TERRY CROWSON

September 10, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Crowson: 5/4/46.

Mullan: Why don't we start back at the beginning, and tell me a little bit about you, and where you were born and grew up.

Crowson: I was born and raised in Rochester, Minnesota, and went through high school there. Many people have always wondered if we were associated with Mayo Clinic or not, and we weren't, my folks weren't.

Mullan: Must be a rare person in Rochester who isn't.

Crowson: My father is actually a carpenter, he built houses.

Mullan: And was he was Rochester, or no?

Crowson: A long history of being from southern Minnesota. I came up to the University of Minnesota and went to medical school.

Mullan: Tell me a little bit about Rochester before we jump to medical school. What was it like?

I should say before we get going, you're in Doctor Crowson's new office, I gather. It's been a month or so?

Crowson: Yes.

Mullan: In the Heath Partners headquarters, which is a magnificent off-green skyscraper on the south side of Minneapolis, near the airport. It is the tenth of September on 1996, a warm Minnesota afternoon.

So we're talking about Rochester and what it was like to grow up there.

Crowson: I think it was a great town to grow up in. When I grew up, it was about 25,000 people when I was in my formative years, and it was a great place to grow up. I worked as a veterinary assistant and kind of got interested in it, and at one time was thinking of being a vet.

Mullan: How did you find your way to the veterinary assistant job?

Crowson: Just was looking for a job. I think I was twelve years old when I went to work. I'm sure that violated some child labor laws. I started working after school taking care of the animals. I really found I enjoyed the science and the diagnostics and the

caring and stuff, although I wasn't doing a lot of that. I was just watching it being done.

Mullan: Was that, indeed, as you started to say, something that interested you in the possibility of medicine?

Crowson: Yes. I think that's where I got the first exposure to medicine, although veterinary medicine. That kind of stimulated me to think about a career in medicine.

Mullan: Were there others who influenced you about medicine?

Crowson: There was a biology teacher in high school. I enjoyed biology, and he counseled me about all my career planning, what I would do, encouragement, and that type of thing.

Mullan: Anybody in or around your family was in medicine or health at all?

Crowson: No. I was the first one to go to college in our family.

Mullan: When you went to college, had you yet articulated the notion you wanted to be a doctor?

Crowson: No, I wasn't sure. I was headed that way. I think I went right into premed. I thought, "I'll give it a shot, see what happens."

Mullan: And were they supportive?

Crowson: Oh, very supportive. The family was supportive, and both encouraging me to do it and financially with the training.

Mullan: They stuck with you.

Crowson: Yes. And my dad pounded a lot of nails to put me through school.

Mullan: As you look back on your youth in Rochester, were there other influences that you would point to that have had an impact on what kind of doctor you have become?

Crowson: No, I really can't tie it back. In retrospect, I think my encounter with physicians down there as a patient was mainly in the Mayo Clinic system, which was very specialized, and I don't recall ever having a primary care doc.

Mullan: Personally.

Crowson: Personally. I remember having the Mayo Clinic fellows come out to the house when I was sick.

Mullan: To make house calls.

Crowson: They made house calls. In fact, they drove these sort of light brown sedans, everybody knew if you were having a visit with the doctor, so when that car pulled up in front of your house, the kids would all run around and knew somebody was sick.

Mullan: This was a Mayo service, or training?

Crowson: I think it was service and training. I think there were fellows at the Clinic, they'd come out and make the house call, you'd usually get $5 worth of penicillin. I was growing up during the polio epidemic, a couple of summers, and there were some kids with polio in the neighborhood. But I can't think of any individual that I ran into in my growing up that I emulated in terms of a generalist or even a physician.

Mullan: Do you have brothers and sisters? Any of them take medical paths at all?

Crowson: No.

Mullan: How about religion, church? Was that one factor in your youth at all?

Crowson: Yes, up until about the age twelve or so, and then I sort of parted ways with a Lutheran background, like the joke

about a Lutheran minister who couldn't get rid of the mice. Have you heard that? A Lutheran minister was having trouble getting rid of the mice, so the congregation comes in. "I bought all these traps, they didn't work," and he got approval from the congregation to use an exterminating company, and they came in and still didn't get rid of the mice. Finally he came back to report that all the mice were gone, and the Executive Council asked him how he got rid of them, and he said, "Well, confirmed them all," and they never came back..

Mullan: You wouldn't count it an important factor in your upbringing or your ultimate career?

Crowson: I think it was important factor in my life, but not the career.

Mullan: So you went to university for undergraduate work?

Crowson: Yes.

Mullan: And how was that?

Crowson: It was pretty good, except I think I got locked real early on this is what I was going to do. I envied my kids when they were going to college, the courses they were taking, and thought I'd like to go back, because I didn't really get out of my educational experience what I could have.

I got into a program. At that time, after three years of premed, I went to medical school, and got my bachelor's degree after your first year of medical school, so you finished in seven instead of eight years.

Mullan: So you really were kind of fast-tracked.

Crowson: I was fast-tracked. Also, after my freshman year, I was married.

Mullan: Freshman year of college?

Crowson: College. So I was also interested, I think, in finishing school ASAP.

Mullan: You grew up quick.

Crowson: Grew up quick. I had married when I was twenty. I think we lived in married student housing through my residency, on the university campus in St. Paul, for seven years.

Mullan: Let me ask one of the questions doubling back on the vet. Was the vet, himself--I presume it was a him--an influence, or was it the practice? What was it that made the connection for you?

Crowson: I think it was the vet and there was a group of vets. There were four of them in a group practice, and they encouraged me, too. There was encouragement for me to go on and get further education. There was a lot of positive feedback working there. They gave me more and more responsibilities. They were willing to teach, let me scrub in with them on things where they may or may not have needed the help.

Mullan: They kind of mentored you.

Crowson: Yes, in a way.

Mullan: But it was not for veterinary medicine in particular?

Crowson: No. I was interested and they were always willing to help teach and do things and let me participate and try new things. Usually my job was to keep the cow from falling down. But they'd tell me what they were doing, they'd answer questions, and I say, "What are you doing? What did you do that for?" That was a great experience.

Mullan: And what was it that appealed to you in that?

Crowson: I think it was partly the science, the biology of it all, the wonder of it, how the organisms work and the bodies work, and how all this anatomy and physiology fit together. I think that was part of it. Part of it was watching, over time,

to see the change in the physiology of the parameters of the health of the animal. I think that was intriguing.

Mullan: Coming back, then, the university, you spent the years undergraduate right on to medical school itself. How was that as an experience?

Crowson: As I said, premed was--I just sort of plodded through and did the work. Medical school was fine. I think the first two years I wasn't an outstanding student of any kind in medical school, but I think the first pre-clinical years I didn't enjoy as much, I don't think I performed as well. Once I got into the clinical years, my interest increased, and I started to work. I think I felt better about what I was doing, and I performed better, really fell into the grove of practicing medicine.

