CARL TONEY

Fitzhugh Mullan,
interviewer

Mullan: I'm with Mr. Toney in his office at the University of New England in Biddeford, Maine. It is a beautiful July morning on the Maine coast, a twinkling sky. We're in a Quonset hut trailer, very comfortably appointed, which is the current home of the Area Health Education Center Program for the State of Maine.

Mullan: Carl Toney is the deputy director of that program. Thank you for having me.

Toney: It's a pleasure. Thank you.

Mullan: I want to start with a bit about you and your background, your early life, and how you got interested in health sciences in general. So why don't we start way back about where you were born and brought up, and what your early thinking was about your career.

Toney: I was born and raised in New York City. I was raised on the Upper West Side of Manhattan, about half a mile south of Columbia Presbyterian Medical, which my father worked at for twenty-five years as a maintenance supervisor, and my sister worked there for a while as a licensed practical nurse.

Mullan: Where exactly did you live?

Toney: I lived about a half a mile south of there. Columbia Presbyterian is on 168th Street and Broadway in Manhattan, and my family lived on 157th Street between Broadway and Amsterdam. So it was a real part of our community. I guess that connection really was the impetus for my ultimate interest in health, that and the family physician that we had, our local community family physician, who was someone who, to at least me, epitomized what medicine and being a physician and community care was all about. He was a really intriguing individual, whose name was Dr. Reginald Weir. I grew up in the fifties and early sixties, and he made house calls, and he was the kind of physician who incorporated the family--in particular, my mother was kind of the head of the health care of the family--into the decision-making. So he was an extraordinary model to watch.

I got into health care originally by doing a job. My mother arranged for me, through a contact that she had, to get me a job as an orderly at Columbia Presbyterian, and that was my introduction to health care formally in 1965. I graduated from high school in 1964.

Mullan: Where did you go to high school?

Toney: I went to high school in the Bronx at Samuel Gompers High School. In those days, if you went to public school in New York, they had a rule where you could go to any high school in the city

that you were eligible to gain entrance into. My father had been an electronics technician, engineer, and I was following in his footsteps, and Samuel Gompers was one of two schools that offered a major in electronics, so I went there.

So I started at Columbia in 1965 and was there until October of 1966, when I was drafted into the armed forces, into the U.S. Army, and continued my health care orientation by becoming a combat medic, infantry medic, in the Army and served for a year in Kansas, at Fort Riley, Kansas, and then a year in Vietnam.

Mullan: What was that like?

Toney: Difficult, to say the least. I was with a combat unit, the 9th Infantry Division, and our area of operation was everything south of Saigon in the Mekong Delta, so we had from Saigon to the South China Sea, which is the tip of Vietnam. I served in support of a combat engineering group, a regular infantry unit, as well as a mechanized infantry unit. So I was in the field for the duration of my time there, with the exception of about two weeks. I learned a lot of medicine, as one can imagine, and really enjoyed being a medic. I didn't enjoy the war in terms of being there, but if I had to be there, at least I felt I was doing something that was life-supporting, rather than life-taking.

I came back out of the service, came back from Vietnam in 1968.

Mullan: Let me follow that up for a second. Did you see much combat?

Toney: Yes. As I said, I was in for a year, and I was in the field for ten months and two weeks out of my year tour, and we were in an area that saw a lot of action. I was there during the Tet Offensive, for example, and we did a lot of support work for some of the other units in the Mekong Delta and central highlands. So it was a fairly busy time to be there and a fairly busy area to be in.

Mullan: How did you feel about your training and your positioning vis-a-vis what you had to cope with clinically?

Toney: I actually, interestingly enough, thought that my training was superb. During the time that I really went in the service, Vietnam obviously was already under way and had been for a few years, and medics were being killed at a fairly high rate. Medics had the third shortest life expectancy in the war, behind officers and radio operators.

Mullan: Was it that they were targeted?

Toney: Yes. The basic philosophy from the enemy was that you try to identify the officer and kill him and disrupt the leadership. You then try to find the radio operator and kill or wound him to disrupt communication, and then try to find the

medic to kill or injure him to disrupt their ability to take care of the other wounded. So it got to a point--even at that point, and we're talking 1966-67--that the need for medics had gotten so great that they set up satellite training centers for medics around the country. Most medics prior to that had been trained at Fort Sam Houston in Texas, but when I went in, I was trained as a medic at Fort Riley, Kansas, at one of the satellite settings, and the people who were doing the training were senior non-commissioned officers who had already served not only in Korea, but most recently in Vietnam.

So the training that I had was really focused on the type of situation that I was going to find myself in, and it was clear that if you were a medic, you were going to Vietnam. So I thought the training was excellent. Being a front-line individual, in terms of my role, certainly under combat conditions, was to stabilize, to the best of my ability, patients and get them medevaced out to more sophisticated medical care, and I thought both the equipment and the support that I had to do that was excellent. In a combat situation, dealing with those kinds of circumstances as a medic, you really become the senior person in that scenario, and so what you say goes in terms of your decisions. If you say you need someone medevaced out and this is what you need, the company commanders, the local commanders, are bound to honor that to the best of their ability. So while casualties obviously were high because of the circumstances, I felt that I was well trained. I thought we did

a good job, and I thought those of us that were out in the field saved a lot of lives that otherwise would have been lost.

Mullan: How did that role contrast with your noncombatant role the year you were in Kansas where, I presume, you did more on the order of sick call and--

Toney: Right. In Kansas, once I completed my medic training, I was assigned to Irwin Army Hospital, which was the base hospital at Fort Riley, and as a medic there, the role that you had basically was the same role I had had as an orderly prior to coming into the service. So it was a much more defined and much more limiting role in terms of what you got to do.

Mullan: And one that you did not, from a clinical perspective feel the same about? Which did you like better as a role?

Toney: Well, certainly, while no one wants to go into a combat situation, you're trained to this level of skill and decision-making from a very pragmatic and practical perspective, and you've got those skills and knowledge, and you want to be able to use them. At that time stateside you could not, and in a combat situation, obviously, that was everything that was brought to the forefront for review. So from a perspective of using my skills and my knowledge, the combat situation in Vietnam was clearly preferable to what I had to look forward to stateside.

Mullan: So you were fortunate to come out unhurt?

Toney: Reasonably. I was wounded once.

Mullan: Badly?

Toney: Not too bad. I received a wound from a rifle grenade, shrapnel wound in my leg and knee. So, some chronic bursitis and osteoarthritis problems.

Mullan: Did you go back to the field after that, or did you come home after that?

Toney: No. I was removed from the field for about a week for treatment and convalescence and then reassigned to the field.

Mullan: Alas and alack, at the end of a year, you got to come home?

Toney: Yes.

Mullan: What happened at that point?

Toney: Because it was so close to my discharge date, I was within ninety days of what would have been my discharge date, I got an early discharge out of the service, and returned back to New York as a civilian and took a few months off, but then went

back to work at Columbia Presbyterian, essentially in my old job, did that for a while, found it to be somewhat frustrating.

Mullan: As what?

Toney: As an orderly, and at that point I was working on a general medicine service in the hospital. I left Columbia and went to New York Hospital for a brief stint at the Payne-Whitney Psychiatric Clinic, again basically as a psychiatric aide, which is another name for orderly. Didn't find that to be particularly rewarding either, particularly with the level of knowledge and experience that I brought back from my military experience. So in 1968, '69, I left health care altogether.

Mullan: At that point there were no programs that would allow you to pyramid your new knowledge into a new career?

Toney: The only one that was around at that point had started a few years earlier was the physician's assistant started by Dr. Eugene Stead, at Duke University, in 1965.

Mullan: That was in existence, but that was the only one?

