TERRANCE SHEEHAN

July 10, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: I'm with Dr. Sheehan, in his office at the Southern Maine Medical Center in Biddeford. It's the 10th of July, 1996. It is a beautiful day, a few more clouds in the sky than earlier. We're sitting in a corner office, overlooking the parking lot. Dr. Sheehan is the medical director of the Southern Maine Medical Center, which is a general hospital of how many beds?

Sheehan: One hundred and fifty beds, but we function as a 70- to 85-bed hospital.

Mullan: Serving what area?

Sheehan: Biddeford, Saco, Old Orchard Beach, Kennebunkport, and Kennebunk are about 80 percent of our catchment area, and there's a lot of small towns amongst those towns that we also serve.

Mullan: How large a population area?

Sheehan: About 65,000 people.

Mullan: What sort of income level? What sort of demographics?

Sheehan: Mostly blue-collar town. Kennebunk, and Kennebunkport are middle-class to upper middle-class, but together they represent only about thirteen to fourteen thousand people. Biddeford is a very blue-collar town, 80 percent French, the largest French population, percentage-wise, of any city in Maine.

Mullan: Is this French origin, or actually francophone?

Sheehan: Mostly from Canada--Montreal, Quebec. They came down in the early 1900s, when the paper mills started. The industry started, and they sort of filtered down from Canada.

Mullan: But at this point they're English-speaking?

Sheehan: Yes, except the grandparents, some of those speak predominantly French. So we have a couple of French-speaking internists that are extremely popular. The next generations below that, the little children and their parents, speak either English predominantly or both languages, particularly if their parents speak mostly French. But the older population--I'd say 65 to 85--some of those have a heavy French accent, or some of them speak very little English.

Mullan: Fascinating. And we're not close to the border, either.

Sheehan: No, no. We're not close at all, and there's a big influx of Canadians in the summertime that come down to the Old

Orchard Beach area, predominantly from Quebec, that come here in large numbers. This area just swells in the summertime. Towns of 10,000 or 15,000 become 50,000 or 60,000 people.

Mullan: You look to be from Maine to begin with.

Sheehan: Yes.

Mullan: Tell me about yourself. Where did you come from? What was your date of birth?

Sheehan: November 29, 1937. It's the year that Joe Lewis became champion, the boxing champion.

Mullan: Where were you born?

Sheehan: I was born in Gardiner, which is a small--six, seven thousand population--town, just south of Augusta. And grew up there, and then went off to Bowdoin College, which is in Brunswick.

Mullan: What did your dad do? What did your mom do?

Sheehan: My mother was a secretary, forever. And my dad was a shoecutter in a shoe factory which was located in Gardiner. He worked in that factory for about fifty years.

Mullan: One particular company?

Sheehan: Commonwealth Shoe, which was in Whitman, Massachusetts, and that's where he went to work when he was fourteen years old.

Mullan: He went to work in the Gardiner factory?

Sheehan: In the factory in Whitman, and then moved, when he was probably thirty years old, to Gardiner. When they started the factory in Gardiner, he moved up to work there.

Mullan: I went to summer camp in Litchfield, down the road from Gardiner. Camp Tacoma Pines.

Sheehan: I'm very familiar with that.

Mullan: It's no longer there as a camp, although it was for a number of years.

Sheehan: When I was in high school, we used to play the counselors from Tacoma. They had some black kids there, and we used to play them in baseball, and then we would take our bats and put them away, and go play basketball--

Mullan: Play basketball in the gym, in that [unclear] gym.

Sheehan: Yes. Hot, steamy. But we would play both baseball and basketball on the same day.

Mullan: I remember it well.

Sheehan: And they were very good.

Mullan: The camp was run by the gym teacher from the school in New York that I went to, called Dalton School. McCook was his name, John McCook. And he was a basketball fanatic, particularly. So at that period of time, basketball at summer camps wasn't a big deal, and if it was, it was outside court, etc. But he had that Quonset hut built so that we could play in all seasons. I went back a few years ago, and the whole place had been divided up. There was a development, and there's no more camp, but that hut is still there, that basketball court, which to me seemed huge in the day. You look at it now, it isn't. I mean, if you've got a ten-foot basket, it's got about a twelve-foot ceiling. You had to shoot a line drive to get it in. I remember it well. We probably played on the same court.

Sheehan: Gee. We used to love to do that, because they had a lot of good players. I remember one particular afternoon, we had heard that they had a pitcher that was supposed to be really something, I think he was from the Philadelphia area, and I knew he ended up throwing his arm out later, but he could throw a baseball about a hundred miles an hour.

Mullan: "Lefty."

Sheehan: Yes, he was a lefty.

Mullan: I think the same guy I remember. I was wondering what ever happened to him.

Sheehan: I don't know, but I was scared to death.

Mullan: I remember he threw the fastest balls I ever saw.

Sheehan: We played against him, and we played seven innings. Of the 21 batters, 20 struck out. One guy had a soft line drive back to the third baseman, because he tried to bunt the ball. The rest of us just were petrified. We had a pitcher that was as good as any in the history of the school--and they won one to nothing, and I think that our pitcher gave up one hit, and struck out about 17, and this guy struck out 20.

Mullan: Must have been the same guy, I think, because I would have been a camper, which I was, five or seven years down the line from where you were. I was born in 1942. So it must have been the same. It would have been about when you were in high school. I was in grade school.

Sheehan: I was in high school. I was probably, at the time, I'd say, sixteen, seventeen, because we were on a legion team.

Mullan: That's right.

Sheehan: The same legion team, we also played basketball. In a small town in Maine, in those days, it was baseball, basketball, and football, and I would say maybe a third of us played all three sports, and then the rest played at least two sports. So you just went from one season, to the next, to the next, with literally no time in between. So it was easy for us to play baseball, and then go play basketball.

Mullan: A double-header.

Sheehan: Yeah, that was very natural, because most of team members played basketball, also. But I do remember that pitcher.

Mullan: We used to all emulate his delivery. I remember he was left-handed, I was right-handed, so we'd work on his left-handed--

Sheehan: I know he was left-handed, because we had a lefty, and we said, "He's going to hit you." And he did. He hit him on the elbow. I just remember, I had never seen a baseball go that fast. Our pitcher could throw at maybe 90, 91 miles an hour, and for high school, that was very fast. And nobody could hit this guy. We'd heard that he was fast, and we saw him warming up, and it wasn't very impressive at all. And then we were doing something else, and we heard the "pop" into the catcher's mitt, and another "pop." Everybody froze, and just turned around. He

had started to really heat it up. I remember just standing there, and it just seemed to accelerate. I had never seen anything like that before, and I thought to myself, "The first thing I want to do is make sure I don't get hit. I don't care if I swing or just stand there. I don't want to get my life ended by this guy." He was a little bit wild, you know. So we just either watched the ball go by or we took these sort of swings after they were in the catcher's mitt.

Mullan: I don't remember what he did as a counselor. He was a counselor. But he was a [unclear] around him as a pitcher. That's all I remember. He spent his entire day on the mound. I think he must have had a cabin or done something else. But he was definitely Big League material.

Sheehan: And I had heard, because we always wanted to sort of keep track of him, and see what happened, we heard that he threw his arm out at some level, because they never really picked him up in the major leagues, and he certainly had that sort of speed. I mean, he had to be close to a hundred miles an hour. He had a major league fast ball.

Mullan: He had a guy who came with him, who was a friend, who was his catcher. This guy was a pretty good ball player, came from Philadelphia. He just sort of hung with him.

Sheehan: I remember that the catcher didn't have any trouble catching him, so I figured that he must have had some experience.

Mullan: Gardiner must have been an interesting place to grow up. What did you think about, in terms of college? It wasn't every shoecutter's son who went to Bowdoin, I presume.

Sheehan: No, not at all. Nobody had ever gone to college in both sides of the family. I had a brother that was two years older, and he went off to college, and he was the first one in both families to go. My mother was adamant that we go to college. For her, that was probably not a means to an end, it was probably an end, in her mind. To say that she had educated her two sons would be an enormous accomplishment. And when I went off to Bowdoin, that kind of set us back a little bit, because we didn't have any money, and Bowdoin was pricey--is now, and it was in those days.

Mullan: Why did you choose Bowdoin?

Sheehan: Because of the academics. I had a full football scholarship to Boston University. There was even spending money and stuff. In those days, they were playing Syracuse and Pittsburgh, and Army, and Navy. I went down there, and they told me that I'd have to major in physical education, and I wanted to be an engineer. They literally spent from two until nine o'clock at night, either playing football, practicing football, or

studying football, and one wouldn't be able to take a course that had a lab, or an academic bent to it, because one literally wouldn't be doing much studying in the football season.