Mullan: At that point in your life, what was your sense of what you wanted to do? As you entered medical school and then as you went through it, did you have an image of what kind of practice, what kind of practitioner you wanted to be?

Crowson: No, I really didn't. I had an open mind until I got into medical school. I sampled a number of different things and realized there were certain things I thought I liked or I felt I was good at, and certain things that I wasn't as good at. For instance, I went through pediatrics, I remember taking pediatrics, and at that time I had young children, and that was

very hard on me, because we had these very ill children, very ill tiny kids, that was just very hard. I think for that reason I stayed away from pediatrics as a specialty or primary care. I think surgery, I found that I wasn't particularly adept at that, I wasn't good at it.

Mullan: Cow-holder that you were. [Laughter]

Crowson: Yes, I was good at holding stuff, but that was about it. That just didn't fit for me. As I got into the internal medicine and took rotations, that seemed like what I enjoyed doing. I liked the patient contact. I liked the whole exercise of diagnostics, figuring out what was wrong, and coming up with therapeutic and diagnostic strategies. I enjoyed it.

Mullan: So as you graduated, what were you thinking about, and what did you do?

Crowson: What I was thinking as I graduated from medical school, at that time, I think our exposure, at least in this medical school, to family medicine, was not very emphasized or positive or thought much of. It was 1971. I think family medicine was getting a foothold, and internal medicine was the one that I gravitated to. I think if I were going through today, I don't know if that would be the same, because I think family medicine was a lot different than it was.

Mullan: Which years are we at? When did you graduate?

Crowson: '71. I took an internship at University of Minnesota, internal medicine. I started heading that way in my senior year, and about maybe halfway through my junior year, I started locking in on internal medicine courses. I'd taken cardiology and oncology, and kind of targeting toward internal medicine. I did my internship at the University of Minnesota, which had a separate program then, separate from the V.A., the Hennepin, Ramsey, all had separate programs. I think it was almost the last year they did that, and then they all started to become more integrated. Then did the rest of the internal medicine residency at the university. I finished the residency and I signed on as chief resident at Ramsey.

Mullan: Which was a separate program at that point?

Crowson: Yeah, it's a chief residency program. A year after you finished your regular training, at that time it was a case of spending about a half a year very integrated with the educational programs in serving in the hospital, working very closely with the residents, making sure the call schedule, making sure things were covered, making sure conferences were put on. So it was sort of an educational administrative position. And then half the year you got to do whatever, take some more clinical experience somewhere and work with the cardiologists, or work in

clinic, do whatever. I thought that was a good experience for me.

Mullan: Tell me a bit more about Ramsey, because I know it's important to your career. It's a hospital in St. Paul?

Crowson: Ramsey, at that time, was a city/county-type hospital. It was run by the county.

Mullan: The county being Hennepin?

Crowson: Ramsey County.

Mullan: Ramsey County, which is the St. Paul County, whereas Hennepin is as you leave Minneapolis.

Crowson: Right. And Ramsey, at that time, was truly a city/county hospital. There have been several evolutions. It's changed quite a bit since then. But at that time is was really like a county hospital, it was affiliated with the University of Minnesota, and most of the care delivered, in fact, all the care delivered was by teaching services. The faculty at Ramsey was just starting to grow. When I was a resident, I think, I can't be absolutely sure, we only had a handful of full-time faculty. The rest were people from the community or the university, and they were just in the process of growing the faculty and building

the service delivery system when I came out of residency, when I came out as chief resident.

Then I joined the staff as a general internist.

Mullan: This would have been '76, 77?

Crowson: '74 I was chief resident, so it would have been halfway through '74, '75 I started on the staff as a general internist in ambulatory care. At that time, the people who were running the institution had the wisdom to say, "We need to build our primary care base, we need to build clinics on this campus that will provide continuity of care for our patients. We've got to build a delivery system that includes ambulatory care." A lot of wisdom and foresight there. I had nothing to do with it. I was just brought on as one of the people to help build that ambulatory care.

At that time, the clinic had residents coming down there for half days, they were supposed to be up on the wards. The patients were scheduled for two times. You had an appointment for either eight in the morning or twelve noon. You came, and you were seen in order that you showed up, and if you weren't seen, you were sent home to come back tomorrow. The residents came down to the clinic usually about ten o'clock, and, of course, there was a conference at eleven, so they all left. There was an inordinate number of cardiac arrests, it seemed, during clinic hours. Nobody liked to be there.

It was not a good system of care for the patients who had to wait for long periods of time. The residents received very little teaching. Usually the staff at that time in ambulatory care would sit and read their current contents and hoped you wouldn't ask them a question. There really was a lack of commitment to thinking that clinic was valuable or important.

Mullan: You described a milieu, an environment in which there was an intent to reform this, on primary care principles. 1974-'75 was fairly early for the articulation of those ideas. Who was that coming from? Where was that coming from?

Crowson: It came from a number of different sources, I think, within the community, within the university community. The immediate source of it were two people that I worked with, Bob Mulhausen, Bob was the chief of medicine at Ramsey. He had come in a year or two before, and he had a vision. He was an academician, a real specialist, but he had a vision about what needed to happen. And Mike Spilane was another general internist that was a year or two older than I, and he was in charge of General Internal Medicine Section, and Mike is a great visionary. They saw the importance of having this primary care and building this primary care. Ironically, both Mike and Bob still worked with us. Bob's back now, running our Medical Education Institute, which is a new enterprise, it's very exciting, but that's for another day we can talk about that.

At any rate, they had the vision and foresight to say that's what we needed. I don't know why I bought on, except I'd worked with Mike before, I liked general medicine, I liked the whole scope of things, and I think Mike was probably as big an influence at that time as anybody.

Mullan: That was successful? Did you re-engineer, as we would say today, the clinics?

Crowson: Yes. I always like to say I look back at that as being something I'm proud of having been part of. We took it from a level of function to a new level of function that needs to continue to improve. I told you about what the clinics were like, and what we did was built an educational program. We put it in place in 1976, so it's about twenty years ago. We had staff heavily involved in seeing patients with the residents, general internal medicine staff, occasionally bringing in some specialists, because we didn't at that time have as many generalists around.

We built an educational program for the residents. It was part of the residency that was a six-month block of time in ambulatory care, that's all they did. They covered the inpatient on a call schedule at night, but basically, they were in the clinic, and spent a six-month block. What we did during that six-month block was we were able to build a curriculum around ambulatory care that we could deliver. We had the problem of trying to deliver a curriculum over three years. At that time,

to get any kind of depth, having a conference before clinic and talk about hypertension in the outpatient setting wasn't very effective. For the ambulatory care rotation, we built an entire curriculum, we had a set of conferences, we had a seminar series. We talked about what we thought it was to be a generalist.

Mullan: Were you using that word, do you think, do you recall back then?

Crowson: General internist. Well, we talked about it as primary care doctor, general internist, and what's the role.

Mullan: But those terms were current?

