AMOS S. DEINARD

September 11, 1995

Dr. Fitzhugh Mullan,
interviewer

Mullan: What is your date of birth?

Deinard: 11/12/35.

Mullan: We're in Dr. Deinard's office at the CUHCC, which is the Community University Health Care Center/Variety Children's Clinic, is the full name of the clinic. We'll probe the full name and its history. It's the eleventh of September, 1995. We're in Minneapolis, Minnesota. It is a clear but cooler morning.

Tell me a bit about yourself. Are you from this part of the world to begin with? Where were you born and brought up?

Deinard: I was born right here in Minneapolis. I have only been away from Minneapolis for four years when I was in college. Other than that, I've spent my whole lifetime in the same neighborhood.

Mullan: Literally the same neighborhood?

Deinard: Yes. I actually live in the house now that I grew up in.

Mullan: What neighborhood is that?

Deinard: It's over by Lake of the Isles, in the Kenwood neighborhood.

Mullan: Tell me a bit about your background. What do your parents do and what brought them to Minnesota?

Deinard: My father was an attorney. My mother was a faculty member at Hamline University, St. Paul, for 16 years, teaching nutrition and biochemistry.

Mullan: They were Minnesotans to begin with?

Deinard: No, my mother came from Syracuse, New York, and my father was born in Terra Haute, Indiana, and moved here when he was two years old, I think.

Mullan: What was it like growing up here? What sort of community was it then and what was your youth like?

Deinard: My youth was unremarkable. Nothing special comes to mind as I think back on it.

Mullan: Everybody's youth is special. A pediatrician certainly believes that. How would you characterize it?

Deinard: Oh, it was comfortable. Certainly I wasn't lacking for anything, not that I had any great need, but it was a comfortable childhood with two professional parents who were out and about probably more than they were home.

Mullan: Brothers and sisters?

Deinard: One sister who is two and a half years younger, who also lives in the same neighborhood.

Mullan: Still?

Deinard: Yes. She's just a couple of blocks from where I live.

Mullan: You got the house.

Deinard: She had no interest in that. I bought it from my mother after my father died eleven years ago. But my sister had no interest in it. So there was no fight.

Mullan: Were there particular medical influences in your youth?

Deinard: I suppose my role model was my pediatrician, Max Seham, who was a practicing pediatrician all his life. After he retired, he was one of the folks who was involved in getting Group Health started, which now is one of the major HMOs in the community and in the state.

Mullan: He was influential in that he was a point of reference or you knew him or saw him?

Deinard: He was my physician. I went to him until I was older than some of the mothers in the waiting room, i.e., all the way through college. Whenever I needed medical care, I would go see

him. I believe that when I went to college, there was no question that I wanted to go to medical school and be a pediatrician.

Mullan: When did that form up? Literally before you went to college?

Deinard: Yes. I remember sitting, before I went, looking at the course book and deciding, knowing already what Minnesota required as electives for admission to medical school. It was a numerous list at that point in time, so it required some critical planning to be able to get all the courses in without having to go to summer school and still meet all of the graduation requirements at the university.

Mullan: Even majoring in a science?

Deinard: Well, I ended up majoring in chemistry because after I did everything I needed for admission, I needed only one more course for a major. I don't think I'd do that again if I had to go back and redo it.

Mullan: Because?

Deinard: Because I could have probably become more well rounded if I'd majored in economics or history or something like that. I was not that imaginative or daring in those days.

Mullan: Before we go on to college, in terms of your youth, were there other influences in high school? Was religion a factor? Anything else that was part of your upbringing?

Deinard: Nothing that I can think of that pointed me to medicine.

Mullan: So you went to the university here?

Deinard: No, I went to Harvard for four years. I came back and I went to medical school here. I've been here ever since.

Mullan: That was four years away. They came early.

Deinard: Four years away, yes. Other than that, I did my residency here. I've been on the faculty since I've finished my fellowship and didn't move very far.

Mullan: What were the four years at Harvard like?

Deinard: Fairly intense. I doubt that I could get in there today. The class that they're accepting today is so incredibly bright. It was not a very friendly place. I don't have any friendships that have remained from the folks that I knew there. I roomed with four people, one I've not heard a word from since the day we graduated, and one I had seen a couple of times, but even though I last went to see him, I haven't heard from him in four years since then.

Mullan: Did you feel like a Midwesterner or like you were from a different culture?

Deinard: I can't remember. I sort of moved on.

Mullan: A chemistry major was basically getting the premeds?

Deinard: Yes. Minnesota at that time required including physical chemistry for admission to med school. Since then, the requirements have been relaxed considerably so that today, were I to do it again, I wouldn't have this real long list of courses facing me I had then.

Mullan: The sense or the preconclusion that you were going to go to Minnesota for medical school came from what?

Deinard: My parents said, "You've been away, you can come home now." So I did.

Mullan: It was not a financial issue so much as it was a territorial issue?

Deinard: I don't know. I never asked. That was in the fifties. We just marched along in lockstep and did what we were supposed to do. It's a different time today. Kids today would, I suppose, behave differently.

Mullan: But it was not with any sense of disappointment that you came back. You were happy enough to come back to the university?

Deinard: Yes. If the truth were known, I would have been very happy just going to Minnesota. When I got accepted to Harvard, I would have been just as comfortable in Minnesota.

Mullan: So you did come back. And how was medical school here?

Deinard: How was medical school? A lot of work. I don't know the medical school has changed much. Here, at least in Minnesota, it is far more outside the walls than inside the walls today. Students spend much more time at the affiliated hospitals here in Minnesota than they do in the university hospital. In fact, apparently, from what I hear from the medical students is that today the hospital's not a very friendly place or a place that anyone really wants to spend time, but I did it. We spent most of our time in the hospital. Same with residency. Residency is far more focused outside the hospital than on the University Hospitals' pediatric wards today than it was in the sixties when I did it.

Mullan: Was your experience a difference between the first two years and the last two years? Did you like the preclinical work? Did you like the clinical work?

Deinard: I liked the clinical work. I almost dropped out that second year. Pharmacology was so incredibly dull that I was at my wit's end. But since it was just a finite period of time that I had to endure it, I did. The clinical years were very pleasant. Pediatrics was my first rotation, and there was no question. Everything paled in comparison.

Mullan: You maintained your intent of pediatrics.

Deinard: Yes.

Mullan: By this point, you'd certainly had a chance to explore the world a bit more, think about other possibilities within and without medicine. What was it, to the extent you can remember, beyond the influence of your formative pediatrician, that made the care of the child important to you?

