GWEN WAGSTROM HALAAS

September 10, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Halaas: 2/7/54.

Mullan: We're sitting at Doctor Halaas' dining room table. It's the tenth of September, 1996. We're in Minneapolis. It's a warm September evening. Doctor Halaas was good enough to see me in her home, since our daytime schedules were sufficiently cluttered that we couldn't get back together.

Tell me about yourself. You're a North Dakotan, to begin with.

Halaas: I am actually a Minnesotan. I happened to be born in North Dakota, because that's where the hospital is. I grew up in Fargo-Moorhead, which is a border city, a twin city like this.

Mullan: Fargo being North Dakota?

Halaas: Fargo, North Dakota; Moorhead, Minnesota.

Mullan: Is there a distinction between being a North Dakotan and Minnesotan?

Halaas: Oh, not really, other than I've always lived my entire life in Minnesota. I worked in Fargo, North Dakota, for a while, but I don't know that there is a difference. I'm sure people would say that there is. North Dakota is a farming community, I think probably a Republican state as opposed to Minnesota, which is a Democrat state and has more industry and other ventures, less farming.

Mullan: I suppose in that micro-economy it doesn't make too much difference which side of the river you're on. They're similar communities?

Halaas: In that community, the only difference that it seems to make is the taxes are lower in North Dakota. [Laughter] So the more money you make in Minnesota, the more likely you are to live in North Dakota.

Mullan: What took your family to Moorhead, Minnesota? Many generations, or newly arrived?

Halaas: That's the college where my parents attended and graduated.

Mullan: Which college?

Halaas: Concordia College. My dad actually attended and graduated there. My mother attended and then graduated later in

life from Moorhead State University. There are three colleges there: Concordia College, North Dakota State University, and Moorhead State University. So it's interesting. It's about 100,000 population with three colleges, so there's a lot of cultural opportunities and events, rich in music and academic interests, and sports, so it's a nice community.

Mullan: And your parents stayed there to associate with the college?

Halaas: Yes. They all were born and grew up not far from Minnesota, in more rural communities from Moorhead, and then moved there for college and stayed, basically.

Mullan: And what do they do?

Halaas: My father is a social worker, and my mother is a school psychologist. Both are retired now, though.

Mullan: What was it like to grow up in Moorhead-Fargo?

Halaas: It was a very pleasant Midwestern environment, but very enriched with lots of opportunities because of the colleges being there. There weren't a lot of women role models, professional women, at the time when I was there.

Mullan: What got you interested in the path of life you've chosen?

Halaas: I didn't consider medicine until after I graduated from college. I was headed toward social work. I had a major in psychology and social work and a minor in music in college. I was headed toward a graduate degree in psychology, and was encouraged by my professors not to worry, I was such a great student that I could get in. I picked my two top schools and applied, and didn't get accepted to a Ph.D. program in counseling and psychology. So I took a job as a biofeedback therapist and a neuropsychological tester at The Neuropsychiatric Institute in Fargo.

Mullan: What does a biofeedback therapist do?

Halaas: You teach people how to use biofeedback, the technology of biofeedback, to control things like migraine headaches or muscle contraction headaches, by feeding back the muscle tension in the form of sound, basically.

Mullan: With success?

Halaas: Yes. For those who are motivated, the success rate is quite high, or at least in my experience it was.

Mullan: And how did you learn how to do that?

Halaas: I worked for a neuropsychologist who supervised me in that setting in both. I had to go get some additional training in some of the neuropsychological testing, some of the intelligence testing and the additional tests that neuropsychologists use.

Mullan: How was growing up in Moorhead? What determined your decision to go to college essentially at home? Was that a given, or was that a decision?

Halaas: I think I was free to make the decision where I wanted to go to college. The nice thing about Minnesota is that we have excellent private colleges. I knew that I had the option to go to any one of them, and I don't know why I chose Concordia. I chose Concordia over Augsburg, which is here in Minneapolis, and ended up at Concordia. I chose to live in the dorm my first year, which I think was a good idea, rather than live at home. But I met my husband and was married when I was nineteen, so I moved out of my home for the last two years of college.

Mullan: That was the second year you met him, first year?

Halaas: I met him after my sophomore year.

Mullan: And got married quickly, I gather. You were nineteen.

Halaas: Yes. Actually, I met him after my freshman year, and married him after my sophomore year.

Mullan: And was the Concordia experience good? You were glad you went there?

Halaas: Yes. I guess I would credit Concordia with preparing me for anything I wanted to do, and being supportive. It's a very rich liberal arts college. Like I said, when I went there initially, I didn't have the interest in medical school.

Mullan: And when you left, you really didn't have interest in medical school, either. You weren't thinking in that direction.

Halaas: That's right. I worked for this neuropsychologist, and because of The Neuropsychiatric Institute, I worked closely with neurologists, and ended up doing research with a neurologist in the area of ALS and MS. We did a double blind placebo controlled drug trial. And I also, actually, helped him write a book on neurology for the primary care physician.

Mullan: Is it [unclear]?

Halaas: Yes. He was the one that said, "You know, If you're going to graduate school, you really ought to think about medical school," and I told him he was crazy.

Mullan: Why is that?

Halaas: He talked me into it. Well, I just had never, ever considered medical school. No one in my family was a physician. Physicians weren't necessarily held in high esteem by my family. My dad is a social worker, worked with a lot of psychiatrists and had some difficulty understanding their ways.

Mullan: In terms of their therapeutic concepts, or in terms of their personal or professional behavior?

Halaas: Both. I think he'd get frustrated with them for their lack of respect of other professionals and of patients, to a certain extent. And in Minnesota, in this culture, Scandinavian culture, you don't go to the doctor unless you're dying, so doctors weren't thought of in the same way. You didn't really think of your GP as your friend who would be helpful with this or that. You only went if you absolutely needed to go.

Mullan: That's interesting. Did you have family physicians that had made any impression on you, good, bad, or indifferent?

Halaas: No. I had a very nice pediatrician who I remember fondly. I had one visit with a very interesting woman physician, who treated adolescents. Her name was Georgie Burt, and she made adolescents her practice, and I think was a very interesting

person. I didn't really get to know her, because I didn't have the interest in medicine until I was grown.

Mullan: The Moorhead area is largely Scandinavian in background?

Halaas: Yes.

Mullan: Tell me more about the cultural attitudes toward medicine and medical practices, something I know nothing about. I'm interested in general.

Halaas: I think that's just Scandinavian heritage, speaking from a personal point of view. They don't look for help from anybody, and not from physicians either. They're just not people who call up for any little thing. They tend to deny that they're sick until it's obvious that they're sick.

Mullan: Is independence a fair word to describe it?

Halaas: It's a strong work ethic, and, sure, some independence, self-reliance. They'll keep to themselves. We're an introverted culture, I think, primarily, not real extroverted.

Mullan: And how close is your background to Scandinavia?

Halaas: Great-great grandparents, maybe, great-grandparents in some instances.

Mullan: Going back two or three generations.