Toney: No, there were a few other programs around. In fact, when I was in Vietnam, my old head nurse from Columbia had written me and sent me an article that she had found about this new profession and felt that it would be something I should look

into, should I decide not to go into medicine. She had been urging me to go to medical school. But I really wasn't ready to do something like that. So I left medicine in 1969 and took a totally different direction and went into aviation maintenance for a while and worked at Pan American Airways at Kennedy Airport as an avionics technician for a few years.

Mullan: How did you learn the skills?

Toney: From high school, actually, when I was majoring in electronics. Then after I graduated from high school, I went to night school and got a broadcast engineering license from the Federal Communications Commission. So I had this training and license that had been sitting in my drawer for about five years that I had never thought I would ever use.

Mullan: What had your thinking been about further education either at just a standard collegiate level or in terms of nursing?

Toney: I was very ambivalent. I wanted to do more, but I didn't know what I wanted to do, and I just didn't want to go back to school for the sake of going back without some legitimate direction, clear direction. So I basically put that whole issue on hold for a number of years.

Mullan: In terms of impediments, as you saw them there, was it academics? Was it finance? Was it uncertainty? As somebody who clearly had academic achievement under their belt and capabilities, clearly had career-type interest, what held you back?

Toney: I think it was a combination of all three. First and foremost, I think, was a lack of clarity on my own part in terms of what is it that I wanted to do, which direction did I want to take, but I was also keenly aware, having come out of a blue-collar background, and if I went to college for whatever reason, I was going to be the first in my family to ever go to college, and it was going to be an issue of my paying my own way or my parents trying to support the effort in some very meager way, so there was that pressure on me from myself to not just do this in a flippant way. So if I was going to go, I needed to be clear about why I was going and then address the other barriers such as cost.

The other issue was, to a degree, academics, in that I'd been an average student in school, did well in some subjects and not so well in others, and it was very competitive to get into college at that point. It was right around the time that open enrollment was being tried as a model for encouraging people to go to higher education at a college and university level in New York, and, in fact, it was open enrollment that, when I ultimately decided to go, that got me admitted into college. But mostly it was my lack of clarity for myself.

Mullan: You tried avionics?

Toney: Yes and I loved it, but then got caught in what we now call downsizing and was part of about four thousand guys laid off in 1970, in December of '70, and so I went back to Columbia Presbyterian yet again, partially because I knew I could get a job, but also because I really missed health care. Airplanes are fun, but they're not people.

Mullan: How about the wages?

Toney: When I went back to the hospital, I think I was probably making about $65 a week. I think that was the most I ever made.

Mullan: Compared to the avionics?

Toney: Oh, the avionics, I was making a small fortune. They paid very well in terms of union negotiated wages, plus they had overtime benefits that could make you close to wealthy, in a relative sense. So it was a real gap in my income, but it really put me in a better place in terms of what I wanted to do.

So I went back in '70 and ended up initially going back to the general medical service position but then being asked to take a position in the cardiac intensive care unit for a new type of position that they had defined that they were calling a technical nursing aide, which means I got to do a bit more than the usual bedside nursing functions. At that time, Columbia was just

getting into doing some clinical experimentations with things like the intra-aortic balloon pump, and I got involved in working with that, with the cardiac and basic teams and so forth. So it gave me a chance to somewhat go back to a skills level, albeit a technical one, that was a bit closer to what I had been doing in the military.

I did that for about four years, working in the cardiac ICU, loved it, but began to realize that this was pretty dead end, "I'm not going to do this forever," and that didn't feel very good. So I began to rethink my options and look at nursing school, look at medical school, and it was at that point that I also remembered about the PA profession. The PA profession was actually my third choice after looking at medical school and after looking at nursing school. I decided I thought at that point in time of my life in terms of who I was and what I wanted, that the PA profession actually held the most promise for me.

So it was at that point that I applied for entrance to college and to go to undergraduate school in preparation for applying to PA school.

Mullan: Had you known any PAs at that point?

Toney: No.

Mullan: Except for your knowledge that the programs existed?

Toney: Exactly.

Mullan: And now were more than the Duke program, a few more?

Toney: Yes.

Mullan: We're talking 1974?

Toney: '74, '75. There were a fair number of programs around. I basically had made the decision based on the recommendation of my old head nurse, who I trusted explicitly. She said it was a good profession. She thought that it had a real future. Her father had been John Loeb, coauthored Cecil and Loeb Textbook of Medicine. So she knew Eugene Stead and she knew the people at Duke, and she said, "You really need to do this, and if you want to do it, you need to go to Duke." And so that was where I set my sights.

Mullan: But you needed to get some undergraduate work.

Toney: Right. Because I had no college, and you needed to come in basically as a transfer student into the program. So I applied for enrollment at City College of New York. I also ended up being a biology-psychology double major. I did two years at City College, and then applied for entrance to a PA program. Interestingly enough, I applied to, I think it was ten programs, and got rejected without even an interview at eight out of the ten, which was rather devastating. The only two programs that I

got an interview for, which were the two programs I got accepted to, was George Washington University and Duke University.

Mullan: Pretty substantial programs.

Toney: Yes.

Mullan: How did you find the City College years? Was it tough? Was it good?

Toney: I loved it. They were tough, and I don't want that to sound arrogant. They were challenging, but I love learning, and I love education, so to have the opportunity to sit in a classroom and learn philosophy and learn economics and learn this and that was absolutely wonderful to me. What I found tough about it was because I was paying my own way, so I was working full-time and going to school full-time and studying on the subways in between. That was the tough part.

Mullan: So you decided to accept Duke, I presume?

Toney: Yes.

Mullan: Other than that, what was it like?

Toney: Well, both programs are excellent. When I went to Duke to interview, they took me on the tour of the campus, and I

looked at the Duke campus, it was like every university I'd ever seen in any movie. It was so beautiful, and you could just feel the education. And then meeting the faculty at the PA program and the medical school faculty that were involved with the interview process, I was so impressed, and I was so impressed with the quality of the other applicants that it more than exceeded my possible expectations, and I felt there was no chance in the world I'd ever get in there, considering the competition I was up against. So it was no contest. If they were going to take me, I was definitely going to go.

Mullan: And they took you?

Toney: And they took me.

Mullan: And you went.

Toney: I went.

Mullan: What was it like?

Toney: It was the hardest two years of my life, without a doubt. I almost didn't make it the first year. I went in there being what I thought was very self-confident, to the point of probably a bit of arrogance in what I could do, and the amount of work and the quality of--and the level that they expected, demanded, began quickly to wear away both at my self-confidence and certainly my

arrogance. So by the end of the first year--and at that time you did a nine-month didactic and then a fifteen-month clinical--I was physically and emotionally exhausted and absolutely drained of self-confidence to the point that when finals came, I decided I had made a terrible decision and I could not do this and that I was going to leave. Fortunately for me, the faculty, who were superb at that time, and still are, intervened and did some wonderful crisis intervention and helped me get through that, because I was going to leave, and helped me transition successfully into the second year.

Once I got into the second year, which put you back out on the clinical clerkships, I basically was back in my element, if you will, in terms of being with patients and doing the things I knew I knew how to do, and I really blossomed. So I went from almost failing out, flunking out, walking away, if you will, at the end of the first year to graduating as the outstanding student in my graduating class in 1979 and being awarded the Sheeley Award as an outstanding student. It's somewhere around here. In any event, it was very, very difficult, but it was extraordinarily demanding and I loved it, and when I graduated, I was absolutely convinced that to be a PA was the greatest thing to be, and to be a Duke PA was to be the greatest PA of all.

Mullan: Tell me a little more about the substance of academic life and like in general at Duke in those years. How large a class?