Deinard: There's a lot of attention wrapped up in children. One of the goals, I think, of primary pediatrics is to try to do whatever you have to to ensure that that child can realize full potential. Children are dependent, at least for the first twelve to fourteen years, on their parents doing right by them. That does require the interventions of pediatricians. That's what part of the anticipatory guidance is about. Children, when they complain, are usually genuinely ill. Adults, when they complain, are so often not.

Mullan: The four years at the university were followed by, was it three years of residency?

Deinard: Yes, it was a three-year pediatric residency, and then I did a four-year fellowship, and then I joined the faculty at the end of the fellowship.

Mullan: Tell me about both the residency and the fellowship. What sort of period was that?

Deinard: Minnesota had then one of the premier pediatric residencies in the country. I think it's still a good one. There are more good ones today than there probably were back in the sixties. But it was a very pleasant three years and a year of internship/residency. It was designed so the interns were in charge of the patients. The interns wrote the orders and even the surgeons' orders weren't implemented until the pediatric intern had countersigned them. So there was a lot of responsibility, but that included not only doing the initial history and physical and writing the orders, but also being responsible for the discharge letter.

It was an excellent residency, I think, partly because there were few fellows in the early 60s. There was the opportunity, both as an intern and as a resident to care for patients. Back in those days when you interned, at least here at Minnesota, I was an employee the first year of the hospital. The second two years (the residency years), I was an employee of the Department of Pediatrics of the University of Minnesota. It's done differently today. I was selected. It was a hospital kind of selection, not a department selection, and that may have been true across the country. I don't know, I never looked into it. But that was the way it worked in Minnesota.

Fellowships were just beginning, so between the senior staff and the patient there was only the resident. You weren't basically the handmaidens of the fellows who so often today control the care of the patients under the fellowship training. So it was a different time.

Mullan: Was it a good time?

Deinard: Oh, it was an excellent time. Yes. But today the residents complain so much that oftentimes all we're doing is just following the orders of the fellows.

Mullan: Then you were more on the front line.

Deinard: Oh, absolutely. Hardly any fellows. When the fellows had things to do, we could say to them, "You do it. We don't have time to do it. We're too busy taking care of the patients. So if you want bloods drawn, you draw the bloods." And they did.

Mullan: In terms of the quality or the nature of the folks you worked with, your fellows in house officership as well as the faculty, what was it like? Was it a rich environment? Was it a struggling environment? Was it a work-laden environment? How would you characterize it?

Deinard: Well, it was a work-laden environment. We were on call practically every third night, third or fourth night. The rule that you could only work so many hours in a week hadn't been thought of yet. But it was a very exciting time, at least here in Minnesota. The whole field of immunology was opening up and Bob Good was here, who still is a giant in the field. He had some of the best conferences that were held in the department.. He (Good) was a very stimulating, thought-provoking individual.

I don't think Minnesota Medical School has seen a good day since the sixties. It's been downhill for this school since then. The school has been plagued by faculty misbehaving and lots of bad press because of faculty activities. There were some

giants here in surgery, medicine, pediatrics, distinguished leaders in the field, and they were not hiding in the laboratories. They were at the bedside. They would teach first from the perspective of the patient, not the laboratory. They didn't want to know about the laboratory at the outset of a presentation, only at the end. It was really patient-focused [unclear]. I felt that's the way to teach.

Mullan: You were finally at the point of laying hands on pediatric patients. How was that? Was it what you'd expected, or were there surprises? How'd you feel about being a pediatrician on the [unclear]?

Deinard: Well, probably okay, since I've continued to do it, and I could have moved in another direction, but I continued to enjoy the patient care, and the challenges of the practice. When I joined the faculty, it would shape the rest of my life. When I joined the faulty in '69, coming out of a fellowship where I had spent my time with a fellow who had trained under Bob Good, and I was working with him in the area of evaluating neutropenic patients. I continued to do that after I joined the faculty.

One of the expectations of faculty members at Minnesota then and today is that you have to find some of your salary support, grant, primarily grant, but any other opportunities that would bring in a dollar towards salary, because the department as a whole, unlike the undergraduate side of campus, where most faculty are supported almost entirely from state dollars, the dollar that comes to the medical school from the state to support faculty is not that great. Probably today it's 18 percent or

something like that. The rest is dollars that come in from private practice or from grants.

So in '69, I had an opportunity to become the pediatric consultant to the Maternal and Child Health Program at the Minneapolis Health Department. That was in the earliest days of the Children and Youth Project that the Minneapolis Health Department had. So I did that from 1969 to 1984 as 25 percent of my university commitment.

Mullan: This was to the program as a whole, or to the clinical?

Deinard: No, it was to the program.

Mullan: So it was the Children and Youth Project of the Health Department.

Deinard: It was C&Y money from Title V (Federal dollar) Maternal and Child Health Bureau. The city applied for and got in 1966 a C&Y grant, which continued at least through last December. Things have changed at the city since then, but there's still money coming to the city today through the block grant program of the State Health Department.

Mullan: It's Minneapolis or St. Paul?

Deinard: Minneapolis. So I became the pediatric consultant to the Maternal and Child Health Program. In that capacity, I did a clinic every week, and I was responsible for programmatic content of the pediatric program, and some involvement with the maternity

program. I used the clinical base as an opportunity to eventually bring medical students and pediatric residents down Health Department clinics and developed it over time as a site for students to get out in the community and see the real world.

Also, then I realized in about 1971 that I wasn't really going anywhere in the area of white cells, and money was getting harder and harder to get. So through the Health Department, because of that contact in that context, I got interested in kids with iron deficiency anemia, and it really shifted my research focus from white cells to anemia of kids, and then more recently to the problems of lead-overburdened kids and how to prevent it. So the grants I've had more recently really were focused on things that I was doing in the clinical arena. I can trace it back to the Health Department.

In '84, I was asked to come to direct the clinic where I am today. The university and the city of Minneapolis in 1966 both applied for a Children and Youth grant. Neither side knew of the other's application. The federal government said it wasn't going to fund two C&Y projects in the same town. So the Feds insisted that the two programs come together, and because the city had its application in first, the city became the grantee, and the university became a line item in the city's budget. So the program I came to in '84 had had C&Y money along with the city since 1966, so I was moving essentially from one C&Y project to another.

Mullan: And that's the CUHCC.

Deinard: This is where I am today. CUHCC, yes. Although it started as a pediatric program, today it is a full-service primary care program for patients of all ages. They added an adult program in the early seventies.

Mullan: I'd like to go back and trace that. Tell me a little more about your early years with the city. Your interest in bringing students to the community, tell me more about that and what the background to that was. Your training was university-based hospital focus as you described it, and yet your efforts here were to move students outside the university, outside the hospital setting, I presume, in pediatrics.

