, was still in power. He became more and more paranoid the older he got. Two of the ministers who had

been in his cabinet the Spring of 1984 had a disagreement with him and died "in an auto accident." They were murdered by the Special Police. There's been a trial ongoing because of that.

Mullan: Hold on a sec.

Nighswander: The total contribution that we made in 1984-85, I think, in retrospect, was what Ruth did in teaching at the Kamuzu College of Nursing where she had nursing students on the hospital wards. Although, again for us, personally it was a wonderful experience. Heather was in standard six. She went to Bishop MacKenzie Boarding School as a day student and Sammy was too young to remember. He was a couple of years old.

But wonderful friends. We re-established contacts with Malawiars from 20 years prior from former Peace Corps days. Malawi is called the warm heart of Africa. That's on their travel brochures. They are wonderful people, and the country is beautiful--called the Switzerland of Africa--high plateaus, lakes. It's a great place. You ought to go visit.

Mullan: Yes. So the year was up, and you had to figure out whether you're going to come back to Public Health Service or something else.

Nighswander: Yes. I was a free agent. We left. I had been in the Public Health Service 13 years, and Ward Huolburt, Indian Health Service Medical Director, called. I don't know if you've

ever met Ward when he was chief medical officer. He wanted me to go to our perennial difficult-to-fill spot in Aberdeen.

Mullan: Aberdeen, South Dakota?

Nighswander: Yes, the Dakotas, the plains. I had promised Ruth and Heather, in particular, both of them, that we'd come back here. Actually, we had a house in Anchorage, and it was leased for the year. Although I inactivated my commission, we wanted to come back to Alaska to do something. There was a position soon to be vacated called Director of Community Health Services for the Alaska Native Medical Center. I came back and went into that position shortly after I returned.

I was in charge of all the activities that occur beyond the walls of the medical center. It was at a time when Alaska Natives were in the process of developing contracts and compacts to manage their own health care. I was interested in this early on in my career, starting in the Peace Corps in Malawi in 1964. There had been enabling legislation passed in '77, '79, the first 638 legislation, to give tribes more and more power, to manage their own health care. I've said many times, when you own your own health care system, you own your own health care. The issue of "looking at the enemy, it's us, and what are we going to do about it?"

This movement was really getting going at this time, with some high energy and enthusiasm and it has continued. To give you the bottom line: the Indian Health Service does not exist

in Alaska anymore. The only program the federal government runs is the Alaska Native Medical Center. The Alaska area offices downsized to less than half of what it was, and it's continuing to shrink. The hospital is going to be managed by a consortium of Native corporations, probably within the next two to three years. They'll work it out politically. Originally the government ran seven programs including seven hospitals. All are now being managed by local tribally run boards, who are part of regional non-profit Native corporations .

Mullan: Successfully so?

Nighswander: Very successfully so. Absolutely. They sometimes have shaky starts. Brystal Bay is the best example. They took over in the mid-seventies and they fired all the physicians but one. You know, "Dr. X treated my aunt, made her wait, and didn't give her the right medicine," dah-dah, dah-dah, dah-dah. A lot of the tribal boards have gone through that kind of thing, and then the boards have matured. They have been able to generate more resources, and frankly have had more flexibility, captured third-party reimbursements. They are nonprofit organized in the state of Alaska. Not only have they been able to do it successfully, but the clinical system has stayed intact. Our ANMC physicians travel to the field, to these regional-based hospitals doing clinics. The health system has been able to remain intact

I think that was a big worry we all had. As hospitals were separated out, people feared there would be this great loss of the system that we've had. Frankly, it's the best I've seen anyplace in the world--starting with the village community health aide, to the regional hospital, to our tertiary center, and if we needed heart valve surgery, Dr. Shumway did it for us down in Stanford. We bought it.

So it has been a regional health care system. In fact, it's an HMO. There a defined community-based population. In many places it's the whole community. This lends itself to the kind of concept that Sidney Kark was talking about in 1952, it turns out.

Mullan: You have a defined population and deal with epidemiology.

Nighswander: Absolutely. The community is really deciding its own priorities. Physicians are part of the team. The only piece that didn't work was Kark's original idea as the physician as the leader of the team. If you're really talking about community ownership, I think that the physician may or may not be the leader of that team. The physician and clinical people are a part of that team. As we have progressed in our thinking about team approaches up here with the medical center, we've gotten very involved with Dr. Don Burwick. I don't know if you know the

Institute of Health Care Improvement (IHI). Do you know Don at all?

Mullan: Yes.