Its campus, as you know, is right in the middle of Boston, and that was sort of a culture shock for a rural Maine boy. I just decided that that had no future. I clearly had figured it out that I wasn't going to be going to play professional football. To do that I would have had to train and work out and lift weights, and really try to pursue something like that. I just thought that I would never make that, so I decided that maybe I ought to look at academics a little more seriously.

Mullan: So did Bowdoin give you any help?

Sheehan: They did, yes. Between scholarships and a job, and my summer job, I could pay for the whole thing.

Mullan: And did you play football?

Sheehan: Yep, played football.

Mullan: Good. Did you have a good experience?

Sheehan: It was a good experience, until my senior year, when I missed a lot of practices, because of labs and stuff. The coach that we had until my senior year was Adam Walsh, who was famous. He was the captain of the team that was named the four horsemen

and seven mules of Notre Dame. I don't know if you remember the four horsemen of the apocalypse, a poem by Grantland Rice, a famous sports columnist. But anyway, he was sort of immortalized, and he coached the Los Angeles Rams to a National Football League championship, and then came to Bowdoin, and was our coach. But he liked the idea that I was going to be doctor. So I would often start and played in all the games.

When I got to be a senior, he left and the new coach said, "If you start missing practices, I won't play you." I had to miss practice because of my labs. I started the first game and then I played half of the next game, or part of the next game, and then, by then, he had decided that he wasn't going to play me at all. It ended up being a miserable experience for my senior year. Before that, it was fun.

Mullan: Where did you play? What position?

Sheehan: I played running back.

Mullan: And was Bowdoin a good experience, overall?

Sheehan: Wonderful.

Mullan: What decided you on medicine?

Sheehan: I went there on a three-two plan--three years to Bowdoin, two years to MIT [Massachusetts Institute of

Technology]. I wanted to be an engineer. Nobody in my family had ever been in medicine. Well, you can imagine, nobody had gone to college, so everybody had low level jobs.

I decided I wanted to be an engineer, and when I got to Bowdoin a lot of the people that I started to know, because of science classes, were going into medicine, and were pre-med. After about, I'd say, two, three months, I started to read about medicine and the academic pursuits that seemed so enticing and so attractive. So I decided I'd switch at that stage and become pre-med. I decided to go to medical school than go to MIT.

I came home to talk to my mother, who was so worried about paying for Bowdoin College, and was convinced that we would go to the poor farm. I came home after about two months at college, and told her I'd decided what I wanted to do with my life. She said, "What's that?" and I said, "I want to go to medical school, and be a doctor." She just looked at me, and was speechless, and walked away, and went through a couple of rooms and into her bedroom, and closed the door.

I could understand her shock, because she was convinced we couldn't pay for Bowdoin College. When I told her I wanted to go to medical school, I think her problem was to tell me the reality that I couldn't afford to go to medical school and dash any hopes that I might have, versus saying, "That's fine," and then letting it play out, because I still had three years, three and a half years of college left. She came back, after about an hour. I think she probably had been crying, thinking that she would have to tell me that this was a hope that would never materialize.

And when she came back, she said, "You know, I think that's wonderful. I think that's just wonderful." And it worked out okay.

When I went to medical school, I had a full-time job there, which paid very well. I worked in a lab at Boston City Hospital, nights and weekends. I would go to work at five at night and work until seven the next morning. I had two scholarships, and between the job that I had, and the summer jobs, and scholarships, I did fine. I was making $100 a week, in the sixties. So that was pretty good.

Mullan: Were there figures in your life that were role models, or that influenced you?

Sheehan: Not really. I knew that there was a lot of prestige that went with medical school and becoming a physician. In Gardiner, there were only family physicians. There were no specialists, and there were about ten or eleven people. They all worked every night, every weekend. Nobody cross-covered. But I know that everybody seemed to admire them. So I looked upon it as a profession that would hold my interest and had an enormous academic bent to it. You had to read and study, and do that for a lifetime. It was interesting, it was fascinating. There was always new knowledge and new information. It was really, I'd say, the intellectual allure of the profession, and the fact that it had the admiration of the public, and something that seemed

extremely worthy to do. It wasn't like I would be doing things that weren't valuable to a community.

But there was no individual who was a role model. It was more learning about it, and then having my closest friends at college, whom I admired and with whom I got along, pursue similar interests. That was the influence, really.

Mullan: What was Tufts like? It must have been very different than Gardiner, then Bowdoin. You did make the big city, finally.

Sheehan: Yes, I did. Didn't like living in the big city. I couldn't wait to get out of that atmosphere, but I enjoyed medical school. The part I didn't enjoy was working nights and weekends. If I had it to do over again, that's probably the one thing that I would have changed. I probably would have tried to take some loans on or something.

Mullan: What did you do for work?

Sheehan: I worked in a laboratory. There was one laboratory, for nights and weekends, at Boston City Hospital, in those days. It was about 1,200 beds. It had a Tufts, BU, and Harvard service to it--medicine and surgery--and we did all the emergency work--so, BUNs, electrolytes, salicylate levels, bilirubins--any stat chemistries done nights and weekends were done by one individual, who was a medical student working his way through medical school.

So it was a busy job, and they'd call you all night long, and you'd have to get up and do things. So I didn't like that, because I'd go to school the next morning, I'd be tired. So the next night, I'd sort of catch up on my sleep, and then the next night, I'd be working again. This went on for three years. But that's probably the one thing I would've changed. I started out in the top third of the class, and I ended up in the middle of the class. I knew it was because I just didn't have the time to pursue my academics like I really should have.

So when I became an intern, to me, it was like being on vacation. It was easier as an intern than it was in medical school because of the job. I think I acquired the skills and knowledge that I felt that I probably should have acquired in med school. I think I got it back in my residency and internship. In those days, internships were all rotating internships. Everybody did six two month rotations--pediatrics, medicine, surgery, OB/GYN, emergency room, and then some surgical subspecialties.

Mullan: What had you been thinking about? As you went through medical school, there were obviously potential decision points. and we now refer to it in generalist/specialist terms, which were not obviously the terminology at the time. But did you have any reflection on what kind of doctor you wanted to be?

Sheehan: Well, I think initially, the only exposure I had were family physicians, and they were called general practitioners in my day. I thought that that was the way to go.

I remember when I went to one of my interviews at NYU [New York University], I got up at three o'clock in the morning and drove down with my girlfriend, who is my wife now, and arrived about an hour before the scheduled appointment. I was interviewed by somebody who clearly had the interest of sub-specialty and saw NYU as putting out specialists. Clearly, if you mentioned the word "general practitioner," you had said something terribly wrong. He asked me, he said, "Well, what kind of physician do you want to be?" And I said, "A general practitioner." And he spent the next twenty minutes berating me, and telling me that I could go to a GP school if I wanted to, but NYU produced specialists, and was a cut above that kind of interest.

Mullan: This would have been 1959, 1960?

Sheehan: Exactly. It was 1960. It was probably February. It might have been '59, November--October, November, December--in the latter part of the year, first part of the academic year.

What I do remember was one of my early interviews. I clearly changed my delivery style in my subsequent interviews. I thought, "I'm going to find out who my interviewer is, and maybe mention his specialty, the word, 'general practitioner' is not going to come out of my lips again,." He told me when I left,

"I'm going to highly recommend that you not get into this school."

Mullan: This is the NYU guy?

Sheehan: Yes. He said I should go to a school that produces general practitioners, and should never come to an institution like NYU. And he said, "The dean's name is Sheehan, so I'll be interested in what my recommendations are, and whether they're heeded or not. But you should never come to a school like this."

It really galled me, because there was a fraternity brother that was two years ahead of me that had a worse academic record than I had, because he was a fraternity brother, and I knew him pretty well. He was there at NYU, and he wanted to be a neuropathologist or something like that, you know. And I just thought to myself, "This is very upsetting," because I didn't feel like I wasn't qualified for that school, and yet, boy, he really had a problem with what I wanted to be.

Mullan: That was really a period piece, that thinking.

Sheehan: Oh, yeah. Very much so.

Mullan: Did they reject you, in the end?

Sheehan: Yes. Yes, rejected me very quickly. I think within a couple of weeks, I got a letter saying that they just rejected

me. They didn't give me a lecture on being a family practitioner. [Laughter]

Mullan: But Tufts did not have that animosity? Or you played your cards differently?

Sheehan: I didn't mention the word "general practitioner" ever again. As it turned out, Tufts looked at Bowdoin College very kindly, and there were some Bowdoin grads that were on the admission panel. When I went down, I had a letter of recommendation from the chemistry department chair at Bowdoin. But almost everybody was a chemistry major who went to medical school from Bowdoin. And he wrote a very favorable letter. Halfway through my interview, the guy said, "Well, when we get a letter from Dr. Karnerling, we always accept the applicant." So he said, "You're accepted. I can tell you that right now." And within 48 hours, I had a letter of acceptance. So it was a very different experience.