Deinard: Yes. I think it was a third-year medical student course back in the seventies that was to orient the students to doing a history and physical in a primary care kind of setting, although at that time the medical school was willing to take any staff doctor who was willing to spend time with a medical student in whatever clinic the doctor wanted to take the student to learn how to do a history and physical. So I agreed to do it, and I thought it would be an interesting opportunity to get the students down into the Health Department clinics where they could (a), see a group of patients whom they might not see at the University Hospital, inner city kinds of patients, but (b), to try to learn histories and physical as medical students at the primary care level, and not trying to do it on a diabetic with renal insufficiency.

So I pleaded with my boss at the Health Department and with the Commissioner of Health to be allowed to bring a student down

there. Because the city was very fearful of the university, it took a lot of pleading to get the powers-to-be to say, "Okay, we'll give it a try." I felt as though I was always down on my knees begging, but with a lot of assurances that the students wouldn't misbehave, and that there would be accountability, and any time the powers-that-be wanted to come to the clinic to see what was going on, they could. It was a big to-do to get the first student from the university into a Health Department setting.

Mullan: Because this was unorthodox?

Deinard: And because the city had no relationship with the university. They would send money to the university for the C&Y Companion project, but that was it. There was the Commissioner of Health, although he was a public health person, had no interactions with the School of Public Health. That was sort of a town/gown split, and it isn't the same today. But it was fairly impressive back in the seventies.

So anyhow, I can't remember his name, but I can remember his face, the first student that I took down to the health program. Over time, once it became apparent that it was an honest deal and the Health Department wasn't going to suffer in any way, it became more acceptable. After the first two students, I think nobody paid any attention really there afterward to what I was doing. They had a comfort level and it wasn't a problem.

So over the years I did more with medical students, and then in the residency program I and others woke up to the fact that residents were not getting the training that they needed in

primary care. A group of departmental people and I think I was the chair of that committee at that time, we did a survey, and we took a look at pediatric residents who finished the program from one year before out to seven years before. We put together a list of twenty-six questions. I'm sure we could have thought of another twenty-six. "How comfortable did you feel dealing with this particular issue when you completed your residency and today?" There were many who didn't feel comfortable when they got out of residency and seven years later still didn't feel comfortable. It became apparent that as a training program we weren't meeting the needs of the folks who were going out to practice.

Mullan: These were questions in the ambulatory area, or dealing with family?

Deinard: Dealing with families, dealing with child protection, dealing with sports injuries, dealing with the problems of the teens. The training program in Minnesota was primarily an in-patient training program, with heavy emphasis on all the subspecialties that made up the department. When I trained, I was one of twelve house staff. I don't think anybody went into practice. They all ended up in academic positions. Today, starting in the late seventies, about 50 percent of the group was going out to practice. It was those folks who, it became apparent, we were not training very well. So the department decided to start doing some continuity care.

Mullan: What year was this that the survey was done?

Deinard: I want to say late seventies--'79, '80, somewhere in there.

I don't know that the academy hadn't already identified this as a need within training programs. I doubt that Minnesota was a leader in this particular venture, because the faculty was so committed to the old days when we as a training program were at the top of in-patient subspecialty training to make academicians out of the house staff.

The department started a continuity care rotation that wasn't nearly as well focused as it is today, but I started using the Health Department clinics as a site for that, and had residents a couple of times a week in clinic.

Mullan: You just moved from having one student to now having several residents?

Deinard: I had residents and medical students. The medical students continued. The Health Department used to run an evening clinic, so I had a couple of residents doing an evening clinic, five-to-seven sort of thing. Then they started to complain that nobody else had to do an evening clinic, so it only lasted a couple of years before they had to stop. But anyhow, that was the beginning. Then when I came here in '84, we've had students and residents here continuously. But here there was never any question, because although we're currently a clinic of the University Hospital, we're still embedded in the university, and need to pay some attention to the educational mission of the university.

Mullan: Let's pick up the story of the Community University Health Care Center. It started with C&Y money?

Deinard: No, it started actually with the university's central administration in 1966 responding to the south Minneapolis community's insistence that the university show more interest in the community. Similarly, the legislature was on the university's back to do the same thing. So the university decided to start a small clinic. Now, this was in the pre-Medicare, Medicaid era. So there were a lot of kids who were at best getting episodic health care from emergency rooms. Although the insurance industry wasn't as well developed in the sixties as it is today. So there were families that were well off, parents paid for care out of pocket. Those who were not well off ended up going to Minneapolis General Hospital or one of the neighborhood community hospitals ER and getting care [unclear]. So the university decided to start a small pediatric program. The neighborhood that was selected was selected because it had been and continues to have one of the highest medical-social risk factors of any of the cities in the 84 neighborhoods.

Mullan: What is this neighborhood?

Deinard: It's called the Phillips Neighborhood. It's here on the map. It is a neighborhood that is more populated than thirty-seven of the state's counties.

Mullan: Tell me a little bit more about the Phillips Neighborhood. We talked about its being a diverse neighborhood. There had been both Habitat for Humanity working here.

Deinard: They put up some houses recently, and the neighborhood has got a number of boarded-up houses where citations have been issued against the property by the city inspectors, and the landlords have chosen not to make corrections. Some houses have burned down, others have been razed because they were uninhabitable. The neighborhood has got about 80 percent rental property. It's a very ethnically diverse neighborhood.

Mullan: Urban Indian?

Deinard: It's been referred to by some American Indians as the largest urban reservation in the country by virtue of the large percentage of American Indians who live there. The neighborhood is bordered on all four sides by major thoroughfares, including two interstate freeways. Thus the lead content of the soil is high, and that poses a problem to the kids in the neighborhood.

Mullan: It's soil as well as paint? Or just paint as well as soil?

Deinard: Much of the housing was built in the latter part of the last century, the early part of this century. So it clearly has got lead paint in it, unless it's been renovated.

Mullan: At some point the clinic moved from being just pediatrics to full service. Tell me about that.

Deinard: In the early seventies, the parents of the kids decided that they liked the care that they had seen the kids getting for the preceding six or seven years and decided they wanted something similar for themselves. Keep in mind that the clinic started in the pre-Medicaid era. Unless the family had dollars or some kind of health care coverage, they were paying out of pocket for care, and since they were poor, their kids were at best getting episodic care at the emergency rooms.

So the governing board of the clinic in the early seventies went to a national foundation--it was either Kresge [phonetic] or Kellogg--and got money to test the efficacy of a prepaid health plan. At the clinic level, the plan is pretty much like what most community clinics operate, except that payment is on a capitated monthly basis rather than a sliding scale fee for service. We also have a sliding scale fee-for-service program. But the prepaid plan allows a family to pay based on family size and income, a certain dollar per month. For that dollar they then get as much in-clinic medical care as they need. They pay that money whether they come to the clinic or not. For the dollar you get as much medical care as you need, and ten free mental health visits a year if the need for mental health services can be documented. Dental care is on a sliding scale fee-for-service basis.