Halaas: Yes.

Mullan: From where?

Halaas: Mostly Norway, some from Sweden, diverse background.

Mullan: Do you count Scandinavian identity as part of your portfolio? Do you think of yourself as Scandinavian or as Norwegian?

Halaas: I think of myself as American, I'm sure, but I recognize Scandinavian traits in me. I feel most at home, or just kind of intuitively understand others from the Scandinavian culture, so I understand that I'm a part of that. It helps to understand yourself. My kids' names are Per, Liv and Erik with a K.

Mullan: You kept the culture.

Halaas: Wagstrom is a Swedish name. Halaas is a Norwegian name. That's my husband's name.

Mullan: He's a Lutheran minister?

Halaas: He is.

Mullan: And he was in school when you met him, or he was a minister already?

Halaas: He had just graduated from college and took a job as a college administrator, had always planned to go to the seminary. His father was a Lutheran pastor. But postponed it to work when we were married, and just wasn't certain that that was what he wanted to do. So he worked in development and fund-raising and some alumni work at the college.

Mullan: At Concordia?

Halaas: Yes.

Mullan: And then went to seminary, divinity school?

Halaas: He went to seminary when I was a resident, so that was down the road a bit.

Mullan: So you got heavily into neurology, neuropsychology, and the notion of medical school came over the transom.

Halaas: Right.

Mullan: And what happened next?

Halaas: Well, I only had BIO-101, so I had to go back to college and get all my pre-med studies. So I worked full time and went back and picked up those courses.

Mullan: At Concordia?

Halaas: Yes.

Mullan: And how was that? Did you like science? Did you have it school?

Halaas: I didn't necessarily originally like science, but I'm a good student, and enjoyed it when I took it. I had to go back and take physics, chemistry, and I had to take a second semester of calculus seven years after I took my first.

Mullan: I believe it was about three years after college you then went to medical school?

Halaas: Right.

Mullan: And you chose Harvard?

Halaas: Well, I applied a little more sensibly this time to probably, I don't know, several, ten, I don't remember, medical schools, and refused to consider Harvard. Bill Olson, the neurologist that I worked with, is a Harvard grad, so he

suggested early on that I apply to Harvard, and I said, "No thank you, I'm not interested."

And he said, "Oh, come on, just get the application."

I said, "No, thank you, it costs thirty bucks." But he finally talked me into getting the application and making an application.

Mullan: And you were accepted, and decided to go?

Halaas: I was invited for an interview. I thought, "Well, I'm not spending the money to go to Boston, because I'm not getting in." So I went to a regional interview in Chicago, which was foolish, because it probably cost me the same to go to Chicago as it did to go to Boston. I interviewed and thought, "Well, that was interesting," but I interviewed with such elitist nerds, I thought, "Well, there's no way I'm getting in here. I just don't fit."

Mullan: But you got in.

Halaas: I did. I got accepted at the University of Minnesota. I didn't get accepted at the University of Minnesota-Duluth, because they're all family practice oriented. At the time, I said I was interested in neurology. I was shocked, because from Minnesota I got a big manilla envelope full of stuff, and my husband called me home and said, "You have a letter here from Harvard."

I said, "Well, that's fine, I'll read it later."

He said, "No, I think you should come home and read it now." And it was just a little envelope, like a business envelope, with a window in it. So I thought, "Well, it looks like all the other rejections I've ever gotten." But it said, "Welcome to the family at Harvard Medical School," or something like that, and I said to my husband, "There's something wrong with this letter." [Laughter] Took me a while to believe that it was an acceptance.

Mullan: You decided to go East?

Halaas: I did.

Mullan: How was it?

Halaas: It was great. It was a little frightening, because I lived all my life in Moorhead, but I had my husband to bring along with me. I didn't have the support of my father, who was sure that it was going to be the end of my marriage. I went to him very proudly with that letter, and he was discouraged. He said, "Well, what's Mark going to do?" He was fairly kind of discouraged. Actually, he was concerned that I wouldn't survive, I think, and went and talked to Bill Olson with that concern, that I wouldn't survive.

Mullan: And what did Mark do?

Halaas: He thought about the seminary, but in the process of interviewing at the seminary, they found out his development background, and they hired him to do development work for Boston University's School of Theology. Then he worked for the School of Law for two years.

Mullan: That turned out okay?

Halaas: Yes. So he worked while we were out there.

Mullan: So what happened to you during those four years? You seemed to have shed your neurology interests?

Halaas: I think I just discovered through the process of medical school, like most of us do, what you like and what you don't like, and I discovered, which wasn't too terribly surprising, I really liked all ages, and I liked to have a variety of things to choose from. I really wasn't interested in the science, the pursuit of the science to the nth degree. I was really interested in the people and what I could do to help them. So that brought me back to family practice. I was familiar with family practice, because Minnesota is a strong state for training family physicians.

Mullan: That's contrary to the current, in general, at Harvard.

Halaas: There were two family physicians in the city of Boston when I trained, and they were admirable people. They were full-service family physicians. I know one of them was doing versions for pregnant women, which was more than most family physicians were doing at the time. I didn't decide until, I suppose, my fourth year, third or fourth year, late, anyway, in my training, so I didn't have a lot of exposure to them. I was quite discouraged by the faculty, who was disappointed that I would choose something like that. They tried to talk me out of it.

Mullan: But you had, by that point, pretty well made up your mind?

Halaas: Yes.

Mullan: With the notion that family practice would fit you well for life in Minnesota, or because that approach to the human being appealed to you the most, or what?

Halaas: I think that approach to the human being, or recognizing that I would enjoy more being able to work with babies, children, adults, elderly, some prenatal care. I just really wanted to be involved in all the aspects of a patient's life, not just be limited to one perspective. It was easy when I made that decision, because then I could choose to go back to Minnesota, because Minnesota was full of family practice residencies, but I think I chose more for the job than the location.

By that time, though, I had my first child in medical school, so there was some pull to go back closer to family, I think. When my first child was born, and I didn't have any family there, just the new friends we'd made in Boston to rejoice in the birth, it was a little lonely.

Mullan: How about your classmates, in terms of choosing family medicine, what were their attitudes?

Halaas: I had an extraordinarily interesting class, and I think that's what sets my experience at Harvard apart from other medical school experiences, not that I can say that I did them, fortunately. My classmates were such an enriching experience in many ways. That particular class turned out one of the highest percentages of primary care physicians, and was particularly not held in high esteem by the medical school. But for some reason, that particular class was much more drawn to--I think we had twelve, probably, in a class of a hundred and thirty, or something like that.

Mullan: Going into family medicine, or going into primary care?

Halaas: Going into either like ambulatory medicine or family medicine. I don't think it even included peds [pediatrics].

Mullan: What happened next?

Halaas: My first child was born in my second year of medical school. I was pregnant with my second child when I graduated. Those were experiences that were a little bit unusual, too, I think. Then I decided to come back to Minnesota, interview for residencies, and chose the residency at Bethesda.

Mullan: And what was it like?