I had wanted to go to Tufts because an upperclassman, who was a fraternity brother, had gone to Tufts the year before. He was either first or second in his class, and I figured if that was good enough for him, it was probably good enough for me. So I really wanted to go to Tufts, and I didn't want to stray too far from Maine. That was my number-one school.

Mullan: By the time you were doing internship, at that point, rotating internships were pretty much the standard, still?

Sheehan: I think almost everybody did a rotating internship.

Mullan: What was your thinking? Did you have pediatrics in mind at that point?

Sheehan: I favored internal medicine--internal medicine, then pediatrics. I'd say I was 60 percent towards internal medicine, 40 percent towards pediatrics. In going through the rotations of medical school, you sort of figure out what you like and what you don't like. I clearly thought that I wanted to do some sort of primary care thing, but probably internal medicine or pediatrics. I ruled out the surgical specialties, general surgery, those kinds of interests.

Mullan: What happened in an internship?

Sheehan: I loved pediatrics, and I didn't love internal medicine as much as I thought I was going to. So I took my first two months of pediatrics; my second two months were internal medicine, and I'd ask them to do that, so that I would experience both of them, and then I declared my intention to do pediatrics, and stayed at the Medical Center.

In those days, I refer to it as a totem pole, as opposed to a pyramid, there was one first-year resident, one second-year resident, that's it. Two residents. And so we had two interns, a chief resident, and a junior resident, and that was the entire house staff of pediatrics.

Mullan: And the notion of becoming a general practitioner, somewhere along the way, faded?

Sheehan: Yes, it did. And I think, in those days, as you went through medical school, there were no people in medical school who said to you, "Be a general practitioner." Every training period that I had, either in the hospital or outside the hospital, was always with pediatricians, internists, general surgeons, sub-specialties. You never saw a family physician at Tufts. I mean, I didn't see anybody.

So you didn't even think about it once you got into school, and it was sort of assumed that the way medicine was going was away from general practice, and instead of having a general practitioner, have a pediatrician and an internist, and that seemed to be the bent. You were also just sort of told, in those days, that if you wanted to do general practice, that you were probably at the lower part of the class, that if anybody went into at all, it wouldn't be somebody who would do better academically. Even though maybe those words weren't used exactly, it was sort of felt that that was, in general, what people did in those days.

Mullan: That really was the low point, because my sense is that in earlier years, the general practice, as in one year of postgraduate training and out into practice, was still respectable. At that point, it really had, at least in academic

circles, become unrespectable, and the family medicine concept had not been born yet.

I was four years behind you, at the University of Chicago, and I had what I will call generalist instincts, but the notion of being a family doc was just beneath consideration, and the notion of being a GP was beneath consideration, and the family physician had not been born, really, as a viable residency concept, as yet. And I went into pediatrics with a similar--I wanted to be generalist, and I liked kids better than adults, as it turned out, and it did the job.

But you have returned to Maine. You did your training here. As you came out of training, what were your prospects? What did you want to do? How did you see yourself and your career?

Sheehan: The chief of pediatrics was a fellow by the name of Phil Good, who started the Department of Pediatrics at Maine Medical Center. He looked upon us as his boys, if you will, and he sort of saw to it that he would help place you in the state of Maine. I was at the very beginning of the residency program when it started at Maine Medical Center. I was the sixth resident graduate from that program, and the first graduate was a fellow by the name of Ted Russell, who had located in Augusta, which was right next to where I grew up. And he said, "You know, you really ought to go up and practice pediatrics with Ted Russell. He needs a partner. He's starting to get burned out, because he's the only one there."

There were probably fifteen pediatricians, thirteen or fifteen pediatricians, in the state. This is 1967. Portland had about five or six, and they said, "We have too many pediatricians in Portland. Nobody really wants a partner here. This is the right number for this area." There was a place in Brunswick, and one of my classmates at Bowdoin, who was a year ahead of me, and was a year ahead of me at Maine Medical Center, had located in Brunswick, and I had thought of going there and joining him, or joining Ted Russell in Augusta. But I sort of preferred the Augusta experience, because it was around where I grew up. And Phil Good encouraged that, and said, "We really need to start to fill up the state of Maine with pediatricians, and we need more of them, but these are the places that look most favorable, and I think you'd fit perfectly with Ted Russell in Augusta."

So I went up and interviewed, and obviously I liked the area, and then ended up making up my mind to go there, as opposed to Brunswick, which was the other place that I was looking at.

Mullan: So you entered practice. What was it like? How long did you stick with straight practice?

Sheehan: Twenty-five years. I stuck with it until I came down here. It was great. There were two of us. We worked every other night, every other weekend, and each took an afternoon off every other week. So you'd get a Wednesday afternoon off one week, and you'd work everything the next week. And then the next

week, you'd get an afternoon off, and that seemed pretty good. I sort of like that pace and that style.

Pediatricians weren't prevalent in the state of Maine. It was mostly family physicians who did the pediatrics. So my partner, who had been there five years before I arrived on the scene, he had sort of fought the battle of establishing a pediatrician as somebody that you would go to, as opposed to a family physician or a general practitioner. General practitioners did a lot of the deliveries. There were a couple of obstetricians that clearly favored pediatricians, because they were sort of competitors with people who did deliveries and took care of everything. One of them was a very strong personality, who just told his patients that he was going to send the babies to the pediatrician, and that caused a little bit of a stir. But we were trying to establish ourselves as sort of specialists, if you will, compared to the general practitioner in town, and we clearly had more skills and more knowledge of things.

It became a very successful practice, a very busy practice. I think we worked nicely with the family physicians and general practitioners. It worked out, I thought, pretty well. A lot of the pediatrics, the more complicated stuff, they gladly turned over to pediatricians. They were happy to have us around, because we were starting to get into intensive care units, and neonatal intensive units, and more complex things, and outcomes. There was a little more expectation that babies just didn't have trouble, in those days, when I first arrived on the scene. It wasn't unusual for them to put the baby in the back of the room,

and just say, "Well, there's not much we're going to be able to do about this." And there wasn't much of a diagnostic workup or a treatment plan.

So we clearly changed those kinds of things, and, I think, brought a better kind of medicine to the town. But that was fun. So to build that, so to build a practice, we added a couple of other partners, eventually, and had a pretty good life there.

I found, coming from my home town, going back to my home town, was an advantage. I think people probably wonder, if you go back and live among the people that you kind of grew up with, would that be an advantage or a disadvantage. But I found that that was an enormous boon to the practice. A lot of people came because they knew me growing up, and had gone to school with me, or had gone to the same school. It's sort of a known presence in the community, and so they would come to me because of that, because they knew who I was. That was fun.

You get to know your friends' families, you get to know their children, and you work as a pediatrician. After twenty-five years, about a third of my practice was second-generation families. You sort of grew up with them. I mean, you remember when newborns that you saw the first year in practice--there's sort of stages, and one of the stages is when those kids go to kindergarten. That's sort of five years in the practice. And then the kids that get into high school, and then when those kids start to have children, and you remember when they were born, and all of a sudden, they're having babies, and then you get into that second-generation family.

We probably had about a 70 percent market share of the kids that were born. I would say, we probably took care of 70 percent of the people in town, their children. And so when you go into the store, or when you go to a game or something, you literally know 70, 80 percent of the people. You either know them on a first-name basis, or you know who they are, even if you can't remember their name. And you know their children.

I never realized until I came down here as to how much I enjoyed that. I mean, I knew I enjoyed it, but you get a different perspective here when you come into a town and you don't know anybody, and you go to the grocery store and you don't know anybody. You don't talk to anybody. You know, you're sort of this anonymous figure, a ghost in the town. And when I go back to Augusta, even now, I'll see people that I know, and their children, and get a chance to talk to them. But I enjoy that. I mean, I enjoyed the small town. I enjoyed knowing people.

Mullan: Was it hard on family life? I mean, the call schedule was--

Sheehan: Well, really, it wasn't. But I think that's probably the perception. When we added a third partner, I took a course at the university, because I thought I had so much free time that I wanted to take a course, or do something extra, because now, all of a sudden, I had free time. I never wanted to add a fourth doctor, because I felt that I would lose touch with my patients. Every fourth night, every fourth weekend, I thought was a

terrible schedule, because you wouldn't be around as much as you should be. So I thought that every third night, every third weekend was about as much as I wanted to spread that out.

Also, I have four children. As they got ready to go to college and things, if I took on a fourth doctor, I might not be able to afford to send my kids to school. So that became an issue and a concern also. There was a number of good reasons that I wanted to keep it at three.

