JACK KIRK

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Kirk: March 25, 1944.

Mullan: We're sitting in Dr. Kirk's office in New London, New Hampshire, the date being the sixteenth of July, 1996, and it is a spectacular afternoon outside.

Kirk: Indeed.

Mullan: And it's even a nice afternoon in here. Dr. Kirk's been good enough to entertain me in his practice. Why don't we start back at the beginning and tell me, if you would, a little bit about yourself, where you were born, where you grew up, and what your early years were like.

Kirk: I was born and grew up in Oak Park, Illinois, a suburb on the west side of Chicago, a comfortable though not extravagant suburb. I guess I grew up very much in sort of what might be described as ethnic Catholic enclave in that suburban area, went to Catholic schools all my life, and was very impressed growing

up with the need to serve my fellow man, I guess. I had a bad case of that altruism growing up, certainly, and it was always just whether I was going to a priest or a doctor or both. For a long time I planned do them both.

I didn't have any family members who were really in medicine, didn't have any early experiences in medicine. It was purely and simply that it was an honest sort of serving ideal that was always there, and certainly by the time I graduated from high school, it was perfectly obvious that I was going to be a pre-med major wherever I went to school, and if I didn't get turned completely to the Dominican fatherhood, that I would be in medicine.

Growing up, I had one brother two years older than I, and mostly we spent our lives with sports, an intact sort of very supportive family group. Anyway, the whole environment on the West Side, in our parish, and in our subsequent high school, was a very warm and nurturing place, and a sense where, again, you came out of it with this sense of wanting to serve in some way and be good to somebody else. I was fortunate and didn't have any pressing family or other problems. Life was simple, as the fifties were supposed to be.

Mullan: What did your parents do?

Kirk: My father was a salesman who, himself, had grown up in a small town in central Missouri. When he got out of high school, moved to Chicago to try to find work, basically, and never completed his education. My mother's family was a little closer to Irish roots, but she grew up in Chicago. We were always proud that she was George Halas' executive secretary for a number of years before she and my father met and got married relatively late in life. I think they were in their early thirties, and were close to forty when they had my brother and I, which is often used as the excuse for why we're perhaps as simple as we are. We were had late in life.

But anyway, certainly, my brother and I were clearly college ordained. The Catholic high school we went to was a real solid college preparatory school, that that was expected of everybody, and there was never any question that we were going to go on to higher education and somehow be of service.

Mullan: The milieu of the Catholic upbringing was important to you, in general. Were there particular teachings or particular figures that enforced or to which you connect this service principle?

Kirk: I don't know that I can name it beyond that it was very much seemingly the nature of all of the messages working

together, certainly both the home as well as from school. At least that was the message I heard. I'm sure there were fellows in the next seat who heard perhaps a different message, but that was always the message I heard. I don't think of any one role model in that sense that sent me on this way.

I think what I was most impressed with, I guess, as I think back on it, is that the education, especially at the high school level with the Dominicans, was very focused on logic and natural law as the way to understand what ethical behavior was and how one solved problems. I'd always thought that that part of my high school and subsequent college Dominican education at Providence College was all very much focused on logic and on a very careful reasoning of how one solves problems both in the ethical sphere and the moral sphere, and just in general in life. So I think apart from the idea of service, it had a lot to do with what I hope is still a very sort of logical problem-solving approach to things, and what was always interesting to me about medicine is that it is about solving problems and getting in there and seeing if you can figure it out and solve the problem in a logical fashion.

Mullan: Were there medical figures in your early life that influenced your interest in medicine?

Kirk: I think not at all. Again, no one that I can recall had any--I suppose I shouldn't say nobody had any significant medical problems. My mother had colon cancer when she was in her fifties, and had a colostomy, but that was just sort of--I mean, I was vaguely was aware of that, but in those days it was sort of kept from you, and she lived well on into her life without any further problems. And my father had a heart attack when he was in his mid-forties when he was away traveling. I remember that my grandmother from Missouri had to come and take care of my brother and I for a couple of weeks until he was able to come home. But again, in general, there wasn't a lot of talk of those things, and I didn't have any medical exposure myself. It was just always kind of an ideal, and something to do, and it had no particular experience behind it.

Mullan: So Providence was the college.

Kirk: Providence was the college.

Mullan: I was going to say, a distinctly non-Catholic but, of course, Providence is.

Kirk: Right. They really twisted my arm. I was going to stay in Chicago and go to Loyola or someplace where my brother had

gone, and the Dominican fathers at Fenwick wanted me very much to stay within the fold, partially because they were convinced that I was cut out to be someone in a white robe. I was all right with that, but I think going to Providence was a good idea anyway, because certainly the focus at Providence was a very nice environment that certainly broadened my, at that time, very parochial horizons, which I think was undoubtedly a very good idea, and provided a real good preparation, as it turns out, for medical school.

Mullan: You were committed at that point to medicine? You did a pre-med course?

Kirk: Yes, still with no more logic behind it than this general idea of service, the whole idea of what kind of a doctor I used to think I was going to be. I was impressed as a child, I remember, reading somewhere along the road about the Shriners hospitals, and it seemed like being a pediatric orthopedic surgeon sounded about right as the ultimate in service. It was never more reason than that, and I'm about as far away from being a pediatric orthopedic surgeon as I could be.

Mullan: What did your brother do?

Kirk: Bill was two years older than I and actually was accepted to medical school after his four years at Loyola, and declined the offer and has a Ph.D. in biology, and is a vice president for environmental affairs for Commonwealth Edison in New York. He's an industrial biologist, so to speak, working in environmental affairs.

Mullan: As you went through college, did the notion of the priesthood stay neutral or fade? Presumably it ultimately fell by the wayside. How did that come about?

Kirk: Yes, I think probably the height of it was probably in high school, and probably in college as I got more interested in what I was doing, and certainly in biology, I had, I guess, less interest in that. Certainly, at least, it never heated up any further. It was during my college years, also, that I met my wife, and our relationship developed the last two years of college. I think somewhere in the midst of all of that it was clear that I was going to go on to medical school and not enter a seminary. I think probably about midway through college, there was not even any thought anymore that I would do that. I just threatened her now that if she gets tired of this whole thing and leaves me, I still have the priesthood to go to. But otherwise, it doesn't occur to me anymore.

Mullan: Then you chose Cornell for medical school. What prompted you and how was that experience?

Kirk: Well, by then, certainly, I had more or less opted to stay in the East, partly and largely probably because of my relationship with my wife-to-be. So I looked seriously at that point at Eastern medical schools, and I guess there was also a sense that those were the ones that were "the best." I'd been a very high achiever at Providence, and Providence, though it had a small program, had been capable of getting a few people into very good what were considered to be the finest Eastern medical schools. So those were where I applied. I probably applied to Harvard--I know I did. I think Cornell was probably second. My wife was from New York, and I figured if I didn't get into Harvard, although I didn't know anything about Boston, but that was just, once again, that was sort of an ideal, that that's where you went. You couldn't not give it a try. So I didn't get into there, and I got into Cornell, and that was a good choice, because my wife was from there, and so our relationship would be fostered by that if she returned home to finish college and then we would be able to stay together. But we subsequently got married halfway through medical school. That was a part of our plan. So Cornell was obviously, as I was led to believe at that

point, a very good school and, in fact, I think it was, and it was sort of the right place for us geographically at that time.

Mullan: Going into medical school, were you still entertaining the orthopedic surgeon notion, or what were you thinking at the time?

Kirk: I don't think I formally had that idea anymore, but I don't think I had replaced it with anything very concrete at that point. I'm always amazed when I think back at how it was like having blinders on. I was just a very focused person on studies and on doing certain things, and I could do them well and shut out the rest of the world. If you told me to study biochemistry, I'd study biochemistry, and I didn't necessarily ask the question, "Why do I have to know that? I'm not sure what I want to be yet." So it probably came from my Catholic school upbringing. Point me at it and turn me loose, and I'll get an A in it.

Mullan: This was a whole period of political ferment on the campuses in general, not particularly Providence or Cornell Med. Were you tempted or involved in any civil rights, anti-war, or any kinds of movement kind of activities?

Kirk: That's interesting, because that comes on the heels of this, as I look back, about how focused and narrow that focus was. I, frankly, would have said, "I don't have a political position." I was shocked that anybody would really think that the government in a vague way kind of wouldn't do right, or at least they'd be honest even if they were wrong.

I wasn't actively anti-demonstration, I kind of wondered how people had time to do that, because I was up to my ears in very focused things. So I was kind of apolitical. I was just kind of the war went on and I was doing my thing. I think if I had ever thought in a larger way, even though Cornell provided a wonderful education and I enjoyed my years there, as I look back on it, it was in a social setting that if I looked at it today would be very uncomfortable to me. I was in sort of an ultimate one of the ultimate Ivory Tower kind of institutions with a certain of that kind of arrogance; it never occurred to me to even begin to sort of list places with regard to things like that. I was studying that biochemistry. So, yes, I was kind of indifferent to social causes.

We had grown up very simply. Actually, I mean, probably the most intimate awareness I have now is that this western suburb of Oak Park was quite comfortably well off, and the parish school and all that I went to, we lived like at the very periphery of the parish, and I was the only person that I knew who lived in a

two-flat sort of house. Never knew anybody else who didn't have a big house with a professional father. So I always kind of socially felt uncomfortable. I don't ever think that I determined that I was going to work hard to make up for that, I just did. Sort of what I dealt in then, since I didn't reckon I could compete in those social areas, was I did good at things, whether it was sports or school. I mean, if you said, "Let's go do that," I was determined to do it and do it real well.

