COLEEN KIVLAHAN

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Dr. Fitzhugh Mullan,
Interviewer

Mullan: We're at the Holiday Inn Executive Center in Columbia, Missouri, with Coleen Kivlahan, Director of the Missouri Department of Health.

I'd like to start, Coleen, and ask a little bit about your background, where you grew up and just a few words about how you got into medicine.

Kivlahan: I grew up in Alliance, Ohio, a small town in northeast Ohio, industrial and farming area, had four brothers older than me, all ten years older, one younger sister. My father was a roofer, my mother was a secretary. No family members who were part of the medical establishment in any, no nurses, no doctors.

We had an annual income throughout my childhood, until I left for college, of about $10,000 per year, for a family of eight, and so on Friday nights we subsisted during the spring, fall, and summer by frog hunting, hunting frogs to eat, had about fifty to seventy frogs that we caught on a weekend, and I dissected those frogs for hours and hours and hours, learning more and more about animal biology, science. Being the oldest girl in the family, I quickly became a caretaker and nurturer,

ended up taking care of several--

Mullan: The boys were older?

Kivlahan: They were all older. They were all in Vietnam at the same time.

Mullan: There were younger kids, too?

Kivlahan: One younger sister, but many extended relatives. Spent a lot of time nurturing sick older relatives. My father was one of twelve children, all of whom were in the neighborhood, many of who were sick. So I'd say by age nine I'd already decided I was going to be a doctor. Everyone knew it. It's the family lore, it's the high school memory in the yearbook, and it happened.

I went to St. Louis University for undergraduate school because Tom Dooley went there. I sent a letter, when I was ten years old, to Tom Dooley in Laos when he was still alive and in the Navy, asking him if I could come to Laos when I graduated from medical school and work with him.

Mullan: How had you heard of or read of Tom Dooley?

Kivlahan: I think I heard about it in the newspaper as I was

growing up, and then I read his three books that he authored while he was in the Navy in a medical career, and I decided that's what I wanted to do. Never heard back from him, but that didn't discourage me. When I learned by his books that he had gone to St. Louis University, I"d never been to Missouri, had no idea of St. Louis, but that if, in fact, he could be the kind of doctor I wanted to be by going to that school, there was probably some value in me going there.

I applied to St. Louis University, the only college I applied to, got a full scholarship, and graduated in three years from St. Louis U. In pre-med, biology major, and then came back to my home state in Ohio and did medical school there.

Mullan: How was that?

Kivlahan: A very innovative school.

Mullan: Where was it?

Kivlahan: Toledo. Medical College of Toledo during those years was a new school. I was the third graduating class. It was an all-year-round three-year curriculum with a focus on producing generalism in the mid-seventies, which was an amazing phenomenon at that point, with five other medical schools in Ohio, many of

which were very specialty oriented. This was supposed to be the medical school that produced generalists. So a fascinating integrated problem-oriented curriculum in the seventies.

Mullan: When did you graduate?

Kivlahan: '79.

Mullan: So you did three years in college and three years of med school

Kivlahan: Right.

Mullan: You were young.

Kivlahan: Yes.

Mullan: How was that?

Kivlahan: It was fine. I was very driven. I knew exactly what I wanted to do. I knew I wanted to have children at some point. I really did fine. There were three women out of the ninety-eight people in my medical school, which didn't feel unusual, given my family background.

I guess the most striking thing about medical school was that I came in thinking I wanted to be a generalist, didn't really know what that meant, but I came in with the picture of a family doctor. I never had one; I went to the health department for my immunizations and for any illness care. We didn't have a family doctor when I was growing up. Neither one of my parents had health insurance.

I was at the top of the class in medical school, and so was quickly pushed into specialization, especially internal medicine and its subspecialties by several mentors.

Mullan: At the medical school?

Kivlahan: At the medical school. I was told multiple times that I was "too smart" to go into family medicine.

Mullan: When were you born?

Kivlahan: June 26, 1953.

Mullan: Tom Dooley's image, as you read about it first and then as you reflected on it, what was it of?

Kivlahan: Service.

Mullan: Did that rate out in any kind of service? Was it the international aspect or was it generalism? Was he a surgeon?

Kivlahan: I think he was a pediatrician, actually. It never really mattered to me what his specialty was--obviously, I don't even recall what it was--because he was doing primary care in Laos and Cambodia and Thailand. So I think to some extent it was the excitement of the international issue, it was that very soon thereafter my brothers were gone in that same area. It was a sense of service to my brothers and my sisters.