I lived within a mile of the hospital, and within two-tenths of a mile of my office. So I always went back at noontime and had lunch, and I always had my dinner at night with my children and my wife. So I felt like I was around a lot, even though I got pulled away, back and forth. Instead of hanging out at the hospital, I would go back home, because I lived within two or three minutes. I know people now that stay in the hospital if they've got things to do. They don't go back home. But they live fifteen or twenty minutes away. It's not worthwhile going home, and then turning around and going back to the hospital. And so for me, I always lived so close, that I would always come back home. So I never really felt it was a burden.

Mullan: At this point, your wife and kids, reflecting on that pattern of living, how would they reflect on it? Would they agree with you that even though you were pulled away, you were around a lot?

Sheehan: I think they knew that, when you have four kids within four years--I mean, they were all right in a row. The month of July, we have sequential ages. They just clearly remember Mom doing the home chores. In those days, physicians were males. The spouse clearly felt like she was there to support you, to take care of the family, to cook the meals, to work her schedule around my schedule. I think that that wasn't so much our family as it was that generation's feeling about medicine, is that the wife--and it was the wife in those days, it wasn't the spouse or the husband--you could go anywhere--

Mullan: No, "the significant other."

Sheehan: Yeah. Well, in those days, it was the wife. There was no significant other. Eighty percent of my classmates were married when I graduated from Tufts, and I think that was a national average number. We had, I think, two or three women in a class of 120, and that was pretty typical--1 percent, 2 percent, 3 percent.

She and my kids would go anywhere. If I wanted to move to Oklahoma or Hawaii or Texas, they wouldn't have thought anything about that, except, "If Dad wants to move there, and that's the best for his practice, then that's where we're going to go." And so it never became an issue of, "You're not home enough," or "You don't support me enough," or "You don't help with the children as much as you should." That never became an issue in my family. Never. My wife never even mentioned it, and the children never

made me feel like, "Gee, dad, you're not around enough." I think they appreciated the fact that I had a job that was highly valued in the town. I think they admired that work ethic, a profession that was very worthy of that kind of dedication. And so I saw that as something that they enjoyed having, a father as a physician. I took care of most of their classmates, and I think that there was a lot of prestige that went with that. "Oh, you're father's my doctor." They liked to come to our house, and since we had so many kids, my house was always full of children the age groups of my kids. In the mornings, I never knew who was going to be sleeping on the floors, or downstairs. We have three daughters and a son, and the daughters sort of took over the downstairs, so they had their own bathroom and living quarters, so they could have some privacy as they got older. You'd never know who was down there. There would always be a cluster of girls down there that would be sleeping on the floors or in beds or in sleeping bags and things.

But I think that they enjoyed that. I don't think they felt shortchanged. I really was around a lot, because I was so close by. So I would come and go, and be there. There would be nights and weekends that I'd get pulled away, that I couldn't attend certain things, but I enjoyed my children so much that I tried to involve myself as much as I could with my free time. As a matter of fact, almost all of my free time was devoted to our children and their interests. But I don't think, even now, when they look back at it, that they felt that I wasn't part of the family or

that I'd missed a lot of their lives. I don't think that they felt that way at all.

Mullan: Over that twenty-five years, the practice of pediatrics, at least what was available to pediatricians, continued to grow more sophisticated, more technological. How did that impact on your practice, and how did you respond to that, or attempt to respond to that?

Sheehan: I think the biggest change, as pediatrics evolved for me, was probably newborns. I remember, it was in about 1971, the state was talking about starting a neonatal intensive care unit at Maine Medical Center, and that being the referral base. Ventilators for newborns were sort of talked about, and CPAP was talked about. I'm sure you got into pediatrics about the time that this started to evolve. I remember being adamantly against a neonatal intensive care unit at Maine Medical Center. The reason, I said it was, "I'm going to lose my skills in newborns, and I don't want to lose those skills, because I really, really enjoy newborns." And we got into some CPAP, and taking care of real sick kids in Augusta. Then it sort of happened that I started to take the real bad ones down to Portland--the ventilator babies and the little tiny babies. And we ended up stabilizing them and transporting them.

As it evolved, it got to the point where I wasn't able to take care of a ventilator baby, even in Augusta. I just wouldn't have the skills or the knowledge or the experience. So that part

sort of was pulled away. I still wish that I had more skills in the newborn area, because as the new docs sort of came out, they had acquired these skills because they spent so much time in the neonatal intensive care unit, more time than they ever wanted to spend. I thought that they had better skills than I did, with those kinds of issues, because they had dealt with the sickest kids. I felt comfortable transporting them, but wouldn't feel as comfortable as some of the new docs, in taking care of those kids. That's an area that I think my generation all sort of faced, eventually.

And then in the early eighties, the lawsuits started to take place for pediatricians. Any time there was a bad baby, they started to involve pediatricians. They would question their stabilization techniques and how they treated the newborn in those first couple of hours, before they got transported. That drove almost all the family practitioners out of the newborn nursery. Any child that became sick in the newborn nursery, family physicians readily gave that up, as soon the lawsuits started.

So it complicated our lives. We went to all the meconiums, and all the C-sections, and any fetal distress, and those kinds of things. And so you get pulled away a lot. The C-section rate, which was about 4 percent in the mid-sixties, then became 20 percent. And so initially I didn't used to go to many C-sections, because there weren't many, then all of a sudden, we'd have about five a week--C-sections to go to. In the middle of

the afternoon, or nights, it always disrupted the flow of your practice in some way.

I'd say the newborn nursery was the hardest thing for me to adjust to, as my career evolved. I didn't enjoy transporting newborns. Sitting in an ambulance, with a bag, and a tube down them, and doing that. If they would have come and gotten the baby, I would have loved it. When I left Augusta, they finally developed a transport system, where they now come to the hospital, and they get the baby, and they transport to the Maine Medical Center. If I had that, I said, "You'd change the whole course of my life," because I didn't mind putting tubes in and all that sort of stuff. It's just to get in an ambulance, and bend over--I have sort of a bad back. It would always go into spasm halfway down. It always took me six hours from the time of the birth, stabilization, going to Maine Medical Center, and get back. That was just a long period of time, and we did that forever.

Then when I came down here, about the next year, they developed a transport unit where they came and got babies, and I'm sure everybody was happy that they did that. It just made their life easier, because sometimes you'd end up with--on a weekend, you'd be trying to do everything--transporting kids, and trying to take care of the sickest kids in the community.

Mullan: Over time, you became more involved with politics of medicine. That's not quite the right word, but you got involved with the Maine Academy of Pediatrics, and eventually moving to

this job, more on management level. Tell me about that evolution. Where did it come from in your thinking, and how has it developed?

Sheehan: I think, early on, a CEO from Kennebec Med Center, Warren Kessler, had asked me to become the physician regional representative to the American Hospital Association.-

Mullan: Kennebec Valley is in Augusta?

Sheehan: In Augusta, right.

Mullan: That's the hospital in Augusta?

Sheehan: Right. And he asked me to be on the American Hospital Association, some boards, and the district representative to the Hospital Association. I did some of that, but didn't have enough time to do all of it. But I got my first taste of administrative kinds of duties.

Then in the mid-eighties, the medical director we had ended up getting sick, and he left. We had a search committee, and we couldn't find anybody to our liking, and they asked to become the part-time medical director in 1984. I had been chief of staff prior to this event, and so had gotten involved a little bit in sort of leadership positions.

Mullan: Chief of staff was an amateur job, whereas medical director was a professional job? Is that fair to say?

Sheehan: That's fair to say, yes. One had very well-defined duties and expectations, and the other one, they were happy if you did anything, because it was a voluntary job. I think in '83 or so, I became chief of staff, and then in '84, I became a part-time medical director. So in the mornings I would be the medical director. In the afternoons, and nights, and weekends, I'd be the pediatrician. As you know, both of those jobs want 100 percent of your life. I did that from '84 to '87. At the time, all my kids were in college, and my wife was in law school in Vermont, and so I decided, "Well, I can do everything, because there's nobody home, and what difference does it make if I'm gone forever, because I just go back to an empty house. So I might as well be working." And so I did that for three years.

Then when my wife graduated from law school, I decided this was an insane sort of life to live, and, at that point, resigned my job as medical director, and just did pediatrics. My partners were happy, because they wanted more of my time. Then we recruited somebody to take my job over.

While this evolved, I became attached to southern Maine, because we used to go down to Kennebunkport every summer. We started out a week at a time, and then two weeks, and then three weeks, and then four weeks, where my kids would go down there and spend the summer with my wife, and I would go back and forth. I would cut my vacation time so I would take a long weekend, and

those kinds of things. We rented a place on the beach called Goose Rock's Beach. My kids have childhood memories of skiing at Sugarloaf in the wintertime and being at Goose Rock's Beach in the summertime, and they said, "Dad, you know, we want you to move to Kennebunkport, so when we come back to visit you (after they'd grown up and left the nest), we don't want to come back to Augusta. We want to come back to Kennebunkport. So would you please find a way of living down there?" And they sort of said it seriously, but half in jest.