Life was simple. We were sort of the least well off, though never in any way that was discomforting, and always had what we wanted. And other than having this general idea of service and altruism, it was not focused on anything in particular. It was probably focused one by one by one in terms of my interactions with people, but it wasn't aimed at larger social sort of things.

Mullan: You then went back to Chicago and you made a choice for medicine. Why was that?

Kirk: I know very well the experiences at Cornell that made a difference. One was that it was the beginning of third year when--maybe it was the end of second year--that we had a public health seminar course, and Walsh McDermott himself, beloved and revered Walsh McDermott, lead that series of seminars, or at least was my group leader, and the world opened as it had never

had before. I always remember having a discussion about air pollution. I didn't care anything about air pollution and the physics of air pollution didn't interest me, but it was like suddenly there were a whole bunch of sort of social decisions in a way that had to be made. It was called, "Yeah, it's nice to clean up the air, but if you do, you're going to put somebody out of business over here, in the company that's polluting the air," and that there were issues suddenly that were very bigger than what I'd looked at before. So I actually found that these other issues for the first time kind of made a difference, and that it was hard to just focus narrowly on what was in front of you.

We also spent time--gee, I did a project in the Bedford Styvesant part of Brooklyn on tuberculosis follow-up. Certainly, that was the first experience that I had had really experiencing minority populations and the problems that people have, and some of those kinds of challenges. Again, though somewhat challenged economically myself by comparison to my peers, I had never really thought much about the specific problems that people had. So that was a very awakening experience.

Mullan: Your Chicago West Side community was all white?

Kirk: Oh, indeed. Yes. Mostly Irish and Italian Catholics. That's all that were allowed into the community as far as I could

tell, at least as far as my vision saw it. Yes, it was a very sheltered--it wasn't the North Shore kind of wealth, but it was a very middle class and somewhat upper and a little cross-section of middle class. Nothing challenging about it.

Mullan: So Walsh McDermott and Bed Styvesant were both eye-openers for you.

Kirk: Real eye-openers. Then there was an elective in tropical medicine. For a brief period of time, all of us wanted to be Ben Kean, who was a professor of parasitology in the Department of Public Health at Cornell, who was a most charismatic and Runyanesque figure, somewhat deformed by an old Bells Palsy, with a stump of a cigar hanging out of his mouth all the time, and he'd spent his life--we all knew that he had dated Joan Crawford, and that he had this social life in New York that was really kind of exciting, and he spent half his time traveling the world and looking at schistosomiasis in places.

There was an elective in Brazil in the north part of Brazil, in a poor part where schistosomiasis and CHAGAS' disease were very much prevalent. My wife and I, at that time, spent four months there. Again, a very exciting sort of experience where I guess I remember that I was as excited by being out in a Jeep trying to figure out how to get the snails out of the watershed,

as I was truly more interested in that than in the surgeon's problem of removing a hugely enlarged spleen from a patient with schistosomiasis. So that the kind of geographic, these other elements, including the social elements of life that surrounding disease were by then--

Mullan: Population health.

Kirk: --were clearly--I mean, I guess the skills that I thought I had which were not purely scientific. I was much more interested in these sort of peripheral science areas than I was in playing with tools and calculations that had to do with technology related to patient care. I always reckoned I could get an A in calculus if I had to, in order to get the job done, but none of that stuff ever was of interest in and of itself to me.

Mullan: So the Brazilian experience, the tropical medicine course or teachings and Walsh McDermott were things that stand out as beginning to shape your thinking in a somewhat different way?.

Kirk: Right. And I certainly have to add that Ken Johnson was one of the other professors of public health at Cornell with Dr.

McDermott, with whom I had a lot of experiences. Some of these experiences were with him as part of these seminars and writing the paper on TB in Bedford Styvesant, and subsequently, again, that's how I ended up coming back here.

Dartmouth was another step. I guess after medical school, somewhere in the midst of all that, it was clear that medicine was my choice. I don't remember ever having a one time when that was clearly made or when I sat down with my internship advisor and they said, "So what are you going to do?" I mean, certainly by my clinical years, I think that surgery just didn't interest me. I didn't enjoy the thought of spending time doing that, and the technology surrounding that was not of interest. So medicine was clearly what I had opted for, although I wasn't sure where in medicine I would go. I wasn't interested in pediatrics as such, and I don't know why, but it was going to be medicine, not surgery, and vaguely after the Brazilian experience and the other experiences, I frankly kind of wondered about whether some kind of a public health career at that point might be mixed with some kind of clinical work. But I knew I wanted to do clinical work.

Mullan: The University of Chicago is a pretty traditional choice.

Kirk: Yes. I had decided then it was a simple thing, because by then my parents were a good deal older and both were having significant medical problems and were very much alone at that point, and it was very much a conscious decision to go back to Chicago after being away from them for about eight years. I was feeling obliged to be back and participate in their life.

We looked at three or four places in Chicago, and I guess I was most impressed at that point with the academic challenges at the University of Chicago. I remember looking at Northwestern and thinking that the internship was a little too easy. I was still pretty much kind of hard-core focused and reckoned that I would flagellate myself with as difficult a program as I could find, and that wasn't the Northwestern hospitals.

My wife Jane and I were looking at the intern housing at the West Side Medical Center at Pres-St. Luke's, and at that internship, and an elevated train went by about four inches outside the window of the apartment that we were looking in. Although Jane didn't grow up in wealthy surroundings either, that would have been a difficult setting. So we ended up at the University of Chicago, with that choice for several reasons, and living out of the West Side of Oak Park near where my parents were with me commuting to the University of Chicago.

Mullan: How was it?

Kirk: The experience was indeed challenging academically.

Mullan: Al Tarlov, chairman?

Kirk: Yes. Right, indeed. Mark Siegler, who's the ethicist, was our chief resident then. There were a couple of things. One thing that I was disappointed in, I know, was that most of the rest of the interns and residents were clearly much more interested in academic medicine than in caring for patients, as I saw it. I was very proud of the fact that I spent a good deal more time at the patients' bedsides. I always reckoned that I may not have been the quickest to figure out the problem, and I may not have studied all the literature quite as well as some of my peers, but I would be up at night, and I would be there, and I wouldn't give up until I had the problem solved. I always felt that that sort of dogged determination and stick-to-it-iveness, and spending time with patients and figuring it out was what I was good at.

I didn't really get a sense of a great deal of support for that part of what I was doing from the rest of the people that I worked with. Some wonderful preceptors and teachers there, but, in general, there were a lot of people who were focused on academic careers that were much less clinically oriented than I.

So I knew by the time the year was over that I really didn't want to stay there any longer.

It was also a very uncomfortable year, as it turned out, for Jane. We had our first child. Our daughter Jean is twenty-five now, was born that November. Basically, Jane was away from all of her usual supports and I was at the hospital one night out of two, so I'd come home for about eight hours exhausted every two days. So it was really a difficult year for her. I was not happy with the program at the University of Chicago, or it probably would have been, I suppose, a tense time for us in deciding what to do next. I think we, in general, decide things pretty much together, but as it turned out, I was not happy with the program, and she really needed to get back, realistically, closer to her support system in the East.

About that time, Ken Johnson, who had been a professor of public health at Cornell, and who'd really been a close mentor there, had left Cornell to become the first chairman of a new Department of Community Medicine at Dartmouth. His first job was to begin a residency that was called the "physician-manager primary care residency," which was specifically intended to train primary care physicians for rural careers, recognizing that their training needed to be clinically broad and that they needed "managerial skills," that is, community-oriented primary care skills, epidemiologic skills, skills and knowledge about how community health systems work and what a physician's role in a

community health system is all about. That was clearly a very revolutionary thought. This was now 1971 that this program was to begin.

Mullan: What was it called?

Kirk: The physician-manager primary care residency. I think of it because it was Dr. Johnson who moved on to the Robert Wood Johnson Foundation, sort of the Robert Wood Johnson Clinical Scholars Program, I think, to some extent, at least the content of some of that was shaped, as a separate fellowship, to take primary care physicians and give them sort of, not just academic, but sort of health planning and epidemiologic skills. You probably know more about that than I do, I'm sure.

But the program, at that time, it wasn't that I decided yet that I really wanted to be in a rural area, I hadn't thought about it. Again, I'd never planned things like that. Dr. Johnson was somebody I respected greatly. It was very clear at that time that I knew I wanted to be a clinician, and, relatively speaking, a community-based clinician. And I still liked problem-solving skills and some of the social problem-solving skills that I had learned to respect. So this program was very inviting.

We had never, neither my wife nor I had ever had thought that we would particularly want to live in northern New England. We hadn't thought about it one way or another. But we knew we wanted to come back in general to the Northeast, and this program was just perfect, and Dr. Johnson was somebody we had had the greatest respect for and relationship with in medical school, so it was a natural thing to come back to.

Dartmouth, of course, at that time, until very recently, didn't have a family medicine faculty; in fact, in a very traditional way, looked down its nose quite firmly at the thought of family medicine.