Crowson: They were being used. And the leader there, for me the person who shaped my thinking about primary care more than anybody, was Ben Fuller. He actually had started the Family Medicine Program as an internist. He started the Family Medicine Program at the U, and then stepped away from it, and started working in structuring this tract in internal medicine. We had a two-tract system then. You either went for career in academic medicine, or to go into practice, and Ben essentially devised and helped design this curricula, and it was largely his curricula.

Mullan: He also took lead in setting up the Family Practice Program prior to that? Those were two separate contributions?

Crowson: Two separate contributions. He had a model that I think was just outstanding for what the generalists needed to do, what kind of skills were needed, why the generalist was needed, and had, I thought, an excellent series of seminars to teach that. So we put that in place starting in '76.

Mullan: You stayed at Ramsey right on through, it that right?

Crowson: Yes. I think I was actively involved in that educational block up until, I think, for maybe ten years or so that I was real actively involved, and then I started to drift away into other things.

Mullan: Tell me a word about the nature of the clientele population of Ramsey and of the nature of the hospital. What kind institution was it? How did you feel about it?

Crowson: About the institution?

Mullan: Yes, and its population. Who was the population?

Crowson: Population that we were caring for was mainly indigent.

Mullan: Which in St. Paul terms means what? Who were the indigent in St. Paul, in terms of ethnicity, background, migratory, stable?

Crowson: First off, St. Paul, Minnesota, has pretty good programs for getting medical care to people. I think, regardless of ability to pay. Our hospital took patients, regardless, and still to this day, takes patients regardless of ability to pay. That's not a criteria for being served by us. We have an obligation to care for the citizens of Ramsey County, regardless of whether you can pay, that's actually mandated by law.

Ramsey started in the 1850s as a sort of county poor house, county hospital, and evolved into what's called the Old Ancker Hospital, which is named after Arthur Ancker. It was the biggest hospital west of Chicago at the turn of the century. And the indigent care mission has been carried forward.

The patient population that we set up to serve were mainly the indigent patients who either they had no money at all, or they were on general assistance medical care, or they were on Medicare or Medicaid. Initially, as time evolved, and I don't know the exact times of this, but the system started to evolve so that they could go anywhere they wanted, they didn't have to come to Ramsey. Now we're getting more and more new Americans, and a lot of Southeast Asians, black, Hispanic, but the demographics of Ramsey are mainly indigent. I don't know the percentages.

Mullan: So for ten years you were involved largely in the educational, ambulatory, primary care, delivering programs.

Crowson: Right.

Mullan: Then you evolved?

Crowson: Still doing that, but then started getting into more administrative things. One of the things, I think it was in '86, we set up, was a prepaid system with the county for providing care to the enrollees on GAMC, on General Assistance Medical Care.

Mullan: Which is Medicaid?

Crowson: No, Medicaid is state and federal. This is the local.

Mullan: Patients who probably didn't qualify for Medicaid, who were poor.

Crowson: Who were poor, didn't have resources, usually were in the system because they had health problems. The reason they couldn't work was because they have health problems. I got involved in setting up--

[Begin Tape 1, Side 2]

Mullan: This is Doctor Crowson, tape one, side two, continued.

Crowson: So we set up this prepaid medical plan with the county for the people out in GAMC. The county, I think, saved significant dollars, and we made it work by getting patients into

a delivery system, whereas before they received care anywhere they showed up. I don't know that we studied it enough to know exactly all the impacts it had, except that I think it was successful from this standpoint.

Mullan: Was this under the conceptual mantle of managed care, or was this less ambitious than that?

Crowson: No. It was a managed care program. We received a capitation from the state, and we tried to manage the population as best we could.

Mullan: So that an individual who qualified for GAMC--

Crowson: Would get a card.

Mullan: And that gave them eligibility to you, but they had to come under certain circumstances in terms of seeing a set physician, I presume, etc.?

Crowson: Well, part of it, the challenge was that the average person was only on the program for a few months, so that continuity idea, while ideal, not necessarily did the best. I think we were able to do some things with setting up alternatives to showing up at the ER and helping people so they didn't feel they had to use the ER.

I got more involved in sort of medical administrative issues, started looking at our whole ambulatory care setting. I said a while back that when I first started at Ramsey, we were just starting to pull the clinics together and make them work, and try to make them work better, meet the needs of the population to build a primary care business. By 1990 we were one of the largest hospital-based outpatient facilities, and today we're still fairly large. We'd see over 250,000 visits a year, right on the campus, not including our other outlying sites. So it really was a successful strategy that was put in place through the vision of many people at Ramsey.

Mullan: And it remained, throughout this period, a county hospital?

Crowson: Well, in the 1970s, about the time I came on, it was becoming apparent that Ramsey County could not continue to support the hospital to the degree that would be ideal, mainly because Ramsey County doesn't have that big a tax base. It's geographically a small county, it's got a lot of government land, and by comparison, it's got one-sixth the tax base of Hennepin.

We realize that in order to provide the service to the county, we had to have a different model, and so we started moving further and further away from governance by the county and funding from the county, and in 1986, we made the split with the county and became a public benefit corporation; a not for profit corporation that would carry the mission, i.e., forward for

providing care to the citizens regardless of ability to pay. The hospital gets less than 1 percent of the budget from county tax revenues. So it's an interesting model, because, I always like to say, we're fulfilling a public mission through private initiatives, which I think is one of the ways it can work.

Mullan: And who governs?

Crowson: There's a board of the hospital. Things are evolving now, but at that time we formed a corporation called Ramsey Health Care, which was the public benefit corporation, which had three subsidiaries. One was the hospital, St. Paul Ramsey Medical Center, the second was Ramsey Clinic Associates, which is a not-for-profit, multi-specialty group practice.

Mullan: That's called Ramsey Associates?

Crowson: Ramsey Clinic Associates. And Ramsey Foundation.

Mullan: So the Clinic Associates were essentially the medical group?

Crowson: Yeah, its a doctors' group. We have about 180 to 200 docs.

Mullan: And the third was the Foundation?

Crowson: Ramsey Foundation.

Mullan: And what was its role?

Crowson: Its role was fund-raising, which is new. When we were with the county and perceived as the county, you know, people don't want to give you money, if you get their tax dollars, so we started building that fund-raising, and that has grown significantly. It's the vehicle through which we receive grants for research and administer research efforts.

Mullan: What year was this?

Crowson: 1986, '87.

Mullan: And the public benefit corporation, this is when it came into being?

Crowson: Yes.

Mullan: Under the aegis of the public benefit corporation, there were the three subs?

Crowson: Right. And the Ramsey Health Care, essentially it was a PHO, a physician-hospital organization, that started working very closely together to be successful, but it was under the

governance of a board that is a representative of the community. There are three physicians on it, otherwise it's all community.

Mullan: What I'd like to do is quickly walk through your story up to the present, and then go back, since it is intertwined with the organization in specific, and developments in Minnesota in terms of evolution managed care, as I understand it, in general. So let's just quickly do the personal side, and then come back and look at it in the big picture.