Toney: We had a class of forty, which they took that size up until very recently. I think they went to fifty, but for most of the seventies and eighties, they maintained a class of forty.

Mullan: Men? Women?

Toney: At that time that I was there, it was about 65/35 in favor of men, with many of us coming out of the military.

Mullan: What percent might have had military medic background?

Toney: Probably about 50 percent of the men had either military background, which included in most cases, though not all cases, combat experience, and the others tended to be people who had had significant civilian experience at top levels of being paramedics, particularly full-time paid paramedics coming out of big urban cities. So people that had seen a lot, done a lot, but we also had pharmacists, nurses, a real array of individuals.

The curriculum, both the didactic and clinical curriculum, was very tied into med school, so the medical school community teaching faculty, from the attendings down to the house, they had a lot of input. The standard that you were held to, both didactically and particularly clinically, was the same standard as the Duke Medical School. So there was no such thing as, "Well, I don't need to know that," or, "You don't need to know that because you're a PA." The philosophy of the program at Duke, which is certainly the case in most, if not all, programs,

is to teach from a very applied practical model. But within that framework, the material that they taught and what you were responsible for, you were held accountable to the same level. So congestive heart failure was taught the same way at Duke to the PA students as it is to medical students and residents.

When you were on clinical rotations, you were expected to pull your full weight in terms of functioning as a team member on your team, whether it was either in-patient or community-based practice, and whatever your team did and for how long they did it in terms of the hours and responsibility, you were expected to do. So you were fully integrated in, and there was no difference. The PA students at Duke were seen analogous to the second-year medical students, because at Duke the second-year medical students did their initial clinical rotations in their second year, and then they did their advance rotations and electives in the fourth year. So you were seen as on par with second-year medical students.

Mullan: What was life like in North Carolina? This is the first time you had gone South?

Toney: I'd never been in the south, up until that point, except for one brief week in South Carolina I'd never been further south than Philadelphia, because my father came from Philadelphia and my mother came from New Jersey. We had a very small family. I was petrified about going to the South, for obvious reasons, in terms of the potential for racial issues, and I ran into that on

occasion, but, to my surprise, I actually found being in the South a very positive experience in that, one, people were far more honest in the South than in the North. They let you know where they stood in terms of their feelings and attitudes, whether they were positive or negative. You didn't have to guess. But I also found that there was a much greater sense of community, and particularly amongst the black community in the South, because of the tradition of black community in the South. So that even coming as a stranger with no family, no roots, no connection to Durham, North Carolina, or North Carolina as a state, I was embraced as a member of the community and got a lot of informal support, which was very, very helpful. So I enjoyed my time there, and only on very rare occasions had anything come up that spoke to the negative side of the racial situation within the South.

Mullan: So what happened next?

Toney: I graduated in 1979, and then I came to Maine. I had applied for and had been accepted into a brand-new residency program in emergency medicine that was based at the Maine Medical Center in Portland, Maine, and I was in the charter class for that residency program. It was a one-year residency for PAs that had been started as a model pilot project under the sponsorship of Robert Woods Johnson Foundation.

Mullan: How was coming to Maine?

Toney: It was extraordinary. I had never been north of New York before. So everything was new, and when I came up here to interview, there were four of us four of us from Duke that were invited for interviews, and three of us drove up from Durham, North Carolina, together. So I got to camp out in the green mountains of Vermont, which was something I'd never done before in terms of camping. And then when I arrived in Maine, I just thought it was absolutely beautiful and that the people were extraordinary, and it was probably the quietest place in America I'd ever been, and you could walk around and the quiet, the silence, was deafening. So I was really looking forward to it.

Again, I didn't think I was going to be accepted into the residency. It was very, very competitive, and particularly with four of us applying from Duke, or getting invited from Duke, I figured my chances were nil, but there were two of us selected from Duke, and fortunately I was one of the two. My best friend from Duke turned out to be the other.

So we came, and I went through the residency, which was a very, very challenging program. It was an excellent program that Maine Medic put together, and I did part of my training in Portland at two of the hospitals there and then rotated around the state at four other hospitals. So I got to learn a lot about the state. I got to learn a lot of good emergency medicine from some excellent preceptors, and got a bit of social education, because there aren't very many blacks in Maine. During that time it seemed as if I met and treated most of them, because they would hear about this black doctor or PA or something that was in

the emergency room, and people would come to see who I was. I would go to an area, as I did in Scowkegan, Maine, where there hadn't been a black living in that area for over a generation, so families would come in and particularly bring their kids in so that they could see and meet a real black person.

Mullan: Black families?

Toney: No. No. White families. Because their children had never seen a black except on TV or playing basketball. So that was fairly interesting for a guy from New York to sit there and explain to people in Scowkegan, Maine, why black people can jump so high in basketball. But everyone was very, very accommodating and very welcoming wherever I went. So socially it was a wonderful experience, and educationally it was a superb program.

Mullan: And from there you didn't stay in Maine, though?

Toney: I did not stay in Maine. My plans were to stay in Maine. In fact, when I came out of the residency, I had been offered a contract, along with one of the other fellows in the residency, one of my colleagues, to staff a small ER in Gardner, Maine, which is just outside of Augusta, just about an hour north of Portland. But at that time, my wife, who was a registered nurse and had been a registered nurse for about twelve years, decided that she wanted to go back to school and become a PA.

Mullan: Let's drop back and pick that up a little bit. Tell me about your life outside of medicine.

Toney: I have been married twice. I was initially married when I first came back from Vietnam. I came back from Vietnam in August of 1968 and met someone who I eventually married in the spring of 1969, and we were married for about seven years all told, and subsequently got divorced, found out that we were better friends than we were husband and wife, and have remained very good friends over the years.

Mullan: Kids?

Toney: Had one child as a result of the first marriage, who, unfortunately died shortly after birth from hyomembrane disease. That was the only child from the marriage.

Met my current wife in 1971, and we dated for a number of years and got married in 1978 while I was a second-year student at Duke. In fact, we got married in between my internal medicine and general surgery rotations.

Mullan: She was a nurse?

Toney: Yes. She was a nurse. She had graduated in 1970 from Georgetown University, and we've been together ever since.

Mullan: Got any kids?

Toney: No. Our careers have kind of driven our lives in toto, and we also figured after spending a fair amount of time together that we were probably kid enough for both of us. So we've never had children.

Mullan: So as you contemplated what to do next after Maine Medical Center Emergency Medicine Program, her career dictated maybe a different direction?

Toney: Yes. She was very committed to clinical care and had done basically everything in clinical nursing that she could do, and she loved patient care. She did not want to get into administration or teaching in nursing, and she also wanted to be able to do more as a clinician. So she initially looked at becoming a nurse practitioner, which was an obvious possibility for her, and she ultimately decided that while that offered some opportunities, that based on what she had seen watching me go through both PA school and residency and what I was about to do in terms of going into practice, that being a PA appealed to her more in terms of the level of knowledge and the level of responsibility. So she decided she wanted to go to PA school.

So she dragged me, kicking and screaming, out of Maine, not because I didn't support her decision, but because I didn't want to leave Maine. She ultimately decided to go to Duke as well, and we went back to North Carolina. She was admitted into the program, and I was invited to join the faculty within the Department of Community and Family Medicine at the medical

school. So I taught in the PA program, and I also was part of the attending staff within the department that had clinical responsibilities at the Duke Family Medicine Center for some patients, and as part of those faculty responsibilities, I precepted second-year medical students and occasionally first-year family practice residents. So I was on the faculty at Duke within the department for four years.

Mullan: How was that, precepting particularly medical students and residents? Were there stresses or strains there or not?