Nighswander: He's up here. In fact, Don's will spend a year up here. I don't know how many people know that. He and his wife are going to start a sabbatical year this summer. We were involved. IHI has tried some of these concepts in total quality management for community-based work. We've been one of the developmental sites. Two in Canada, and eight in the United States, and we're one. I've been the team leader for the one up here called Nutaqsivik to try to change the infant mortality rate. But clearly the lesson is community ownership. Yes, physicians or clinicians are part of those teams. And when communities get organized around health issues, things change, just like we thought it would.

I'll tell you a true story. Actually, this is on video--Eleanor McMullan, of the village of Port Graham, across from Homer. In 1974, she returns. This is an Eyak community. She returns after a number of years back to her home. I'll paraphrase this a little bit. The community ceased to exist as an organized, social society. At any time of day or night, you could walk through this community and hear people getting beat up--men, women and children. She took her kids out to do a beach walk, and there's something stuck in the tidal flats in the distance. It's an elder woman who has been beaten up by her son,

the night before, broken arm, and she is out there trying to get food, but is stuck in the mud. Elders are the most revered people in Native society up here. The respect for the elders is deeply ingrained. Eleanor is aghast. She gets together a group of women.

Mullan: Eleanor is an Eyak herself?

Nighswander: Yes. She's Eyak herself. You betcha. In the meantime, there have been some health care workers who come into the community from their Regional Native Corporation at the time called North Pacific Rim. A social worker and mental health worker go into this community, meet with the village council, and hold up the mirror. "This is what we see in your community." They are promptly kicked out of the community and told never to return. The village council is part of the problem. The village council is full of people who are alcoholics and abusers.

So Eleanor got together a group of women, and they met in private. They said, "We looked at the enemy. It's us. We've got to do something about this." They didn't say it quite that strongly at this time. So they invite outside helpers. We go in, the Alaska Medical Center, the Indian Health Service. We took our resources and s did the North Pacific Rim, the Division of Family Youth Services, Parents United. Everyone took their programs to this community of 300 people. Eleanor said, "And two years, later nothing had changed." In fact, she told me the other day, she said, "You know, Tom, it's worse." That's when

the epiphany occurs. "We looked at the enemy, it's us, and what are we going to do about it? It's got to be ourselves."

Mullan: When you say "ourselves"--

Nighswander: The community. "If we're going to make changes in our community, we've brought in the outside folks and it did not work."

Mullan: This is Eleanor saying this?

Nighswander: This is Eleanor saying this. She does say this, actually, on the tape. Sidebar. We're trying to develop this idea (community ownership)t, and we've had some people in from the villages--kind of a focus group from various communities--to talk about these issues. Eleanor said, "You know, I can't come, Tom. Can I send this video?" And here is this videotape taken from her kitchen table, you know, shaky camera, and she tells this incredible story. It is really powerful.

When these women actually do meet in private and say, "We've got to do it ourselves," they proceed to do a whole series of things. I mean, they developed an abused women's shelter in this community. They owned the abuse issue personally. When there was an abuse case they would go to whoever did it and confront them in the streets. They had their lives threatened. It's this tight community.

The bottom line is, in 1996, Eleanor is tribal chief. They have a fisheries program. Alcohol has disappeared in that community. If we have a smoke-free Native community, that's going to be the first one. It's just an incredible story. It's another Alkali Lake story. I don't know if you're familiar with Alkali Lake. It's a British Columbia group of Indians who basically have the same issues and do the same thing. They took on the issues themselves. There are four or five models around like that in our state where this has happened.

Part and parcel of Native health care being taken over by the corporations, the people are finally saying, "We can't depend on the federal government. It's us. And what are we going to do about it?"

In my own personal career, I've been part of that process, a player in that process--I've certainly been a promoter of it, but it's been Alaskan Natives themselves doing it.

Mullan: Since '84 or '85, your position has been--

Nighswander: Yes. Community health services.

Mullan: As such you've been a promoter, a facilitator of these processes?

Nighswander: Yes. Absolutely, and real involved as recently as recently as Friday in the transition to Native ownership of the hospital.

Just to give you another couple of other little stories in the big pieces of work in which I have been involved that have been real interesting, I do want to mention the Exxon Valdez oil spill. Once that happened, I didn't think I'd really be involved at all. It turns out the one of the many Native issues was oil spill and subsistence foods for the villages. That was in our bailiwick. During the oil spill years, I spent 20 or 30 percent of my time on oil spill-related activities, as chairman of the Oil Spill Health Task Force. There's a manuscript we're working on now. Through the many resources that Exxon had to provide, we developed this great database of over 1,000 samples from various beaches of various subspecies of fish and shellfish. They were potentially contaminated with hydrocarbons. I knew nothing about this. Had to learn to tell fingerprints of oils and about aromatic hydrocarbons Fascinating stuff. I led this group was made up of an Exxon toxicologist, two Native groups, Department of Fish and Game Subsistence Division, State of Alaska Department of Health, and Division of Environmental Conservation, and NOAA. Unlikely partners. The FDA was involved in it. But fascinating stuff. The bottom line is, I can't imagine having a greater career.