Crowson: So in '86 I started looking at other things. I became director of ambulatory care, which was a deputy medical director, and then by--I can't remember the dates, it was '89 or '90 or something, I became medical director of the hospital. At about the same time, we had sort of a double crises in the clinic: a financial crisis, and also our leader died relatively suddenly of cancer.

Mullan: Your leader being?

Crowson: Doctor Taddeini, who was head of the doctors' group at that time. So we had a vacancy in leadership, and I ended up taking that role, and I served both as president of Ramsey Clinic and as medical director for the hospital. So we've had essentially one medical hierarchy system that worked for both the clinic and the hospital, and so I filled those roles.

Mullan: You became the medical director of the hospital, preceded becoming--

Crowson: Yes. I don't know, some months, shortly also became president of the clinic, of Ramsey Clinic.

Mullan: And that lasted for a while?

Crowson: Yes. Actually, I'm still holding those two roles, although the roles are evolving. Two years ago we merged with the Health Partners organization. I served in those two roles up until just this July. I still hold those titles, although the roles are changing, and I became co-medical director with Health Partners. We're the Health Partners Medical Group, which is a merger of the old Group Health Medical Group and Ramsey Clinic.

Mullan: Have you stayed active clinically? Do you see patients still?

Crowson: Up until last Friday, that was my last day. That was hard. When I took on the administrative roles, I maintained clinical practice, I'd attend on the wards, and I'd do all this, and I just found that I couldn't do it, and I'd start cutting back. Finally, last couple of years I've only had one half-day of clinic. As a primary care doc I couldn't do it. There are two issues that I had to confront. One was maintaining my competence, which over time you start losing unless you're doing

more of it than--I don't know where the line is, where you're doing enough to maintain your skills and to keep up. I felt that I wasn't, so I had to make that decision.

The other was, as a primary care doc, I couldn't be there when patients need me. You have a contract with the patient to be their doc, and then they can never get hold of you, and the nature of that contract I found unsuitable, I didn't feel I could deliver. So I found myself telling patients, "Well, I'll try to be available, but you've got to understand I won't be." I think it got to the point that I just couldn't do it, so I made the decision, probably last spring, to start weaning out of patient care].

Mullan: Again pursuing the personal theme, for many people, I suppose in all walks of life, but certainly in medicine, by the time they reach their latter part of their forties or their fifties, they have "done it" in the sense of become the clinician that they wanted to be, or established a level of specialty proficiency, or what have you, and I found that it's often a time where people kind of rethink what they want to do with the balance of their career. Did that enter into this evolution for you?

Crowson: Well, I think it did. I guess I've looked at it as doing something that I find interesting, and, personally, I like starting up stuff, getting it rolling, and then after it's rolling for a while, I kind of like to go start something else

up. And if I look back at my career, that's kind of how I've done things. I love getting stuff up and started and run it for a while, and then turn it over to somebody else. I'd rather go on and do something else. I facetiously, maybe not so facetiously, tell me colleagues that I surpassed all my career goals when I graduated from high school. So I've never had that "This is where I want to be at the end of my career." I've never set a goal like that. So it's been whatever's in front of me, what's interesting, what are the opportunities, maybe head in this direction. So it wasn't a stage of calculated moves, it was more of what opportunities were in front of me at various times that I saw that were an interest to me. That's sort of how it evolved.

Mullan: Let's go back and pick up the sociopolitical health care developments both in the Twin Cities and with Ramsey. We were in the late eighties, talking about the new currents were blowing, were affecting the institution. Tell me a bit more about the environment. Minnesota, as I understand it, has had a somewhat more progressive tradition in terms of health care, in terms of a lot things, but health care in particular. You referenced it before with the "Ramsey mission." Tell me more about that, and then how did the managed care currents intersect with that?

Crowson: I don't know that I have a good explanation for how that all fits together, other than it seems like this setting was ripe for development of managed care to develop as a way of

delivering care, as an alternative way of how we could get the services to people. I guess I just don't know enough about what was going on at the time. At that time, when I think back to the early eighties and '86, I was somewhat cocooned, frankly. We were in an academic-based practice focused on our mission, and really not in touch with the market, and I think that's part of the story of how things played out. So I don't know that I can shed a lot of light on that. I wish I could.

Mullan: Managed care was a force in this city before it was elsewhere?

Crowson: Yes.

Mullan: Going back to the early seventies and Paul Elwood [phonetic] being here, and the concepts were at least in play early on.

Crowson: Yes.

Mullan: As a practitioner, if you can think back to the mid-eighties or earlier, were you skeptical about that, or that might have been okay for some other segment of the market, but it didn't have anything to do with what you were doing?

Crowson: Yes, I think that's kind of--I guess I'd go back and say, first of all, if you look at Group Health had its foundings

as a cooperative, as a traditional group health cooperative. It started and it was in the community and received a lot of criticism, and went through a real rough time of the medical community.

Mullan: How far did it go back?

Crowson: I think it started back in the forties. But I remember when I was going through medical school, they were growing, and there was a Group Health right on Como Avenue. The medical community and provider community was not at all enamored with that approach, and they went through some really rough times back then, but I remember that it progressively grew in the community. As a practitioner at Ramsey, I think we were isolated from that because of our special place in the market, or at least viewed ourselves isolated. We were not isolated. We viewed ourselves isolated, that we were in an academic-based practice, providing a special service to the community, and we didn't have to go out and play in that market.

Now, as things evolved, obviously in 1986, we started to see that the state and some of our traditional populations were going to be cared for differently, and we started to realize that we had to do things differently. Also I think we started to realize that in order to build a patient population base that would support the organization, that we were going to have to get more involved in managed care.

From a practitioner's standpoint, a lot of us felt we were sort of isolated, but when you look back at the history, we started an HMO, don't quote me on the year, but we had Ramsey from shortly after the time I got there, it must have been the late seventies, early eighties, we started our own HMO, Ramsey Health Plan, in order to participate in that market.

Mullan: So by the mid-eighties, these developments were rolling?

Crowson: Oh, yes.

Mullan: And you described the public benefit corporation transition. Walk me forward then, from a Ramsey perspective, that as it began to merge with Group Health and Partners and so forth, how did that unfold?

Crowson: We looked at what was happening in the market, and at that time the Minnesota care legislation had gone through. That was legislation passed a couple of years ago that started to address the care of the uninsured, and started to look at how the health care system was going to be designed. It was clear to us that one of the things that was developing was the whole concept of--I think at that time they were called integrated service networks, which, in essence, were going to be networks of providers, both physicians, other health services, hospitals, and insurance function, all being in a package, put together in a package, and that that was how the market was going to evolve,

and that the purchasers--our read was that when we looked at our strategic planning, that the market was evolving, that the purchasers were going to be looking for these ISNs. They're going to be looking for a broad geographic distribution, integration of all these services, rather than this piecemeal, putting together--

Mullan: The Minnesota care legislation, that was designed to enable integrated service networks?