So the program really consisted of combining Medicine and Pediatrics under Dr. Tom Almy, who'd been a professor of medicine at Cornell and had moved to Dartmouth as the professor of medicine, and Saul Blatman, who was a professor of maternal and child health, and Ken Johnson, who had formulated this program. It said, "You will get your boards in either medicine or pediatrics, and spend most of your time in that, but you will spend another year of doing other clinical stuff. If you're an internist, you're going to do six months of pediatrics and a lot of psychiatry and orthopedics."

It was called a clinical complementary year, and another year would be spent doing fellowship work during which time boards in preventive medicine were satisfied. There was a question about whether to make it a master's in public health or

exactly what sort of academic degree could give it. There were technical reasons that I never fully understood that made it easier to make it under preventive medicine boards rather than an MPH program for these experiences.

So I did then two more years of internal medicine residency at Dartmouth to complete the total of three, and then did a clinical complementary year, and then did this fellowship year that gave me boards of preventive medicine.

Mullan: It was five years total. Four years at Dartmouth and--

Kirk: Actually, it was '71 to '74. I did one more year of straight medicine at Dartmouth, and then the clinical complementary year actually had some more medicine in it as well as six months of pediatrics in it and a couple of months of psychiatry. So actually, I spent a total of two full years in medicine, and a year at this clinical complementary one, and then the fellowship year.

Mullan: How did you feel about that? How was it?

Kirk: Well, it was an exciting program, because, well, the first year of it was my regular what might be called my PGY2 year of internal medicine. It was obviously in a very different clinical

setting than at the University of Chicago. I remember being a little frustrated at first. But the environment at Dartmouth, with much closer attention of private clinicians who knew their patients and cared about them, was so different from the clinic atmosphere at the University of Chicago. In fact, I remember several, at that time irritating to me, encounters with Dartmouth attendings who were upset because we, the house staff, had taken some liberties and made some decisions that would have been not even looked at twice at the University of Chicago. I've subsequently come to understand that and to respect it, but at that time, as a trainee, I kind of thought, "Wow, they're awfully tight about things like that."

But I certainly learned a lot more about the relationship of clinicians, physicians to patients who they knew and cared about than I'd ever learned at the University of Chicago, but I'm sure I learned a lot more about some especially esoteric, but also just an awful lot of clinical experience at the University of Chicago that came fast and furiously, and it was all a little more slower paced than Dartmouth. But in the setting it provided probably more learning about how to function as a real physician for people who expected to have a relationship with their physician. So that was a sort of real transition.

Then the next year after that was this clinical complementary year, most of which was non-internal medicine stuff. I remember I enjoyed pediatrics a great deal. It was a

real sense, at that time I was functioning like a pediatric intern, but they all knew that I was older and kind of knew some stuff that they didn't know. So I had a sense of seniority, and it was fun working with children. I enjoyed that part of it and some of the other skills that I otherwise would have known nothing about. I knew how to put casts on, working with orthopedics. I knew much more GYN than any of my internal medicine colleagues, much more psychiatry, from spending some very good time doing things like that. So the clinical training was fun for me. I was certainly happy being broader rather than inclusive and narrowly focused in a subspecialty of medicine, which is what all my colleagues were doing.

So clinically I was excited by it and, clearly, was prepared in a much more logical way to go out to the world and see what was going on. I also spent a month of that year, so it was about 1973, here in New London working in the office that we're sitting in now with Dr. Ohler, who was a general internist here in New London, who was a wonderful role model, and highly respected by the folks at Dartmouth, which is why I was farmed out to this experience for a month. So I came to know the New London community and this particular office, and the way one very caring and charismatic and capable clinician worked with his patients. I had no intention at that time that this is where I would subsequently end up, it was just one more experience. Subsequently, it's come back to haunt me, I guess.

And again, Dr. Ohler's very extraordinary capabilities as a clinician were a very strong further influence on saying that's probably what I wanted to do.

Mullan: The preventive medicine element of the program, toward the preventive medicine boards, what was that and how did that play itself in the program?

Kirk: So for the follow-up for our fellowship year, it was a lot of lecturing focused on me and I think there were two other individuals in the program at the time. We had a lot of one-on-three sort of lecturing in biostatistics and in epidemiology, after taking some courses in that ourselves in a very special way, we then by later that year were being small group leaders as part of the medical students' epidemiology and biostat courses. So we were forced to really use it ourselves and being seminar group leaders. So we had a lot of that information, and we spent some time in--I don't remember what it was all called, I remember the curricular book that had been hurriedly put together for this pilot program. And we spent a lot of time in seminars examining community health systems as they existed then, and as I just thinking about it now, they've come back to life.

The first HMO that any of us had ever heard of, called Matthew Thornton [phonetic] HMO in Nashua, we visited it, and

examined what this new breed of cat twenty-five years ago was all about, and there were efforts made to organize care in the upper valley of New Hampshire. I'm blocking on the name. It isn't that important, a name of one of the Indian tribes here, and this coalition was an effort to even organize a regional hospital from Dartmouth, and to really organize satellite clinics around it and have an organized rural health system. Anyway, so we studied a lot of these kind of things.

Then we did a lot of exciting community work. I traveled with Mike Taylor, who was a junior faculty person in the department, all over most of Vermont and New Hampshire, coming to know all the communities first hand. Our job was to answer communities' calls for help. "Our old physician is retiring, we have nobody left, our hospital's closing. We can't get more physicians. We have no focus of health care."

We wrote two or three applications for National Health Service Corps sites. We formed a couple of community health clinics. We had an architect, one man who still architects in the area, Ted Lewis, who traveled with us all the time, and we would take old doctors' offices and figure out how to make them into community health centers.

We went to Lincoln, New Hampshire, where Sherman Adams, the man of the Vicuna coat and President Eisenhower's aide, had been disgraced for taking a Vicuna coat in the fifties. He had returned to his home in New Hampshire, in Lincoln, which was an

old mill town up along the Pemigewasset River, a beautiful part of the White Mountains. As the paper mill died, the town was left completely without anything, including physicians. We sat with Sherman and other community organizers and figured out what they needed to do, and we sort of, with Ted's help, designed a little health clinic, and, anyway, got National Health Service Corps people and that site is still going, as is the one in Londonderry, Vermont. So we spent a lot of time really grass-roots organizing with the community.

Mullan: Was that a good year?

Kirk: Oh, it was an exciting, absolutely exciting sort of year. I was actively involved as a participant in it, who was expected to perform, and so I had a real sense of responsibility that I was trying to solve problems with a small cadre of people who were very helpful to me, but also needed my help.

Mullan: That was before the clinical complementary--

Kirk: I sort of forget myself the sequence of those three years.

Mullan: As you crank towards the end of this, you now are approaching the real world. What was your thinking?

Kirk: Well, it didn't matter what I was thinking, because the Navy had their hooks into me. I was a Berry Plan person, one of those folks whom the Navy promised that if I signed up for the Navy in medical school I would be guaranteed that I wouldn't be drafted after my internship, that I'd be allowed to finish my residency before going into the Navy. So as I went through my residency, they actually tried very hard to get me shifted from the Navy, with responsibility to the National Health Service Corps. It was an absolutely natural sort of thing for me now to build one of these sites that we'd organized. The Navy said no, despite Senator Norris Cotton and everybody else in power and influence in northern New England writing in and saying, "This man should be a National Health Service Corps assignee."

The Navy wanted me, and sent me to Iceland for two years, which turned out, again, an exciting experience for Jane and I. It was a wonderful opportunity to practice medicine, as would have been a National Health Service Corps site. We took care of about 2,000 Americans, families, all ages. I was the base internist and the closest thing to a pediatrician that was there. So the depth of my skills were needed there and also I was the base preventive medicine officer, which, with the other skills that I had learned as part of the clinical complementary years, it turned out to be a wonderful setting, and plus we got to

travel more than we ever had before or since. So it was an exciting couple of years.

Mullan: That was two years following the residency. By this time you must have been pregnant with ideas about what you were going to do.

Kirk: Right. And certainly at that point when I looked back as we were coming back to the area, we wanted to come back to northern New England at that point, and the choice was between taking an academic position at Dartmouth. Actually, they needed somebody to direct this residency that I had been the first member of. But we looked around hard at two or three very rural and needy sites in northern New England.

[Begin Tape One, Side 2]

Mullan: This is Dr. Kirk, tape one, side two, continued.

Kirk: So we looked at some of these far-flung sites that needed physicians badly because of the nature of the isolation and the rusticness. Jane and I, we had our second child, too, by then. Ian had been born. So we had two small children. As we looked at these isolated sites that needed physicians, we discovered

that there were good reasons why they needed physicians and a lot of other services, and everything from educational opportunities to other halfway cultural experiences seemed to be lacking. Neither of us is highly involved in any of the arts or culture as it might be, but clearly it would compromise a lot of lives to live in some of these other sites.

So as much as I was really sort of committed to practicing, we finally decided to take this full-time academic position as the director of this residency at Dartmouth. So we moved back to Hanover and I spent a year trying to further develop the curriculum for this position of manager primary care residency.

Mullan: Who had been the leader or mentor earlier?