Mullan: The stories you tell me are fascinating in that the web of experience they weave I think is coming through, but let me try to tease it out a little more. As I understand it, since '85, your focus has been a variety of community health projects emanating from, but not based at, the Alaska Native Medical

Center, or related to, not based at. But you've been a promoter, you've been a facilitator, you've been a catalyst.

Nighswander: Sure. I think part of it is holding up the mirror, provide community-based data, trying to fairly divvy up and talk about resources, and how we're going to deploy resources. In the bigger picture, I've had specific projects related to community health development, and the most recent one has been the Nutaqsivik, which, translated, is "the place of renewal." It's a post-neonatal mortality reduction project we're working on with IHI, Institute of Health Improvement.

But in terms of working with the Native community, in the community groups, it has been as a facilitator, provider of data, individual meetings in communities with local health boards. At the same time I maintained an active clinical practice. I've been clinically involved by half of my time, including doing Emergency Room rotations, I took ER boards two years ago, because I was working in the ER. So I kept active clinically until these last six months when I was back in D.C.

Mullan: I want to understand, because you've the only person I'll probably be talking to from the Indian Health Service. I'd like to understand a bit more the perspective of the IHS position. But let's back into it by talking about your relationship to, and your feeling about, the IHS as a career-long employee. For the sake of the record, the Indian Health Service is part of the Public Health Service. Most of its physicians are

commissioned officers, but it's a kind of subset of the larger entity and has a bit of an identity of its own.

Nighswander: It's real interesting. I think in all honesty, Fitz, the reason I joined the Public Health Service as a Commissioned Officer in 1972 was to avoid going to Vietnam. Coming to Alaska sounded like an interesting opportunity, and this was a conduit, a mechanism for doing it. I suppose if it hadn't been Vietnam, I could have been in civil service or commissioned corps. I mean, I didn't give it that much thought, frankly, except that it obviously waived my military responsibility.

Mullan: It fulfilled your military responsibility.

Nighswander: Yes. Yes, that's right. That's exactly right. The Alaska Native Health Service has almost been a separate entity from the Indian Health Service, because many of the generic issues that have been faced across the country, we've had, but not to the extent that it's been felt in the Lower 48 states. Yes, we've had recruiting problems, but not nearly what they've had in the Lower 48. We've been blessed with this stable and senior clinical staff.

Our relationship with the Native tribes is quite different than in many Indian Reservations. I think Alaska Natives were never disenfranchised to the extent that the Lower 48 Indians were. So it's unusual to come along, around, amongst an angry

Alaska Native. When I talk to some of my colleagues in the Lower 48, working on some of the reservations, there's a lot of anger there. It's unusual up here.

Over the years many of my physician colleagues around the Indian Health Service have viewed Alaska as different, for all the above reasons. In many ways Alaska has been a model for other places in the Indian Health Service. That's not to say other groups are not successful. The Navajos are quite well organized and have identity of all their own. The program has worked. I think, in my view, it's worked very well down there also. It looks different from Alaska, and that's fine.

Clearly, the direction of ownership is a national agenda for the Indian Health Service. It was part of Dr Mike Trujillo's testimony at the recent congressional hearings. He's the Director, who now is a political appointee, director of the Indian Health Service. I think the reason that he feels so strongly, and the other senior leadership of Indian Health Service feels so strongly about this is that it is the basic principles we talked about in terms of ownership, and who owns this program, and where is the problem, and how's it going to get solved?

The best example of this is in the Northern Plains Indians in the Aberdeen area. When I first walked into headquarters in 1978, Emery Johnson was the Director of the IHS, and the first words out of his mouth were the problems they were having in Aberdeen. I returned to headquarters in January of 1996, and the first words I heard out of the Director's mouth were the problems

they were having in Aberdeen. I felt like saying, "The Emperor has no clothes. There's something wrong with what we've been doing in Aberdeen. It hasn't worked. It hasn't worked."

I don't think that it will work until whatever has to happen with the groups up there, and I don't know the northern tier Indian groups well, but until such a time that they say, "It's us and we're going to take it on. We're going to do it." They agree that the federal government has not changed fundamental social programs and they're right. Even though the Navajo have not been as aggressive with compacting and contracting, they certainly are much more involved in taking ownership of their own health and their own program.