One day, somebody was talking about this job in southern Maine and when I heard about it, it was serendipity. We were talking about a mutual friend, Tim Townsend. Steve Sears, who is the current medical director in Augusta, whom I had recruited to take over my job, knew Tim Townsend, because they worked together at Hopkins, and I knew Tim Townsend because of ties in Augusta. He said, "Gee, Tim Townsend was thinking about applying for the job in southern Maine."

I said, "What job in southern Maine?"

He said, "Oh, they're looking for a medical director."

I felt that I could never move to southern Maine, because you can't really take your practice with you, and to start all over--

[Begin Tape 1, Side 2]

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

So, starting in southern Maine was a challenge.

Sheehan: Yes. I looked at the job, and I said, "Gee, that means moving." My wife had gone to law school from '84 to '87, and we disrupted our lives, major league, because she went to law school in Vermont. I thought, "This is going to disrupt things all over again." But I thought about it for about a month.

Mullan: She got into practice in Augusta?

Sheehan: Right. She was working in Augusta. She was working in state government. So I sat down with her one day, and I said, "You know, I'm looking at this way of getting down to Kennebunkport, and this looks like one of the ways that we can do it. Being a medical director, I did that for three years, in Augusta, and I have some comfort with that." So I talked with her about the possibility, knowing that I would be down here and she would be in Augusta, and that would disrupt our lives again. And she said, "Hey, if that's what you want to do, go for it. I pursued my career goals, and there's no reason why--if you want the change."

So I came down and interviewed, and got the job, and told my practice, after twenty-five years, that I was leaving, and I know that I put them in a state of shock, because--

Mullan: This is a full-time job?

Sheehan: Yes, this is a full-time job. Came down here January of 1992. I used to go back to Augusta and work in my old

practice. I'd take vacation days and work up there. I had a hard time pulling away, I really did. There was a period of about six months into this job that I was all set to come back to Augusta, and figured it was just a lousy idea. I almost, at that point, decided that I was going to go back, because it's a different job, you know. It's an administrative job, and even though I do some consults and work in the clinic and do those kinds of things, it's 5 percent to 10 percent clinical work, and 90 percent to 95 percent administrative work. It's very different. And you don't really have responsibility, longitudinally, for anybody. So you don't get to know patients, and you don't get to know families, and those kinds of things. I still have a hard time with that. I'm more comfortable with it now, but still some days you sort of long to go back and do what you did before, because you had so much comfort with it.

I think being in primary practice, it's more gratifying than being an administrator, because you get constant feedback from the patients, and most of your patients appreciate you. Most of them say "thank you" and most of them, if they see you, there's a certain amount of deference that goes to the job, and prestige. People know you very well and appreciate your efforts in working with them for their health.

This job is more crisis oriented and problem oriented, and putting out fires. There's a lot of strategic planning that's very satisfying, but it isn't like practice. It's very different, and physicians view you as being in the administrative camp, and that's hard, because for twenty-five years, I was never

there. And now, all of a sudden, I am, and the people down here know me as an administrator. They don't know me as a pediatrician. The other pediatricians do, but they still don't see me as a pediatrician. They still see me as an administrator.

Mullan: So are you going to stick with it?

Sheehan: I'll stick with it, yes.

Mullan: Is the schedule easier?

Sheehan: Well, it is, and it isn't. What is easier is that they don't call you in the middle of the night, and you know when you leave here, you sort of leave the job. And even though there's an administrative on-call, it's nothing. It's literally meaningless. You might get a few phone calls. So that part is different. When I go home and sit down, I know I'm not going to have to go back to the hospital. I'm not tethered to the phone, and I'm not going to have to deal with a crisis at two o'clock in the morning.

It's harder in terms of it's a harder job to get a sense of--in pediatrics, I really felt like I knew an awful lot, and that most of the things that I would be faced with, I would have had experience with, and would know how to handle, and would have a solution. I knew that I could make almost everybody better that had an acute illness, and I'd seen almost everything, and I sort of prided myself on being a diagnostician. I enjoyed that

part of it, difficult cases, and felt that I had a comfort with the unknown.

In this job, it's very difficult, because you involve other people, you depend upon other people, and we have meetings upon meetings upon meetings, and there's no quick fix. So the job is hard to get your hands around, and say, "I'm really a good medical director." You can list almost anything, and I've got an answer for it, and I can accomplish it, and I can make it all better. But there's too many people that have a piece of the decision-making, and sometimes things are put on the back burner, despite the fact that I don't want them there, or things get done a little bit differently than I would do that because it's a team approach. So it's harder from that point of view. I probably work more hours here. I work, I would say on the average, between 60 and 70 hours a week in this job. So it's a lot of hours. Now, part of that's just that I enjoy the job, and don't mind working those hours, and I could leave earlier if I wanted to.

Mullan: Are you commuting, or do you commute some of the time?

Sheehan: We don't live in Augusta any more. We live in Kennebunkport, and I live fifteen minutes away.

Mullan: Does your wife commute up to Augusta, or how does that work?

Sheehan: No, as a matter of fact, she works down here now. She became the commissioner for the Department of Human Services, which is a horrible job, by the way, and worked in that job for almost three years, and was living in Augusta at the time. So between my job and her job, we would see each other on weekends, mostly. Probably once a week I would be up in the Augusta area and stay overnight, and would get up and come down here in the morning, and vice versa.

But about a year and a half ago, she left her job with state government. We got a new governor, who immediately appointed somebody different in that job, because it's a political appointment. She came down here to work, so the last year and a half, she's been down here, and now she's got a full-time job. She went into law practice, and then as a full-time administrator of a laboratory that's in Scarborough. It's about thirty minutes from our house. We've got a big house, so when our kids come, and we've got bedrooms for everybody.

Mullan: You've seen a lot of changes in the practice of medicine, in general, moving beyond pediatrics now, particularly, I would presume, in the last decade, in terms of--let's stay in a primary-care issues, where the generalist concept has enjoyed more currency and more favor, at least, in policy circles and among the purchasers of care, to some extent. And yet specialism, in terms of the ability to deal more and more precisely with smaller and smaller parts of the body, has continued to prosper. How do you see that playing out in terms

of medical practice, as you see it, participate in it today, one; and two, how do you see that playing out in the future, in terms of the role of primary care?

Sheehan: I think we have swung a little bit too far towards the generalist. With managed care the way it's evolved, and with the pressures on--I'll pick family physicians just as a sort of focal point. They're being asked to do more and more, and there's an economic incentive, if you will, or a disincentive, to take on more responsibilities than they've had in the past, not to call on the cardiologist, not to call on the neurologist, not to call on the gastroenterologist, or whomever, because it's expensive, or there's another fee there, and they're sort of responsible for that. Their withhold is generated towards resource utilization. And so they're expected, and have pressures on them, to do more.

My concern is that, for years, many of them have not functioned that way. They have, very quickly, some of them, asked specialists to get involved in a whole host of things, and that might have gone too far, also. But now those same people are being asked to do a little less referral, and one of my concerns is that they're going to get themselves into some issues where people are going to get hurt by that. They're going to hang on to that patient maybe a little bit longer than they should.

Mullan: Are you seeing that, or are you speculating?

Sheehan: I haven't seen it. I'm more speculating. I don't have case histories that I can talk about, and say, "Well, I remember this case and that case." But my concerns are there.

Mullan: You'd be referring to the family physician hanging on too long. How about the pediatrician hanging on too long, not referring to the cardiologist?

Sheehan: Yes, there's some pressures there, too, I think. I know from my personal point of view, four years ago, I'd probably been five years into managed care, but it was still 1 percent of my practice, and so, it didn't change anything that I did, because it was meaningless, because there was such a small percentage. It's becoming more and more now. I guess I can say, personally, that that wouldn't be an issue with me. One of the reasons is that when you practice pediatrics in Augusta, you don't have a neurologist in town--a pediatric neurologist--you don't have a hematologist, you don't have an oncologist, you don't have a neonatologist, you don't have a cardiologist, you don't have anybody. You're the most knowledgeable person in pediatric care in town. There isn't one of those sub-specialties that isn't 60 miles away. And so you end up doing a lot of those issues.

If you're at Maine Medical Center in Portland, where all those people exist, then I suspect they practice a very different brand of medicine than they do in Augusta or Skowhegan, or Waterville, because they never take care of a sick newborn, they

never transport anybody, they never stabilize anybody, they never get called in the middle of the night to go to a 29-week gestation delivery. When somebody really crashes, and they go to intensive care unit, they've got doctors to sort of do that work for them, if you will.