Kirk: Well, Dr. Johnson had been the chairman of the department and really the mentor, and several junior faculty members like Mike Taylor and some of these. Arthur Jacobs had been sort of the people who did most of the teaching. But Dr. Johnson himself was closely involved with everything which, again, it couldn't have been a more wonderful experience in that sense of being right with a very senior and very capable mentor who was very much interested in your education. While I had been away, basically, nobody else had been in the--the residency had more or less not recruited. They began recruiting again with the

anticipation that I was going to come back. So I had three residents starting with the program when I arrived back on the scene in 1976.

But by then Dr. Johnson had left, and Mike Zubkov had taken over the department. I think Dr. Johnson had become frustrated by the basic resistance within the Dartmouth-Hitchcock community to this idea. Dartmouth was still basically committed to very traditional modes of education and had never really supported this program in any major way. In fact, Dr. Almy was no longer the chairman of medicine, and Dr. Johnson had moved on, and clearly the forces of tradition had taken the upper hand again.

I got back into the middle of that, and was expected to try to develop a curriculum for these residents who were there, and it was like pulling teeth to try to just be certain that I could say to these folks, "You're going to have three months of this, and six months of this, and you're going to be treated like an internal medicine resident on the internal medicine services, and you're going to get a good program." All of that was a challenge.

There was a challenge secondarily that we were going to be site-visited by the boards in preventive medicine, and it turned out, as I learned during the course of that year, that there was no way that we could really fulfill the requirements in the years that we had allotted for the boards in both medicine and preventive medicine in that period of time, and I was given the

job to make it look like we could, and it was very obvious that we couldn't. There was conflict there that I was uncomfortable with in that regard, and conflict with the clinical folks. Late in the year, I was eager to get back into seeing patients, and the resistance, the opposition to what the Department of Community Medicine was doing, both clinically with this residency and the fact that we were out there establishing National Health Service Corps sites, which some folks saw as direct competition to the somewhat undefined mission of the Dartmouth-Hitchcock Medical Center. Were they're doing primary care? Were they doing tertiary care? What was their role? But they were not comfortable that we were going out establishing physician sites outside, and then some folks inside felt that that was a direct threat.

They gave me a hard time. I was as good a clinician as they could ever ask for, and I'm totally unapologetic about that. They made it very difficult for me to see patients within the Hitchcock system. When I finally did begin to see patients in the system, I was seeing folks for general medicine consultations. I'd see somebody who would come for his/her physical exam to the Hitchcock instead of to their family physician twenty miles away where they lived. The relationship, there were few long-acting, long-lasting relationships. There was none of the satisfaction that I was looking for in clinical medicine, so I was unhappy clinically. I was unhappy with the

administrative job of trying to get a residency through a system that didn't want to do it.

I wrote doing that year a primary care internal medicine/pediatrics grant that, when site-visited, clearly, the folks were wise enough to say, "You know, this is good on paper, but we don't think you can do it, because these other folks don't want to." And that was very true.

So by about six or eight months through that experience, Dr. Ohler, who I had been with here for a month, happened to call me up one sort of late winter afternoon and said, "Hey, you know, we really need somebody here in New London. I don't suppose you're interested."

It hadn't occurred to me yet that I was going to leave, but when he called that day, Jane and I talked about it, and it was like a light went on, and we came down and looked around, and looked at houses, and within a couple of weeks announced that we would move on, which was just a fine, fine decision. So that was twenty years ago. It was clearly the struggles and the frustrations of administrative and academic medicine, especially in a system that was not by any means ready for what we were talking about, and the lack of opportunity to do clinical medicine in a real one-on-one primary care way within that system as it existed were just two things that there was no point in staying.

Mullan: So what was his practice like when you came to it? We're talking now '77, '78.

Kirk: Right. [Tape recorder turned off]

Kirk: I can certainly summarize the early practice. They wanted somebody with a very general set of skills, which is what I possessed at that time after the residency, and after the Navy years. There wasn't a pediatrician here. There was one family physician and a number of general internists.

Mullan: Here being New London, New Hampshire.

Kirk: Here in New London, serving this community. Anyway, so I did a lot of pediatrics. I put casts on simple non-displaced fractures. I never was interested in doing OB and was not trained to do so, and there wasn't any need for that. Gradually over the course of the years, as the community has gotten a pediatrician and as my own practice and that of the community has aged, my practice has become a largely geriatric practice. It's been closed to new patients for the last probably eight years. So the practice has indeed aged with me.

Mullan: Has that been purposeful? Why?

Kirk: Oh, just too busy. Just too busy and I tend to spend too much time with people, probably, and at least for the style of practice that I do, I can't keep up with what we're doing now. We always reckoned that by closing the practice and as people literally died off, as they certainly do in an older practice like this, we have a barn full of old charts to attest to a lot of old friends that have passed on. Yet as the other people get older, their needs get more intense, so the intensity of the need hasn't seemed to diminish, even though we haven't taken new patients in all this time. So anyway, I'm not sure whether to follow that tale further or not.

Mullan: Dr. Ohler remained in practice with you for some period?

Kirk: Right. And none of us in terms of the organization of the practice here in New London, or the practices as you've seen here, there's a medical office building immediately adjacent to the small hospital. All the practitioners were always solo independent practitioners, and I came as a solo independent practitioner, being more or less promised by Dr. Ohler and several others that I could probably make $35,000 without too much--they just felt that would be easy, and that's about what I guess I was making then at Dartmouth, and I wasn't really looking for--that seemed like a great deal after residency and the Navy.

They sort of vaguely guaranteed it in kind of a way, you can't not make $35,000, so come on, implying that if somehow I didn't, that they would make it up, but there was never any need for that anyway, because, indeed, they knew well that there was a need for somebody working very hard. And it has continued that each of us here has remained as independent practitioners, each of us taking care of our own business, but working together in the office building and having a very wonderful collegial relationship with each other for the sake of coverage and care of patients. I mean, what was back then about four general internists and one family physician is now six general internists and a couple of family physicians and a pediatrician, and still all of them in the same building adjacent to the hospital, with a lot of input. Dartmouth is thirty-five miles away, and Concord is thirty-five miles away. So we have adequate support from subspecialists who come here and help us when we have problems. But a very tight collegial practitioner community, not individual physicians scattered around town fighting with each other, but very, very closely working together, and not getting on one another's hide because of business relationships that often, I think, destroy groups. So I don't care if somebody else wants to make more money than I. That's their business. If they want to make less, and they don't want to work as much, that's their business. But when it's their turn to be on call, what I care about is that they're good, responsible clinicians who will do a good job of

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caring for my patients when I can't. That kind of relationship has always been true here.

Mullan: Has the growth of physicians paralleled the growth in the population, or has the physician availability and intensivity greater now than it was twenty years ago?

Kirk: I think it's more the latter. Certainly, the communities here have grown some, but not hugely. I probably can't describe enough about the demographics in specific terms to address it in a more concrete way. The growth in physicians has been modest. The community, certainly, has grown modestly, and the community is New London, and some however you want to throw a circle around it to include seven or eight or ten rural communities that are much smaller.

So exactly how one defines the catchment of the community is kind of hard to do. And there's a big seasonal flux with a lot of people here in the summertime who aren't here the rest of the time. But I think it's a community that has a large retirement, an increasingly large retirement population, so older people who come from urban areas where the expectations of medical care is that it's pretty intense, that it's time intense, that physicians spend a lot of time with folks.

I have an uncle back in Missouri who's been an osteopathic GP for many years, now retired, who always talked about, and quite proudly, how he saw fifty people a day on a bad day, and more than that on a good day. I know the nature of the problems he dealt with were probably different than ours, but I think, also, there's probably a good deal of difference in what the expectations of the folks are, and here there's no giving somebody a pill and saying, "Take three of these a day." With it goes an explanation of all the pros and cons, and ifs and maybes, and "Is this really what you're"--a real negotiated process of almost every decision that we make. So we spend a lot of time with folks who have complicated medical problems.

Mullan: You entered into practice at a time when the concept of primary care was, I'll say, first being articulated. I mean, the idea had been around forever in a sense, but it was in the early to mid-seventies when there was a kind of recognition that we were beginning to drift away. In fact, we had moved fairly briskly away from the generalist concept towards one that was much more governed by specialist and subspecialists. You entered into practice under a fairly clear banner of primary care internal medicine. Your residency was so dubbed. You got into practice as a primary care internist. How has that evolved? How

has that worked in terms of your practice and how you've seen the landscape around you change, if it has?

Kirk: It's funny. As much as I was involved, I guess, in teaching and trying to articulate the concept of primary care medicine and practice in those years, both as a resident and the one year directing that residency, I think I probably didn't and couldn't have articulated those in my own life in terms of what I was unhappy with. I'm not sure that I could have said what it was I was unhappy with in terms of the practice at Dartmouth, but I had this great sense that what I had experienced as a resident in a community like this, in a small rural community, clearly something I've never lived in myself, otherwise, but that what I had experienced here was suddenly like a light coming on when Dr. Ohler called and said, "You wouldn't think about coming down here, would you?" And suddenly it's like, "Yes. How come I didn't think about it before?" It was a very visceral sort of immediate feeling, and I think it more or less stayed that way. It was the opportunity, I guess, to develop very personal relationships with the people with whom I was working, presumably coming to know them in various capacities from life in the community, from church, from school, from neighbors, from all of those ways, so that you became very much a part of a community, obviously, and played a particular one-on-one role, as a

professional personal advisor to people on matters that happen to relate to their biology and whatever might be referred to as their health care. So it was clearly, I think that relationship with people, that was very warm and satisfying to be in that relationship, and again, I probably would have never articulated it as clearly. It was a very visceral thing that I enjoyed doing.