Mullan: Say a few words about what compacting means.

Nighswander: Compacting is an evolution from the 638 contracts.

Mullan: 638 contracts being the first movement away from Indian Health Service federally provided health care?

Nighswander: Correct. The new iteration of the 638 law under compacts, in concept, is a direct transfer of money from government to government, from the federal government to the tribal government, bypassing the middle man-- Indian Health Service headquarters and the area offices. There are minimal to no reporting requirements. Some would say it is the federal government leaving the money on the stump. In fact, compacts

monies to the tribes are coming through a side channel of the Indian Health Service, but that is just for the accounting of it. There are negotiated annual funding agreements. That is the document that's being used now. The only reporting requirements that the tribes have are an annual three- or four-page report. This does away with line-item funding like what we had in the past. We've had AIDS; fetal alcohol syndrome; maternal-child health funding as line item funding. This does away with that. All the money is green. And in principle, at least, the tribes could decide to use the money for building roads. In fact, they do define briefly in their annual funding agreement how the money is going to be spent. It is a mechanism where the traditional role of the Indian Health Service really disappears. It's quite different. So who is the tribe responsible to? Who is going to monitor their program? That's the question I get asked by the traditionalists in the Indian Health Service. The program will be monitored by the tribal members. The responsibility belongs to the tribal community.

Mullan: How is that working?

Nighswander: In Alaska, it's worked well. We've had our first experience. Here it's blended, compacts and contracts, because we've had 638 contractors since the mid-seventies. For Alaska tribes, this is the next movement to even additional independence and self determination. We're early into the experience, because compacts have only been around for a couple of years, but I see

it perfectly appropriate for our next step as our programs up here have matured. I expect that although the tribal priorities might change, and there is risk for some economies of scale, to the extent that we can keep our clinical program intact, our systems, our clinical consultation roles in the field, I think Native health care is going to be in good shape. I think Alaska will be well served. Frankly, I don't know. It's an experiment. I mean, I think the answer's still out yet.

Mullan: You spent time, speaking now on the personal side, serving in the interim role as the chief medical officer for the Indian Health Service. As you travel back and look at things from a national perspective, how are the physicians in the Indian Health Service? How is that all developing?

Nighswander: Well, a couple of things are at play. One is the commissioned corps, which I think for physicians in the Indian Health Service is going to be a historical artifact, because there is a new hiring authority called Title 38. This is a VA hiring authority which gives a lot more flexibility in terms of negotiating salaries, and also it makes the entry-level salaries for physicians much more competitive. Translated the last seven physicians hired in the Navajo area, have all been Title 38 physicians. The most recent physicians we've hired in Alaska are all Title 38 physicians. At least for the physician component, I think that the commissioned corps members' days are limited. I don't know about other professional categories, and I'd love to

be proven wrong, but that's the way it appears as you sit back there.

The programs that have been strong clinically, that had senior staff kind of feed on themselves, they were always stable before, and that remains the same. I worry about the Tom Nighswanders and the Fitz Mullans of the earlier days, that some of the younger physicians who I see coming out, have not been exposed to the Karks and Castles of the world, and are pretty oriented towards hospital-based managed care and issues related to product design, market share, etc.

I've been called a dinosaur [Laughter] but I happen to think that we're right. That worries me a little bit. I think that some of the physicians we get in the Indian Health Service, the young physicians I've talked to in the last six months, they have the interest in public health and community health. I don't know if they've had the exposure that you and I have had to community issues, and that worries me a little bit. Everyone's getting caught up with market driven medicine, and it's certain true in the Indian Health Service, although it is less of a problem. In rural areas, it's just not going to work that way, large markets are not present.

Mullan: You'd mentioned your interest in, and your activities, in regard to total quality management, bringing quality concepts into play in medical care, government-mediated medical care. Do you see that as an important component of where the system's headed or where your work is headed?

Nighswander: Certainly, that is where the Alaska Native Medical Center is headed and the feature issues are several. One is this idea of not only defining your various customer groups, but defining what they need and how to provide service to them. That is a real critical issue. The other is to put the decision-making and problem-solving in the hands of the people who are doing the work. That's something that I've always intuitively believed. I've never really had all this put together in a discipline like it's put together in total quality management.

The other very interesting feature of it, is this idea of doing rapid turnaround trials, little experiments which you do with some discipline: trying to decide what you're trying to do; how will you know when you got there; and what changes you're going to make that you predict will make a difference. It puts a measurement piece up front. You've got to define a change, and you have got to define the measurement piece before you ever start these pilot projects.