Halaas: I had the extraordinary experience of talking to a classmate who followed me at Harvard. I didn't know her well at the time, but she called me during my internship here and asked me what it was like, because she was thinking of coming out here and doing the same thing. And I said, "I love it." [Laughter]

And she said, "Are you crazy? What is wrong with you?"

I had a wonderful cohort. There were eight of us, and we all got along very well. And Bethesda Hospital was a family practice hospital, so we were the only residents, so it was really like a family. They welcomed us, and we were trained by family physicians, but consultants were all there at the invitation of the family physicians, and everybody got along great. It was just a wonderful learning environment, so I had a great residency. I learned a lot, and really enjoyed the community of it.

Mullan: As you approached the end of that, what was your thinking in terms of what you wanted to do? Particularly, was

there any instinct to go back to a real rural setting or to stay in the city, as it were?

Halaas: I didn't have a pull to go to a more rural setting in it. I suppose part of it might have been that I didn't grow up in a very rural setting. It was a city. So I had never really experienced rural life. I don't think I really thought about it at the time, because what I did, about in my second year of residency, the administrators at Bethesda kind of had a talk with the residents, and offered, "If you're interested in setting up a practice, why don't you come and talk to us."

So I talked with one of my partners in the residency, and said, "You know, why don't we think about opening up a practice together," and he agreed to that, and we went and talked to the administration, and they agreed to set us up in practice.

So we started from scratch in my second year of residency, picking out a geographic location to practice in, designing the clinic, hiring the staff, going through all the legal work, and all the things required to hang out your shingle. We had thought of practicing in a suburban area, but they actually talked us into the opportunity of practicing downtown, so we actually hung out our shingle in the skyway location, downtown St. Paul, which was never done before. There were no family practice clinics downtown. So I had the fun of kind of being a pioneer without going rural, as it were.

Mullan: And how was the practice?

Halaas: It was wonderful. It was wonderful.

Mullan: Skyway location. For those of us who are not downtown Minneapolis, that's the connecting--

Halaas: It's the second-floor level. Ours was kind of on the corner of a building near the skyway that is a bridge across, an enclosed bridge across the street.

Mullan: Which mean downtown, center of town.

Halaas: That's right.

Mullan: And what kind of practice do you expect? What kind of practice grew up?

Halaas: We designed the contract saying, if this is not a full family practice, or if we have problems with the business of running this clinic, we could opt out at the end of three years, because we didn't know what kind of practice we'd build downtown. But, in fact, we built a rather interesting practice downtown. It was young working people who enjoyed the clinic and brought their families. It was elderly who lived downtown, and it was the handicapped who lived downtown. So it was a wonderful, interesting place to practice, and ended up being really full-service family practice.

Mullan: There were just the two of you?

Halaas: Just two.

Mullan: And how did you get going? How did other people know you were there? Was it literally your shingle on the skyway?

Halaas: Primarily. We did some footwork. When we were residents, we were involved a little bit with the marketing department at the hospital, and went out and made some contacts. We'd visit people downtown. When we first opened, we had a health fair there, and we did free cholesterol screenings and that kind of thing.

Mullan: You enjoyed it, I gather, when it got going?

Halaas: We had a lot of fun, the two of us. We were good friends. We enjoyed each other. We enjoyed each other's patients.

Mullan: You admitted to Bethesda, to Lutheran?

Halaas: We admitted to the hospital where we did our residency, Bethesda Luther Hospital.

Mullan: Which is downtown?

Halaas: It's not far away. It's in the same area.

Mullan: Did you stay at it for a while?

Halaas: We were there for three years. Probably after the first year and a half, or into the second year, we recognized that the finances weren't as good as we had hoped. The hospital administration was really running the finance part of it, and we asked for a consultant to come in and take a look at their financial information, and they refused to do that.

Mullan: The hospital refused?

Halaas: Right. We hired our own independent financial consultant to come in, because we were concerned. Eventually we did that.

Mullan: Concerned that you were not optimizing, or you weren't making as much as you should?

Halaas: Well, we didn't exactly know, remember, we were not well trained in business, but we did know that we had a pretty busy clinic with a pretty good revenue stream, and I assume our accounts receivable were probably too high, we weren't recognizing any increase in salary or anything, and we weren't really savvy enough to understand why business wasn't better for the work that we were doing.

The financial consultant that we hired came in and took a look at it and said, "You're in trouble here, and it has nothing to do with your practice. There's some trouble with accounts receivable, that sort of minor thing, that could easily be fixed. Where you're in trouble is the overhead expenses, given the downtown location and the amount of money that they spent in the improvements to create the clinic in the first place. To be able to pay that back, it's going to take you a long time, so it's going to be a while before you, if ever, if you--"

Mullan: Before you come into the black.

Halaas: Yes. So we went back and negotiated with the hospital, and it wasn't a very pleasant scene. We had to hire a big-shot attorney to get us out, because, of course, they were more savvy than we. They had had us sign for some personal liability.

[Begin Tape 1, Side 2]

Mullan: This is Doctor Halaas, tape one, side two.

You had signed for liability.

Halaas: We had a lawyer to get us out of the contract with the hospital. We had been already searching out other opportunities for where we could move our practice, because we had a good sense that we would take a lot of patients with us. We chose to join a

larger group that had three sites, and we moved our practice quite a ways, actually, to a northern suburb, Vadnais Heights.

Mullan: The year now being 19--

Halaas: 1988.

Mullan: And how was that?

Halaas: That was good. It was a nice suburban practice. Most of our patients followed. It was an interesting experience that we had come from. It was a different call situation. We had been on call every other weekend, and we'd switch weeks. In the new practice, during the week we moved to being on call every tenth, or something like that, so it was pretty pleasant, but you got killed when you were on call.

There was one other partner there, an older man, who was just pleased to have us, and I think we fit pretty well, and our patients were pretty satisfied. Where I got into a bind there, I sat on the board of that group, and was involved in making important decisions about the group. I worked very hard, so did my partner, we were big producers, and I did a lot of OB, I did more and more OB. Did lots of complicated high-risk OB. I had two other women partners initially. Actually, one kind of left before we even got started, and the other was there for a year with us, and then left, so I inherited all their patients, and all their OB patients. And I really burned out with the OB. I

was up most nights. I did all my own OB patients, so I was up many nights out of the month, in addition to practicing in the clinic, and just got to be too much.

And the board was all-male board, who were kind of the original senior partners, who were basically trying to work less and earn more, and cash out eventually, working the young folks hard until they could earn their way in. That wasn't so bad. You kind of expect that as a traditional way of practice, but there was a certain level of disrespect. Some of it was toward me as a woman, some of it was just toward me as a younger partner. Between working so hard and getting burned out, and having to deal with some of that, I began to get real frustrated, and looked around to see what else I could do.

I had taught the whole time. I started teaching at the residency program in 1986, in addition to this full-time practice. It was very busy.

Mullan: This was at Bethesda?