What makes the program unique, I think, in the country, is the relationship that the university hospital and the private practice groups of the university faculty made with the plan at

its beginning in the seventies. That is that at no time will anybody who is on the plan, who gets care at the hospital, for whatever reason, whether it's a lab test, an X-ray, an ER visit, an in-patient stay, or an out-patient subspecialty clinic visit, at no time will the patient ever be billed for the care. Either the patient comes with some insurance, and there are some people on the prepaid plan who have union health care coverage, which covers in-patient, but with a large deductible. It doesn't cover out-patient. So they joined the prepaid plan, and to get the out-patient coverage. But if they get hospitalized, the union policy might apply once the deductible is paid. Either the patient comes with some insurance, or because of the indebtedness incurred, the patient becomes MA-eligible. We ask all of our patients to apply for MA if they incur a bill of $1500 or more.

Mullan: MA being medical assistance.

Deinard: Medical assistance.

Mullan: Which is Medicaid?

Deinard: Yes. We ask all of our patients who we know either will or have already incurred a bill of over $1,500, we ask them to apply for MA. They don't have to get it, but they have to apply. If they choose not to apply, then any bills are theirs. If they apply but don't get it, then both the hospital and the private practice group write off the charges. The hospital actually has a line item in its budget of $600,000 this year that will go exclusively towards the writeoff of care provided to

prepaid plan patients at the hospital. The private practice groups have never set a cap. I've not found another fund in the country that's organized that way.

Mullan: Who subscribes to the plan? The working folks in the neighborhood?

Deinard: Well, it started in the old days with the Un and Underinsured, Corridor Poor joining the plan.

Mullan: Corridor. Which corridor are we referring to? That's what this geographic area is? Or we're talking about the corridor between the insured and the uninsured?

Deinard: Yes, it's that latter. The plan started after Medicaid had begun. So the lowest income were then and are now covered by MA. Then there at the other end there's a group who have insurance through work, whatever. But there's a group of people who may be working, but the federal law says if you work in a place that has a small number of employees, the employer doesn't have to provide health care coverage. Or they're part-time workers and they don't qualify, even though they're working.

Mullan: The working who are uninsured.

Deinard: Yes.

Mullan: Did those folks buy into the plan? What is the premium like, and do they pay regularly?

Deinard: Well, the lowest premium for a single adult who is at step zero, and the steps are based on the federal poverty guidelines. The lowest amount would be, let's say, $24 a month. For $24 a month, that person could come to the clinic every single day. For people on the plan, it's insurance. So they pay the $24 and don't come to clinic for many, many months. But they're still making the payments, because we let them know that if they don't pay, they don't stay on the plan. We're not obligated to keep them on the plan if they don't pay. We've got presently about 1,800 people who are on the plan.

Mullan: You're serving as an insurance company. I mean, you're performing the function.

Deinard: That is an issue that has just surfaced. Ten years ago when I started here, I and some folks from the hospital--although the clinic started in central administration in the university, in 1972, when the Office of the Vice President for Health Sciences was created, the clinic was moved administratively within central administration to the vice president's office. When the second VP for health sciences came in '83, he didn't want clinical programs in his office. So a year was spent trying to decide what to do with the clinic. I didn't come until after the deal was done, but I think he basically told the hospital, which he also controlled, "You're going to take the clinic." I've always felt for twelve years now that the clinic is an albatross around the hospital's neck, that they never really wanted it, but they've got it and couldn't do much about it.

So in '84, the clinic became an entity of the hospital, and all of the staff who had previously been university employees then became university hospital employees. The hospital had established a degree of autonomy from central administration, in that it managed its finances a bit apart from the university, but its budget still flows in to the university's budget, and it was able to create its own civil service system, personnel system. So all of the staff except for the academics became hospital employees.

So in '84 when I started here, some folks from the hospital and I went to the state and told them about the plan and asked the question, "Are we okay?" Or "Do you want to call this insurance and run us out of business?" They never got back to us.

I ran into one of the people on several occasions, and I asked him whether we were ever going to hear and, basically, the message was, "You're okay. You're not bothering anybody. We know about you, and silence is in your favor." That was where it stood.

We have more recently, in the last six months, gone back to the state to ask the question all over. Health care in this state has changed a great deal since 1984. We wanted to be reassured that all's well with the prepaid plan. Now the state has come back and said, "Sorry, but we look upon you as insurance. Therefore, either you're going to have to follow the rules of the insurance industry, which includes having a large reserve, which the clinic doesn't have, or you're going to have to fold your clinic into a community integrated service network or HMO, or you're going to have to shut the plan down." So the

clinic is at this moment trying to figure out what to do, given this bit of news from the state.

But at the same time other things are changing. The hospital is in the process of merging with one of the large community hospitals, and now the next step is to ask the new owner, or the new entity that will result from the merger of these two hospital systems, whether it wants to, one, support the prepaid plan. If the hospital doesn't want to give the writeoff, the prepaid plan loses a cornestone. It has to change. The beauty of the plan is that the patients today have total coverage. They can get care if they're sick; they can get care if they're well. They have to get care within the University Hospital system. If they get sick someplace else and can't get care at the university hospital, the plan doesn't cover it, and they know that when they join. But in the old days when we truly had poor people on the plan, they probably weren't going to go skiing in Switzerland anyhow, so if they broke their leg it was going to be in Minneapolis, and they could come to the University Hospital and get care, and then the care would either be written off or there would be some kind of coverage to cover it.

Mullan: What you have, if I understand it, you have, at least in form, a sliding scale, low rent, prepaid insurance plan, where the risk was being carried by the university or the University Hospital, $600,000 set aside in the budget, the risk being always the issue for any plan if you get very sick people. Can you handle it without folding?

Deinard: The clinic had the risk of being able to carry that population of patients with its resources given what the patients were paying for. If everybody on the plan came to clinic every single day, we wouldn't fare very well.

Mullan: I would think the larger issue, from a plan's point of view, would be when you had a patient with AIDS, or when you had a premature infant who had three months of NICU care.

Deinard: But many of those people would quality for MA, so then the hospital would bill MA. What we have found more recently, even if we keep the clinic, we're going to have to modify the plan. What is happening today is that people with means realize that the prepaid plan is one of the best deals in town, and so they join, even though they may be at one of the higher steps because of their income. But when they need to apply for MA, MA says, "Unless you divest yourself of some assets, you're not eligible." There's nothing, as the plan is currently written, that obligates them to divest themselves of assets.