This is as opposed to what we've done in the past. I compare this a lot with traditional health services research. You go through this elaborate and time consuming methodology and do a regression analysis to try to find out what makes a difference in a program. These new methodologies are much more amenable to working with communities, because they're much more short-cycled and are timely. The problem I've had working with communities with health services research is that it takes two years, three years to figure out what made the statistical

difference. By that time the community has gone on to some other issue. It's just way, way too slow.

In Nutaqsivik, for example, where we're looking at post neonatal infant mortality. There's a whole menu of interventions that we're doing. We have not actually put in any new resources to do this project. We've redesigned how some people are doing their work. It makes less of a difference to me what out of this menu is making a difference.

Let me tell you how we're measuring it, incidentally, then you'll understand a little better. In Anchorage we only have a few infant deaths in a year--small numbers. There's another way of measuring it, besides infant mortality. This is Tom Nola's work--look at the days between death. It's the concept of walking into a plant and a sign over the door says, there's been 375 days gone by since our last accident. You can do the same thing with post neonatal infant mortality--the days between post neonatal infant death. You can apply a whole bunch of statistical analysis to that.

We've had this project going for two years now. We were having a death on the average of every fifty days in the greater Anchorage area from that group that was just described. It's now 180 days. As long as that remains true, the more strength certainty we are that the actual interventions made the difference. We can update this data monthly. We do, by the way. So it's real quick turnaround of information. It's a pilot. We've changed interventions from what we started back two years ago. We're doing it differently now because of the things that

we've learned in the beginning. We knew we had a high risk group from some data that we saw that showed that post neonatal deaths were occurring preferentially in a group of highly dysfunction families.

Mullan: You've had an interesting career as a generalist, part time as a clinical generalist, part time as a kind of public health generalist. I'd be interested in your reflections on what we now are calling generalism, but as you have observed this phenomenon personally over the years, both in terms of your own experiences and what you see going on around you.

Nighswander: I worry a little bit about the public health perspective, the community health piece. I don't know what's going on now in graduate medical education because in that I'm somewhat removed from the family practice training programs. For example, in the generalist training programs, what is mentioned about being responsible to the health of the community? I think there has been, and there continues to be a body of knowledge about these set of issues. I don't know how well that's being translated to medical students and into the general primary care internal medicine and so forth.

It's been intuitive in pediatric over the years but there I'm afraid that it might even get lost. One of the pediatric nurses in private practice said to the pediatrician for whom she worked, "Gee, maybe we ought to get some programs to help adolescents. We ought to talk to some parents, get a focus

group." He said, "I know what parents think." That's disappointing.

Mullan: Do you think that we ever have taught, from your experiences in family medicine, say, have taught public health principles, if you will?

Nighswander: No. No, I don't think so.

Mullan: Yes. I would agree. I mean, when I use the term "generalist," I am referring to the clinical generalist whose perspective goes beyond the organ system or the technical intervention, be it surgical, or radiological, or anaesthesia. But still and all, that does not take into account a population perspective which is not generally well taught in American medicine. I'm not sure it's generally well taught in general. I used to think this was an astigmatism and a blind side of American medical education. I rather think that the skills that are necessary to worry about the individual one after another coming to the examination room are not necessarily compatible, or particularly compatible, with the skills necessary to think about the community or the population as a whole. Yes, there are people who can cross that street and, yes, it's not an impossible eight-lane highway to cross, but its people seem to dwell more contentedly on one side or the other. It's hard to get clinicians thinking, and given their responsibilities day in and day out for opening the door of the next examination room and

dealing with Mrs. Smith's headache, or Mr. Jones' prostate, it is not easy to get them to think about the epidemiology of headaches or the course of prostate disease in the community as a whole. That little lecture is in the hope you'll tell me I'm wrong.

Nighswander: Well, yes and no. I don't know. Maybe we do it at the wrong time. I don't know. One thing that would be interesting to me is after you've talked to people around the country and you talk to more senior physicians. Many start to practice only interested in one-to-one patient care. I wonder how they end up their practice? Are they still in the same mind-set?

There are some things that a physician you can do that are relatively simple. I'll give you a for instance. Emergency rooms are sentinel units in a community. If you have an emergency room physician who is thinking about the community, when he sees a case of carbon monoxide poisoning because of faulty heating in the home, he should say, "You know, this is an issue that can affect other people in the community. I ought to call the radio station. I ought to call the television station, because I'll bet you they'd do a story on this." Actually, we do that at ANMC and you know what? Television is there in a split second. It's a public health issue that's newsworthy, and it's a story that needs to get out. If you're going to deal with the public, and deal with communities, there's a professional group who knows how to communicate with them at your doorstep waiting to be called.