Halaas: At Bethesda Family Practice Clinic. On my day off, I precepted the residents, and my partner kept saying, "Well, give it up. You're crazy," and I couldn't because I liked it so much. It was kind of an escape for me, actually. So finally a little light bulb went on that said, "Maybe you ought to teach. Try that."

I'd always thought I would do that eventually, perhaps, but I figured it would be after ten years of practice or so. But

that was about seven years, and I chose to leave, and go full time to the residency program as assistant director.

Mullan: At Bethesda?

Halaas: At the Bethesda Family Practice Residency Program.

Mullan: And this would have been which year?

Halaas: 1992.

Mullan: You had two children coming out of medical school, you went through residency and through very arduous years of practice.

Halaas: I had my third child at the end of residency.

Mullan: You had three children now. How was that? That's a burden that most people, and certainly all male physicians, don't carry.

Halaas: Well, I was lucky to be healthy and have things go relatively well. Actually I experienced most of the complications that you could think of in pregnancy, but I actually felt well and did fine. The reason I could do it, is my husband is very supportive. He has been the primary parent for

the children, and I couldn't have done it at all if he hadn't been able and willing to do that.

Mullan: So he went to divinity school when you were in residency?

Halaas: Right. He was a student at seminary when I was in residency, which gave him a little more flexibility in his time schedule, so he was able to do all of the child care, really. We had daycare then when they got a little older. But he has always been responsible for the daily needs of the kids.

Mullan: Once he graduated from seminary, what sort of position did he have?

Halaas: He took a call in a church in St. Paul, and he was there for seven years as the associate pastor.

Mullan: And is that, likewise, somewhat more flexible than your schedule?

Halaas: Yes. There aren't really appointments scheduled. It's office time, but it's quite flexible.

Mullan: Has that been rewarding or frustrating, being a mother, and engaged as fully as you were in the practice?

Halaas: There were times when it was frustrating. Never between me and my husband. I think he was always supportive, willing, and happy to do the child-raising. I would feel at times that I wasn't the best mother I could be, because there were times when I wasn't available, or that I was exhausted and kind of crabby. We got along pretty well as a family, I think, and we were lucky to have excellent daycare, so I always felt pretty confident that my kids were well cared for, and the kids were doing well and well-adjusted. So those ideas were kind of supported about how things were going. If there were problems, they were sometimes brought up by well-meaning, perhaps, friends or family members, who would make remarks about "poor Mark," you know, having to do this kind of work, or "what kind of a mother are you" for whatever the incident was at the moment, which was more out of their expectations than there was any reality to the concern.

Mullan: In terms of your experiences as a woman, in general, in medicine during a time when women are gradually, or moving much more rapidly now toward parity in the profession, but clearly still not at parity, in terms of numbers and in terms of attitudes as well, what has your experience been like from that point of view?

Halaas: My experience has actually been pretty reasonable, I think. I didn't think too much about it when I went to college. I thought I could be whatever I wanted to be. I think my parents instilled that in me. They expected me to go to graduate school,

and they expected me to do whatever I wanted to do. They just didn't expect that it would be medicine.

My class at Harvard was about a third women, and I met some very good friends there who were women and good role models. I can't say that I met very many good role models as women faculty there. There were some that were too tough and not nice people, not sympathetic. There was one that committed suicide. There were no women's bathrooms in Harvard Medical School. There was a powder room. It's probably still that way, for all I know. And when I was pregnant, taking the physiology exam, I had to go to the bathroom, and I didn't want to walk for two blocks to the powder room, so I went in the faculty bathroom, and thought I locked the door. The professor came in while I was there.

Mullan: Give you a hard time?

Halaas: No. I think he was a little embarrassed. I think it was a mistake.

During residency, there were two of us in a group of eight, but in other parts of the university system there were more women, so in residency, again, it was a pretty good representation of women in family medicine. Training in family medicine is easier in that regard, because there is a respect for the family. It was certainly true in my program that having family, having children, doing other things outside of medicine was encouraged and supported, so that wasn't a problem. When I

went into practice, I practiced in the same environment that I was trained in, so that wasn't a problem.

Some of the problems that you learn as a woman in medicine are to try to protect your schedule from being overwhelmed with all women and children, and primarily with too many pregnant women who take that additional night time.

Before we move on, the practice in medicine and the training in medicine wasn't nearly an issue until we get into the business of medicine, and then it became an issue.

Mullan: The gender issue became more of an issue?

Halaas: Yes, yes, because there is, all of sudden, a change in approach and a lack of respect related to gender in business that I experienced.

Mullan: In other words, the barriers or the attitudinal issues were more prominent in the culture of business than they were in the culture of medicine?

Halaas: Yes.

Mullan: Let's come back to that, just to get the rest of the story. You're at the point of deciding that teaching is what you wanted to do. What did you do then?

Halaas: It was easy for me to go back to the residency where I was trained. I knew everybody there, and I was welcomed. They'd been trying to get me to come for a long time.

Mullan: And the relationships with Bethesda were not sufficiently fouled by the departure from the supported practice?

Halaas: No, no.

Mullan: That was a different wing of the institution?

Halaas: The people who were most problematic had gone, had moved on. [Laughter]

Mullan: Aha! You waited them out. So you went back to the residency.

Halaas: Yes. Actually, I think there had been a transition at that time of hospital mergers into the HealthEast Corporation, which encompassed several hospitals. Bethesda Hospital closed, eventually, and moved to St. Joe's. I think that was probably '89, so it was while I was in practice.

So when I came back to teach, although it was the same program, it was a different hospital within this system, so it was a little different.

Mullan: And it was all affiliated with the university, or not?

Halaas: Yes, it's confusing, too. Minnesota has the largest Department of Family Practice, as far as numbers of residents, and it's because there are six community-based sites that are affiliated with the Department of Family Practice, and Bethesda was one of those.

Mullan: So when you came back, what was your role?

Halaas: I was the assistant director of the program, and had some curriculum assignments, but ultimately ended up being the medical director for the clinic, which began my next transition, because I discovered I didn't understand that much about the business of running a clinic at that level. I knew more than many, having my own shingle and done my own two-person practice downtown, but running this size clinic with the academic issues brought some problems along with it that I felt I needed more understanding of business to be able to handle. So I began to think about how I could get that experience, and that's how I ended up taking the Certificate in Management for Physicians course at the University of St. Thomas.

Mullan: Is that St. Thomas, Virgin Islands?

Halaas: No, it's here in Minneapolis.

Mullan: What sort of program is that?

Halaas: I think it's a thirteen-week evening course at the university with just some broad concepts in finance and accounting, managed care, practice management.

Mullan: Aimed at physicians?

Halaas: Right.

Mullan: Good?

Halaas: Very good. I was very intrigued. I swore I'd never go back to school again, but that was a lot of fun.

Mullan: And applicable, useful?