Toney: There were really very little, at least from my perspective, and I believe that was the case because of the Duke PA program and PAs at Duke on staff were so well ingrained, both historically and in terms of the actual operation, that the medical students and the residents saw it was a natural relationship. The Duke PA program had emphasized to all of its students that when you go on rotations that, as a PA student, you bring certain things to that process, and that one of the ways you get ahead is by bartering, if you will, what you bring with what other learners bring, and they really encouraged us to collaborate and partner with the medical students and occasionally even with the interns in terms of the kinds of skills and knowledge that we had. What we generally brought to it was either a lot of technical skill and/or a lot of practical experience. What the medical students and house staff had, obviously, were a lot of in-depth theoretical knowledge. And so,

you know, "I'll teach you how to start an IV if you'll help me understand acid-base balance a bit better." So that really everybody kind of grew up that way at Duke, so that when you achieved the level of faculty status, the medical students understood who you were and what you were, and the residents, many of them having come up through the Duke system, also understood that. So it was fairly well received, and it then became an issue of your own individual competency as a clinician and as a teacher.

Mullan: So you were four years there in these multiple capacities?

Toney: Yes.

Mullan: A teacher, a preceptor. Any research?

Toney: No. At the time, our chairman, Dr. Harvey Estes, who was a wonderful, wonderful man and has remained one of my mentors over the years, really saw--I mean, not that he devalued research, but he saw education and service, particularly in the area of primary care and family medicine, as where he wanted to drive that department. So he felt that he had enough other people doing various kinds of research, including some of the senior faculty, for example, within the PA program, but he wanted those of us who were junior faculty members to teach and spread the mission, if you will, of primary care and also to establish,

to the best of our collective abilities, the Duke presence as a deliverer of primary care services. Historically, Duke, as you well know, has been seen, and is still seen, as a major tertiary research center. Dr. Estes wanted to enhance the presence of Duke as a primary care center.

Mullan: That was the thrust?

Toney: Right. That kind of thinking, particularly in that kind of institution, was very cutting edge, and, in retrospect, way ahead of its time, in terms of talking about the early eighties and having someone in that context and environment saying, "We need to really move forward the institution of primary care."

Mullan: What was your own thinking on primary care? Was the term, at this point, early eighties, being used, and what was your sense of the distinction between primary care or whatever you called it, and specialty care, particularly since PAs statistically have become more specialized over the years? What was going on then?

Toney: Well, from a philosophical and certainly in terms of our training as PAs, the programs were modeled around generalist primary care so that right from the inception of coming into the program, that was seen as an institutional and professional goal, and that held true despite the fact that, as you correctly said, more and more PAs, particularly through the seventies and

eighties, ended up being recruited into specialty settings, but the educational programs maintained their philosophy and commitment to primary care. So I would say, as a PA, even trained at an institution such as Duke, that I or any typical PA was far more aware of and sensitive to primary care and the issues than a typical medical student or resident, who were being put through a system at Duke that was almost exclusively specialty-oriented.

What happened when people got out of school, and many of them had a legitimate interest in a variety of specialty areas, but often what happened was because of where the job market was, that even those who wanted to go into primary care couldn't find it where they wanted it or couldn't find it at a salary level that allowed them to go into practice and pay off their educational indebtedness and so forth.

Mullan: It was the market that tended to pull PAs--

Toney: Yes. The market was a significant influence, and we did a lot of counseling for graduates going out, and time and time again we would hear people say, "I really want to go into primary care," or, "I really would like to go to a rural area, but either I can't find the job or I've got all this debt and they're paying this amount over here in this surgery practice, or this cardiology practice is willing to pay me this and I've got a family to support," because, as you know, many of the PAs

represent adult learners who came with adult responsibilities, including family responsibilities.

Mullan: At the risk of jumping of ahead in our story, if you look in the early to mid-nineties at the environment surrounding the PA profession and academic PA programs, had that changed from what you experienced at Duke and what existed in the early eighties?

Toney: Not really. I mean, the philosophy of the programs, the vast majority of programs that have come on line in the past two decades has maintained its commitment to primary care. What has changed and then changed back again is over the years some of the programs under operation began to, out of necessity, dilute to a bit the actual clinical experience so that students ended up taking more specialty rotations than primary care-oriented rotations because of, again, looking ahead at the marketplace and also looking at what was available, because there was a real limiting factor on the number of primary care, particularly community-based primary care, preceptorships and rotation opportunities available for a program, and most programs have very limited resources in terms of how far afield they can send their students for their training. What has happened with the nineties and the reemergence or, in some cases, the emergence of primary care as a policy/service/delivery/educational/focal point is that the PA programs are now able to refocus their resources and their energy and be able to sell primary care to their

students and be able to negotiate more clinical training opportunities. But throughout the twenty or thirty years that we're talking about here, with the exception of programs that were established as specialty programs such as Surgeon's Assistant Program at the University of Alabama, the vast majority of PA programs saw themselves and attempted to the best of their ability to train their students as generalists, with the hopes that the majority of those students would go into one of the primary care disciplines with a focus of primary care.

Mullan: Would it be fair to say that changes in the market with more primary care opportunity brought the focus back a little more to generalism than it had been through the mid- and late eighties?

Toney: Yes, focus back to the programs and, more importantly, has made the concept once again attractive to the students.

Mullan: Why don't we turn the tape over.

[Begin Tape 1, Side 2]

Mullan: This is Carl Toney, side two of tape one.

You continued on South in 1984, I believe?

Toney: Yes, and it was in following my wife's career. She graduated from Duke in 1982, and after graduating, she was trying

to decide for herself what type of practice she wanted to go into. Initially she had thought about going into surgery, but decided that she didn't want to do that and instead wanted to go into obstetrics and gynecology. So in 1983, she moved to Atlanta to accept a position at Grady Hospital, which is the single public hospital in Atlanta. Atlanta at that time had forty-six hospitals; forty-five were private. Grady Hospital was the only true public hospital. So she accepted a position there as the first PA in their OB/GYN emergency room at Grady Hospital.

I stayed on at Duke for another year to finish out my teaching contract and then moved to Atlanta to join my wife. At that time I was invited to join the faculty at Emory University within the Department of Community and Family Medicine there. My responsibilities there were 100 percent with the PA program, primarily working on two federal grant projects that they had gotten funded for. One was the development of a preventive medicine curricula and text, and the other was a minority recruitment initiative that they were trying. Both projects were being tried at the PA program with the hopes that if successful, they could then be possibly incorporated into the medical school.

So I came on board at Emory in March of 1984 and stayed until the projects were completed, until the end of June 1986. I also did some teaching within the program and some other administrative responsibilities as well.

Mullan: Why pilot a medical student curriculum with PAs?

Toney: Well, it's kind of like the old commercial, "Let Mikey try it. Mikey will try anything." PA programs historically and out of necessity have often been willing to try new approaches to education, mostly because they were always facing the battle of limited resources, limited time, and therefore being driven to find a better way to enhance the educational process. I think the medical school saw it as something that was of value to them because they recognized that the PA program overall educational process was analogous enough to the medical school experience that if a particular portion of the curriculum could be successfully developed for this group of learners that were ultimately going to become clinicians and providers, then with possibly some minor changes it might also prove to be of value to the medical school at large. That's been very common around the country at various places.

We worked on the preventive medicine piece and developed a text, a programmed text, that I thought was very good, that, as far as I know, was incorporated into the PA program curriculum, and I'm not sure whether it was ever incorporated at least in the form that we developed within the medical school curriculum, because we completed the project and I moved on, and I'm not sure whether the medical school ever took it on, but I would say that what we developed people were very pleased with at both the PA program level, the federal level, and those people at the medical school who had been involved were pleased.