Crowson: Yes, and particularly mechanisms to provide for the uninsured.

Mullan: What year do you think that was?

Crowson: It was probably four years ago, I think, that was passed, three or four years ago.

Mullan: The way that it was going to provide coverage for the uninsured was to enroll them in Integrated Service Networks?

Crowson: Well, that was going to be one of the strategies that was going to be used. We saw that buyers, the business community and government purchasers, were all going to be looking for these networks. We did not think that Ramsey Health Care was big enough to survive in that kind of a market.

We had a number of integrated pieces, we had a hospital, we had a physician group, and we had, actually, some insurance vehicles, but we just weren't big enough. We couldn't cover the entire metro area, and we didn't think that we going to be able to be an independent service network. The other thing that we saw, the networks were starting to form and not everybody was being allowed to participate. So in a couple of cases, we were having contracts canceled. We were just told "We are shrinking our network, and you're no longer going to play, and you're not allowed to be in the network."

So when we looked at all those forces, we thought we needed a partner. So we went out and went through a process of talking with a number of different entities. We didn't think that horizontal integration made sense to us, because there's already too many hospitals beds, and we thought that it made more sense for us to become part of the health plan. So that led to our discussions with Health Partners, who was interested, and seemed to fit.

Mullan: The point there being that integrating or linking up, partnering with another entity that looked a lot like you that had hospitals was not particularly advantageous.

Crowson: No.

Mullan: Whereas linking to an entity different from yourselves, one which had a population base, but not bricks and mortar, was more appealing, and Group Health constituted that?

Crowson: At point, Group Health had been merged with Med Centers, and they were now called Health Partners. But, yes, that made more sense to us than--we did talk to other hospital systems, but we thought our best bet was to try to work with the network.

Mullan: And again, Group Health had linked with Med Centers. What was Med Centers?

Crowson: Med Centers was a health plan that was a contracted network, whereas the Group Health was a staff model, an HMO. They felt that merging those two brought advantages to them. Together they could have advantages in the market.

Mullan: And when was it did you merged with them to make Health Partners?

Crowson: 1993. Health Partners was formed about two years before we merged. We merged in 1993, the end of '93.

Mullan: And that brought your hospital, your medical staff into this larger network?

Crowson: Yes. We're a division within a larger corporation that had the group health delivery system and insurance functions.

Mullan: And that has stayed intact without major changes since?

Crowson: The last two years. I think there haven't been many structural changes, but there have been a number of operational changes, and we're in the process of merging the two physician groups. Just did that.

Mullan: That would be the Group Health and Ramsey Clinic.

Crowson: Yes.

Mullan: And when you say "merge them," that means?

Crowson: Become one group.

Mullan: That they admit to the same places?

Crowson: We act like one. Prior to this summer, basically we had Ramsey Clinic as a separate physician entity, and Group Health as a separate physician--

Mullan: So the running rules from all different perspectives would have been different, recompense, referral patterns, etc., etc., would have been different?

Crowson: Yes. By merging, what we're doing is saying, "We are now going to behave as one group." We don't want to be two competing groups under one umbrella, that's not a very efficient way to do things, and that we want to become one group to carry out the missions that we both have.

Mullan: How's that going?

Crowson: It's been two years we've been at it, and we went through a lot of planning together. We're coming from very different spots, pure staff model HMO and academic-based multi-specialty practice, you have differing cultures and different views. We've, I think, been quite successful in the last two years at planning, bringing the groups together, forming the vision of what we want to be as a combined group, and then going about the steps to implement it. This summer was when we named the leadership, the combined leadership of the group, and we're in the process of putting that structure into place. We anticipate that by 1998, we will be just completely one group.

Mullan: What I'd like to do is explore a little bit both what it's been like as a physician manager in these various stages of evolution, and then I'd like to talk a little about managed care and how it plays out in the population in its various flavors here in Minneapolis. But focusing for the moment on what it's been like to be a physician manager, you had an identity that was based at Ramsey with all of the attributes that that had, both

with foresight, and, I'm sure, with some degree of market buffeting. That organization has melded into a larger one, and it continues to meld, witness the recent consummation, as you describe it, as a physician group merger. What sort of role have you played? What has it been like for you? What is it to become a physician manager in one of these new integrated entities?

Crowson: Well, first off, there are several key differences between clinical medicine and management. First, is how you get your rewards. In clinical medicine, you do get relatively timely feedback. You do something, and within, hopefully, in some cases, minutes, and other cases, days, weeks, months, you start to get some feedback about what your interventions have done, your patients are getting better, there's some response to what you're doing.

In management, it's very indirect. You try to put into place a system of processes that somehow will improve the outcomes, but by the time the outcome rolls out, you don't have quite the connection you do as you do in clinical medicine. So that's one important difference is the reward that I had to adapt to.

Second thing is the degree to which you're working in teams, teams of different disciplines. I think medicine is evolving more and more toward teamwork and working with different caregivers. We've always had team work, but I think it's the working in teams with different disciplines, that we haven't in

medical practice traditionally worked with such as finance, human resources, legal. The team work is much more complex

[Begin Tape 2, Side 1]

Mullan: This is Terry Crowson, tape two, first side.

Crowson: Mentioning the complexity, part of that relates to autonomy. I think in clinical practice there's a little bit more autonomy in the decision-making and that kind of autonomy in decision-making doesn't work as well in administration. I think you need different decision-making strategies to make sure you get the good decisions and get it done in any kind of timely fashion. So those are significant differences, just generically.

I think one of the challenges that I suspect any administrator, physician administrator, right now is facing is trying to help people through the change of what's going on. I look at it that we are in the third revolution in medicine this century. We went through an education revolution early in this century with the Flexner Report. This is actually Ben Fuller's wisdom, and he also said that with World War II, the technological revolution started, and it goes on. We're now going through a socioeconomic revolution in the United States, and it's still playing out.

Mullan: Socioeconomic?

Crowson: Yes, revolution. It's probably been happening, and managed care is part of that. It's probably been going on for maybe a decade or so, but we're still in it, and it will evolve.

Mullan: The first two come through clearly to me. The third, certainly there's a lot of changes in the society of medicine and the economics of medicine. Is this from the physician perspective particularly?

Crowson: Yes, I think the roles of physicians and what they traditionally played have been changing. How they do their work is changing. How it's financed is changing. It's a major, major change. How physicians work, we're working more on teams, we're working more in groups, and the solo practitioner, who is basically on a fee-for-service model is really just about completely gone. As we go through that, I think one of the things, dealing with the physicians, that is helping them understand that this change is going on and what's driving it, and understanding what changes we have to make to be successful in carrying out our mission.

I tell my colleagues that I wish it were 1974. I loved that year. It was great, you know? And I wish it could be like that from a standpoint of what I felt my role was and what I did, but it's not. That's not one of the options on the table. We can't go back to the way things used to be. We've got to figure out new ways in the new realities to do it. And that's probably the biggest challenge, is helping to make that transition.