Halaas: Very useful. In a nutshell, what happened, I loved teaching, I took my patients with me. They've followed me forever. They're getting a little tired of moving. I love teaching residents, and I tried to develop new curricula in practice management, and understanding managed care for the residents, so that was a big part of my challenge. The trouble was that the faculty who had been here for a long time didn't necessarily agree with some of the ideas that I had to improve the clinic services, and weren't very supportive of being able to teach the residents practice management or managed care. So I began to feel a level of discomfort again in working in an

environment where the kinds of things that I wanted to do weren't necessarily welcomed.

Mullan: Were they explicit in their objection?

Halaas: No, not explicit, it was kind of implicit. But the work that I would try to do would be kind of undermined, and it took me a while to figure out what was going on, and they clearly weren't encouraging of some of the things that I wanted to teach the residents. I think a big part of it was most of the faculty at that time, who practiced with me, hadn't practiced for many years. They hadn't practiced in the community in a managed care environment, and they really didn't understand it. They were a little threatened by it, so they just weren't very supportive.

Mullan: And were they anti-managed care?

Halaas: Yes.

Mullan: As many more senior physicians are.

Halaas: Yes. Understand that the managed care phenomenon here in Minnesota has been over the past twenty years or so, twenty, twenty-five years, so when I trained, it was already well under way. There were HMOs in place, and we had to deal with many different contracts that were managed care contracts, so we

understood a lot of the details about how to deal with managed care just from having to do it.

Mullan: So what happened next?

Halaas: I ended up being chosen to be the medical director for UCare, which is the Medicaid managed care program that the Department of Family Practice developed.

Mullan: Of the university?

Halaas: Right.

Mullan: And how did that come about, and what was it?

Halaas: I was just selected by the department chair because of my interest and knowledge in managed care, to take on this role. It was a 50 percent medical director role, and 50 percent still at the residency program, doing teaching and patient care.

Mullan: And the residency program being based at Bethesda?

Halaas: Right. Same program.

Mullan: So this got to be more directly into managed care administration?

Halaas: Yes.

Mullan: And when was this?

Halaas: 1993.

Mullan: Was that a good job?

Halaas: I really enjoyed that job. I learned a lot. I was the one making decisions about coverage for the Medicaid members. We had about 35,000 members at that time in our program, and I made decisions about what things got covered, the more unusual things. If there were issues about how those members were receiving services or care in certain clinics, that was my responsibility.

Mullan: They wouldn't have been receiving care at the, I've forgotten how many, six, seven family practices?

Halaas: Actually, there were eighty-five clinics that had members of ours, but most of the patients were in the six residency clinic sites. So I was head of it. I was chair of the Quality Assessment Committee, monitoring quality for those patients. I was involved in the development of a number of unique projects for those patients. We had an incentive program for prenatal patients, because many of those patients wouldn't come in for their prenatal care, they would just come in to deliver. So we developed a coupon program where we gave them a

$5 coupon for groceries every time they came in for their prenatal visit, and if they made a certain number of those prenatal visits, they got, I don't remember what it was, $75 Target coupon when they came back for their postpartum visit to purchase supplies for the baby, or whatever. So I was involved in that and in some research related to that.

I developed a UCare 2000 Plan with preventive service goals, trying to maximize the rates of mammography and Pap smears and things for that population. It's difficult because of the population issues, getting them to get their preventive care services, so it involved a lot of creative thinking. I continued to teach the residents some of the issues about coding.

Mullan: Were you meeting in the context of the Family Practice Department as a whole, in which you were now working, as opposed to one residency program?

Halaas: Well, that's where I wanted to go. I felt that I had more to offer them in two ways. One was in the leadership of the development of UCare, and that role had really been more restricted to specific medical issues, not so much the business issues. I said I wanted to be a bigger presence so that they would know who I was, and I would have better opportunities for communicating with physicians, so I wanted to be able to teach at all six sites, rather than just the one. I was really just in the process of wanting to make those changes when HealthPartners called and wanted me to come.

Mullan: Before we go to HealthPartners, was your interest, which I presume persisted, in teaching about managed care and practice management and the like, was that better received in the larger forum of the family practice network as a whole as opposed to your previous single hospital experience?

Halaas: Yes, yes, it was, although there's still some lack of understanding or resistance in the academic setting, or some lack of understanding of how to do it. But, yes, it was better received. It was working. I was chairing committees and working with different faculty who had more interest in the kind of things that I was doing. So, yes, it was improving.

Mullan: You were there from when to when, roughly?

Halaas: I was there for about two and a half years all told, full-time academic, from '92 to '94.

Mullan: That was both iterations, that is the Bethesda-based one—

Halaas: Including the UCare job. I was in that UCare medical director job a year.

Mullan: And one day the phone rang?

Halaas: One day the phone rang, and it was Maureen Reed. She had known me when I was a resident, because I had done urgent care work in her organization. She said, "I don't know if you remember me, but I'm medical director for HealthPartners, and I would like to talk to about a job opportunity."

I said, "I'm not interested. I'm happy where I'm at."

She said, "Oh, come on, come and talk to me. I just think it would be interesting to have a conversation with you." So I did, and she was very clever at asking me what it was that I was good at and what it was that I like to do, and she pretty much recreated the position from what it was originally to appeal to what it was I told her I wanted to do.

Mullan: What was the position?

Halaas: It was the associate medical director for Health Partners in one of the divisions, the Contracted Care Division, and initially she wanted me to do data management, quality and utilization management. It was more of a data-driven job. She insisted that it was important to practice, to maintain a certain percent of clinical time. She said I could do whatever I wanted to with that.

Mullan: And that was the job, or you refit it?

Halaas: Actually what it ended up to be, I told her I was interested not so much in data, I wasn't much of a number

cruncher, I was interested in the development of policy and in medical education and in mental health issues. So she offered me the job as associate medical director in charge of medical policy, involved directly with the development of some medical education opportunities.

Mullan: And you took it?

Halaas: And I took it.

Mullan: And that was?

Halaas: Two years ago, September of '94.

Mullan: And how has it been?

Halaas: It's been great.

Mullan: What does it entail?

Halaas: I'm 75 percent administrative and 25 percent clinical. With my clinical time, I still have my cohort of patients, it's just smaller, and I see them at the Ramsey Family Physicians Clinic, which is the residency clinic for HealthPartners-St. Paul Ramsey Medical Center. Also in my clinical time, I precept the residents, and I teach them in labor and delivery.

With my administrative time, I'm the medical director of medical policy, so I make the coverage decisions for certain things that need to be prior authorized. It's two roles, really. I have a department that helps me develop the policies which are in a manual, which go to all of our clinics, which explain what is covered.

Mullan: Let me pause and turn over the tape.

[Begin Tape 2, Side 1]

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

Halaas: Development of medical policy is where I stopped. The other part of the work has to do with case review for certain individual cases requesting coverage for things that require prior authorization, things that are experimental, or extremely expensive, or cosmetic, or controversial. I do those individual case reviews and make decisions about coverage.

Mullan: In the context of Health Partners, do you have a sense of mission? What sort of culture, what sort of institution is it?