I enjoyed the sense of trust, I guess, that people would have. I probably greatly enjoyed, and still do, the sense of satisfaction that comes from having a problem presented, grappling with it, resolving it, given uncertainty, and accepting uncertainty as part of most of what we do. But probably then even more importantly, the satisfaction of being able to then sit with the person and say, "Here's what I think it is, this is why, these are your choices. You don't really have to worry about that thing you're worried about, and this is why you don't have to worry about that. It's much simpler than that. You've got various choices. Maybe it's enough for you just to know that it isn't anything serious and you don't have to do anything further, just knowing that." But we could talk about the choices, we could articulate them, we could negotiate whether it was serious business around death and dying or whether it was less serious things about something else.

So that role as a counselor and sort of hopefully trusted professional friend was very clearly what has been satisfying.

It's sort of an aside, but every now and then, when I think about whether I really wanted to continue a more full-time academic career, and I've done a lot of stuff part time, but really, do I ever have a regret about not having done that, or stayed in it, or gone back to it, and every time I think about that the answer is clearly no, because there is an incredible satisfaction just in that relationship, in that simple problem-solving. At the end of the day you can really say, "You know, I saw ten people today, and in four or five of those cases, they came in worried and they left feeling better." Maybe every now and then a couple of times a week I did something clever. Most of the time it isn't that, it's just more on a personal level of satisfaction.

So I think that's what primary care means to me. When you think about the words, yes, you're there. My phone number has been listed in a phone book for anybody that wants to call, although we had a call system. I guess I sometimes abuse that by being available, although, frankly, as I've gotten older now, I mean, it's nicer to use that call system and to know that my colleague who's on will indeed do a good job, and I don't expect myself to haul in there myself each time when I'm not on call. But I'm still incredibly available and accessible.

I've been very fortunate in that my office staff, our secretary/receptionist, Mrs. Gambino, and our nurse, Mrs. Baffa, have been with us now for ten or twelve years each. They know the patients as well as I do, and these are really people who are

now our friends. People know that they can access us. So accessibility is no problem. They can call Bonnie; they can call Kelly; they can walk in the office; they know where we are, and very few people abuse that. So we're available; we're accessible. The continuity of the experience with people has been there over a long period of time, and will continue to be. What we learn about how to care for this individual and other individuals by following them over time, knowing that you can take your time and you don't have to solve the problem today, you can wait and let it play out over more time, all of those characteristics that we talked about as primary care are there.

Finally, organizing care for people, or managing care, is something that we've done without thinking about it. If a person trusts you, they rarely go--there are exceptions, clearly--but they rarely go on to those referral folks without working that out through you, knowing that we're not going to be an obstacle to that, that we will facilitate it, we will talk to them about it, and pick a person who we know who is good, who will communicate effectively, and take care of them. And we're pretty comprehensive. Especially now as I've progressively limited myself to adult medicine, there aren't a lot of adult medicine problems now that I can't deal with myself, but we have easy access to specialists who can help them when needed. My colleagues in the community, surgeons and other folks, are

readily available to take care of the things that I shouldn't be involved with.

Mullan: What do you say to the charge, sometimes stated, sometimes in the air, that primary care is boring? Certainly one of the reasons that was attributed to why medical students, or young physicians, seem to be abandoning primary care in the '85 to '95 period. Was this simply misperception? What's going on here?

Kirk: What a strange point of view, at least after you're out here. I guess I would comment that, clearly, people find different things exciting. I think there is clearly nothing inherently boring about primary care unless what one really wants to do is play with machines in a high-tech atmosphere, in an operating room, and worry about heart-lung machines and things like that. Certainly, if really high-tech things are what excites you and human experiences don't, then maybe primary care would be boring.

In the first place, the human part of it is the most exciting part for me, and those challenges, and the excitement of everything from, again, telling somebody that they're dying and how to make something good of that, and even be able to have a laugh at the end of it, or relieving people, anyway, the human

part of it is clearly there. But the next thing that medical students who come and share our experience with us recognize very quickly is that it is a wild and wooly experience. Certainly, from the life-threatening acute myocardia infarction, with all the riveting disturbances and thrombolitics that we are intimately involved with in this community, we're not a backwater. We're able to do all of that kind of thing very efficiently here. So from that at one extreme to complicated metabolic problems, the spectrum is so broad and so varied, and because we're not so highly specialized, one frequently finds oneself struggling with something that's on the margin of your experience, whether it's an ENT problem or an orthopedic problem of interest, there's a never-ending challenge in terms of the actual clinical stuff and such a breadth of experience, clinically, that it's hard to call it boring unless one really wants to take each of these things to the technologic end point and play with machinery.

Mullan: How about the repetitiousness, the mundanity? These are words that are used.

Kirk: Right. Right. There still remains very little that I would call repetitious. Goodness gracious. What could be more repetitious than being an orthopedic surgeon who's replacing hips

as their major life work. Clearly, the spectrum of clinical activity that we have is much broader and, hence, much less repetitious. I sometimes wish I had a recording of myself instructing people about low back pain or about some approaches and the dangers, the pros and cons of treating hypertension, and there are certainly occasional times when you wish you didn't have to go through that again. But I guess the individual human element, and that's the part that ultimately makes every one so very different, that each and every person is so different.

The thing that for students to come and learn is that whatever they've learned in textbooks and generalities have to brought to bear with this person sitting in front of them right now, and that makes it a whole new game. You bring the information that you have from the book, and you have to know that. But then you, more importantly, have to know how to apply that, and how to negotiate that information with this person in front of you. So every case ends up being so very different.

So I think inherently it's broad because what comes in to us as first-stop caregivers is very broad, but even if it were more narrow, the fact that each individual is different, everything is cast in a different light. So that certainly doesn't seem to be a problem for any of us.

Mullan: Let me ask another sort of difficult question, and it's really about the internal medicine part of the primary care spectrum. It comes most recently from a provocative chat that I had yesterday with Beach Conger. He maintained that his kind of internal medicine practice, not unlike yours, was a dying phenomenon. We were sort of exploring this, and I think he was kind of playing with the idea in his head, although it related to stuff that you've thought about. The thesis goes like this. You are going to have, on the one hand, some fairly low-tech primary care practitioners who emphasize prevention and education and teaching, of whom the generic nurse practitioner is probably is a good example, but PAs and the family docs who do that kind of work well, and perhaps at a lesser cost. Then you clearly have a fleet of specialists in internal medicine and elsewhere, I mean subspecialists, who are ready, willing, and eager to intercept patients at as early a point as possible in the system. Appropriately or inappropriately, they're hungry, and cruising, and cardiologists want to get them, and gastroenterologists wants to get them.

The diagnostician, the thoughtful general internist who lives in between the low-tech, repetitious educator, counselor, preventionologist, if you will, who does the Pap smears and does the breast exams, and does the health maintenance kinds of stuff, and does it quite well, and the high-tech subspecialist waiting

eagerly, the role for this thoughtful diagnostician who was born of a day when lab tests and technological interventions were relatively minor players, and osculation, percussion, and good diagnostic thinking were critical, that day has, at least in this formulation, is rapidly leaving us. Therefore, that middle ground is going to be squeezed out by the low-tech people on one side and the high-tech people on the other.

Kirk: Right. I know Beach well. Beach is always provocative. Never known him not to be. I think in general that that picture is certainly a plausible direction. I guess I think that particularly, and certainly my own experience right now in one area, and that is certainly with older folks, I think that it would be hard to find a better fit for older adults than a general internist. Their problems are multiple. Clearly, clearly, their care would be compromised if it were cut up into the pieces that it could easily be cut up into, because they all have, or so many of them have so many different medical problems, they clearly need a central clearing ground and somebody who's looking after the entire spectrum of their needs.

Indeed, prevention in that population, do you know it's something that we almost don't even think about. As a separate item, it is integral to what we do. For me, the most important instrument that I have for prevention in older people is a

carefully kept flow sheet on the back of my problem list that allows me to look and see, at a moment's notice, each time they come in with their chronic problems, to know when I last did their mammogram, last did the breast exam, or the prostate screening, whatever you want to do is arguable. It all ends up being negotiated with the individual anyway, but it tells me when I last did it and whether it is probably due or not. These folks rarely have a health maintenance visit. It happens as a part of their regular care.

Anyway, I mean, it's arguable with people who are much younger, who have no medical problems, and who just need an occasional preventive visit. It may very well be that people with a lower end-of-the-spectrum set of skills--I try not to put "lower" in the sense of important or unimportant, it's just a different set of less technologically-oriented skills--may very well be appropriate. There may be more time for counseling over things that I'm maybe not as good at as might be for dietary counseling and things like that. In any event, there may be, certainly, a role for the lower-technology people doing some of the care and then for the singular problem, the [unclear] to refer them to the appropriate specialist.

But certainly, I think as adults age, I think that a general internist is a good fit for older adults who may have multiple medical problems. Most of us here have worked side by side with family physicians over the years in the community, and simply

consider ourselves to be the same breed of primary care physicians, which is what we would normally think of ourselves as, who need the same set of behaviorally oriented skills, of management skills. If we are going to deal with older people a lot, we need more of these internal medicine skills, and if we're going to deal with young families with children, and obstetrical needs, and orthopedic needs, that the mix of clinical abilities that we have should be shifted in another direction.