We recently had a family that chose not to divest of assets and the hospital wrote off a bill of about $160,000. One bill. You do that five times over, or four times over, and you can eat up the whole $600,000 for the year in short order. That's not fair any longer.

So if the new hospital entity decides it wants to continue to write off--and keep in mind also, this whole thing started back in the days of Hill-Burton, when the hospital, because it was getting Hill-Burton money, had to have some kind of charitable care. So this was a good way of doing it.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Deinard, tape one, side two. Continue.

Deinard: There is no Hill-Burton money anymore, so the hospital is not mandated by some other entity that it has to. It could feel obligated because of the community spirit, to do something for the community, but it's going to be up to the new management to decide whether it wants to continue the writeoff. If it does, since the new entity already has an integrated service network, we could probably fold the plan into that and keep it going, with some new expectations of the family, that they not only apply for MA, but comply with MA.

Mullan: This is fascinating in terms of a variant on the themes of care of the poor with the effort to do a prepaid plan within the confines of the clinic. Let me pick up on your story. Let's go back to 1984 and both the offer to and your decision to undertake the directorship of CUHCC. At that point you'd had both an academic career with, as I understand it, a fair amount of attention to research in the hematologic area in general, and the MCH work that was more applied public health, clinical medicine in a public health setting. At the point in 1984 you made your decision to change or shuffle out a little bit. Why and how did that come out the other side in terms of percent of time and interest and so forth?

Deinard: In the early eighties, because of my time spent at the Health Department, I decided to get an MPH degree. I started in

the early eighties, and my department chair at that time told me that it was a waste of time, and he really couldn't support it. But I did it, and he couldn't say I couldn't do it as long as I continued to do everything that I was being paid to do. So it took me a couple of years longer to get the MPH, taking a course at a time, but I finished in '85.

So when the offer came along to come to CUHCC, in view of the fact that the new director at the Health Department was a far more controlling individual than anyone I had worked for previously, the fun was gone down there, because of the disposition of my department chair, it seemed reasonable that the best of all worlds was to be as far from the department chair as I could get. Coming to the CUHCC made sense, because it got me a full-time salary and the department chair couldn't control me. He was a person who quite predictably--people today say, "My God, look what he did to the department." It could have been predicted before he took over what he would do to the department. His personality didn't change one iota. People who decided to install him were blinded. Anyhow, he almost destroyed the department.

Mullan: But this gave you a degree of independence.

Deinard: Yes.

Mullan: It was a full-time directorship?

Deinard: Yes.

Mullan: Had there been a director before?

Deinard: Yes. There had been several directors before. It was started by people in the pediatrics department, and then for a period of about ten or twelve years, it was directed by a person who, I think, was a general practitioner. She completed her training before family practice had ever been born. She spent most of her time keeping herself as far removed from both the city and the university as she could. It was a university clinic with city money in it. Whenever the city got too close, she would complain to the university. Whenever the university got too close, she would complain to the city. I have spent the last twelve years trying to get closer to the university, and I didn't have any problems with the city, because I'd been part of the city for fifteen years before I came over here.

Mullan: As you took on this job, though, it meant a major increase, I would presume, in your administrative activities.

Deinard: Yes.

Mullan: Some continued clinical work and some continued research work?

Deinard: Yes.

Mullan: Tell me about that.

Deinard: I tried to keep all the balls in the air.

Mullan: Which were your major enterprises, or how was that played out?

Deinard: Well, I do probably 10 percent, 10 to 15 percent clinical a week, and I've got a couple of research projects going which, I hate to admit, I don't devote enough time to, because the administrative work has just escalated, particularly now since the hospital is in the process of merging, and the university decided unilaterally, and without any discussion, to keep the clinic and not let it transfer to the new health system, even though all the other hospital clinics are transferring to the new health system. The university decided to keep this one. So now we're going back into the university structure, back where we started.

Mullan: So you spent 70 percent of your time in administration?

Deinard: Well, 100 minus 10 minus 20, but that doesn't translate to .7 times 40 hours per week. The hours are way more than a forty-hour week, but the percent effort, I suppose, is 70, 75.

Mullan: Tell me at this point in time how large an enterprise it is, how many physicians you have, how many staff.

Deinard: Right now the clinic has got ninety-six full-time equivalent staff, which translates to about 130 people.

Mullan: FTEs?

Deinard: Ninety-six. About 130 people, doctors, nurses, nurse practitioners, midwives, dentists, dental hygienists, dental assistants, social workers who do counseling, psychologists, psychiatrists, acupuncturists, lab, clinical.

Mullan: What percent pediatrics?

Deinard: Our registered base is approximately 8,000 patients, of whom around half are kids, and about 60 percent of the registrants are female visits per year, roughly 8,000 pediatric visits a year, and 9,000 adult health, and about 1,700, 1,800 OB/GYN visits.

Deinard: So you have 17,000 visits a year. It was 8,000 pediatric, 9,000--

Deinard: Eight pediatric, nine adult, OB, then we have dental visits, and mental health visits counted separately. We are currently the hospital's largest clinic, about 18 percent of out-patients census is here.

Mullan: How much teaching in terms of presence of students or residents?

Deinard: We have currently, I think, twenty-one residents here.

Mullan: At a given time?

Deinard: No, during the week. All of the primary care programs today have a continuity care expectation. So we have pediatric residents and we have internal medicine residents. Minnesota has the largest combined medical-pediatric residency program. So we have some of those residents. We have six OB residents, we have four psych residents. Plus, we have School of Public Health students who want to do a field placement here. We have clinical psych students who do field placement here. We have baccalaureate and master's-level social work students who do field placements here.

Mullan: You've got a lot of teaching going on.

Deinard: So I think we're holding our own as far as fulfilling that mission, given the amount of space we've got, and the fact that until the current fiscal year, which just began, we had no university money in our budget to support education. We had for a number of years some financial support from central, but about eight years ago, central just turned it off without so much as bothering to tell us that it was happening.

So this past year, or for the current fiscal year, I worked a deal with the dean of the medical school, that unless he could support some education here, we couldn't have residents any longer. We are expected by the hospital to have a balanced budget. When you're mentoring residents, you see two, three patients less per half day than you would if you were seeing patients without any students.

So we calculated what amount of revenue could be attributed to that difference in patients, and the dean's office is matching

that dollar this year. Now, that was all negotiated before the merger came along. Now that the university has decided to keep the clinic, and the dean has now become the provost for the academic health center, there's a new set of discussions about to begin as to what kind of support there will be from the provost's office hereafter, because the clinic is multidisciplinary. It's going to be at the provost level rather than at the medical school level in the administrative structure.