Mullan: How about the politics of it? Tom Dooley is known now as a firm anti-Communist, John Birch Society sponsor, founder? Is that right?

Kivlahan: Yes. There's very little, at least that I've seen, that's very carefully documented about Tom Dooley. Randy Shilts certainly recognizes him in his second book about gays in the military and clearly was a very strongly committed homosexual.

Mullan: And Tom Dooley was gay.

Kivlahan: Yes. Nothing I was aware of in terms of his--other than his religion. I knew he was Catholic, but so were we. And

he was Irish, and so were we, so all of that rang true. Didn't have any idea of his politics or his religious affiliation or his sexual affiliation at the time.

Mullan: And as you discovered those in later years, did that--

Kivlahan: Doesn't cast any shadows.

Mullan: So you get towards the end of medical school, and the specialists were working their ways on you. How did you respond?

Kivlahan: Two primary mentors during medical school were both cardiologists. I respected their charity, their bedside manner, their technical skills, and their intellect, and I thought I'd like to aspire to that.

Mullan: And?

Kivlahan: Listened. I listened, and every time I was alone with a patient, I found myself frustrated that I might only know about their heart, when, in fact, they wanted to talk to me about their depression, or what was going on with their wife, or their ingrown toenail, and I found myself in every specialty rotation in medical school continually frustrated that I couldn't put it

all together. There was a fledgling family medicine department in that medical school at that point, and it was clearly seen as the younger brother, much younger brother, and not a place you'd go to respect yourself.

As I began looking at residencies, I was looking at internal medicine, and I met Jack Colwill at a meeting, who was an internist who had turned family physician, and encouraged me to come to his program and look at it. It was in Missouri. I enjoyed St. Louis and I thought I'd come back and look. When I came back and saw family medicine department at the University of Missouri at Columbia, it was absolutely right, put all the pieces together, both mental and physical, service. The folks were really dedicated to what they were doing.

Mullan: So in terms of whatever you were being told in medical school, that overcame it?

Kivlahan: I felt very clear. I was able to go back to medical school after that, talk up family practice in my medical school, talk about the goals and the visions of that specialty, and left feeling very comfortable, despite a lot of negative feedback. There were very few people in the medical school who went into family practice, and the people who were my best friends in that three-year all-year-round school, who were very close, none of

whom went into family medicine, we've completely lost contact because of that choice on my part, so there were some real disadvantages in making the move.

Mullan: How about your family in terms of medicine in general and in terms of family practice? How did they deal with that?

Kivlahan: My father was very proud that his daughter wanted to go to medical school and be a doctor, and never really believed that I would do it. My mother, very bright, graduated from high school but got married early and had six kids, and spent her whole life being a secretary. She was worried that we didn't have the money to support me and that because I didn't have any family ties, I wouldn't be able to be accepted into medical school, and so really just worried about the career opportunity that I'd chosen and that it really wasn't very practical. But after that, after I was accepted, they knew that it was the same nine year old they saw who said she was going to be a doctor. I was going to be a doctor then, had an internal drive that wasn't going to stop.

Mullan: Discrimination between family practice and anything else, did that matter?

Kivlahan: Zero. It was, you know, I finished high school, college, and medical school. It didn't matter what I was.

Mullan: Did they come from Ireland, or their parents?

Kivlahan: My father did.

Mullan: From where?

Kivlahan: County Cork.

Mullan: Any your mom was Irish also?

Kivlahan: German.

Mullan: My family's from D_____, for the most part. That's another discussion.

Once in residency, was it what you'd expected?

Kivlahan: Everything and more. It was already, even in those years, a strongly socialized department. It was a department who knew what they were, who, while struggling with the edges like, "Do we deliver babies? Do we do C-sections?" the interaction between obstetrics and family medicine, the interaction between

internal medicine, "Do we put CVP lines in or not?" while those edge discussions were ongoing, there was a very strong sense of identity about what a family medicine physician is, despite have a chairman who was not one, so a strong sense of--

Mullan: That being Jack Colwill?

Kivlahan: Yes.

Mullan: An internist by training.

Kivlahan: Yes. Strong sense of departmental identity, and already, even during those years, an increasing sense of national prominence and choosing the best and brightest from medical schools. So it was a very comfortable place to be, for the most part.