We have done this with our electronic media in Anchorage. They've caught onto it. They need news. We need to get the information out. Everyone wins. The stations and the paper are interested. They get good public information from their hospital. This happens by just thinking in terms of what is our responsibility to the community.

I think some of this is teachable. You're absolutely right in that this is so overwhelming when you're in training programs. You're just trying to learn clinical medicine. Can this be taught after postgraduate education would this make a difference? I don't know.

Our Chief Medical Officer retires and goes to HFA in Utah. It's a for-profit HMO--a big outfit, California-based. He tries to introduce community medicine/preventative health to the organization. They said, "30 percent of our beneficiaries turn over every year. We ain't interested. It doesn't add to our bottom line." Eight months ago they said, "Quarterly earnings are down. We've got to fire some physicians." They wanted to fire thirteen or fourteen primary care physicians. He left. I worry about that.

Mullan: I think the best hope in that regard is a little bit more back on your thinking, that is, to the extent that systems are developed that are stable, I mean, right now where you have this churning managed care profiteering environment, that term I've heard before. Ironically, even as the HMO arrives, the HMOs

are stepping away from responsibility for health maintenance because it isn't profitable when you have high turnover.

When and if that market stabilizes, and you have a limited number of large players who are providing long-term risk-sharing of a managed sort for a population, there is much more incentive to have a system, including the physicians, generalists, and otherwise in it, concerned about monitoring and intervening on population health. So I'm optimistic, or guardedly hopeful in that regard.

Nighswander: Dave Lawrence--I've heard Dave in the last six months ago or so--

Mullan: Hang on a second.

[Begin Tape Two, Side 2]

Mullan: This is Dr. Nighswander, tape two, side two.

Nighswander: Dave Lawrence, as you know, is now a CEO for Northern California. Dave says he sees this churning going on for ten years before it really shakes out to some kind of stability. Kaiser is closing their flagship hospital, Oakland. They've got a brand-new hospital. I don't know where it is in Northern California, that is being mothballed. They and Group Health, are victims of their own success. They enrolled people in 1948 who are still with them. They are now old and are using

a lot of resources. They have had a very stable physician staff, including senior cardiologists who they're paying $220,000. New plans coming into Northern California can get cardiology services for a lot cheaper than that. Also, they are apparently going to do away with their physician bonus, the capitated bonus that we mentioned. A gastroenterologist who I know of took a $40,000 pay cut in the last year. I don't know what she made. I would guess she made $180,000. Each Kaiser Hospital has its own business plan, and it was either laying off physicians or everyone taking a pay cut.

Mullan: Let me ask just to pursue your perceptions and your story a little bit more to tie this together. You have been a generalist throughout your career, ranging between clinical generalism and population generalism. I'm characterizing. You have observed the family medicine movement come alive. You've observed trends over the eighties which mostly could be characterized as backsliding in terms of the well-being of the generalist perspective, and perhaps some trends in the nineties that seemed to be favoring generalism. What are your observations about the growth and well-being of the generalist concept in the hands of the medical community over that time?

Nighswander: Actually, I am encouraged, Fitz. I think that with the increasing interest in trying to do things in a cost-effective way, that generalists are in a position to grow and thrive in that environment, as long as they pay attention to

their roots, and that is looking at their patients and trying to best serve them.

For example--I don't know if you can quote me on this one, but we're building a brand-new hospital. It's all finished, almost. We're moving in June. It's over a $100 million plant, and I hope it's not an anachronism. I worry about it being such, because I can see doing a lot more things out of the hospital, at home, starting to make house calls with various kinds of teams. I think it would be very cost-effective. I think it would be popular with patients and the generalist is going to be in a position to push that issue, because if they know their community, and they know their families, a lot of stuff that we've traditionally done in the hospital can be done in a community-based setting, even in the patient's home. Who else is better able to do that? The physicians going to have to balance a whole bunch of issues when you try to do something like that.

It's peculiar to American medicine, compared to other systems where I know, where a patient with a sore toe can go directly to an orthopedist. That really doesn't make sense in terms of being cost-effective. Actually, Don Burwick has got an interesting thought about this in terms of HMOs, and even our medical center. We've always tried in the past to have one-size-fit-all program dealing with our population. We have this package that we provide. Then at the other extreme is the most highly customized piece of medical care, fee-for-service private solo practice. They can design anything they want. Is there

some way to meld these two so that you could do some customization and still make it cost-effective?