Halaas: HealthPartners is the merger of a staff HMO, Group Health, which has been in place since the early 1950s, a staff model HMO, a group model HMO, which was MedCenters, and most

recently Ramsey Hospital and Ramsey Faculty Associates, which is an academic teaching hospital which serves the underserved, and its associated faculty. So it's an interesting blend with a very strong mission that is present everywhere you look. Our mission is to improve the health of our members and our community.

Mullan: And that's real, not just letterhead stuff?

Halaas: No, it's very real. Absolutely. It's part of most conversations.

Mullan: What sustains that sense of care and community-oriented mission?

Halaas: The leaders, I think, believe. The CEO, certainly, George Halvorson, the medical director, George Isham, all are really motivated by that mission, and Health Partners is very strong, I think, particularly because the staff model origin was in preventive health care.

Mullan: Does it seem like a more clement place for you to practice your brand of medicine than those who've been in before?

Halaas: I don't know that my practice of medicine changed critically.

Mullan: I mean practice in a broader sense, not just clinical medicine.

Halaas: It's been an interesting transition, truthfully, from hanging out my shingle downtown and starting with one patient, to being, in my perspective, the family physician in charge of 700,000 members. That's really how I see my role. I'm not the only physician there, I'm not the only leader there, but I have a big impact on the members' lives, because I am a big part of determining their benefits and making decisions about coverage.

Mullan: Would you work for any such integrated systems? One hears all kinds of descriptions of the cultures and modus operandi of HMOs, managed care organizations. As somebody who's viewed those from a number of perspectives and is now is working in the middle of one, are there differences? Would you work for anyone, or is there something special about HealthPartners?

Halaas: I'd like to think that I would not work for anyone. I feel very comfortable at HealthPartners. It was a good fit. First of all, Minnesota state law requires HMOs to be nonprofit, so all of our large organizations here are not-for-profit. That makes a difference, I think. And in Minnesota, the quality of health care is very high, and the cost is very low already, and that makes it a different environment. But the culture is very different. We really have three large players, and we're the smallest. We have Blue Cross/Blue Shield of Minnesota, which has

1.2 million members, or something like that. We have a Allina, which has about 900,000, and we have about 700,000, which altogether is 80 percent of the population of Minnesota probably, or more.

Mullan: My impression was your population is entirely Twin Cities-based?

Halaas: No. It's also outstate Minnesota, some western Wisconsin. Actually there are some other national kind of affiliated contracts that we have.

Mullan: So do you see yourself at this time as a practitioner, or a businessperson, or a policy executive? How would you characterize yourself?

Halaas: I still see myself very strongly as a family physician who is primarily involved in the development of medical policy for a health plan, but who also practices and teaches.

Mullan: And that amalgam is working pretty well?

Halaas: This works well. The 50-50 job was lousy. It just doesn't work.

Mullan: Which way?

Halaas: At UCare. You can't do either job justice, and both expect you to be full-time. Here, it's clear that my main job is the administrative job, and for that reason, the clinical part of it has to be quite clearly focused. It's not that I don't have some kind of continuity with my patients, I handle issues over the phone and whatever, but what I do in that clinical time can be contained a little better.

Mullan: Let's double back and pick up. We're up to date, am I correct?

Halaas: With the exception of that fact that I went back to get my master's in business administration, which was already happening before I took that new job. I had the certificate in management which kind of inspired me to go ahead with the--

Mullan: You liked that well enough to get serious about it, and has that been helpful?

Halaas: Yes, because I anticipated that I'd have more and more administrative work, it just seemed to be falling on me, so I wanted to be better prepared. It was very helpful, and it was the right thing at the right time. I learned a lot.

Mullan: Talk a bit about what has to be one of the most important developments in the Twin Cities in terms of health care, and that is that managed care is taking hold. The vast

majority of market is in managed care, today, I believe, is that correct?

Halaas: Yes, it is. Actually, the highest percent will very soon be self-insured, as opposed to typical managed care. But it's managed by managed care organizations with the large employers.

Mullan: That's in terms of the insurance side of it, they will essentially accept the risk, but then they will purchase a company to manage and provide the services for them, presumably? Is that what you're saying?

Halaas: Yes. We're basically the third-party administrators for their employees health care--they pay for the coverage.

Mullan: They function as the insurer.

Halaas: Through our providers, and we administer.

Mullan: Obviously, throughout the country, the specter of managed care, which is, in fact, multi-faceted, or many manifestations of forms of practice is much in the lines of physicians, and many still resisting it or being angry about it, or feeling that it's ruining, or invading health care as they knew it, etc., etc. You have grown up with it in the Twin Cities, and I'd be interested in knowing how the concepts extant

managed care when we talk about those, perhaps, if we need more definition, but sort of jumping over that, how the concepts implicit in it, in terms of both relationship to patients and relationship to the system, how you've experienced all these, whether you embrace them with enthusiasm across the board, or presumably you haven't rejected them across the board. You've moved into managed care. Tell me how it's affected you, and what you think about it as an instrument of providing or adjudicating care.

Halaas: Fortunately, I guess, the transition here in Minnesota has been rather slow and steady, even though it seems like things have been happening dramatically in the past few years. The stage was set for all of that to occur. As a physician, I wasn't particularly happy with managed care, having to deal with lots of rules and limitations and different formularies for different payers, having my patients be frustrated by being limited in their choices. But because I was familiar with that even during residency, that that was happening, and that part of learning how to take care of patients was to learn something about their insurance, so that you made both of your lives easier by making the best decisions, without creating a lot of extra work or hassle, you just kind of become accustomed to that as a way of life.

The more I got into it and chose to advocate for my patients with the medical directors of the plans, I realized that there were reasons for doing these things, the formularies really

didn't limit me from giving drugs I wanted, they just cut out some of the more expensive ones or some of the newer relatives of the drugs that were already in place.

The medical directors I spoke to were always thoughtful, and understood about advocating for a particular patient, most of the time agreed, and covered whatever it was that I thought was appropriate, so I didn't really find it so terrible. What was most frustrating, I think, were patients who would insist that they needed to have a CAT scan because they had a headache, or a treatment for Lyme disease even though they didn't have any diagnosed Lyme disease, or whatever it was that they thought that they needed to have. It's frustrating, because you want to try to meet their needs and make them happy, and explain to them some rationale for the decision-making that you make, but they don't always leave happy in those circumstances.

So the nice thing is, I've been through it from the beginning and learned about it, and grown into it, and understood how it works at that end, while I've gradually gotten into the other end of understanding the contract decisions from a clinic point of view, or administrating the coverage from the payer point of view.

Mullan: Of your generation of physicians who have grown up particularly in primary care, but across the board, are you typical of your level of acceptance, or atypical?

Halaas: I'm atypical because of the experiences I've had. Most physicians my age have continued to remain in practice, some of them teach, but not very many, few of them administrate or would choose to administrate, they would prefer to continue to do just straight practice. I think most physicians my age are comfortable with the concept of managed care and understand the rules and how to play them. They may be a little frustrated, and then they find it frustrating for their patients.