Mullan: You must have engaged multiple positions on both the clinical, the quasi administrative, and the administrative levels dealing with these changes over the last decade or so you've been involved in this. In the more recent period, when it's become pretty intense, you see people making it, people not making it? How do you characterize how you see physicians responding?

Crowson: My experience has been that the people who are probably within five years of retirement are just hanging on. That's been true for the last five years or so. They're in their last stage of their career, a lot of them are just hanging on, so they won't change or see the need to change. Some of them are just happy to be getting out and not have to go through it. The young people adapt. They're adaptable, coming out of training, adapt pretty quick. I think it's the doctors in my cohort who are most trouble, because we have twenty years or so of our careers in a system that's seen a significant amount of change, and I think that's probably the group that's having to go through the most change.

Mullan: One hears stories of physicians' extreme angst, anger, frustration, and obviously there are many who have adapted well. Do you see people just on the negative side, other than the folks at the terminal stage, or people who cut and run and take early retirement, do you see people being broken by this? Do you see people who can't adopt, who are being extruded by this system?

Crowson: I don't think so. I'm sure there are people who are just throwing in the towel and saying this isn't what they signed up for. In general, I think in health care, we didn't go into it because we saw it as a rapidly changing field. I sure didn't, and I think this is true of a lot of different providers, not just physicians, that there was going to be this much change. But I don't see a lot people broken, just throwing in the towel, and saying, "I don't want to do this anymore."

What I found interesting, when we started talking with our docs about what we wanted to do, and we started talking to our groups about what's the ideal group that we want to form, this new group. How do we want it to work, what do we want it do, how do we want it to continue? What you saw is, you saw it coming back with those kind of core values that drove us. You kept seeing that. We had these two very disparate groups in terms of cultures but when we get down to talking about what you value, there's a lot more there that's alike than there is different, a lot more alike than they are different.

I see it as sort of a redirecting, kind of stepping back and redirecting in the current realities of what we're dealing with, how we best carry out what we set out to do in the first place with medicine, and I think it presents all kinds of opportunities that weren't there before. I see some of the things we're doing here, and it's just exciting. The population-based health initiatives that are going on this organization.

Mullan: Which means what, exactly?

Crowson: Looking at saying we have this group of members now in our health plan. How do we improve their health? It starts right where the missions did. Health Partners' mission is to improve the health of our members in our communities. Pretty simple. It's to improve the health. Now let's get serious about this. What do we do to improve the health? And there are a number of initiatives that have come out within a program called Partners for Better Health, that have targeted things, and saying, "Let's do some specific things that we can look to as improving health, and let's target certain areas," and we've got specific goals that have been set out for reducing cardiac events. We've got goals that look at immunizations rates. We've got goals that look at maternal infant health. We've got goals that relate to diabetes, identification and early treatment and maybe even initiatives that would identify people at high risk and hopefully prevent some of them from developing types of diabetes. There are also initiatives related to domestic violence, breast cancer, early detection and treatment. Let's go out and set some goals, put some initiatives in to improve how we preform in those areas. I think that's exciting stuff.

Mullan: In terms of this theme of adaptation of the new environment, any observations about the adaptability of primary care physicians versus specialists?

Crowson: It'll all be biased. I have biases. I just told you I'm biased. In general, I think the primary care docs are more

flexible in being able to adapt. Maybe that's a generalization, and I can't give you any data, it's just my impression. I think they tend to adapt better to changes.

Mullan: I would think there might be even a more elementary level in which primary care doctors are sought by, or retained by, a system as it forms up, whereas the specialists are much more at risk in terms of what I presume is the downsizing of the specialist fleet most organizations have. Is that a fair observation about this?

Crowson: I think, in general, if you look at Twin Cities market, I think that's a fair observation, that the specialty market here, depending upon what figures or what assumptions you want to make, there probably are more specialists, particularly in certain areas of what we need to serve the population. I think that's true, that, in general, right now, I think the specialists are feeling more threatened and there may be more angst.

Mullan: I tried to look at the figures that you've been good enough, or I think George Isham had been good enough to send me a snapshot of Partners in the various merged groups, the composition of specialists versus generalists, and, of course, that's just one point in time, I don't how that's evolving. What is the strategic balance between generalists and specialists, and are you trying to downsize one and upsize the other?

Crowson: We brought together the two groups, and Group Health was maybe two-thirds primary care and one-third specialty, whereas the Ramsey Group was just at two-thirds specialty and one-third primary care. I think what we're trying to do is we want to make sure that we've got the right balance. There are some specialties where we think we may have maybe some work to do, but I think there are options in terms of how we deploy our people. So I don't think we're envisioning any massive changes.

Mullan: Back to the primary care theme. As the systems, in general, have formed, and as this one in particular has formed and reformed, tell me a bit about the role of the generalist, going back to your roots, struggling in those ambulatory clinics in the mid-seventies, trying to make sense of them. Has the hour of the generalist arrived, or, as I hear in some sectors people sort of saying, the generalist is being abused and misused, and has been become a policeman, or a variety of other things. How has the life of the generalist evolved in your systems here?

Crowson: I don't think I ever felt like a policeman for the system, and I don't think the docs in Group Health have either, the primary care docs. I don't feel they've been put in that position. When I first started as a generalist, that was not the thing to do. I think the attitude was that if you were in general medicine, then you were too dumb to get a fellowship. I remember one of my former professors came over to give grand

rounds at Ramsey, I hadn't seen him for a couple of years, and he said, "Gosh, hey, Terry what are you doing?"

And I said, "Well, you know, I'm in general medicine at Ramsey," and you would have thought I said I'd been in jail for two years. The look on his face told me that somehow failed. I think that was sort of a prevailing attitude, that there wasn't much merit in generalism.

I happen to think there's a lot of merit in generalism, obviously, and I think it's exciting. I think it's intellectually challenging. When you think about it, when you're the first person to hear the person's story, you're not the fourth person, you're the first one to hear what's bothering him, and you start with an infinite number of possibilities, and through listening, hopefully through listening, and examination, you're able to narrow it to a small number of possibilities of what could be wrong, and that's an incredible, incredible exercise. Whereas I think sometimes I don't find it as challenging when you get into some of the technical specialty areas. It's almost rote. It's not as exciting.

The other thing is that I found was that in regard to the illnesses and the diseases, I lose interest. But the illnesses always come in such interesting packages. Every individual's different. In primary care, you really get to appreciate that. It's sort of a privilege, a professional privilege to be able to see how the same physiology, i.e., a ruptured disk, plays out in different people, and I think that's fascinating and interesting. So from a personal standpoint, the rewards are exciting.

I think the role is very important role in the decision-making, the decision-making role of the primary care doc. Somebody has to collect enough information to be able to either nail the diagnosis, or get close enough to know what to do next. When you figure that there's, what, probably less than twenty complaints, I mean generically, i.e., weak and tired, but there are 4,000 diseases. That's an exercise. How do you get from, "I'm weak and tired," to what's the right treatment? That's why I think it's important. And the other thing is that subtlety makes a difference. The majority of information is coming from listening to the people. I think that the primary care doc, the work has to be structured in such way that the primary care doc has the skills and the time to do that well.