Mullan: You've had twelve years here in the leadership of this enterprise. How has that been? How have you felt about your work? How has it evolved and developed, speaking on a sort of global level as opposed to a particular level?

Deinard: I think it's been very rewarding from the perspectives that in the twelve years the clinic has grown. When I came here, we probably had 5,000 registrants; now we've got eight. When I came here, we had about a $2.5 million budget; this year it's 6.2. We've moved into a new building five years ago, and it took seven years to achieve.

Mullan: Which year was that? 1991?

Deinard: 1991. When I was hired in '84, I was told the first thing that the hospital was going to do for me was to get a new clinic built. The building that the clinic was in then was a building bought by the university in 1966. It was an old four-story apartment building which, when we tore it down in '91, was about 107 years old. It was a pit.

Mullan: You got this built, then opened.

Deinard: I came in '84. We started serious discussions about the building in '88. We finished it in '91, moved in in '91. The building was supposed to last ten years before we outgrew it, and we grew so quickly that we outgrew it in three years. That's a testimony, I think, to the quality of care that's provided here and the staff. Not me.

Mullan: Who do you feel you work for? There's the university, there's the hospital, there's the Health Department, there's the community.

Deinard: I don't work for the Health Department anymore.

Mullan: The Health Department's off the table.

Deinard: Currently, I've got two bosses. I report to the Department of Pediatrics chair and to the hospital, because the clinic is a clinic of the hospital, and I'm a director of the hospital clinic. After the merger, I will report to the provost as well as to the Department of Pediatrics, because I still am a faculty member.

Mullan: How about the community? You mentioned at one point a community board.

Deinard: Well, the clinic had a governing board in the early seventies. When I came in '84, there was still a board of sorts.

It was very dysfunctional. Most of the members were mental health patients, and it just was not a very functional board. It was mostly a time for people to talk about their mental health problems.

So then in '88, when we were in the process of starting to talk about the new building, we were approached by a community clinic that was having financial difficulty, and whose board asked if we, the University Hospital, would acquire their assets, which we did, with the expectation that within a year we would all move into one building. That year stretched to three. So for a couple of years we had the old board of that community clinic as the board for the clinic as a whole. But that board realized that when you're part of the University Hospital, you really don't have much opportunity to make independent decisions, in that everything that was decided had to be approved, or more often the case, disapproved by the hospital. So the board died.

In '93-'94, I started to put together an application for a federally qualified health care center (look alike designation). It took a long time to work that through, because the first response I got when I called to inquire was, "We don't want to fund University Hospital out-patient clinics." It took over a year to convince the powers that be at the Bureau of Primary Health Care and at HCFA, that really we were quite separate from the hospital and a degree of independence, and did our own billings, and had our own budget, and paid our own bills, etc. So finally I got the designation, with a waiver that I had to create a governing board. So I went back and put together a governing board. The governing board started in July of '95.

The governing board will assume much more importance in terms of the running of the clinic once we're out from under the hospital. The provost's office doesn't run clinics and, once again, you as a program in that office, he is looking to the board to exercise more management of the clinic.

Mullan: You've been the lead of this clinic during a time when issues of health care for the poor have been prominent. It's waxed and waned a bit, but clearly there are many uninsured, many problems with care of the poor. Do you see yourself as a pioneer in this field, or do you see yourself as an university emissary to the area? How would you characterize your role in regard to health care for the poor?

Deinard: Well, certainly, I wouldn't call myself a leader. The clinic is one of nineteen community clinics that's providing health care to the un and underinsured.

Mullan: Nineteen in--

Deinard: In the Twin Cities area. In fact, a meeting I have to go to next is as the treasurer of the consortium of community clinics. So in one respect, I'm not doing anything different from any of the other clinics. We're the biggest clinic; we've got more services than the other clinics; we're the only clinic that has a tie to a hospital. We have a much more seamless care program for patients since we use the hospital's clinics and in-patient service. We have the chart here. When a patient goes to the University Hospital, the chart goes over there with the staff

writing, and the chart comes back. So we don't have to wait for letters, faxes, and E-mails about patients. We just have to open the charts. None of the other community clinics has that. My staff would argue with me that it's not the best, because so often you don't have the chart, because it's at the hospital. But when you do get the chart, you've got full information on the patient. I think that's a plus.

So I think we're a good clinic, a good model for this community. It's got a very good reputation in the community. Our growth over the last five years has all been by word of mouth and reputation. There's been not one promotional item to promote the clinic. My job is to hold it together, to keep relationships up. My predecessor did great harm to this clinic by distancing herself from the university.

Mullan: The question of how to provide universal coverage has been one that's dogged American politics and American health care for a long time, and certainly this is a marvelous representation of one effort to put a university finger, if you will, in the dike. You've experimented with prepaid care, you've experimented with comprehensive care. I don't mean experimented, but you've tried, demonstrated, prepaid care, community-based care, university affiliated care, etc. You clearly lived among others who were trying other kinds of community care approaches to things. What would you conclude from that in terms of how we ought to close the gap, close perhaps that corridor we were talking about? If you were king, how would you put in place a permanent and satisfactory system for bringing the rest of the population in under the coverage of the system?

Deinard: We can't do it without money, and if you had the dollars, I think the model we've got here to clone this clinic, this model, would not be such a bad idea.

Mullan: Which aspects do you mean? Obviously the universities of the country cannot, will not be able to handle either the health care or, goodness knows, the cost of care of the poor. Or are you suggesting that they expand and do that?

Deinard: It's the cost of the care. If to cover everybody you need a dollar or two to support it, certainly the University Hospital in Minneapolis is dying for patients. It's in such financial difficulty that a merger, other university hospitals are likewise merging, Stanford and San Francisco and two of the big New York hospitals. One after another [unclear]. What's happening in Minnesota is going to happen elsewhere in the country in the next few years.

Mullan: So there's potential capacity in university hospitals because of the change in the system.

Deinard: Yes. And the fact that I'm sure that in other communities there's the same problem. At one time the University Hospital was the only place you could go for certain kinds of care. Over the years we've trained the competition. They stay here. Minneapolis is a nice place to live. So you don't have to get your heart transplanted at the University any longer. You can go to Abbott Northwestern down the street here about six blocks from this clinic. You can get your kidneys transplanted

in two other hospitals here in town. The university has got very few areas where they are the only providers in town for services.

I thought for a long time, the clinic--the prepaid plan has really managed bad debt. We're the gatekeeper for those patients, we say to the patients, "If you go to the hospital for services without our approval, then you pay for the care. It's not a writeoff. We'll send you there when we think that you need it." That's what all of the payers are saying to do. "We want gatekeepers in place."