Mullan: Let me ask a question I should have asked earlier about financing PA training. How did you pay for your two years at Duke and, as you have looked at over the years at Duke, Emory, and elsewhere, how much is individual funding? What other sources is money coming from?

Toney: Well, I paid for my education through student loans that I negotiated through Duke University, from national loans and other funds and Duke-oriented funds. I also had some support through the Veterans Administration in terms of their educational benefits for veterans. And then the rest I tried as best I could to pay out of pocket, but I came out of school with about ten years' worth of debt. It wasn't a lot of debt relative to what we're talking about now, but it was still significant for me. And I think that that's true of most students. Most students come with a combination of a bit of personal resources, never a whole lot, because they, again, as I said earlier, tend to have family responsibilities. But they come with a bit of personal resources and then finance their education through either institutional loans or governmental or private loans.

One of the things that has been increasingly more helpful, which was either not available when I was a student or certainly we were not aware of when I was a student, was the support from sources such as the National Health Services Corps. So we see now a lot more students using that either through the scholarship program at the front end or through the federal loan repayment programs or federal/state partnership repayment programs in terms

of paying off indebtedness, which really makes a significant difference, both in terms of people who can attend school and what kinds of decisions they make in terms of where they want to practice afterwards. If they know that they don't have that indebtedness on their back, then they have the opportunity to follow what may be their first choice.

Mullan: What is the tuition nowadays at PA schools?

Toney: I believe at Duke it's probably around $35,000 a year.

Mullan: So it's like medical school?

Toney: Yes. It closed the gap, unfortunately. But there's a real spread in terms of some schools are still twelve, fifteen hundred or two thousand dollars a year, particularly at the public schools. If you look at Medical College of Georgia, for example, which is publicly supported, their tuition is a half of or possibly even a third of what it costs to go to Emory. So where the difference really comes is whether it's a public institution versus private.

Mullan: While we're on the subject of finance, the federal government has had a program to support PA schools almost from the beginning. What sort of role has that played in the growth of the profession?

Toney: Without that support, there would not be a PA profession. It's as simple as that. I mean, the early programs such as Duke and a few others got some additional funding from private foundations such as Kellogg and Robert Woods Johnson and Josiah Macy [phonetic] and some of the others, but the real truth is that they face having to convince their own parent institutions that this was a viable investment, and dollars are always scarce. So had the federal government not stepped in, particularly at the level it did in 1971 through the [Richard M.] Nixon Administration with a comprehensive health education bill that covered PAs and established family practice and nursing and so forth, I don't think that either the educational component or the profession as a whole would be where it is today, because virtually every program, including the first programs such as Duke, were dependent at some point on those federal funds to either establish and/or maintain the programs.

Some programs such as Duke were fortunate that they quickly developed a significant amount of in-house institutional funding so that they could begin to come off of federal support, but other programs, because of a lack of local resources, have had to maintain a close association with the federal government. So I think that's been critical.

The other piece that people tend to forget about that that I also think is as critical, outside of just the support, has been the direction and guidance around how the professions should evolve or what kinds of things should be looked at as priorities. Often the Bureau of Health Professions has, through its own

initiatives, established priorities that they would like to see the educational programs address, whether it be HIV/AIDS, whether it be prevention, whether it be geriatrics, as part of the process of receiving federal support, and I think that that has been very good for programs because often it raised issues for programs that programs otherwise would not have raised for themselves as issues that they wanted to incorporate, including allowing those programs to turn to their parent institutions, who may have had little or no interest in these areas, and say, "We need to do this because it's part of our grant requirements." I think that that has helped in introducing issues and addressing how to educationally address those issues at one level and for one group of learners, but again through cross-pollinization, institutionally and individually, then it helps get spread to other learners. So I think that that has been a part of the relationship between the federal government and the educational programs that I think people don't really appreciate to the level that they should.

Mullan: You mentioned HIV and underserved.

Toney: HIV, underserved areas, prevention, geriatrics. PA programs were involved in trying to develop a geriatric curriculum at that level way ahead of where most medical schools were, as far as I'm aware of, in terms of legitimately trying to incorporate that into the initial undergraduate medical training experience.

Mullan: But with apologies for weaving in and out of your story and the policy issues, you've done a couple years now at Emory, a year and a half. What happens next?

Toney: I finished up the projects at Emory, and so I was there for two years, and I decided that I'd had enough of academia. I had been in academia now for six and a half years, and I had enjoyed it, but I thought it was time to move on to other things. So I went back into full-time clinical practice in Atlanta with an internist, a general internist, and we were doing a combination of general internal medicine, occupational health, and geriatrics.

Mullan: How was that?

Toney: Overwhelming. We had a very, very large practice, and the physician I was in practice with had partners that they shared call with, but for all intents and purposes, he was really operating as a solo practitioner. We had three offices that we had to cover. We had, at our height or our depth, depending on how one looks at it, in terms of our geriatric responsibilities, we had a geriatric patient census of five hundred patients that was spread out in five nursing homes across the breadth of Atlanta, and plus we had patients in the hospital that he admitted through his general practice. So it was challenging and exhausting.

Mullan: How did you pick him, and how'd he pick you?

Toney: I was looking for something in primary care and community based and, obviously, in Atlanta. I had heard through some colleagues of mine--well, he was practicing at Piedmont Hospital, which is one of the community hospitals in Atlanta, but it's also affiliated with Emory as a teaching site for Emory folks, and I'd heard through some of my colleagues that he was looking. He had been well established. He was an older physician when I met him. He had just turned sixty, had been practicing in Atlanta for some thirty years, and the connection that we ultimately had that led to my joining his practice--because we were very different. He was white; I'm black. He was from the South; I was from the North. He's a capitalist and a conservative; I'm a socialist bordering on being a Marxist. But the two points that we intersected was that he had done some of his training at Columbia in New York. Most importantly, as it turned out, we both had trained under Dr. Stead at Duke. Dr. Wiggins had gone through medical school at Emory, but had done part of his internship and residency at Duke and had trained under Dr. Stead. And that, I think, is what convinced him. I can remember at the interview, he said that since we both had survived training under Dr. Stead, that said a lot about both of us, and if I was willing to put up with his capitalist conservative ways, he would try to put up with my radical socialist agenda.

Mullan: And how did it work?

Toney: For four years, it worked pretty well. It worked pretty well. I ultimately left after four years, partially because I just thought that the practice was growing and had grown to a point where morally we were out of control. We couldn't control the responsibilities we had taken on. I was very concerned about that. But at the same time, I was also personally moving in a different direction in that while I love and do love patient care and loved all my patients, I was becoming increasingly frustrated at seemingly being unable to effect any legitimate change in terms of the system and how things were being done in terms of patient care and patient issues, health care issues one patient at a time.

So I began to rethink maybe where I needed to be, and began to come to the conclusion that I needed to--at least I thought I needed and wanted to move into an area of health policy and planning. So I think I was kind of coming to a closure all on my own about my own life's activities at that point in time.

Mullan: Did you enjoy clinical practice?

Toney: I enjoyed it a lot in terms of the patient contact. What I discovered, after spending all this time in health care, going all the way back to 1965 to now, 1990, was that what I enjoyed was the patient contact, that medicine in terms of a biological science bored me. I mean, to pick up an issue of the *New England Journal*, while I recognized it was important and relevant, bored me. On the other hand, if I picked up a copy of the *American*

Journal of Public Health and read it or similar-type journals that talked about the issues around health care, including clinical issues but from a very different perspective, that really intrigued me. So I realized after all these years that maybe it was wasn't medicine that so enthralled me as health care.

Mullan: And therefore what did you do?