My experiences as a primary care doc, about 50 percent of the people who come in the office are there specifically because of something that's going on their life right now, and it's not due to a typical illnesses that we are all taught so well to diagnosis. The majority of the headaches I see are not brain tumors. The majority of the bellyaches I see are not ulcers or ulcerative colitis. The majority of the diarrhea I see is functional bowel, it is not inflammatory bowel disease. You've got to know the difference. It's not to trivialize it. It's that that's very important. Just think of having to sort through what "Am I dealing with the person who has functional bowel," versus somebody who's got ulcerative colitis.

I think it's very important. The primary care doc uses history and physical in appropriate use of diagnostic tests by

setting apart probability of disease. And that's where, just from a decision-making standpoint, that's what the primary care doc needs to do, as accurately as possible. say, "What is the prior probability of disease that I'm testing?" If we use Bayesian logic, you're going to get the most information when you're about 50 percent sure before you test. And if you think about some of the testing strategies you end up with a low prior probability, and then after the test, you haven't really made much progress in certainty of whether they've got the disease or not.

I think understanding all that, and being able to use it and have the work structured so you can use it, I think that's very important. I think it really makes a difference. You see it with the cardiologist. Maybe 50 percent of the people or more, a cardiologists sees with chest pain may have coronary artery disease. If I took all the chest pain that walked into my clinic, it's probably going to be about 5 percent, where coronary artery disease is the cause of their chest pain. Makes a difference in your mind-set, depending on what you think the prior probability is.

So I think that's an important diagnostic issue. It's important that you have skilled people who are knowledgeable as the first contact. Ben Fuller taught that we deal with two kinds of data. We deal with primary data, which is everything that is unique to the patient, and we deal with secondary data, which is sort of the fund of medical knowledge, everything that's known

about medical knowledge, and we have to integrate those two, to come up with a rational diagnostic or therapeutic strategy.

That means that your primary care doc has to be good at certain things. They ought to be darn good with communicating. They've got to be real good at interviewing and in listening to patients, because that's where the majority of information comes. They ought to be knowledgeable and skilled about decision-making, rational decision-making. I keep going back to Ben, because I sat through his lecture series twenty-five times, so I've never forgotten. I've got it hammered in. I needed to sit through at least ten to get it. But he pointed out the importance of the primary care doc and the decision-making skills. He says that basically the primary care physician's commodity is the decision. We have technology, we have other things, but basically it's a decision, an informed decision that we present to the patient in the form of recommendation, and they can either accept or reject it. I believe that is the fundamental commodity that we provide, and that's what people come to us for.

It's not to say that patients aren't the ultimate decision-makers at all, but I think we do have an obligation. We just don't turn the data over to the patient and say, "Well, what do you think we ought to do? Here's the data I collected. What do you think ought to do?" We take that primary and secondary data, put it together in a series of recommendations for the patients, and we should be good at that. We should really trained for that.

I think there's always room for improvement. When I went through training, I essentially unlearned anything I learned about appropriate medical interview, because of the system. The system was such that you were the fourth person to work somebody up, and you just had to collect the data so that you could report it to an attending physician for decisionmaking. It really wasn't used. I spent very little of my training time in clinic. My first years of practice I learned more than I learned in my residency about what was relevant. I wasn't well trained, I don't think, for what I ended up doing. I shouldn't say well trained, I should say optimally trained. That was one of the things we set out with this educational program, was that was one of the things we wanted to do was to take it and say, "Let's go in this direction. We'll build on this."

Mullan: This very eloquent discussion of what the essence of primary care practice is, would that be appreciated, both understood and also valued, by the majority of the primary care physicians that you have collected in your network, many clearly educated in other ways, and not at least with their basic education, subjected to this kind of both systems thinking and particularly primary care philosophy? Would that be appreciated, and to the extent that it isn't, what could be done about that, or what are you doing about that?

Crowson: I don't know that I got a great assessment of that. From what I've see, I suspect that is appreciated. You see it

surfacing in various ways as people look at, "Let's figure out better ways, more rational ways to take care of people." You listen to the discussions that go on between the generalists and specialists about how you ought to approach certain problems, and you start looking at practice guidelines that are best practices. You start developing what our best practice is, and you start having discussions between the specialists and generalists, and you start seeing, you start understanding those things. I think there is an appreciation for that, the difference amongst the primary care docs. I can't say I've gone out and really assayed it, I'm just saying I think it's there.

Mullan: When you talk to the leaders or proponents of some managed care systems, they lament the primitiveness, or the ill-appreciated skills of even graduates of very good primary care training programs coming into their systems. They're not decision scientists, they're not good communicators, etc. A major issue for them is retraining or recrafting or doing remedial training for people who have excellent minted, newly minted, internists or pediatricians or family docs parchments.

Crowson: That is still an issue. That is an issue. I think the docs who've been in the system, it's sort of like, like myself, I guess, for the first two years, I didn't have a clue. I don't know how I learned what I needed to know but I think I got both a fair amount of mentoring from Mike Spilane and some of the others

who were working with me, and kind of started learning the real importance of this.

I think that the education program has a significant ways to go in turning a lot of people who are going to function in that kind of role. I think that's both locally and nationally, but I'm not as familiar, I've not been in touch with what's gone on with primary care training as close as I was ten years ago, when I was involved with SGIM. But I certainly think that that's been a problem certainly locally, that we do not feel that the trainees have received the kind of experiences they need to practice optimally as primary care physicians.

As a managed care organization, we have a lot to offer the educational system. Ramsey has traditionally had an academic background. At any given time at Ramsey Hospital there are probably 130 residents and probably 50 to 75 medical students.

[Begin Tape 2, Side 2]

Mullan: Second side of tape two, Doctor Crowson.

Crowson: Ramsey has a longstanding relationship with the university for involvement in education. Group Health has also been involved for some time, probably not quite the same degree as Ramsey had. One of the challenges is how to carry our education mission forward within the new Health Partners relationship. One of the things that we decided we needed to structure was the separate entity within the Health Partners

organization, a separate corporation, which we called the Medical Education Institute. It has a separate board of directors and Bob Mulhausen, my former mentor, is medical director. We're just in the process of establishing this as the vehicle through which we, the Health Partners Organization participate in education. We restructured an affiliation with the University Minnesota so that the Medical Education Institute will be that vehicle. I think it has a lot of potential for being a new way of educating health care providers.

Mullan: Because that's been a rap against managed care, that they aren't carrying their weight in terms of education.

Crowson: This organization is stepping up to the plate, and saying, "This is important. We think it's important. It's something that we need to be involved in and we want to help the process." I think we want to be part of the process of how education is conducted. I think we've created the appropriate relationships, we've laid the groundwork for the relationships and the structures to be able to carry that forward in a new way. So I'm optimistic about education and our educational programs.