If there were no plan and those patients ended up here at University Hospital anyhow, I think the hospital would see them. Probably carry a lot of bad debt, and we wouldn't collect that. We're controlling that in some fashion. The hospital also benefits by virtue, even though they wrote off last year $600,000, the revenue that they generated from all of the patients who came over, including those on the prepaid plan who did become MA eligible, the hospital generated somewhere between $2 and $3 million. That they didn't make a money is a reflection of their expense side of the ledger. Reimbursements are no different for university hospitals than any of the other hospitals. The DRGs say you get so much for a certain kind of patient. MA pays a certain dollar regardless of who's billing. You make or you lose money on whether you can control your expense.

I've wanted for a long time to clone this clinic in an area where there are a group of doctors who are saying the same thing. "We've got a lot of bad debt and we'd like to manage it." And a hospital. All you need to run this is a hospital that is going to care for the patient, and a group of providers who are willing

to see the patients. Play by the same rules. Have them apply for MA, and write off what you can't bill for. Show that over time you have fewer patients showing up inappropriately, or with a lot of illness that could have been prevented if only we had a primary care site to go to.

Mullan: Let's focus on that for a moment. This has been in recent years a period where the notion of generalism in primary care has been more prominent. How have you seen that, having worked in this area during the period when it wasn't so prominent, it wasn't seen as such an important part of the system? Has that changed in terms of the quality of people that are coming to practice primary care or the career decisions that are made? How do you register, or have you registered any change in the environment significantly?

Deinard: I mentioned earlier that 1962 when I finished my pediatric residency, nobody went into practice. In the last fifteen years probably half of every graduating class of pediatric residents has gone into practice--primary care.

Mullan: That's directly into practice without doing a fellowship or subspecialty.

Deinard: Absolutely. Right out of residency into practice. The new provost says the new focus, or the next focus, for education is going to be in the community. In fact, the university's medical school and nursing school recently got a four-year grant from the Kellogg Foundation to create a community-university

educational partnership to train medical students, nurse practitioner students, pharmacy students, dental students, nursing students, etc., how to work within communities, with communities, on behalf of the communities, to improve the health of the communities. This clinic was written into that plan as one of the central places where that education's going to occur. That may have been another reason why the university decided to keep the clinic, because of that grant.

So that's the direction the training's going to go in. That's the direction where health care is moving. There are way too many specialists being trained today. You don't need that many specialists.

Mullan: So you're pretty well positioned for the future.

Deinard: I think we are. If there were two or three more clinics like this that would be willing to work with the university, the university is desperate for places to put trainees and students to get that kind of experience, because that's the real world today. No sense pretending that you get your education caring for tertiary care patients on a ward. There are very few of those patients today.

Mullan: What has the phenomenon of managed care in the Twin Cities in which it's been a much more prominent part of the system for longer meant for your work here?

Deinard: I've been part of it for so long that I feel as though I've grown up with it. When it first started here in the medical

system's population, in '85, the state got a waiver from DHS to test the efficacy of managed prepaid care for a third of the medical assistance recipients in Hennepin County. The Department of Family Practice created an HMO as a way of protecting its residency training clinics. We were able to get into that system as the only non-family practice clinic.

I've been doing it for eleven years now, since it started here. I suppose, for the outsider, one, there's some control. There are expectations that the plan has that you meet as a provider quality indicators. You have to accept the fact that you're getting a small dollar per month, but you're getting it on a larger number of patients and you have to somehow organize your budget to live within that dollar. You're told what each plan considers to be primary care services, and if you don't provide those services, you might lose some of your monthly capitation. But if you can adjust to the rules, we do okay by the prepaid plans.

We have our own prepaid plan. We do very well. A few years back, I took a look at a group of prepaid plan patients who started in the plan a year earlier to see how they used it over time. There were several of the patients who had never been in the clinic in a whole year. They were paying; they knew they could come; they just didn't have any need for it. Did they use the University Hospital a lot? No. Some of have never been to the University. I don't think any referrals to the hospital were in that population of patients.

Mullan: So you're comfortable with managed care as a movement.

Deinard: I am, yes. We participate in two managed care programs in town. It's very interesting to me, since each of those plans is getting the same dollar from the state for each patient.

Mullan: These are managed Medicaid, as it were?

Deinard: Yes. The state is saying for each--they have a rate cell mix. So depending on whether you're male or female and what age you're at, the state has figured out it will give the plan X dollars per patient per month, and then the plan turns around and give the clinic a lesser dollar per patient per month. One of the two plans pays us roughly on the average of $32 per patient per month. The other plan pays us $16.50 per patient per month. They're each getting the same dollar from the state. So where is that revenue going? One of the plans was put together by the Department of Family Practice, at the University, to protect its family practice clinics. That's the plan that pays us $32 a month. Their own clinics are doing okay by the plan.

The other plan was put together by the county to protect the country hospital. So I would imagine that the difference between $16 and $32 is somehow buried in the county budget.

Is that fair? It seems that the plan shouldn't be protecting the county hospital. It should be protecting the clinics. I may not be able to continue to do business with that clinic if I didn't have FQHC. With FQHC it doesn't matter whether you get $30 or $16 per patient per month. FQHC is going to reimburse up to 100 percent of reasonable cost for that population of patients; it'll just come out of a different pocket. But if FQHC disappears, then at that point I may not be

able to do business with the plan that is keeping so much revenue for the county.

Mullan: Is that because you're federally qualified, regardless of what the plan pays you, the feds make up the difference?

Deinard: Yes. That's the way FQHC works.

Mullan: Holds you harmless or makes you whole.

Deinard: For Medicare-Medicaid patients. But the state, in its desire to save a dollar, has gotten an 1115 waiver from FQHC, which, in part, eliminates FQHC in three years. So if that isn't reversed by either the state or the federal legislature, in three years there's no more FQHC.

Mullan: Who pays you the FQAC? Does that come through the state?

Deinard: Some of the money comes from the state and some of it comes from the feds. We haven't done our first settle-up yet. I haven't seen a check.

Mullan: You have moved from white cells through--we hadn't talked too much about it--through--

Deinard: Red cells to lead to public health.

Mullan: Right. Tell me a word about that, how you see that, how you feel about that.

Deinard: Public health is far more meaningful for a large group of patients. My working in white cells was insignificant. I've done a couple of things in the area of red cells, and anemia, and lead. That maybe made a little bit of a difference but, I suppose if you want to measure it on difference per hundred thousand lives, the public health clinics work is the far most important thing that I do.

Mullan: It's a very different set of perspectives that one brings to looking at a cellular configuration such as the white cell and looking at a population such as the Phillips neighborhood. How do you carry both those in your head? Many people, of course, don't.