Toney: What I did was I went back to school at that point at Georgia State University and got a bachelor's degree in political science with a minor in economics. When I had graduated from Duke, I had not received my degree from Duke because I had been sixteen credits short of being degree-eligible. At the time I didn't think that was a problem, and I would just stay at Duke for an extra semester and do advanced basket-weaving. I needed some credits that had nothing to do with my professional training. But I found to my dismay that the board of trustees of Duke had many years previous to my arrival passed a rule that only applied to the PA program, that said that if you did not receive your degree at the time of graduation, you could not receive a retroactive degree from Duke in that discipline. So I was basically locked out of the process.

What I then found was that in trying to go to another institution to get my degree, that I ran into the problem that other institutions didn't know what to do, literally, with how to evaluate the academic credit I had earned at Duke within the PA

program. They knew what physiology was, and they knew what anatomy was. They weren't sure what to do with pulmonary medicine or general surgery. So I would always be told, "Now you're going to have to start all over again," which was totally unacceptable. And it wasn't until I made this decision in Atlanta that I was going to go back to school and change directions that I decided, "Well, I'll try one more time," and I went and spoke with the folks at Georgia State University, explained my situation, brought copies of my transcripts and let them look at them.

Fortunately for me--and it may have just been the person I talked to that particular day, but they said, "We can work with you on this," and worked it out so that they could bring me in as a transfer student and allow me to either continue in my discipline of biology or change disciplines in terms of getting my degree. Since I was interested and knew that I was headed toward health policy and planning, I elected to get a degree in political science with a minor in economics.

Mullan: So you did that while you were in practice?

Toney: Yes.

Mullan: And then?

Toney: I finished up there. I left Dr. Wiggins' practice in 1991 after I finished school and joined the Georgia Department of

Human Resources in what was then their Primary Health Care Section as a health and manpower specialist, and my job there was to be the state liaison with the Bureau of Primary Health Care in the National Health Service Corps around those kinds of primary care state/federal initiatives. That was my initial introduction into health policy and planning.

Mullan: At the federal level?

Toney: Yes.

Mullan: That must have been an interesting time. A lot of National Service Corps assignees in Georgia?

Toney: Yes. It was very active in Georgia in terms of the National Health Service Corps. Plus we were fortunate that the U.S. Public Health Service regional office is based in Atlanta. So we had a lot of very close and ongoing and intimate interaction with the regional office staff, which I think really enhanced my maturity and growth around the issues, because they were very welcoming and were very good teachers in terms of what some of the issues were, but it also allowed us to partner in a way that being located in another state and farther away would not allow you to do. So it was very active.

Georgia's a rural state and has a very large community health center, migrant health center system, as well as it was emerging through the rural health clinics. So there was a lot of

activity that needed to be done around systems development for primary health care services, and we were at the forefront. Shortly after I joined the staff, the issue came up about the creation, the formal creation, of a state Office of Rural Health and who would staff that and where would that be located within state government. Fortunately, at least from my perspective, after a lot of negotiation, the governor decided that it belonged within the Department of Human Resources and that the Primary Care Section that I was currently in would be evolved into and become the state Office of Rural Health. And so it expanded almost overnight, our role and responsibilities and visibility and presence, both at a policy and planning level as well as an operational level. So it was a wonderful, wonderful training ground.

I was the first clinician that they'd ever had within this section, which I found intriguing in terms of making decisions about how you're going to use clinicians. So it was really good, and we had those kind of responsibilities, both urban and rural. At the time that I joined, it was also the time the federal government downloaded the foreign medical graduate situation with the J-1 visa waivers, and that became a state function, and that was immediately turned over by the governor's office to my office. So there were a lot of different--

Mullan: That being that you got the responsibility for deciding--

Toney: For developing the process and working with communities, those communities that wanted to recruit foreign medical graduates to come practice through the J-1 visa labor system.

Mullan: It was a federal waiver, but the state could help?

Toney: The states decided where and when and basically did all the work. All the work up until 1991 had been done at a federal level between the federal agencies and the local community. The federal agencies decided they were being overwhelmed and it made more sense to move the operational level to the state and leave their participation as being the final approval mechanism. So the state agencies became the real broker.

Mullan: How did that dynamic work? Who was pushing and pulling for foreign graduate placements?

Toney: The experience that we had in Georgia initially was not a good one, although I think I need to say that from what I've heard in talking with folks around the country, that our experience did not necessarily represent the norm but possibly more the exception. By that I mean initially we didn't have a lot of interest in this program by communities, and we had to go out and really talk communities into it, and usually they were very, very desperate communities who either could not recruit physicians at all or who could recruit them, but could not retain

them for any reasonable length of time. So then it became a question of finding physicians willing to go there.

There were a lot of physicians who quickly popped up either directly or through representative intermediaries, usually attorneys, because this quickly became a real money-making deal for attorneys, to do these J-1 visas, even though you really didn't need an attorney to do it. So I was inundated with phone calls and faxes and CVs, unsolicited, from people around the country who were trying to find positions.

The problem that we had, at least in the first three years, in the years that I oversaw the program in Georgia, was the way that the program unfortunately was set up at the federal level, and that was that the states were to do all the work, get the match done between the provider and the site. If the provider didn't work out and left or didn't uphold the contract in some way, there were sanctions that could be taken, which included a quarter-of-a-million-dollar fine, possible jail, possible deportation. Well, the first couple of placements that we did, that's exactly what happened. The physician got there and stayed, in two cases, less than sixty days and left. And then we appealed to the federal agencies for support, and then in addressing this, we found very quickly that that support was not forthcoming.

Mullan: That is, support in enforcing the sanctions?

Toney: Enforcing the sanctions.

Mullan: What sort of support were you looking for?

Toney: Well, we were looking for the federal government either to tell this person to come back or to fine them or to deport them, and we saw those as being very important, not so much for that individual, but as a clear lesson to others who may come, to send the word out that you cannot get away with doing this, at least in Georgia.

Where the problem was with the system at that time was the whole labor process was set up so that in order to be able to stay in this country long term, you were going to get a waiver in having to return to your home country and go through two years of service. Well, once you agreed to do that, the Department of Immigration and Naturalization Services gave you your Green Card immediately. Once you had your Green Card, there was no compelling reason to stay, and people would leave. And because the federal government wouldn't enforce the sanctions, it quickly became known through the underground network--and believe me, there is a very, very sophisticated underground network--that you could do this with relative impunity.

So we ran into a couple of major problems where communities who had gotten their hopes really raised around this and rallied around the individual physician as well as the program were just devastated. So in a sense, at least psychologically and emotionally, the community was worse off than they had been. And that made those of us at the state level very, very angry.

Mullan: As far as you've been able to follow it, either in Georgia or here in Maine, for that matter, or generally, has the situation improved any, or is it still a very loose, sloppy system which a lot of people abuse?

Toney: As far as I know, and certainly my experience up until I left Georgia, there was no change at the federal level in terms of their attitude about the program. What seemed to be the case, and it was more serendipity and chance than I think anything anybody was doing, is that as the program evolved and matured, what appeared to be the case, and certainly outside of Georgia and from what I hear since I've left, even within Georgia, that the majority of people that have come through have been honorable people who have been willing to stay at least for the two years of their obligation, and some of them have stayed on beyond that.

Here in Maine, for example, and some other places, they've had wonderful experiences. In West Virginia, from what I have been told from my counterparts there, they had a wonderful experience. I think that we just had an unfortunate series, but it was like the first two or three, maybe even four, placings we did were just horrible. The worst-case scenario was the final case that I dealt with that was a major problem, was receiving a call in my office in Atlanta from the VA in Denver, who wanted a recommendation about this physician who was applying for a position with the Denver VA. And I said, "Gee. You know, I don't know what to tell you. This individual was up in so-and-

so, Georgia, doing primary care. They're not going to even be available for another two years."