Mullan: If someone were looking at the plans for the Medical Education Institute in its fullest extent, from the outside, would they conclude that this was a robust part of both the work of Health Partners and medical education within the Twin Cities,

or would they say, "Oh, this is just a fig leaf they're doing so they can say they can say they're involved in medical education?"

Crowson: I think when you look at what's involved, I think they would see a significant involvement, because, like I say, we're still got 130, just if you take what Ramsey's doing alone, it's 130 residents, that we're providing training for. We're expanding residencies for which we are the sponsoring institution. Since Health Partners took over, our family medicine program has gone from twenty-four to thirty students. We've expanded significantly.

We've started a new emergency medicine residency since they came on. We started a new psychiatry residency in collaboration with Hennepin. We have not cut back on any of our residencies. So I would say that we have a very substantial involvement. I think one of the things we wanted to make sure was that we had a mechanism within the Health Partner family of organizations, a method of managing our education program.

I think the future of our educational endeavors is really going to be dependent on our ability to understand our costs and to understand the quality of our product. One of my biggest fears about the future of education is that the costs are so buried in the operations of most educational institutions, and there's not a good understanding of it, and because of that, things are going to happen by default, that are going to hurt programs as the money gets less. I think that in order to

effectively manage it, we've got to understand what that is and know what it is.

Mullan: The costs need to be explicit.

Crowson: Yes. You can't manage it if you don't understand it.

Mullan: You can buy more, or you can buy less, but at least you know what you're buying.

Crowson: Yes, at least it's up there where you understand. What I'm concerned about is that the system would just evolve, there would be less and less money, and as less and less money came into the system, people would start making decisions about programs or make decisions about delivery systems, or make decisions in their budgeting process that would harm the educational programs, not through a plan that everybody understands, but just because it's so hard to understand it, and people are going to have to make cuts. Most educational institutions are facing financial problems, and are going to be starting to make some cuts. That's one of the other things that I think is a benefit for us to understand.

Mullan: I know the medical school has been at risk here. The simple-minded outside story is that the market was divided up between managed care companies, the university didn't position itself well, and their patient base, or their economic base was

rapidly and dangerously eroded. Is that accurate, and what has happened, and where does the medical school stand?

Crowson: I think you've got to separate out the medical school. You can think about them differently. It's fair to say that I think throughout our community amongst everybody and the providers, we want a very strong medical school. Now, what we need to have that very strong medical school, and how much is linked to the University Hospital and the delivery system is a whole different discussion, but suffice it to say I think it would be a mischaracterization to blame it on managed care.

I think the market dynamics were such, the market dynamics in this community are such, that the university did not position itself to survive, whether it was managed care, whatever was going on. I think it's true of a lot of institutions. We faced that a bit at Ramsey, and I don't think we positioned ourselves as well. Had we taken a different course, we may not have ended up merging, because we would have had other alternatives, but basically the course we took became the best strategy for us. The university is finding that. It is now merging with Fairview, because that's its best strategy.

Mullan: University Hospital.

Crowson: University Hospital is merging with Fairview System. So I think it's fair to say that the university found itself not

having a sustainable market presence unless it did something different.

Mullan: And it is running to catch up by doing that, by merging?

Crowson: Right. I think just to say, "Well, managed care came in and ruined everything," that it ruined it for the university, it's not a--

Mullan: Right. It's a simplistic explanation. It has been held up often as an example of what universities shouldn't do, or as managed care becomes a more forceful presence in cities all over the country, universities need to position themselves to absorb that or deal with that, which they haven't in the past, or at least University of the Minnesota hasn't.

Crowson: Right. And I think that gets back to, how do we position ourselves? What is the best positioning for an institution? And I don't know. I can't say for the university. I think there could have been some things they did differently, or approaches that they may have taken over the years.

Mullan: As I understand the law in Minnesota, for-profit managed care is not legal. Put differently, managed care health organizations need to be not for profit.

Crowson: For HMOs, yes.

Mullan: So that there are no for-profit organizations in the field. Has that made the field different? For instance, when you talk about setting up the Educational Institute, are you given more latitude to move in that direction because you don't have a fellow across town, or an organization across town that's cutting costs eight different ways, trying to get the money to the bottom line?

Crowson: It's hard for me to say. I haven't been in the for-profit market, so I don't know how it behaves, so I have questions about how that would behave. I think that the not-for-profit really has advantages of being able to utilize resources to improve the health. If you go back to the mission of Health Partners, it's to improve the health of members of the community, and we can use resources with different initiatives to do that.

One of the ways that I think we do improve the health of our members in our communities is by training medical professionals, and we're involved in training with all medical education. I think that's one of the ways we do it. I think because we do not have a competing interest of having to meet the needs of shareholders, we have resources that we can put back into the system to make it better. Now, I haven't experienced that, but at least my belief is, if you've got to meet the needs of shareholders, which is what for-profit enterprise, that's their responsibility, is to maximize the wealth of their shareholder, that's what they're there for.

So the question in my mind is always what happens to those resources that go out of the system into shareholders' pockets. I think that margin is what we can, to a the degree that they're similar, we can put back into the system and make it work better. So that's my view on it. But I don't know what it's meant to this market, and it maybe that will be short lived. I don't how long that law will hold.

Mullan: Was that part of the law that you cited before?

Crowson: Don't quote me on it, because I'm not an expert on it, but I think it's been a longstanding law from when HMOs were first formed.

Mullan: Is there anything else you'd like to comment on? Tell me some more about your family, back on the personal.

Crowson: I've been married thirty years. Got a daughter who just turned thirty. She's a wonderful daughter. And a son who's twenty-five. Both married, and don't have any grandkids yet, but that's fine. My folks are still around.

Mullan: What do your daughter and son do?

Crowson: My daughter lives in Wisconsin, works outside a small town. They live on a farm. She and her husband both work in the

town. She works for a manufacturing company, operations management.

Mullan: And your son?

Crowson: He's working for an electronics company, a Motorola distributor up in Duluth.

Mullan: And how does your wife feel about your career in medicine?

Crowson: I think she thinks it's great, but she's got her own business now she's working on, so I think she takes it pretty much in stride.

Mullan: That's good.

Crowson: She's really my balance. She keeps me centered.

Mullan: You made a good choice early.

Crowson: I think so. She really does. There are days I wonder why she puts up with me. I come home and I'm pretty strung out. She's been very supportive.

Mullan: Thank you, Terry. It's been great, and I appreciate all you've told me.

Crowson: Wish we could talk more.

Mullan: Well, we'll do it again.

Crowson: Yes, it's a lot of interesting history there, you know. Gene Rich--talk about training, Gene was one of the people who went through the training.

Mullan: At Ramsey?

Crowson: Yes, we had him in our clinics for six months, then he became one of our chief residents, and he joined us on the staff. Eventually, I turned the educational program over to him, and he moved it on a new level.

Mullan: We have him to thank for this interview.

[End of interview]

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