Deinard: Well, I've forgotten about the white cells. It's not important anymore. The end result is that I have very little free time. When I leave here, I take a bag home, and I have four hours of work, at least ten hours on the weekend, to do at home. So I'd have a little more personal free time if I didn't have the lead project in research. But I would be still putting in if I were just a freestanding clinic and not part of the university, I would still be doing all the things that I'm doing to keep the clinic open, because the clinic's important. Even though south Minneapolis has got lots of docs, you could shut this clinic down and there's still plenty of physicians on paper, and dentists on

paper to take care of the patients, but many of those providers have no interest in caring for this population.

We call a dentist to find out if they take MA patients. Oh, yes. And when is the first appointment? Two years from now! And they really don't. There are barriers there to keep patients from getting care. I think this clinic has addressed those barriers, and the fact that we've drawn in and are bursting at the seams attests to the fact that patients see fewer barriers here. They'd rather wait a month to get in here than go down the street where they may not be able to get in at all, but at least there is somebody else down the street. Maybe they've tested that already and the fallback is here. I don't know, I didn't ask.

Mullan: Tell me just a word about the lead work, as we passed over it but not talked substantively about it.

Deinard: In 1991, shortly after we moved into this building, I was approached one Friday afternoon by three residents of the community who came in unannounced and chewed me out for two hours on the topic of the clinics not doing enough for the neighborhood. I pointed out that we were caring for a lot of the neighborhood's patients, and I was told that that was not enough, that the clinic ought to be a focal point for helping the neighborhood address its problems. After a lot of discussion with the neighborhood and with the elected officials, etc., the conclusion was I would use whatever resources I had available to me through the community and the university or the clinic to help the neighborhood, but the neighborhood would have to think of the

problem. I wasn't about to second-guess the neighborhood on what was most important.

So a year went by, and finally in February of '93, the neighborhood came back and said, "We're concerned that 50 percent of the kids in the neighborhood have elevated blood lead, and the city is being unresponsive to our cries for help. Would you help us?"

We started to meet, and we ultimately created what is now known as the Phillips Neighborhood Lead Collaborative. It's driven by the community. They set up the agendas; they hold the meetings. I still view myself as a consultant to that group. As we looked at solutions to the lead problems, first of all, I don't think that the number 50 percent was accurate. It was way too high, but, unfortunately, neither the city health department nor the state health department had any data to suggest a true figure. So we had to go with the fifty since we didn't have anything else to rely on. We looked at the options and deleading houses, but there wasn't enough money in the till to do that. It's somewhere between $20,000 and $30,000 a house.

The alternative was to try education, on the theory that if parents knew what lead is, where it comes from, what it does to you, how you get it, how you avoid it, it could keep your kids lead-free. I've lived in a leaded house all my life and I don't think my blood lead is elevated. I wash my hands a lot. Families who live out west in the shadows of lead smelters, their kids don't have elevated blood leads either, because their parents know about wet mopping and vacuuming, and cleaning out window sills, and washing kids' hands, and not letting them play in dirt.

So we created an education program that's been funded by the CDC and Maternal-Child Health, to test the effort to see if culture-specific education where we have American Indians being taught by American Indians, and blacks being taught by blacks, and Hmong being taught by Hmong, how to deal with lead. We're only halfway through the project to see whether we can show that education does make a difference. We will have a product that's exportable to other communities.

Mullan: And you've been tracking some cohort of kids' blood levels?

Deinard: We're taking kids. We're enrolling mothers in the prenatal program and following their kids for three years and looking at blood leads and home lead and soil and water [unclear].

Mullan: With a control group?

Deinard: And there's a control group. Basic education. These are folks who learn about lead simply from reading the newspaper, watching TV, whatever you get just from being alive and paying attention.

Mullan: Going back to your initial instincts in medicine which were towards the care of children, towards pediatrics, you've seen pediatrics change and grow over the years. You've practiced in a variety of ways. How do you see yourself as a pediatrician

now? Do you see yourself as a pediatrician now? Where do you see it all headed?

Deinard: I still consider myself a pediatrician, but I must admit that except for doing primary care down at the clinic, I haven't done any ward work in many, many moons. I would be a disaster on a ward right now. If I were to do it all over again, would I do the same thing? Yes. Pediatrics is so vitally important a profession, subspecialty or specialty of medicine. That's not to say that family practice physicians don't do as well. I work with them, and I periodically am a little distressed at some of the things they seem not to know. That may just reflect this particular training program and is not meant to be a condemnation of family practice overall.

I think very highly of nurse practitioners. I think they do a splendid job. I had to do a reference for one of my nurse practitioners who went out East to Stamford, Connecticut. I think she was the first pediatric nurse practitioner hired in private practice. The person who called me was a pediatrician, and I said I think that nurse practitioners provide better care than pediatricians, and she just gasped, "What? How can you say that?" I happen to think they are more committed to the families, they are more detailed--at least the ones that I know. If I were to start a clinic de novo, I would hire a staff of nurse practitioners and have a couple of physicians around to be consultants.

Mullan: Talking pediatrics, or talking in general?

Deinard: I'm talking about pediatrics and internal medicine. I probably would do the same with OB, have midwives with one doc who could take care of the complications and so forth.

So I think the field has got--well, as long as there are children, there is going to be something for pediatricians to do. The issues that led me into pediatrics, they haven't changed any. The kids still have bad potential, and it's somebody's responsibility to make sure that kids are left whole enough to realize their potential. A need tend to protect them from society, and maybe from their parents. Some of our most frustrating cases are families where the parents are both PhDs. They're just so wrapped up in themselves and their work that the kids get short shrift.

Mullan: The future of pediatrics, do you see with the growth of both family practice and nurse practitioners, the pediatricians' role changing?

Deinard: The role of the subspecialist is going to change. Maybe even the role of the general pediatrician down the line is going to be. There will be need for fewer of them, and they'll be more care around the country being provided by family practice physicians and/or nurse practitioners. Now, I'm told that at least here in this setting, because we're thinking about hiring a family practice physician here at the clinic, when my medical director checked with Family Practice Department, they make salaries way in excess of either pediatrics or internal medicine. So if that reflects the community, then the cheaper deal may still be to hire pediatricians. I don't know. I'm not tuned

into the marketplace finances to know long term what's going to be cheaper. But certainly money is going to get tighter and tighter and you're going to have to be more and more thrifty by having expanded resources.

Mullan: This has been terrific. We've covered a lot. Anything else you want to comment on?

Deinard: No.

Mullan: Good. Thank you.

Deinard: My pleasure.

[End of interview]

Index