And the person said, "Gee, I don't understand that. We're communicating with this person, but we're communicating with them at the University of Alabama in Birmingham."

And once I initiated investigation, what I found out was that this person that we had approved and to the best of our knowledge was providing care in this rural community in Georgia was, in fact, doing an invasive cardiology fellowship at the University of Alabama in Birmingham, and his sponsoring physician was covering for him and lying to both us and the federal government, falsifying reports and so forth. And so I had to go up there as an official state agent representing both the state and federal government and confront this sponsoring physician who, under interrogation, finally broke down and admitted that the whole thing had been a fraud. That was kind of the worst there.

Mullan: Let's move your story forward. In 1993 you decided to come back to Maine.

Toney: My plan had always been to come back to Maine, both for personal and professional reasons, and in 1993 I did a U.S. Public Health Service Primary Care Policy Fellowship within the Bureau of Health Professions, and felt that that experience alone, where it evolved to through my work with the state Office of Rural Health had prepared me to a point where I thought it was

time to move on and it was time to make the move back to Maine if I could find a way to do that and maintain the kinds of interest that I had. My wife was also ready to move back.

So I was fortunate enough, at that point, in the fall of 1993, to relocate back to Maine and to be invited to join state government here with the Bureau of Health as the director of their HIV/STD Prevention Program for the state. They were looking for an individual who had primary care clinical background who also had public health administrative experience and who was a mid-level practitioner. So I thought it was a perfect job, as far as that's concerned.

Mullan: Was it good?

Toney: I really enjoyed it. I had a fantastic staff. I had a staff of about ten people that I inherited, who were absolutely superb. The challenges that I found here were two, one that I knew about and one that I didn't appreciate until I actually came and interviewed for a position. The one challenge I knew about is that the program had been without a full-time director for about three years, so it was basically just treading water and not making a whole lot of headway around either HIV or STD prevention activities here in the state at all. Maine is a state that has a unique challenge in that both HIV and the array of STDs are present here and the numbers are small, even though the percentages and rate of incidence reflect the national perspective, but the absolute numbers are small, and so the

challenge here in Maine was to try to convince communities, people at risk, and policy-makers that this is an issue that Maine desperately needed to deal with. So the good news was you didn't have a lot of HIV and STD in Maine. The bad news was you didn't have a lot of HIV and STD in Maine. So the challenge was to make the case. So that was one challenge that I knew about coming into the position.

The other that I didn't really understand until I interviewed and ultimately got here was that the model was very different from Georgia. The public health system and infrastructure had been a mess. Georgia has 159 counties, second only to Texas in terms of the number of counties, and the public health infrastructure is decentralized and present in every county at every level. So you really had this network that you could maneuver through.

Here in Maine, the public health infrastructure is really the people who sit at the central offices in Augusta. There is no infrastructure here at the community or county level. There are three counties of health departments in the state, and all three of those are located in one of the three "urban cities," and the interface between public health and the local community is actually done through a negotiated interface through the private delivery sector of health care. So it was a totally different model than what I was used to and how I had framed, in anticipation of arriving, what I thought I could, would, and should do.

When I got here I found out, well, tear that up because there's no infrastructure to do that. So what that required then was for me to basically get in my car and spend a lot of time out on the road, particularly in the area of HIV, meeting with infected individuals, meeting with AIDS service organizations and other community groups, meeting with community leaders, meeting with local physicians and other service delivery folks to, one, explain the issue and help local communities to kind of figure out where they're at around the issue and what their needs may be, and also explain what public health is and what the public health mission is around this issue. It's that, "I'm from the state and I'm here to help you," type thing.

But it was a wonderful, wonderful experience, and it was an exciting time to be here, because a lot of things were coming together from various corners around HIV with new initiatives, some of them federally sponsored, others locally sponsored. So public health had an opportunity to really be a broker and a presence in pulling private-sector initiatives and federal new initiatives together and begin to weave together public-private partnerships.

Mullan: You described once before how the demography of Maine, where there are very few blacks. As a state official trying to work across the state, how were you received?

Toney: I had a wonderful time for two reasons, and I'm laughing because both of them would seem to be liabilities, but they

actually proved to be assets. To the best of my knowledge, at that time I was the only black in all of state government and had been only the second black ever in the state government other than one other elected official state representative. So even though I did not inherently have a high-profile position in the structure of state government, everybody knew who I was. They didn't know my name, but if you ever asked where I was, "He's the black guy."

"Oh, I know who he is. Okay."

So that really helped because people knew who I was, and people within state government and outside of state government were very receptive. The issue of my being black was not an issue at all. What really was an issue for people and what people struggled with when I met them was how could I have lived in Maine before and left? That's the part they didn't understand, not that I was black.

The other thing that proved to be a real asset, my philosophy is I really think you've got to get out. Whatever the issues are, you've got to go where the issue is located. You can't do it long distance. You can't do it by phone. I'm an old throwback. I mean, I know computers are here and interactive TV are here, but I still feel like I need to go look you in the eye, hear what you have to say, see what's really going on. And so when I went places, people were shocked, because since there was no infrastructure, they very rarely saw anybody from state government, and particularly anybody representing public health. They knew there's an 800 number you could call up and get

information about this issue or this problem, but to actually have somebody come up in the community and say, "I want to sit down and hear what you have to say about this situation," they were literally amazed. So my willingness to do that, out of survival, more than anything else, from my perspective, really afforded me and, by extension, therefore, the program, which is really the important thing, a lot of credibility and a lot of renewed visibility. And all of a sudden people began to understand and appreciate, some for the first time, that there even was such a program in Maine.

And in Maine, unfortunately, like many states and many governmental entities, had split the process. So there was one part of state government that was doing AIDS and STD prevention work, and then there was a total separate part of state government doing Ryan White service delivery work, and there was absolutely no communication between the two. And often, people who had difficulty or problems with the Ryan White side for one reason or another, assumed, since it was all the same and that they heard about this other public health HIV office, they assumed that was the people who were giving them problems. So you either had to run up against people not knowing who you were or misunderstanding who you were.

Mullan: In 1994, end of the year, you moved back to academia. Why?

Toney: When I took the position at the state with the Bureau of Health as AIDS director, I came into that with a promise to myself that I would evaluate the position and how I felt about what I was doing at the end of a year. This was an area that I was very interested in, but my concern going into it was that I had been so involved for so many years with primary care in a rather global and expansive way, that this was the first time I was narrowing down to really kind of a single-focused issue, you know, just take HIV/STD as a single issue. My one concern about taking the position was that it might be too narrowly focused for me, although I said well, part of the way I'll trying to deal with that is to kind of wedge open the door and make people understand, if I can, to the best of my ability, that while this is a very important issue, it's part of a larger picture of health care. And to some degree I think I was successful in doing that, but to be very truthful, at the end of a year, what I found was that my fear was realized, that for me, while this was very, very important, it was still too confining. And as my year went on, I found myself constantly kind of looking over the fence, if you will, to see what was going on in the primary care community here in Maine and both national. I just couldn't settle into what I was doing, and I began to get more and more distracted by what was going on.

It was also a time when, obviously, things are going on at the federal level around health care reform. Maine was going through its health care reform initiative. The school was here. Let's talk about the PA program. Muskie Institute was

coming out with a lot of research and information about health care policy and primary care. So there was all these things right on the other side of the fence. And so I decided that I didn't know what I was going to do, but that I probably would not stay long-term with the Bureau of Health. I felt I'd gotten it to a greater degree of presence. I had done what Dr. Estes had always told me to do, that when you take a new position, the first thing you do is look around and find who's going to replace you, who you want to replace you, and get that person geared up. I had identified that person, and I thought actually I had gotten a lot of energy generated. Maintenance-wise, I felt the person I had identified would probably do a better job long term than I would have done anyway. And so I thought, "This is not a bad time. Everybody's excited." Leave while they're still applauding.