Again, I've experienced that shift myself in my own practice. I, I think, had the same sensitivities more or less, and the same need to be basically a primary care family-oriented physician when I was younger, and was taking care of young families. But my clinical skills now need to be focused more on internal medicine, traditional areas of internal medicine, and less on orthopedics and pediatrics and things like that. I'm starting to feel a little challenged with adolescent medicine except that my own children's growth and development has kept me fairly alert of that realm of practice.

Mullan: I know you've had a particular interest in office-based research. That's really an important and different contribution, different than the vast majority of other people I'm interviewing. In any event, tell me a bit about where that came from, how that's developed, and where that fits in your life.

Kirk: It's been an important and fun professional challenge. I guess it's the sort of thing that, if nothing else, is a sort of sidelight hobby, has allowed me, in addition to practicing, to step outside and do something else that I enjoy and can maybe attach some importance to. At worst, it might be revealed as an effort to sort of maintain some kind of academic respect, having crossed the line twenty years ago to be a practitioner and most proud of that, but I'm not quite sure of my own internal psychic needs all the time, but in any event, it certainly is a sense of some pride and satisfaction to have been able to carry on this other area in addition to practicing.

Mullan: Keeping a little gown with your town.

Kirk: Right. Right. And maybe faintly for a long time some thought that if I ever wanted to go back, that I'd maintain those skills. That isn't an issue anymore. But in any event, it really emerged out of the residency in primary care at Dartmouth that I was in. It started a little bit while I was a resident in the fellowship year, but it really started more seriously the year 1977 when I was the director of that residency.

One of the things that we were responsible for in the Department of Community Medicine was that the department had also started sending medical students out for significant parts of

their clinical experiences to community preceptors. Most of the towns around--Beach Conger's community in Windsor was one of them, and New London was one of them, and others, had these wonderful primary care physicians who were teaching students now. And we had gotten together as a group with these teachers, who all felt that they invested in this, that we wanted to be able to do some research, mostly to prove--it was very direct clinical research. It was called, "How Are We Doing?" "Is the quality of care that we are delivering for hypertension, for otitis media, for urinary infections, is what we're doing of sufficient quality that we can hold it out to the students as something that is worthy of their observation?"

In fact, at that point, when there were still immense challenges within the Dartmouth-Hitchcock system to sending students out from the medical center for any of their experience, it was important from the community medicine viewpoint to be able to say, "We can say something about the experience and the quality of the experience that the students are experiencing."

So we set out to cross the various practices that were doing the precepting to be able to measure the quality of care around certain sentinel diseases or conditions. We realized right away that we had to develop some instrument of data-gathering that could be shared by the practices, and we fell upon fairly quickly the fact that the billing systems in the offices--it was the one piece of paper that everybody filled out. It was the bill. But

everybody was using an assortment of silly, inefficient, and inconsistent sort of billing forms, and we realized that if we could improve everybody's billing system for their sake, while at the same time designing this billing system to allow data-gathering on it that would be valuable for research, that we would have killed two birds with one stone. It was really the birth of the Dartmouth Cooperative Information Project and the excitement that the physicians all had in this was that we helped them in their practices, while also helping all of us figure out how we could do some research together.

Mullan: When was this?

Kirk: This was 1977, '78. So I was starting that. There were three or four of us: Gene Nelson, of course, who's had a very eminent career in health services research; and John Wasson; and myself; and Steve Marian, who's an administrator of Dartmouth now within the system, sort of were the in-house folks, along with Dale Gephart and Beach Conger, and a number of folks who were still in these communities who started that system, and started doing research, and got funding to establish this data system that would allow research and teaching and quality-assurance kinds of activities to occur in these community precepting practices.

It kind of grew from there to doing more larger and larger research, some of which has become internationally known, especially the efforts in measuring functional health status. I was lucky, because even though when I left Dartmouth in '77 to come to New London to practice, I knew that I was not going to be far away, and that I would be able to continue what was at that time an intensely exciting kind of endeavor with developing the Dartmouth Co-op Project.

Mullan: The Dartmouth Co-op has continued since that time?

Kirk: Yes.

Mullan: How many physicians or practices involved in it?

Kirk: It depends on how you count now. We are, in fact, in the midst of redefining the purposes of it. In fact, it's come back around now to where teaching and providing the focus for dialogue and communication about teaching medical students and residents in the community is becoming, once again, the major focus of it. That was a part of it at the beginning as well as doing simple research.

The funding ran out in the early 1980s from the federal government, rather abruptly at that, leaving us to make some

choices. We made a choice that basic research with what we were going to do. We weren't going to be focused on quality assurance, office management, data systems, and teaching issues, we were going to do primary care, office-based network primary care research, because we didn't have enough money to do everything, and that's what we decided with the practices that we were going to do.

That's where the project went for a number of years and, again, developed these charts to measure functional status, something that all of us, as practitioners, were at the grass roots of sort of saying, "You know what's really important, more important than whether this person can run ten mets on the treadmill, or has an FEV1 of X, Y, or Z, what really matters, especially with older people, is how well can they function, and what spheres are important in their function, and how can we measure it simply." Yes, there are ten-page surveys that will tell you about functional status, but we've got to do it quick and dirty in the office and in some reliable way.

The efforts to do that, which were both intuitive clinical ideas that were enriched by the kind of hard research thinking that people like John Wasson and Gene Nelson could add to it and validate these instruments as something that really could be used for research and for clinical practice, was a very exciting experience for all of us, that along with a number of other very

well-done research projects that we all had a great deal of pride in knowing that we were a part of that.

As the projects got bigger, they got further away from the grass roots, they no longer involved us directly with the process as much as they had originally. That was because funding became available to do specific things that often made it impossible to really have us as involved as we used to be. There was recently a certain lack of involvement of the practices as much as they used to be, even though we all stayed in touch and went to annual meetings and enjoyed one another, but there was a little less research going on. John Wasson didn't do it at all.

Now it's evolved to where the teaching part of it, that we originally enriched all of us, is bigger again as the Dartmouth Medical School is much more involved with the teaching in the community. So that other part of it, all of us for the last twenty years have been doing teaching. Students have come to the office initially for just simple experiential, feel good, see the doctor, and kind of try to learn anything you can, but very undirected. It's gradually evolved into a much more central and critical part of the curriculum for Dartmouth Medical students, starting from year one with much more expected of the community--

[Begin Tape 2, Side 1]

Mullan: This is Jack Kirk, second tape, side one. Continue.

Kirk: So just that in the evolution of the co-op project it's coming back now to be the focal point for all of us community preceptors in the area to be talking more about education, and still doing research, but wondering how we can shift the research back to very office-based research, in which the students themselves can participate and see this experience of how community-based primary care physicians evaluate themselves.

Mullan: Give me some examples of other kinds of issues besides measurement of functional status that have been victories for the co-op. Just a sample to put on the record.

Kirk: We published several papers on chronic fatigue as a presenting symptom in primary care, and how it presents, and what the causes of it are. We early on just discovered new and less expensive ways to look at urinary infections with office-based systems that didn't cost as much and accomplished just as much. We've more recently done studies involving the role of telephone calls to patients rather than visits as perhaps a more efficient way of using time.

I think one of the other real important things that the co-op project did was a community cancer prevention project which, instead of focusing on something that is sort of high tech and arguing about how often mammograms ought to be done in different

populations, it focused on how one can change office record systems to do a better job of keeping track of prevention. So research staff came to the practices in the study group versus the control group that didn't get these visits, and sat down with the physician and their office staff and said, "Okay, what are your goals and how are we going to achieve them? Do you need reminders that you need to do breast exams and mammograms and Pap smears? Do you have a flow sheet that allows you to identify who has and who hasn't had these things done? Do you want smoking stickers? Do you want--" whatever. They spent some very focused time and came back on several occasions and really helped offices overcome that, "Oh, my system just doesn't allow me to do it. If I just had some time to really sit and think about this, maybe I would, but I'll probably never take the time to do that."

Well, this provided a focus to do those things and, indeed, it was very clear after this intervention that these practices did a better job of achieving the goals that they had set for themselves in terms of how often procedures should be done in cancer prevention than the control group which didn't have that same focus on office systems.

Mullan: You've also been involved with ASPN, the Ambulatory Sentinel Practice Network. How does that differ from the co-op in terms of its focus? Tell me a little bit about it.

Kirk: The Ambulatory Sentinel Practice Network was really established probably in about, again, in the late 1970s by the academic family medicine establishment, recognizing that family medicine to be accepted as an integral part of medical centers and to be respected as an equal partner with pediatrics and medicine and surgery as departments within a medical center, that they needed, obviously, to be doing research, and that the logical place, the logical laboratory for family medicine research was the place where family medicine happens, and that is in community practices, not typically in medical centers, that it seems so logical and yet have been so studiously ignored, or just been impossible because of the location of research enterprise within academic medical centers.

This was clearly something that family medicine recognized that it had to do not only for its own good, but for the good of the patients for whom they were caring. If they were going to solve the problems of how to do a better job of providing primary care in family medicine, they had to study these matters where the problems were occurring. So the establishment of networks of practitioners in "real" world, "real" community sites, establishing networks of those folks linked to some kind of academic medicine people who had the skills to organize the research, or had the skills to do the things that the community physicians could not do. That was the focus of it.