So they practice a different brand of medicine, and there may be some pressures on them to change a little bit what they do, and maybe they don't feel like they're qualified to do some of those things. But I think for the pediatrician, for the most part, in Maine, they already do those kinds of things, and when they make a decision to refer somebody, I don't think that that's an issue. There's a barrier there already. You know, you've got to go 60 miles, and so you're going to hesitate before you send somebody down. You're not going to send them there because they're in the same new office space, or they're in the next building, where it really is easy to get those consults.

Mullan: That hasn't been an issue so much for you?

Sheehan: It certainly wouldn't be for me.

Mullan: How about here in this setting as you watch pediatricians practice?

Sheehan: I haven't seen that evolve yet.

Mullan: Evolve in which way? Being closer to Portland here--

Sheehan: They're more likely to send things to Portland.

Mullan: And are they feeling pressures not to?

Sheehan: I don't think so yet. No, I don't think that that pressure has kicked in.

Mullan: Because managed care has not penetrated enough?

Sheehan: Not enough yet. No, and we're probably 10-plus percent now, but we'll probably go to 20 or 30 in the next three or four years. I know that they already are faced with utilization review, resource utilization. They get these profiles on themselves. This is how much lab you did, this is how much X-ray you did, this is how much referrals you did. Those kinds of issues they have to deal with. But my fear is that they might get into some of those issues where they're going to be expected to do too much.

Mullan: You practiced, in some sense, as a consummate generalist. I mean, twenty-five years in a setting where, with a general pediatric training, you were the authority, as you put it, I would gather from your depiction of that, you feel pretty good about it. That is a different mode of practice than many pediatricians in more urban settings, where their propensity to refer is much greater, and the circle of illness which they feel comfortable treating is somewhat smaller. Looking at both your

pattern of practice, which you know well, and the pattern of practice of others, which you're familiar with, what do think the right calibration is? Where do you think we ought to be?

Sheehan: I guess I don't know the answer to that, to be honest with you. I hate to have these economic incentives put in place. I don't feel comfortable with that model at all. I don't like managed care. I hate having an extremely powerful and influential third party put in between the patient and the physician.

Mullan: Let's look at the issue from a slightly different angle. There is no--take, for the sake of argument--pediatric cardiologist in Augusta. If we had continued the pattern of medical training that we have developed over the past couple of decades, eventually there will be pediatric cardiologists in Augusta, not particularly because the population had grown, but because the population of physicians was growing, and the balance towards specialization was such that the diffusion of specialists into smaller and smaller communities would take place, so that eventually the pattern of practice would involve more sub-specialists in the immediate vicinity, inviting you to refer more frequently. Would that have been a good development? Is the truncation, or retardation, of that development good or bad?

Mullan: I think the retardation of that development is good. Where you draw that line is always difficult. But I would not

have enjoyed having all of those sub-specialties around the corner, so that they essentially took over my neurology, my seizure patients, and took over my hematology patients, and took over my heart murmurs, and anybody that had anything. I would not have enjoyed that. I would have thought that that was wrong. I don't think you would have seen it. Certainly in this state, you wouldn't have seen that kind of development unfold to the nth degree, and the reason you wouldn't is because cardiologists can't practice in Augusta, Maine--pediatric cardiologists--because there's not enough business. There really isn't enough business. So they are always, in my mind, going to be located in the big cities--in the Portlands. And that's close enough. That one-hour drive, that 60-mile drive, is close enough. I thought that that was fine. But I never saw them.

What they might have done, and what they have done in places, is they come up once a month for a clinic, to see the patients here in the northern cluster, and that's okay. There's no problem with that. But I don't see them--they would never have been able to move to Augusta, because there isn't the population base to be able to support a cardiologist in Augusta. Even if they saw every heart murmur, you know, that I ever, ever questioned, it would not be enough business for them. So I never saw that developing like that. And I wouldn't have enjoyed taking my sub-specialty knowledge base and expertise away from me by turning it over to those people for everything that I had, so that, to me, a heart murmur means refer to the cardiologist. Seizure means refer to the neurologist, and that's as far as I

ever get involved with it. I would've hated that kind of practice.

Mullan: It's interesting. In a sense, what I'll call the semi-rurality of Augusta froze it in a manpower pattern of an earlier epoch, compared to the cities. The cities continued to specialize and sub-specialize with the continued growth of their populations, and a continued--maybe "distortion" is too strong--but a continued migration of a pattern of practice toward specialties in a way, with the generalists doing a limited practice and a great deal of referral. That was the pattern reinforced by many things.

Your semi-rurality kind of, as I say, froze you in a setting, in a situation, in a manpower situation, where those specialties were available to you, but it was not an economic barrier, it was a geographic barrier that made it a real hassle. You had to have a murmur that you were really concerned about to undertake the hassle of sending somebody to Portland, which kind of insulated you in a way that at least from now a global perspective makes the pattern of practice look more sensible.

Sheehan: Yes. I never really felt that we would ever have gotten into that evolution, like the big cities do, where we would have all those sub-specialties. You just can't do it. It's just too small a population base. We were dealing with 75,000 people population base, and 65 down here. It isn't enough to support that kind of a sub-specialization. Just can't do it.

Mullan: I know your time is short.

Sheehan: I'm going to be late. I've already decided that this is more enjoyable than my once-a-month meeting. I'm going to go there, but I'll just be a little bit late.

Mullan: All right. Let me ask you a couple more questions.

Sheehan: I don't want to cut you off.

Mullan: Because your reflections are so pertinent. I mean, you've done it. The growth of the nurse practitioner/physician assistant movements, both of which have enjoyed reasonable manifestations here in Maine, as well as I understand it, what is your view of that, in terms of their contribution to care as a whole, primary care, and pediatric care, in particular? Is this a good development? Is it a development that's peaked and ought to recede? What are your views of it?

Sheehan: I hate to tell you all these things, because it's almost like you're saying things that aren't politically correct, but I never really worked with a nurse practitioner, and I knew that they were around, and they were sort of shopping around ten or fifteen years ago, when they started to kick out with those things. And the reason I didn't find them helpful, at least, from my point of view, was I was interested in nights and weekends, and sharing the call, and they really couldn't take

that first call like a doctor could. So if I had a choice between--because we were so busy--adding a physician versus adding a nurse practitioner, even though you could have made some money, maybe, with a nurse practitioner, because you don't have to pay them as much if you can keep them busy, I wanted somebody who could function at the physician level, and who could function autonomously nights and weekends, and take the call, so that you share that extra burden, which sort of wears people down. That was one issue, so I never really wanted to do that.

The second one is that it's hard to be a physician. I mean, you know what it takes. You know it takes four years of medical school and three years of residency, and then an awful lot of experience and paying attention and reading and trying hard as you possibly can to keep up to date, and to acquire new skills and new knowledge. And you do that with an enormous sort of reservoir, a background, of information. I mean, it adds on every year, if you really try to learn each year, and grow each year.

And, to me, the nurse practitioner--I don't know how you can take that quick course and take some of those responsibilities. I've always felt that primary care--people assume that the nurse practitioners can do it, because she or he can write a history as well as I can, or can write a physical as well as I can. On their physical--they might miss three things on the physical, but they can write it well. And so people said, "Well, of course you can do that. You can't do surgery, because, you know, it requires skills, and if you screw up, someone's going to die,

you're going to cut the wrong thing. And so you really can't do a gallbladder. But you can go do a physical." And to me, that's ludicrous, because a physical can be extremely difficult. You know, a spleen tip, or a node, or whatever. I mean, there's so many things there.

Most of the people you work on, who are healthy, aren't going to have anything new discovered. And so people say, "Oh, of course they can do a physical. Well, yeah, that's the easy stuff." Well, it really isn't that easy. Taking a good history is a little bit harder. And I've always felt that that's been shortchanged by a lot of people, and they've assumed that that person can step in, and they always say, "Well, they can do 85 percent of what a family physician can do," for example. Well, if somebody could tell you which 85 percent it is, then I think you'd be okay. But they can't.

And so, I don't know. I don't like the concept particularly, because I think that it's hard to be 50 percent of a doctor, because you don't know which 50 percent is going to come through the door. I know that they help some people, and I guess I could agree to it in a multi-specialty or a large-group practice that had direct oversight and things. I think you could probably do that model if you needed more work power. I can see them fitting into that, but I think to take a nurse practitioner and to put her into rural Maine, to practice autonomously, is a horrible thing to do to anybody--to do the patients and do to the nurse practitioner, because I think they would be enormously over

their head. I think it's too complex and too difficult a profession to learn by taking a couple-of-year course.