Mullan: And you came here?

Toney: At that time this position open up as well.

Mullan: What is this position?

Toney: As the associate director of the AHEC, Area Health Education Center program. At the same time they were also looking for a director of the PA program that they were trying to start. So I actually ended up looking at and interviewing for both positions. I decided that I wanted to work with AHEC

because it was more in line with where I was at and what I was interested in relative to broad-based development around primary care, and even in this position I could contribute to the development of the PA program, but I didn't want to go back to limiting my activities only as related to PA issues.

Mullan: What do you do for a living now?

Toney: As associate director of the statewide area AHEC program, and we have one program which is based here at the University of New England, and we have one community-base AHEC Center which we relate to through a contractual relationship, and they're located up in the northern part of the state, in Lubec, and we do a number of things. First and foremost, we support, through logistical health and scheduling, clinical training of health professional students. Particularly we do rural training sites for the medical school here at the university. We also have a contract now to develop the clinical rotation sites for the new PA program. We work on an as-needed basis with some of the allied health and other clinical training programs or foreign nurse practitioner programs in the state. There are PT programs and OT programs and other allied health who, on occasion, as needed, will come to us to ask for assistance.

Our mission, even though we're based here at the University of New England, is statewide, so we work with all programs based at all institutions, regardless of the type of program or the location. The other part of our mission or the second third is

to help in support of sponsoring or coordinating continuing education for practicing clinicians, particularly those located in rural or isolated areas, so that they can maintain their clinical skills and competency, but are often prevented, by the very nature of their practice, from getting away to large national conferences.

And the third thing that we do is involved in kind of collaborative health planning and health policy work in terms of trying to do systems development work to develop the primary care, particularly the primary care, but the overall health care infrastructure for Maine. Maine is going through a lot of changes. Managed care is just coming into the state. We have about a 12 percent penetration at this point, and it's going to dramatically increase, and it's a real challenge in a state that's basically a rural state with real isolated small community pockets. We work closely with the community health center organizations. Rural health clinics are very big here, as well--

[Begin Tape 2, Side 1]

Mullan: Tape two, side A.

Toney: So as I was saying, we work on both a policy planning level, support for continuing education of practitioners and on support of entry-level health professionals, and we try to collaborate as well on the regional level. So, for example, we're involved in trying to get a new initiative up,

collaborating with the AHEC here and the University of Maine Interdisciplinary Training Service and the Harvard Geriatric Education Center to develop a new education model around clinical training for geriatrics. So we take on a variety of tasks.

Mullan: Where do you see the system all going? That's too broad a question. Let me focus it. Particularly somebody who has come up through the PA ranks, done practice, done academia, done policy work, really had an extraordinarily broad experience, where do you see the primary care part of the system going, particularly from the perspective of a PA?

Toney: As Uwe Reinhardt said ten years ago, we're headed, at least for now, in the direction of managed care, and I think managed care clearly is, and will be, the driving force, at least for the foreseeable future. Whether it's the ultimate model or not remains to be seen. I think much of primary care will be delivered out of that model.

The two exceptions to that that I think we're still not sure about yet is truly where are the poor, both the urban poor and the rural poor, going to get their care and whether it's really going to be through managed care or not, and for states such as Maine and other rural states where the managed care model, at least the traditional managed care model, seemingly will have difficulty working because there isn't a critical mass of patients that can support it, what are we going to do about that?

So I think primary care, one, is going to continue to grow as a primary policy focus and service delivery focus and therefore an educational focus for the foreseeable future. I think there will continue to be, despite the amount of what's written and talked about managed care, there will continue to be four or five different models of care and operation, stretching from managed care on one end to community health centers and even the traditional fee-for-service local-doc model on the other end. I think the necessity of where people are and the kinds of services they need will ensure that there is a spectrum.

For PAs, I think on the one hand that it's very promising. PAs as clinicians who are trained quickly and put out into practice, who are cost-effective from a training perspective and cost-effective from an overall employment perspective will continue to be attractive and be very attractive to managed care systems. Where I think we don't know what's going to happen and it may turn out to be problematic both for PAs as well as the system at large is what's going to happen as the inflation for PAs in terms of salaries continues to rise, thus closing the gap between physicians and PAs, and if you really do have more and more physicians who are going to become available, then their market value, on one hand, is going to be driven down, but their attractiveness to that very same market is going to rise. So as an employer, if I were to say, "Gee, I can hire this PA for X dollars or I can hire this physician for X-plus-one-dollar," I would probably hire the physician.

I think those kinds of issues and those potentials for competition remain to be addressed. I think there may well be a problem. Some discrete areas have already seen this happen, some of the sub-specialty areas where PAs have become so attractive that their salaries were raised so dramatically by inflation that they priced themselves out of the market. I think that that may well happen to a degree in primary care. Personally, as a PA and someone who's committed to health care, I think it's very important for both the PA educators and the PA profession, including the professional associations both at the national and state level, not to give into the seduction of existing for existing's sake. You know, we came into being to meet a need, to fill a void, and why that void was created varies depending on who you talk to, but I think it was a legitimate need and a legitimate void.

I think we need to be careful that if we're going to exist, that we also need to continue to have a legitimate role. If we don't have a legitimate role or if that role is diminished because of other changes in the delivery system or the marketplace, then we need to have the courage to reorient and retool. If we don't, and if we decide we're just going to draw a line in the sand and that's going to be where we fight, then I think we'll lose.

Mullan: That was well stated. You've had really a marvelous career committed more than I appreciated to the theme of primary care. Every time you wandered off, it tended to come back to

this generalist concept. As you look back on it now, what connects you to that concept? What is it about you and what is it about that approach to people, to health care, to life, that is important?

Toney: Well, that's hard to answer. I think it's a couple of things. I think if I had to narrow it down, it's three things. First, I think it was the philosophy and therefore the training I had from my parents in terms of, you need to make a contribution to the world. No one should just take up space, and if you have skills and abilities, you need to use them for the betterment of something and someone other than yourself.

Second, I really go back to the family physician that we had growing up who I just saw as an extraordinary individual, and so whatever I was going to be, a part of him was going to be in me, to try to be what I saw that he was.

And lastly I was extraordinarily fortunate to go to Duke for my formal training as a PA and to be trained by people like Dr. Estes and Dr. Stead and Dr. Carter and Dr. Michael Hamilton, who was then program director, all individuals who lived and breathed and really believed not only in PAs, but believed in primary care and service and who really drove into you that to be the best was to be the best at giving, not taking. That reaffirmed what I brought to the process. I've always been proud of being a PA and being a Duke PA, and I always want to live up to the standards that they set.

Mullan: Great. We're going to have to end there. When you're editing the tape, if you wanted to add in something along the lines of what we've been chatting about over breakfast, about the role and functioning of the NP, the PA vis-a-vis the primary care physician and particularly the different approaches of the professions to their "independence"--I think it's a more complicated issue than just independence--but you had some great thoughts there, and unfortunately time isn't going to let me draw them out of you, but if you have some thoughts you just want to add on at this point, the question would be something to the effect of tell me about your thoughts about the role of the PA vis-a-vis the ongoing practice of medicine, and how does that vary from the nurse practitioner's role, and what do you see as issues for nurse practitioners in addition to those for PAs in the evolution of this? If you'd take a crack at that on your own, that would be great. Thanks for a wonderful interview.

Toney: Thank you.

[End of interview]