Clearly, the recognition and the respect that the family physician, number one, had the laboratory and the relationship with people, and also the clinical intuition to ask the right questions, to recognize when the wrong questions were being asked, or when the right questions were trying to be answered by the wrong methods. So recognizing that the family physicians were a critical part of this endeavor, but also recognizing that they probably didn't have the time, the resources, or the research technical skills to carry out research and the ideas that they knew were important, that combining the academicians with the family physicians was clearly what the goal was.

Actually, I was asked to be on the board of ASPN because I had been the medical director of the co-op project, which was recognized as one of the earlier and successful enterprises. So that ended up with me subsequently a very happy and, again, sort of challenging life as a practitioner on this board, and I suppose what was the most fun all along was that most of the other charter board members were academic family physicians who were very well known in the field of family medicine and research, and wonderfully inspiring people. Gene Farley and Morris Wood--

Mullan: Larry Green?

Kirk: Larry Green, somebody more my own age, but who was as charismatic as the folks who were somewhat older than us and more recently working with Paul Nutting. I hesitate to start naming names, because it almost diminishes the role of so many of the others.

Mullan: Is ASPN and the co-op different substantially? ASPN is clearly founded on academic family practice, and the co-op is founded on the geographical alliance in this part of the world. So those are different premises. But the concept of office-based, primary-care-oriented generation of new knowledge through application of research methodologies pretty much describes them both?

Kirk: Yes, it certainly does. It certainly does. There were real logistic challenges that led to political challenges for ASPN that the co-op project didn't have. Tried to figured out how to gather data from Canada and the United States and scattered all around. It's a much more expensive process, and how to keep that laboratory going, the expense of keeping that laboratory going, presented real challenges for ASPN all along the way. Accordingly, it was a much more difficult sort of political setting than the co-op ever was, which was nestled in the Department of Community Medicine, which clearly provided the

support and the nurturing, and the physicians all around it had a twenty-year relationship with the department. It wasn't a matter of politics, it was just a matter of what could be done.

Much more complicated to try to do what ASPN has done, which on the one hand puts it in the position to do much more exciting things, but a lot harder to do.

Mullan: Is office-based primary care research a viable and important part of the future of the primary care movement, in your judgment?

Kirk: I think it is so difficult to imagine trying to do good primary care research consistently outside of as real a world of family medicine and primary care as one can attain. Most of the important questions have a lot to do with relationships with the interface of people with their community, the interface of a physician with the person who has the problem. Those kinds of things are very difficult to study, I believe, in an artificial setting. Physicians in practice are better able to ask the right questions and to recognize how to answer those questions. Hence, I think that community practicing physicians need to be participants in the process.

Now, as things happen over the years, and as this organization of medicine is changed so much, it becomes harder

and harder to define who is a community practitioner and who isn't. Does it mean who's salaried by the medical center and who isn't? That's obscure knowledge. Medical centers and hospitals buy up practices. But I guess the idea is practices that are genuinely in the field of primary care, who are seeing people on the frontier as they come in, that laboratory needs to be a part of where the questions are answered.

This is sort of is a sidelight but always has concerned me, because we've encountered it several times, especially in the ASPN experience, much of what the traditional research, clinical research has done at times, I think, is to really take advantage of patients. I think patients coming to clinic settings, where the relationship with the physician is not a lasting one, where people are somewhat at, not the whim, but certainly are not in a full position of control and authority, are often asked to participate in research and put in a position of not being able to say no very conveniently. We sometimes find ourselves trying to answer the same kinds of questions, and doing that same kind of thing to patients in our practices.

For me what has happened is a realization that it is indeed damned inconvenient to do some research in this real-world setting of family medicine. It is very much more difficult to engage patients in studies sometimes if you do it honestly, because it says, "Listen, really, I don't know what the best answer to this question is. I will not sit here and try to imply

Kirk: Certainly, traditionally there has not been. Like most states, public health folks do their thing and we do ours. I think most of what I've done in preventive medicine is just, I think, to be a very critical thinker about what is and what isn't worthwhile doing, and to negotiate things more honestly with patients in my practice.

The other thing that I'm intensely aware of and increasingly so over the years, is that I think there is a very inherent kind of conflict in the information and in the goals of public health systems and researchers in many clinical areas and primary care physicians. The example is that lowering somebody's cholesterol from 225 to 200 may have an impact on a population basis that can be interpreted as important. We have often used some of those relative risk kinds of numbers. "Your risk of a heart attack will be reduced by 50 percent if you lower your cholesterol by thirty points." When you look at that number in the absolute terms for this individual patient, most folks, when you try to present those numbers to them, look at them and say, "Why was I worried? Why was I worried about eliminating entirely the ice cream from my diet? And why was I even thinking about taking this $100-a-month medication? You're telling me that my risk of having a heart attack in the next ten years would fall from 10 percent to 7 percent? Do you know? That's not very significant to me. Thanks for the information."

Those numbers may be meaningful on a population basis, but not to this individual, and I think we've often found ourselves in conflicts with published--some of this is with published research--that tends to, I think, overstate risks to people by presenting things in a relative risk format. When you get down to the individual, most people would interpret that as not so important. My job isn't to tell them what I think they should do, it's to give them the data and let them make a decision. So on the one hand we have sort of a conflict with goals in that sense. I mean, that's sort of public health.

The other problem, really, the public health problem that I really perceive has just been the "we" and "them." The real health problem that I certainly perceive is the uninsured, the people who do not have access to medical care, and how do you as a team get on the same page and try to help that.

Frankly, our community here hasn't had a lot of that problem. There are none of us in our community here that don't accept folks without insurance. We all have our share. Fortunately, compared to other communities it's a relatively small percentage of people so that nobody's at a loss for it, and it's sort of the way we used to think of it as ideally. Everybody takes care of all comers in this community. Nobody is turned away either from the hospital or from our offices. We all take what comes. In that sense, public health doesn't necessarily have to do much more than that, although we know that

the obstacle for many people, because they don't have money, is that they won't try to make access.

Mullan: AIDS is not an issue in the community?

Kirk: No. No, it has not been an issue in this community. None of us has really taken care of an AIDS patient other than an occasional folk in the emergency room in the summertime passing through. It is still a small problem in New Hampshire in general, and certainly smaller than that in this part.

Mullan: Managed care is a problem. Managed care is a large topic. Let's just get on it in terms of your view of how it's affected your practice and what implications it has for the practice of primary care in general.

Kirk: Yes, I'm profoundly disturbed by managed care. I think it is built, for starters, on a basically dishonest principle, including, I think the worst part of it is, the failure to make sure that patients understand the fiscal relationship between their insurance company and their physician. The insurance companies have put us immediately in a position not any longer of advocacy for patients, but in a position of conflict of interest. The term "gatekeeper" is a term that I can barely let that word

out of my mouth without anger and frustration. I am not a gatekeeper. I am the caregiver for the patient who sits in front of me right now. It is my job to help them solve problems and to advise them of their options. I find that job most satisfying, frankly, when people have a large deductible and are on the line themselves for the costs up to a point of the decisions. I don't think that we as a government or as private insurers should be trying to insure every last dollar of people's medical care. They need to be in the loop. There are too many very arbitrary costs that, if people are fully insured, they are not involved in taking responsibility for it. Physical therapy for your low back pain at fifty dollars a shot, times five or seven or ten treatments is a very expensive thing. I have a big deductible on my policy. I wouldn't go get it because it would cost me $500 out of pocket, and I'm not about to do that. I'll survive without it.

I think people need to be involved, and my job is best when I advise them about the risks and benefits, and within some reasonable reason of their ability to pay for it, that they're expected to participate in that. That would be my solution. Instead, I'm expected to sit here and be the one that tells Mrs. Jones that I will not approve her desire to go see an orthopedic surgeon, even after I thought that I'd adequately advised her about her need, but she'd like to see an orthopedic surgeon. The moment that I, as her primary care physician, sit here and say,

"No, I will not allow that, and you will pay for it yourself," you can kiss goodbye the relationship of trust and a sense that I'm her physician. Again, I think I ought to be neutral cost-wise in the issue, and she ought to be on the line herself to decide whether she goes to that orthopedic surgeon. But I think they put us in a position where we are the ones that are going to decide whether they're going to pay for this, or their insurance company's going to pay for it.

Furthermore, the patient is not supposed to know the nature of that fiscal relationship. Well, that's where it all came from. It's probably going to change, and they will probably be required to release more of that information, but I do not think that that is the foundation for an honest, professional relationship with a person, and I find it just profoundly disturbing that we're put in that position.

I guess the next thing that clearly is happening because of the utter complexity of managed care, and even in this community where it's just beginning to touch us, probably 10 percent of what I do is managed care, but that consists of three or four different managed care companies, small by other areas' standards. But for this small, very personal office consisting of me, one secretary/receptionist, a nurse, and the part-time assistance of my wife Jane, we are suddenly really strained to keep up with each of these managed care operations and who their referral list is, and what is the paperwork that we have to do to

fill out, and the nature of contracting with each of them is a terribly obscure kind of thing. Even an actuary full time would have difficulty with a small practice with a small population trying to estimate whether we're going to win--we're not going to win big on the gamble of how much we get in capitation versus how much we spend on the care of people, but we are put at risk for the occasional very sick person that comes into our office to the point where we're supposed to probably worry about whether we're going to take on a new patient, never a concern in my life before. Never would I even question where this person's payment, if any, was going to come from.