Now, if we get into an "oversupply" of physicians and an "oversupply" of primary care physicians, then the nurse practitioner will be the first one to kind of pop out of that system, because the doctors will say, "Hey, those are our jobs, and we don't want you to take those things." People have made money on nurse practitioners, which is obviously the wrong reason to do that. I can hire two nurse practitioners at $50,000 apiece, and have them see twenty patients a day, and I, as a pediatrician, can make money, because I get all the extra. I think people have gotten into that model, and to me that's never been an attractive model. I'd rather have somebody with a good knowledge base, and somebody I can learn from.

Mullan: Any reflections--realizing you haven't worked firsthand with, I presume, either--of the difference between a nurse practitioner and a PA? Do you have feelings about physician assistants?

Sheehan: Oh, I've always favored the nurse practitioner, because they've got the nursing background, and then those extra years and things. They've got more education than the PA, so if I had to pick one, I'd pick the most educated one. But I prefer the doctor over either one of those. I just think it's not as good, and I think the profession's too difficult, and I think people shortchange that. I think that they say, "Well, you can do

primary care." It, again, gets back to that elitist sort of thing, "Well, you can do the physicals, and you can see the sick people and things. But, God, you should never go into the OR, because that's our domain." I don't know. There's obviously a place for them, but I think it's in a fairly good-sized group, with presence in the same building, so that you can get easy consults, that doesn't take a phone call and a car ride to go see somebody. It takes walking around the corner.

Mullan: I heard the nurse practitioners in Maine just conducted a campaign to get a higher degree of autonomy for independent practice, and won.

Sheehan: Yes, you can practice autonomously if you've had a couple of years of a relationship with a physician, a supervisory relationship with a physician, then you can kind of hang up your shingle and do a whole host of things--write prescriptions, see patients, and not have to get consults, except as you think it's necessary.

Mullan: Is that happening, to your knowledge?

Sheehan: I don't know of anybody who's done it, but it just passed this past year. I don't know of anybody that finds it particularly attractive. I would think that most nurse practitioners that are smart enough to know of their shortcomings wouldn't want to be out with that sort of autonomy and

responsibility. They'd rather be with a group of physicians, where you can get consults and things easily. I don't know of anybody who's done it, but somebody will.

Mullan: Was that a bitter battle? Organized medicine opposed it?

Sheehan: Oh, yes. Yes, opposed it, and it was very bitter. It was seen as a turf battle and an economic battle; i.e., physicians protecting their wallets. That's the way it was portrayed to the public. "We've got these people that are highly qualified and we've got physicians that don't want anybody entering their domain and competing with them on a regular basis." The idea that rural areas needed people like this, because physicians weren't in the rural areas, and they wouldn't go there, and so this was something that would help rural communities. I don't think that that's going to play out at all, because there's no more attraction to living in northern Maine woods for a nurse practitioner and her family than there is for a physician. Plus, it's a terrible isolated life. You're on call a lot, and you've got all the responsibilities of--you know, the person that crashes, and you look around, and there's nobody to help you. I don't think anybody that has that kind of training likes that kind of environment. So I suspect it's not going to be a major issue.

Mullan: As you look to the future--it's crystal ball time--with the system in evolution as it is now, what do you see, looking ten, twenty years down the road, and taking the part of the world you know best--Maine--what kind of system do you see, and what is the role of the generalist in that in the future?

Sheehan: I wish I knew for sure, but I see networks or integrated delivery systems forming around hospital service areas, probably--the Biddefords and the Portlands and the Augusta and the Watervilles. I think that hospitals and physicians will become part of one system. I see--I hope, but I'm not sure--that primary care physicians and specialists will be working in a different relationship. I think that the economic insinuations of, "Oh, if you refer, you're going to lose money," I think that's going to dissolve. I think that managed care is going to dissolve, as we know it now. I think that the intermediary that takes profits out of the system is unsustainable, and will disappear. I think you'll find the providers being very close to the patients, and that the people in between will handle claims and handle the paperwork, but won't get into sucking out profits, and trying to control the system where they can de-select physicians and things. I think that that'll go away.

I think that the economic differences between a specialist and a primary care physician will get compressed. The difference between their income and a primary care physician's income, I think, will lessen. I don't think it will ever be equal, if you will, but I think it'll be a lot different than factors of two

and three and sometimes four. I think that that has to go away, because I think it's wrong. Specialists charge two and three and four times as much money for the same procedure that's easily done. Lacerations that can be done by a lot of people--a surgeon does it and they charge $250, and a pediatrician does it and they charge forty bucks. It's very easy to do. Lacerations on a cheek or an arm or something, all you have to do is put three or four stitches in. They evaluate patients in the emergency room and charge $200, and don't bat an eye.

My daughter's daughter, my granddaughter, broke her leg. Don't put this in your book, but the orthopedic surgeon saw my daughter as a physician--saw her daughter. The X-ray had been done the day before. It was a little, small fracture, undisplaced. Didn't have to do anything. She was only thirteen months old at the time. And so no casts, no treatment time, and within two or three weeks she was walking on it just fine. X-ray was done the day before, and the pediatrician saw it the day before. He said, "Well, you better have an orthopedic surgeon look at it." So she went, the orthopedic surgeon looked at the X-rays, and said, "Yeah, I wouldn't do anything. You don't have to do anything. You don't have to come back. She'll walk on it in two or three weeks, and it'll be fine." And you know what he charged? Twelve-hundred dollars.

Mullan: No! That's immoral.

Sheehan: Yes, it is immoral. He called up and apologized, because he didn't want the bill sent to her, in the first place. So he was embarrassed. But he says it's a code, and it's a code for fracture, and that includes all care for that fracture, for how long it takes to take care of that. And there's a code for that. So if it meant two or three cast changes, and eight visits and whatever, it's $1,200, but it got coded as a fractured extremity, and that's what you can charge for that code. That's the maximum that you can charge, and so he put it in, and the insurance company will probably pay it.

Those kinds of things take place, a pediatrician, if they charged a hundred bucks for that, they'd feel guilty, you know, like, "Oh, jeez, I shouldn't have charged that much." And yet those people do those things. Now, not everybody's like that.

There was a patient in the emergency room, who complained recently when an orthopedic surgeon, who, looking in on a patient that had been seen the day before, (he'd gotten a call on it, and said, "Well, put some stitches in and put it on a splint.") came in to look at the wound, and charged $240, and he was there all of five minutes. The patient wrote me a letter and complained, and he reduced the bill to $90, but I wouldn't even have charged ninety bucks for that. But they do things that primary care physicians do, and they charge outrageous amounts of money, because they're so used to getting paid so much for their services. That has to go away. I think that that's wrong.

So I think the difference between specialists and primary care people, will get less, and I think other people will

intervene if it doesn't get less. I think the barriers to the referral, that economic barrier that's there now with managed care, I think that that'll disappear, so that the things that they do really well, I think they ought to have direct access. If you bang up your knee, and an effusion develops, I think people ought to be able to go to an orthopedic surgeon directly, and not have to go through the primary care physician. There's certain things that they're clearly better at, and ought to see initially.

So I think that the economic barriers are going to dissolve for referrals. The high fees that some people get for very minimal things will disappear, and the difference between the specialties will disappear. I think that it will work as a system, where everybody will get paid a reasonable amount, but some of those economic--I would call them almost barriers--to appropriate referrals and things will disappear, and we'll reach a comfort zone of referral having the sub-specialists and the specialists do the things that they do very well, but appropriate things.

We also have to guard against my, as a primary care physician, sending everything to the specialists. You know, a murmur sent to the cardiologist; bruised knee, send to the orthopedic surgeon; and I become a triage expert, and I get out at five o'clock, and I don't have to deal with anything that's very serious. That's clearly wrong, too. I think people ought to have enough pride in their professionalism to do the things that they can do well.

But I see that evolving into that, and with a new generation of physicians coming that start to see those things evolve, it's comfortable for them to do those kinds of things, and where it might be uncomfortable for an older generation to do. I think it's going to evolve into systems and those kinds of issues. I hope, anyway.

Mullan: In terms of your own practice and experience, what would you rate as the important factors that have governed, influenced your career in medicine and pediatrics and generalism. I mean your parents and your parents' values, I presume, would be at least one, for openers. Has religion, other people, or movements or ideas been particularly important to you?

Sheehan: To go into medicine or to stay in medicine?

Mullan: No, that serve as a gyroscope or an ongoing influence.

Sheehan: I think, for me at least, when you grow up with certain values, that I think you learn from your parents and from your friends, you learn, I think, basically, most of what's right and what's wrong and what's fair. And you know how to live your life. You know when you're being a jerk, you know when you're sort of wrong. To me, my basic sense of what's right and what's wrong has probably been the strongest guide I've had in terms of the way I live my life, the way I practice medicine. I think you get that when you're younger, growing up, that somebody instills

that in you and tells you, you know, "That's wrong," or, "This is right. This is the way you ought to live your life." To me, that's my guide and I try to put everything to a common sense/fairness issue. Is this the right thing to do?