But I think that the generalist, even more so than ever, has a place. California is going a step beyond the generalist physician. Maybe it's cheaper and just as effective to have the generalist mid-level practitioner. Put them up front. Actually, I might say this has been our experience up here. We have some mid-level practitioners--you're going to be talking to them--that are pretty impressive and do a pretty decent job of primary care.

Mullan: You work over the years, what have you liked best? As you think back things you've done, or incidents with patients, what's meant the most to you?

Nighswander: I can think of specific kinds of instances and some general ones, too. I think the most satisfying thing now is if you'd walk through the medical center with me tomorrow, it's a very positive experience, families I've known for years and years. I've been involved in some good times and bad. Hugs from patients. Having young women come up and say, "You delivered me. Will you deliver my child?" I can't believe that. Going out to some of these villages and getting embarrassingly good treatment. I mean, it's like getting VIP treatment out in the village. Alaskan Natives are very gracious in the first place. It clearly fits within the personal attachment I feel with my patients. The clinic I had last week, I know all my patients. If I don't know them, I've known their families, or most often I know them and

know their extended family. They've not had easy lives. It's been tough, yet they've made it. Clearly, that is the thing that really sustains you over the years.

Mullan: So the clinical side has been very gratifying.

Nighswander: Oh, yes. And fortunately, I learned a lesson from Jim Felton, before he started stacking his cups. [Laughter] Gotcha! I saw Jim Felson in 1979 or in '80, and Jim had really gotten so far from clinical practice that he couldn't go back to it. I came back and I told Ruth that it was really useful seeing him. I said, "I don't ever want to be in that position of losing clinical skills. But, too, it's a real advantage of being able to mix the two administrative medicine and clinical medicine, because the advantage is that by seeing patients, it really keeps your feet pretty flatly planted on the ground there. You can't get too many hair-brained ideas. Well, you get hair-brained ideas, but they get tested real easily by seeing patients. I get some of my best program ideas from seeing patients, and listening to patients. Patients, as you well know, tell you a whole lot when you sit down and listen.

Mullan: Do you have any things to look back on that you're disappointed or terminally frustrated about?

Nighswander: No, that's not my nature. No, not really. For the things I've been interested in doing, I can't imagine having had

a more satisfying career. Part of it has been the variety of stuff. I mean, petrochemicals in food. Who in the hell would ever think you'd ever get involved with that stuff? New learning, new issues, new people, and an opportunity for working with the information.

Last year, or two years ago, they needed someone who was disinterested, to facilitate the health care reform discussion for the State of Alaska. This included politicians on both sides of the aisle, with all the interested provider groups in attendance, in about seven or eight weekend sessions. I was the facilitator for that group, and presented the legislation bill that resulted to both at the House and the Senate Health and Social Services Committee. Fascinating stuff. I was very successful with the process. The bill never made it out of committee. But still it was a unique opportunity. I mean, I just can't imagine.

Mullan: What do you see doing? What are you going to be doing a decade from now?

Nighswander: I don't know. Ruth and I have been optimists over the years. Ideally, I would like to get together and work more closely with Ruth on some project. I can see us going back overseas. We talked about going back to Africa. The other alternative is to stay here and work for one of the Native corporations. We've talked about that. I don't know, is the bottom line. We've had the happy problem of having had some

interesting offers from several international foundations. It turns out it's one of these foundations which sponsor programs all over the Muslim world needed a program director. Annie Lee Schuster--do you know Annie Lee? Robert Wood Johnson Foundation.

Mullan: Yes.

Nighswander: Annie Lee got them to contact me. God, I don't know what I will be doing. That's not fair. I could ask you the same thing. You'd give me the same answer. [Laughter]

Mullan: Are there things that we haven't touched on that you'd like to talk about?

Nighswander: No. No. I wish there was some way we could capture this community medicine piece in a meaningful way. I don't know enough of your story to know how you got involved with Kark and Castle and that way of thinking, but, gosh, that really has shaped my career. I think they were right. How could we give that kind of experience to other clinicians? Won't appeal to everyone, but it doesn't have to. It just needs a core group. That's what I would love to be able to do.

Mullan: I think that's an ongoing challenge, because you've got a set of perceptions which are, by and large, undervalued, and are closeted for the most part in a rather bunker mentality public health community. "We are the custodians of public

health. We know about population science and those spendthrift, narrow-minded docs are using up all the resources." Then you've got the medical community that either is ignorant of or disinterested in population science, and they don't want to go after their patients, or their procedures, or their organ system, what have you.