I recently took on the care of a young woman who's quadriplegic from an auto accident, and have to ask whether me and the very small primary care group that I am considered a part of is going to be absolutely taken to the cleaners by the predictable excessive costs of her care over the next few years. For her insurance company, I'm considered part of this little ten-person primary care group and, frankly, I can't even speak for myself without speaking for them and whether they're willing to take on this risk. I am not in this to be an entrepreneur. I want to be a simple, honest, professional making bit-by-bit wages, and suddenly I'm involved in something that is much bigger than all of that.

What it is really doing to our community here is that we have been forced by this to begin organizing in ways that we

specifically did not organize in the past because it provided no advantage to us. We now are constantly in meetings trying to figure out how to organize our singular practices together, along with the hospital, how to form physician-hospital organizations, how to manage all of this, lawyers and practice managers and all of these people in suits that were never a part of what we were doing before, and in that sense are never going to provide better care for the patients that we're taking care of. In some grand sense, it's going to bring down the cost of care, and it's probably done it already, including straining small rural hospitals like ours that already take all comers, including people who don't pay, a large Medicare population on which very little profit, if any, is ever made, and now managed care threatens the very existence of an entire rural health system. Nobody ever figured, nobody ever asked, if it was going to do that.

The forces that are changing things are certain beyond the control of people who are actively thinking about the organization of medical care for people. Very clearly the focus is on reducing costs. It isn't seen that the reduction in costs are producing savings that are going to people who don't have insurance, or who can't currently get care. It's being taken out of the system, certainly here, and threatening the existence of a small, rural hospital.

Mullan: Why is the rural system such as it exists and hospital community such as this at particular risk?

Kirk: The hospital, in particular, certainly sees itself at great risk. This is a very strong and relatively well-off community, and a very well-off solid thirty-bed hospital plus fifty extended-care bed, very capable hospital. The managed care corporations that are coming into the area clearly want to make all of their care, including the hospital care, on a capitated basis. The costs, what they are willing to pay the hospital in the capitation system, to the very astute controller of the hospital, he just says, "We cannot do this and stay alive. We cannot do this and stay alive."

What he is particularly concerned about is that Medicare would be capitated. When that happens--and that's 60 to 70 percent of our business here--it is virtually impossible to imagine the hospital continuing as a full-service hospital. And even now, just everything from--you know, those few areas that hospitals could make some profit in to offset the losses for Medicare, lab and x-ray, clearly all of those, any of those areas where any profit could be made are gone with managed care. I don't blame them in that sense, but the change has come without really asking the question, "What if ten more of these hospitals

close? Is that an advantage? Does that do better for people's medical care?"

Mullan: What is going to happen? Where do you see the system headed, particularly from the primary care perspective?

Kirk: I think apart from the challenges, for instance, to this hospital, the other thing that is very clearly happening, I don't think there's any doubt that myself and the five or six other fifty to fifty-five-year-old physicians in this community who've been here for twenty-five years, will be replaced by people who will be part of probably a hospital-owned-and-operated group practice. In fact, that may all be owned and operated by something that owns and operates this hospital, whether it's the Dartmouth Hitchcock Medical Center, the Leahy-Hitchcock Foundation, Health Source, or whoever else, but clearly people of the future are going to part of a much larger system in which individual practitioners within the system, will seem to kind of come and go as kind of hired guns. Patients clearly buying a <u>system</u> with their insurance dollar, not a physician, that they have reason to believe that they can work well with, but rather that they buy into a larger system and become a part of that system which will have frequently interchangeable parts as if clinicians could be interchangeable parts. There will be clearly

motivation for economic reasons to have as much of the care provided, as you mentioned before, by folks at a lower end of the salary level. Efforts will be made in various ways to do it cheaper. Pressure on practices to see people faster, and to see them at the lowest level of technology.

This hospital, as it is now happening, is sort of primarily in charge of recruiting a physician to take over a practice of a retiring physician here. That incoming physician has been notified ahead of time that she will see thirty patients a day. Well, I guess I reckon when I came to town, I saw as many people as I could comfortably see, thinking that I was doing a reasonably good job. It was not because somebody was telling me that I had to see them at a certain pace. It may not have made economic sense, but it made sense to me and to the patients that I cared for.

So I sense the locus of control is clearly not going to be in the hands of physicians. Individual physicians in the cottage industry of it is clearly going to be swept away, because we cannot as individuals figure out how to contract with managed care. They don't want to contract with individual physicians. They want to send their person to talk with one spokesperson for as large a group as possible. So everything is clearly going to move to that higher end of organizational spectrum, which I don't personally think provides better care for individuals. Certainly, the twenty years here in this kind of a setting

convinces me that the best of all worlds is this for individual patients, as long as the physicians are responsible professionals and are not about to take advantage of people for economic gain.

Mullan: What are you going to do? What's the future for you as you see it in twenty years?

Kirk: Well, the changes are just beginning here. A very serious question that has been in my mind on any given day when the frustrations of dealing with managed care, whether it's in meetings or an individual patient that I have to work through paperwork, I swear to myself that I will not work within that system as it becomes the major part of my practice. I still think that that's going to be the case.

Apart from the philosophic thing, I don't think I'd be comfortable within a larger system now where the locus of control and the marching orders come from outside of me. I personally think that we've been an extraordinary responsible professional office, and I think what larger systems do is they may get rid of the worst, but I think they get rid of the best in terms of fitting care to individual patients as well as possible. So I don't think I'm going to be comfortable working in that system.

We're doing a lot more teaching with the Dartmouth folks. The experiences that I've had over the years teaching and helping

design curriculums, and the primary care research projects have put me in a position to do a lot more teaching and those kinds of administrative jobs. I don't want to leave the community that I live in. I guess I would like to see a transition to doing more of that kind of teaching and curriculum development, and less of the practice. I guess it's hard to continue to work sort of twelve-hour days with a lot of on call, and being available to people. It would be nice to have that part of the load shared a little bit more by somebody else and to really free me up genuinely to do the teaching and administrative things, rather than just have that be an add-on, which is what it's been all these years.

Mullan: That would be a neat loop back to where you started.

Kirk: Right. And that's, I guess, how I'd like to see it.

Mullan: An area we've neglected is your family life. Let's just drop back quickly and pick up on your marriage, kids, and all that.

Kirk: That's thoughtful of you. As always is the case, I guess, when one gets wrapped up in professional life, the greatest potential problem is to take the most important thing in your

life for granted. My wife, Jane, who has been very happy as a mother and rearer of children and keeper of the home, has, basically, because of her satisfaction doing that, has been very happy through the years, allowing me to work a lot of hours with her working as many hours being the primary person in the home front. We've had a very happy and satisfying relationship, both kind of understanding each other in that regard. It's that kind of relatively traditional, I guess, relationship that is difficult now for younger people to perceive. Her career was very clearly something that she carried out easily, as well if not better than I've carried out mine, and that has been, being the primary one to raise the children and to take care of the house. Actually, it's interesting because that's sort of in transition as our children are more or less grown and gone, and it's more important for me to be able to find some time now for us to be able to spend more time together than we have in the past.

Our oldest child, our daughter, who was born when I was at the University of Chicago is twenty-five, and out of college.

Mullan: What is she doing?

Kirk: She's married and she actually has been working at the Health Institute with Al Tarlov. Talk about curious circular

things. But she's getting a master's degree in education now, and wants to teach. She spent two or three years as an Outward Bound instructor. She's a little bit of a thing, about four foot-eleven, and weighs about ninety pounds, and has carried canoes in the boundary waters and heavy packs through the Sierra instructing Outward Bound. Anyway, she likes teaching and will be very good at that. I think that's what she's really embarking on that now as she just left the Health Institute doing some research assistant work there with John Ware and functional health status people, and sometimes encountering the work that the co-op has done in functional fields.

Our middle son, Ian, is a snowboarder by inclination and by part-time trade. He's twenty-two. He finished two years at Colorado College where he went because that was going to be close to the snow. He's taken two years off, spending time really working in the snowboarding field, both as a semi-professional snowboarder in the winter, and building snowboards for a little company in the summer.

Mullan: In Colorado?

Kirk: Yes, in Colorado. Never Summer Snowboards. He's made most of them, and they're good ones. He's probably going to get back into school after one more winter of living in Vail and

riding his board. He thinks he may even, which is music to our ears, come back East to finish school.

Our youngest son, Cameron, has just finished his freshman year at the University of Wisconsin, and is home for the summer with us. Cam's very happy. I'm not sure what he wants to do. None of the children have been interested in medicine. I think they saw enough of just hard work to not necessarily want to pursue that. But they all have ideas about their own careers, and I guess ultimately if you can feel any sense that they're happy and worthwhile and capable people, it's a great sense of satisfaction. Certainly, my wife can take most of the credit for that and, me, at least, focused on that when I wasn't practicing medicine.

Mullan: That's terrific, Jack. Anything else you'd like to add at all? We've covered a lot of ground.

Kirk: Yes. I think more likely I should probably subtract a great deal from all of that. But it's nice of you.

Mullan: Thank you.

[End of interview]