When you're a pediatrician, dealing with the public, and you know that some people can't pay, I mean, you know them, because you know where they live, you're not going to charge them $40 for an office visit. You might not charge them at all, or you might write off the bill. Now, that to me, is a sense of fairness. Or you might barter a little bit. You might have the kid mow your lawn, so that they feel like they've paid for the service, and it makes them feel like it's not such a charity case.

We used to have one woman do the typing for us. And we used to have to re-type everything. They said, "Shouldn't we just tell her?" I said, "No. She's typing. She feels like she's paid her bill. It makes her feel good. And I don't care if we have to re-type the thing." I'm not going to charge her anyway, and she can't pay me. But she feels good about it, you know. She feels like she's paid for this service.

I think when I get into medicine, and I get into complex things, I try to fall back on, "Does this pass the fairness test? Is this the right thing to do?" We had a very difficult issue about a month ago with a physician. It ended up in being a career change, and our decisions could have completely destroyed this person's life, and you could've justified it. It had to do with performance issues. We found a way for this person to pursue another career in medicine, but we could have easily,

easily ruined this person's life, so that she or he couldn't pursue the profession. She/he ended up going and taking another residency, and we helped that happen. And to me, we had never done anything like this before, and other parties involved had never done anything like this before.

But to me, it was a fairness issue. In the process of doing what we think is right, aren't you restricting privileges? We now make this person unemployable. So do we find a solution to let them pursue another career? And it meant some money. And you could say, "Well, you know, you shouldn't be about that," but to me, we ended up with a solution that was extraordinarily fair to this person. And the economic hit to the parties involved. They all could afford to do that. And so it ended up being a good thing for the person, and I think a good thing for the institution.

Mullan: Is religion an issue?

Sheehan: No. No, it isn't.

Mullan: Were your parents very--

Sheehan: Strong Catholics. Religion was a big part of my life, growing up. I sort of pulled away from it, although I think that the tenets and the issues that religion concerns itself with--i.e., what's right and what's wrong, and unfairness--those completely dominate my life. I do something wrong and I have

that guilt, you know. It kicks in, and you just know that it's wrong. I don't have God up there looking down on me, necessarily, but something's there, you know. Something's there, and I just know that it's wrong, and I shouldn't be doing it. And so you feel guilty if you want to pursue that. You say, "No, that's wrong." I know that it came from my family values and my religion and all those kinds of things.

Mullan: Did they come from Ireland, or how far back--

Sheehan: Grandparents did. My mother's French, and her family came down from Montreal, came down to this area. And my father was Irish. So my grandmother, on my mother's side, came from Montreal, and were French. And my father's father, my grandfather, came from Ireland. My grandmother came from Ireland. So grandparents came to the United States from another country.

Mullan: Final question. I was going to ask this question in total ignorance, but you said something that led me to believe I know at least part of the answer. The descant that one hears often these days about, "I wouldn't tell my kids to go into medicine," i.e., it's changed from what it was, how do you feel about that? What have you told your kids?

Sheehan: I have four children. I told you, I have three daughters, and the last one was my son. I didn't encourage them

to go into medicine, and I didn't discourage them. Two of the four I thought would make good physicians and would find that a good profession, and two of them clearly didn't have the academic interest to stay with it. They would rather do something else with their lives than sit and study and read and do all those kinds of things. And of the two that I thought clearly had what it took to become a physician and things--one of them did, and one of them went on to graduate schools and pursued a different career. But when my one daughter decided to go into medicine, it wasn't because of my sort of saying, "Gee, you'd really make a good doctor. You really ought to do this." I knew that she could see medicine every single day of her of life, because she could see my life, and I knew it was in her mind. But when she said to me, in her sophomore year--she went to Bowdoin, also--"You know, I think I'd like to go to medical school," I was thrilled. I thought that that was a wonderful thing to do, and was extremely proud that she had made that decision. I learned very quickly that that was the minority opinion.

Mullan: In your family?

Sheehan: Well, not in my family, because I think my wife was happy, and certainly her siblings were thrilled with it, because I think--I don't want this to sound like bragging, because I don't consider myself an exceptional person at all, but I think they admired what I did, and I think when their sister decided to do the same thing, I think that they thought that was an

admirable pursuit, in the use of her abilities. But what happened was, she spent two summers with me in my pediatric office, and made rounds with me, and went to C-sections with me, and I involved her very much in my practice the year before she went to medical school, in between her first and second year. She spent probably five to six months in the summer--spent all summer with me. But we would make rounds, and I would introduce her to my colleagues. I probably introduced her to 50 people the first year, and 49 of them said to her--and this without asking them for an opinion--"I would never have my child go into medicine. Are you sure you want to do this thing? Oh, my God, things are changing, and the government's getting into these things, and other people are controlling our lives."

She went to medical school in 1987, so this is '86, '87, '88. But they would just offer that opinion. I'd say, "This is my daughter Elizabeth," and within two minutes, they'd be saying that to her. And, at first, she thought they were sort of being humorous, but then it became very clear that people felt very strongly about this.

One person, and I can't remember who it was, said, "That is absolutely wonderful. Your father must be really proud." But everybody else said just the opposite, and she said, "Dad, what's the message here? Am I making a mistake?"

I said, "No." I told her, I said, "I still feel that it's clearly one of the greatest professions that you could ever pursue, without question. It has nothing to do with money, it has nothing to with prestige. It's just an extremely honorable

way to pursue your life, to relieve suffering and try to help people. And that's what you're going to be all about. You can forget about how much money you make, or prestige, or where you live in the community. That won't mean a whole lot to you, probably, because you get so involved in what you do, and the lives of the people that you take care of, and those concerns. And there's always a challenge the next day. You never can feel like you're on top of the world, because every day it's a new day, and there's new problems, and they don't come in with labels on them. You have to figure it out. So there's always an enormous amount of responsibility, but I've never gone home at night and felt like I hadn't done something that wasn't valuable. I have never gone home at night and said, 'Oh, I did nothing today. I didn't help anybody.' I know there's a lot of my friends who struggled when they got into their forties, feeling that they were pursuing valueless things. They were making pretty good money, but they never really felt like they were contributing much to society. You'll never feel like that in medicine. You'll never worry about that."

Mullan: What is she doing?

Sheehan: She's a radiologist. [Laughter]

Mullan: Whereabouts?

Sheehan: She's at Johns Hopkins right now. She just finished her residency July first, and she's taken a year of fellowship, and then is going to go out into the bad world. Yeah, she called me up when she was like a junior, and she said--I really thought that she'd go into pediatrics or something with primary care, because of the exposure that she had. And she called me up, and she said, "Dad, I've decided what I want to be."

I said, "Oh, good. What is it?"

There's this big long pause, and she said, sort of timidly, "Radiology." And then there's another pause, and she says, "Dad?"

I said, "Yeah?"

And she goes, "Is that a cop-out?" [Laughter]

And I said, "No. It's a wonderful specialty. You know, with MRIs and CTs, and all those sort of non-invasive diagnostic techniques. You know, I'm still digging out ear wax. Radiologists have got all the bells and whistles." I said, "No, it's a wonderful specialty. I thought you would have been more clinically oriented. One thing I can tell you is, don't be afraid to go out and examine the patient, and take a history from them, if they're available. You're going to learn a lot, and it'll help you. And if there's one knock I have against radiologists it is they don't like to do that, because it adds a few minutes to their day, and yet that's a horrible disadvantage or a wonderful advantage, to go out and be more of a clinician."

They have to do a year of clinical medicine, and she did an internal medicine year at Rhode Island Hospital, and then went to Hopkins.

Mullan: Maybe that's a good place to end. The next generation coming on.

Sheehan: Yes.

Mullan: Is there anything else you feel you'd like to put on the record?

Sheehan: No, I guess not, except that I think--you know, just what I said. Medicine is an absolutely wonderful pursuit, no matter how much they pay you. I would never change my life. I would never do something different, given another opportunity. I think I was fortunate to have the support of my parents. I think the one thing that I learned from my parents, or one of the most helpful things that I got from my parents, was their belief in me as an individual. I always felt that I was worthy of something. And when you get into trouble as a kid--you know, you throw rocks or you do this, you do that--I always felt that somehow my parents thought I was really important, really special. And you try to imbue that in your own children, that sort of self-worth, because that carries you through a lot of days, and there's a lot of days when you don't feel so good about yourself. They sort of gave that to me. I had a self-confidence and a feeling that I

had something valuable to contribute, and I think that carries you through the hard days, where you start to question whether, you know, is this the right thing to do, or whatever. And I think you can give that to your children, or give it to your friends.

Mullan: That's probably a good place to stop. Thanks for a terrific interview.

[End of Interview]