But it's interesting in Minnesota, we're really growing beyond what others understand is the concept of managing the cost of care to population health, and that has made a tremendous difference for me, and helps me sell it more to physicians. It's exciting to be part of an organization that has already developed practice guidelines that are very effective, that has set out public goals for decreasing the rate of heart disease or diabetes, decreasing maternal-child complications, decreasing domestic violence, decreasing dental caries. We have nine public goals that we're aiming for.

So the work that we do goes beyond the usual managing cost to improving health, and we do it because we are not just the payer, we are the payer and the providers. The physicians who run the staff model HMO are part of our organization. The physicians who run Ramsey Hospital and Ramsey Clinics are part of that organization.

Mullan: Do they buy in? I mean, for you to say, "As an institution we have nine goals for population health," and

perhaps those have been well disseminated through the multiple and sundry clinical sites, the hundreds of clinical sites, does the doc on the line who's a Health Partners physician, are they full-time, or do you have some that are IPA models?

Halaas: Right. Actually, the Contracted Care Division has the largest third of it.

Mullan: And that's all IPA type? In the sense that they're not your physicians, as in Ramsey clinic physicians, who are full-time?

Halaas: Exactly.

Mullan: How does it play with your contracted care physicians?

Halaas: A lot of the larger groups that are our contracted care groups have been partners from the beginning in the development of the guidelines and happen to be very active in patient education, health promotion-type activities. So does every physician buy into this? No, I don't think so. Does every physician even know about these goals? No, I'm sure not. The owned physicians, the staff model and the Ramsey physicians, understand and buy into these goals more, but so do some of our contracted care physicians.

We work directly with those contracted care divisions. I, for instance, am assigned to five of those clinic sites, and I go

out on a quarterly basis and work with them about their issues, and also talk to them about our goals, and how can we work together to reach those goals.

I think the nice thing is that Health Partners can offer them resources that they wouldn't otherwise have, and to reach the goals that are put out as public goals and are not terribly controversial. Everybody wants to increase early detection of breast cancer, and decrease the rate of heart disease, and decrease the complications of diabetes.

Mullan: Nobody is going to argue that, that's for sure.

Halaas: They are all trying to do the same thing. So we go out as partners to them, and offer ideas and resources for how could we get there, whether it's in the form of our guidelines, or whether it being able to give them information. We give all of our clinics an updated list on a quarterly basis of all their women who haven't had mammography, who should have. We try to make it easier for them to implement their own ways of being able to improve some of their outreach or ability to provide preventive services.

Mullan: Going back to this question of general level of acceptance, is there a generational or age-related trend that you discern? What you describe to me, I would play back to you about your peers, is a kind of grudging acceptance of necessity, not

enthusiasm particularly, but, "Well, maybe this isn't so bad," Fair?

Halaas: I would say that the leadership of Health Partners is very enthusiastic, and many of them are physicians. The staff model has been doing this kind of thing for a long time, so they are enthusiastic. The Ramsey physicians don't understand as well the concept of population health and begrudge managed care, but get enthusiastic about some of these projects as opportunities to improve their service.

Mullan: Rally around some of the goals.

Halaas: Right.

Mullan: And the contract physicians?

Halaas: All the contracted care physicians actually are quite active and quite enthusiastic, surprisingly so. We have good medical directors that head up many of those groups that are actively involved at HealthPartners on the Board of Governors, or different committees, and because we actually do a better job with the contracted care than with the other groups, because as medical directors, we go out their clinics on a regular basis and work with them.

Mullan: What about any gender gradient of acceptance?

Halaas: Interestingly enough, at least within the leadership, there are more women in the corporation, there are more women than men. That's pretty common in health care, but in the leadership, there are more women than men. It's at least a gender-balanced group, and some would probably say female predominant.

Mullan: Are younger physicians coming into the system more inclined to be accepting of, or even enthusiastic about, managed care, as opposed to older ones, or not?

Halaas: It's hard, because in the academic environment you still have the faculty who is not supportive or understanding what managed care is, so residents aren't necessarily understanding or supportive of managed care, which has resulted in HealthPartner's development of an Institute for Medical Education. We have already a number of residencies that we support at Ramsey and through Group Health, and we have elected to create this Institute to have a better impact on curriculum, to continue to support medical education with the change in funding coming along, and to be able to negotiate with the university about the importance of learning some of these things from the beginning, rather than having to reeducate them when they get hired into a more managed-care environment.

Mullan: Is there receptivity on the university's end of things?

Halaas: Yes, surprisingly.

Mullan: I noticed you're the PI on a grant for teaching managed care.

Halaas: Yes. I'm not as involved with that anymore, I'm not the PI, but I was one of the investigators on a grant for the University of Minnesota in development of a managed care curriculum. I have moved away from that, and that's continuing, but that work is certainly part of the Institute, which will provide the teaching within the managed care environment, and will provide a better opportunity for new curriculum to help. It's not so much managed care as it is teamwork, cross-disciplinary work, having some understanding of--

Mullan: Learning how to work the systems.

Halaas: Right, exactly.

Mullan: You mentioned any difference in attitudes towards women, towards being a woman in the business culture versus the medical culture. Would you develop that a little more in terms of talking about the two cultures?

Halaas: The two cultures?

Mullan: The culture of medicine, as I presume you experienced it, and its both practice and educational centers, and now the culture of business that you're working in, not only HealthPartners, but I gather in your external relations and your MBA, and so forth. Develop that. I'd like to understand better the roles of physicians as you see them in the cultures, and how they relate to women patients' values.

Halaas: I think I enjoy working at HealthPartners because gender is not an issue in the business of running HealthPartners, or at least it's not as obvious an issue within the culture. There's a lot of support for women, and I think the way that things are done are more intuitively understood by women, but some of the differences in the other organizations, I think, stem from being male-dominated organizations at the leadership levels. How they make decisions and run the business seems to me to be quite different, and somewhat related to gender.

Mullan: Characterize that by putting a point on that.

Halaas: I think that in HealthPartners there is more consensus decision making, and I think there is more true concern for the members, whereas in other organizations, it's decisions from the top and financially driven decisions, more so, it seems.

Mullan: More competitive?

Halaas: More competitive.

Mullan: Of course, you've got the luxury of being a not-for-profit, as are the other organizations in Minnesota. A key question is, is the not-for-profit culture mandated by law, as it is you're a good culture for delivering care? Is it a better culture than one of mixed for-profits, not-for-profits, which exists elsewhere, which in the eyes of many, drives not-for-profits to behave more like for-profits, not vice versa.

Halaas: I don't know the answer for that, but I would speculate that it's a combination of requiring that they be not-for-profit in the context of the Minnesota community, which is a kind of a Democratic social service, fight for the underserved, "be nice, do the right thing" kind of culture, there isn't a lot of diversity. So this is where United HealthCare started, you know. So there are obviously exceptions to that, and that's not to question their quality or anything, but they're clearly a different animal.

Mullan: Back on the theme of acceptance of managed care. In your work, do you discern different attitudes in the primary care community versus the nonprimary care community?