Even generalists who have in this country a fairly narrow perspective, and all the, or most of the incentives, reimbursement system in particular, awards piecework. The more piecework you can do, the more reward you'll get, and the nature of the overall enterprise, nobody pays, clinicians anyway, to look after them. So that the long-term challenge of melding public health thinking or population perspectives into the provision of services is terribly important. Ultimately, there is a lot of piecework. Ultimately, there are people who are going to have to be narrowly and largely focused on the ache, the pain, the death, the dying, and so forth. But building in and breaking down these stylized walls that exist between these two communities is important.

I was thinking about my little homily before, and this is more of it. I don't mean it to sound so negative. This is your story. But I have pondered this for some time, and I guess as I get older, I'm less of a missionary thinking you can teach everybody to do this or have this perspective. I think you can certainly expose more people and recruit more people to it. But I believe there is going to be some amelioration in this area as you come from, at least in terms of my own thinking, a somewhat

unpredicted angle. For instance, the mature HMO, or the mature organization that even on a for-profit basis is providing services, all of a sudden has a need to look at the horizon and not just the beach. They are going to spend time worrying about some of the population, the demographics, and the epidemiology, and then modifying their services in a systematic sense to try to deal with those larger perspectives.

We wandered away from your story. You've had an opportunity as a physician, as a person, as a generalist, to observe America and American medicine from the northern exposure vantage point, or somewhat external vantage point as you watched mostly from the perspective of Anchorage. Any thoughts about how you see the system evolving?

Nighswander: Well, a couple of things. I just had a potential medical student tell me that of all the recent physicians that he had talked to, I was the first one that encouraged him to go into medicine.

Mullan: Of the physicians that this student had talked to, you were the first?

Nighswander: Yes. Actually, this was a premed student I met back in Boston. I think that there is so much turmoil in the system right now, that there is a lot of dissatisfaction among the practicing physicians in the community. Interestingly enough, being in the system that I'm in right now, we were always

considered as the renegades doing public medicine. I'm in the most stable medical environment around right now, which is amazing to me.

I am encouraged by the medical students who we're seeing coming through. As I mentioned to you before, I'm on an interview committee for the medical school, and I get a chance to interact with Alaska students that are in the WAMI program. Many of the attributes that I admired in colleagues and students are certainly still there. There is a sense of commitment, of interest, of wanting to help people. And we've got some excellent students. I tell many people I'm glad I'm not applying to medical school today, because I don't think I could get in. The folks that we're seeing, young and not so young, applying now, are bringing with them lots of life experiences, and the applicants that I've been talking to have gone beyond a classic biomedical background, and have had work experiences with various and sundry human services groups. So I'm encouraged by that. I think that my perspective has been tempered a little bit because of my last six months being back in D.C. When I look at public and private medicine there is going to be a lot of turmoil, I think, for the next few years. In terms of the shake out, it's hard to predict what's going to happen.

As an aside, this big debate we had in the country about nationalized health care and physician choice, well there's going to be a lack of physician choice. I'll tell you there is lack of physician choice as the marketplace has taken over. So I think it's real hard to predict what's going to happen.

For the system in which I participate right now, over which I have had the most influence, I like the direction it's moving because of the ownership issue. We've been fortunate to have a mature and experienced group of Alaskan Natives who have been in medical care management on health boards. They have experienced with it. So for our own health system, I'm quite encouraged by it. I'm still very enthusiastic about being a clinical physician.

Mullan: This is a bit of a prosaic question. Would you tell your kids to go into medicine?

Nighswander: Oh, yes, sure. Without question. Without question. I'm just sorry, because a lot of my colleagues who are so disgruntled with it; colleagues and friends who are on the private side, I think it's tragic that they're ending up their career on this note. One of our private practitioners in town, family practice M.D. active in the American Academy of Family Practice, traveled with me a lot, while he was on the Minority Affairs Committee reviewing the Indian Health Service. We always had this running debate. In ten years, would my practice look more like his, or would his look more like mine. I always told him his practice was going to look more like mine, and that at the end of the day, I was going to win. Actually, it's come to pass. I have been in a stable environment, and have been able to do the kinds of things I really like to do. I've had this incredible career with all kinds of opportunities, and I haven't

had to change my employment. I think this probably is what's kept me interested. A lot of my interests that I developed I've been able to pursue, in a setting that has allowed me and, in fact, encouraged me to do so. So it's not been every day opening the door to the next patient. I've been absolutely delighted.

Mullan: This is a good place to stop.

Nighswander: Good.

Mullan: Good. Thanks.

[End of interview]