Halaas: Oh, yes.

Mullan: How would you characterize those?

Halaas: The specialists are really in a fight for their lives, here, like anywhere, I think. I don't really know that I know the percent of primary care versus specialty here, but clearly, like there have obviously been too many hospitals, there continue to be too many specialists. We operate in such a tight economic setting here already, the margins are at 1 percent, and the cost is low, there aren't a lot of obvious opportunities to cut cost. Most insurance companies and for-profits haven't wanted to come close to Minnesota, because why would you want to try to operate in a place where you couldn't make much money?

The specialists, within managed care, have had to play by the rules already, and learned how to manage care and how to relate to the primary care physician, and what it means to be part of a gatekeeper system. But now their incomes are coming down, and they're not replacing the partners who are leaving, and there is much more competition between groups, potential loss of contracts with payers or hospitals, much more attention being paid to the quality of their outcomes, the cost of their care.

Mullan: So this translates back to my simplistic question, specialists are less accepting and more--

[Begin Tape 2, Side 2]

Mullan: This is Gwen Halaas, tape two, side two.

Specialists, I gather from what you're saying, are more resistive to managed care than the generalists?

Halaas: They begrudgingly accept it to a certain degree. I think they have no choice here. There are few are who strictly fee-for-service specialty groups. Some of them are capitated already. Some of them are rather enlightened and are pursuing capitated contracts and different kinds of arrangements, or infertility specialists having money-back guarantees and stuff. But most of them begrudgingly accept managed care and are angry, particularly if they see it begin to threaten their income more and more.

Mullan: Is that different than the rank and file in primary care?

Halaas: Yes, first of all, because family practice has such a strong presence in the metropolitan area, because it has a strong presence in Minnesota. Family physicians kind of intrinsically understand what it means to be a gatekeeper. Because we're trained to do the broader array of services, we would prefer to see our patients all the time, and only refer them out for when we can't meet their needs, so it's just kind of natural for a family physician to be put into that role. Being restricted by rules, if they are explained and they make some sense, is more naturally understood to a family physician. It's not as easy, I don't think, for some pediatricians and internists who, again, are feeling more of a competition for patients.

Mullan: From the family docs?

Halaas: To some extent, but more just a sense of, "Where do I fit? What's my role? What kind of patients am I going to get? How many of us can there afford to be? Should we join the family physicians and be a multi-specialty?" That's been a big thing here. There have been both mergers that are multi-specialty as well as horizontal. We have probably one of the largest colorectal surgeon groups in the world, and they've just all been independent folks who have merged to create one group. Actually, I don't know that that's the accurate history behind it. But it's certainly true for a lot of the sub-specialties that they had merged across the cities to one large thirty-member, fifty-member, hundred-member single-specialty group.

Mullan: As you watch from the very intimate and well-informed position you have, and your physician colleagues railing from all the changes that are taken place, what observations do you have about the well being and mental health of physicians today, and where do you see it all going? What is your current assessment?

Halaas: I think, on the one hand, it's improving, because physicians are being more rational about their lifestyles. They're limiting their work hours to some extent, there are more opportunities for part-time work. So on the one hand, I think the mental health is improving. Again, I think on the whole, the mental health of providers here feels pretty good, because this has been a rather gradual transition. Physicians have scrambled to catch up, or change what they do to fit better. I think it's

going to be much harder in a lot of different areas of the nation where the changes are going to have to be more rapid, and adjustments will not be nearly as easy.

Mullan: Are there physicians in Minneapolis who are going without work, or whose work has been significantly diminished?

Halaas: I think it's harder to find a job. If you choose to leave a practice for whatever reason, I don't think there are--

Mullan: If you choose to leave a practice?

Halaas: Well, some do, you know, because they don't agree with the philosophy, or they're uncomfortable with a merger.

Mullan: So they take off, find another position elsewhere, is that it?

Halaas: Right.

Mullan: How about people coming out of residency, are they finding it harder?

Halaas: I think that there are more residents who are choosing not to practice in this area, in the metropolitan area, because they don't understand the managed care system, and they don't want to be constrained by it. So it's easy enough to practice in

Wisconsin or upstate Minnesota, where managed care isn't felt to be as strong. So there's a clear change there. Primary care physicians who are in practice aren't terribly threatened yet with getting their jobs cut, or dramatic drops in salaries.

Mullan: That is occurring to some extent, salary diminishing?

Halaas: Well, I know for instance, there are physicians who have been let go in situations of merger, when they had more administrative roles and there was duplication of services. But I'm really not aware that physicians have lost a job because there aren't enough patients to support them. I think there's still enough work here.

Mullan: How do you see the future? The enthusiasm you seem to feel for the systems approach, the managed systems approach to health care delivery, do you see that as the way of the future? What is medical care and marketing going to look like in ten or fifteen years?

Halaas: I do see it as the way of the future, because I do believe that there is a limit to the resources that we have available to pay for health care. I think that without a systems approach, we do risk losing in the quality of medical care, or the access to medical care, so if we really want to provide universal access and maintain or improve the quality of care, we

have to have a systems approach. We have to think along the lines of population health and not just individual health.

So I believe that it is the way of the future, and I think Minnesota is leading the way, but I don't know that you can translate what we do in Minnesota to other places, because I don't know that it'll fit the culture.

Mullan: In fifteen years from now, what is Gwen Halaas going to be doing?

Halaas: I've really become much more involved in the ethics of health care related to policy and related to the concept of providing fair and equitable health care benefits. So I'll continue to learn, although I'm trying to stay out of school. I may pursue more in the area of ethics and work in the area of policy, whether I do that at the health plan level, or for the state of Minnesota, or serve as a consultant for other organizations in the nation that are trying to develop opportunities.

Mullan: Do you have any ambition to sit astride one of these things, be a CEO?

Halaas: I don't think so. [Laughter]

Mullan: Sounds like you could be persuaded, though.

Halaas: Well, it would really depend on the organization, and I'd have to feel comfortable about my role. I feel much better about being an advocate for patients and members, even though many would not interpret my role as that, than being the financial or marketing or political person. I may have some problems with those roles.

Mullan: Your husband is a minister. I presume that religion was there. Is that a factor?

Halaas: Religion has always been a strong part of my family upbringing. We're both Lutheran.

Mullan: And does that crosswalk into your attitudes about medical care?

Halaas: I think so. I see myself as a caregiver, and as a role model, and as a person who is committed to leaving the world a better place.

Mullan: You see that on a religious grounds?

Halaas: I think my religion supports me in doing that. I get my reward from being able to do that, from being able to do good in making people's lives happier.

Mullan: That's a pretty good religion. We've touched on a lot of things, and the hour is late. Are there things that we haven't talked about that you would like to comment on?

Halaas: I'm sure there are lots of things, but--

Mullan: There's no question on the top of your mind that you've been waiting for me to ask that I haven't?

Halaas: No, I don't think so.

Mullan: If you have things you want to add when you get the tape back, certainly do that. Thank you.

Halaas: You're welcome.

[End of interview]