Mullan: Tell me about Missouri and, for that matter, the Midwestern setting for the acceptance of family medicine. Was this something that was palpable to you, and how did it compare to other areas you heard about or visited in the country?

Kivlahan: Well, I lived on the border of Ohio and Pennsylvania, so it clearly was an Eastern flavor. In my home town and in the

area forty miles from the Cleveland Clinic, the focus clearly was specialization and no one saw anyone but an internist. In the rural areas, there was still the image and the picture of the GP. When I came to the Midwest, I was introduced to chiropractors and osteopaths for the first time ever and the sense of the generalist as GP, which clearly were maligned initials, so that in every write-up as an intern, I would see descriptors from other residents and attendings that "the local GP" had referred this sick patient, and it might as well have said, "the local, stupid, incompetent GP referred this patient near death's door." So I immediately got a sense that out in the real world, there may, in fact, be much less acceptance than in this cocoon of the Department of Family Medicine at Columbia.

Throughout the medical school, there was a modicum of respect for the department and what we were trying to do, very little understanding of it, and a continued reference that we were the jack of all trades and master of none. But in general, in Missouri I would say there was a recognition that family physicians and "GPs" provided most of the care most of the time outside of university settings.

Mullan: Let's digress for a moment on the osteopath/chiropractor side of the culture in the Midwest, being clear we're not equating osteopathy and chiropathy, but the various traditional

ways that care or the other providers who are extent here, who aren't so much or aren't as well accepted in other parts of the country. How did you see that, how did you experience that, and what was the attitude towards them?

Kivlahan: I think in retrospect now, the GP/primary care doctor was equated with the chiropractor and the DO, so that all of those primary care types who dealt with the undifferentiated patient in the home setting were seen as equally incompetent.

Mullan: From your perspective as you began to practice in the society where these other players were abroad in the land, how did you see them?

Kivlahan: I think I began to differentiate the "us" and "them," so there were the ultimate"us," which were specialists who were godlike, then there were the Department of Family and Community Medicine family physicians, who were at least trying to understand why they were practicing the way they were practicing, and then there were all the rest, who were the family docs out in the community, Dos, GP, chiropractors.

Mullan: I'm sort of struggling to understand. This is not rhetorical; I don't understand why these other practitioners have

been more accepted in the Midwestern setting than they are elsewhere.

Kivlahan: I think that anytime a practitioner chooses to accept the responsibility of meeting needs of people who have no other access to services, they become part of the fabric of that community, and in many communities in the Midwest, it is Doc Jones who has always been there. They may not totally respect him, but he's always been there for that community and he contributes to the United Way and he does those things he needs to do to fit into the community, and there's some debt of gratitude about that. Only when there become other choices, even if it's driving forth miles away, does that become a less desirable or less respectable option. So, I think the rural accessibility issue.

Mullan: Is that changing?

Kivlahan: It's changing dramatically.

Mullan: In which direction?

Kivlahan: More and more folks willing to travel, increase in our state. We're at 35 percent managed care penetration in the

state, about 14 percent in rural communities, and so more and more patients are having increased accessibility to other providers, so it makes their home town guy less interesting and acceptable, and they're shopping for more opinions.

Mullan: Why is that? The automobile's been there and well planted for a couple of generations now, so that can't be the breakthrough. I have a sense what you're saying is happening. I'm not quite sure why.

Kivlahan: I think it's multiple factors, Fitz. I think it really is the automobile on the roads in this state, and I think in multiple other rural states. It is less family farming. In our state in the last five years, when you look at the demographics, about 50 percent of rural women are now leaving their county to work, and it's a dramatic demographic change in the last five years. Many more rural women are leaving their children with daycare centers. That had never happened before. And they're looking for providers where they work and not where they live. So I think there are actually some significant demographic changes going on that are leading folks away to those local community providers.

Mullan: Is that happening with other patterns of commerce-

shopping and so forth?

Kivlahan: Yes, yes.

Mullan: So it does not stand alone.

Kivlahan: No.

Mullan: Let's go back. When you finished residency, where were you and what was your thinking, what was your personal situation? What did you do?

Kivlahan: When I started residency, I thought I was going to be an academic family physician. I was enamored by our faculty. I believed that while I wanted to contribute to primary care rather than being in practice, I really wanted to do that in an academic setting. After I finished residency, I was still committed to the same, but wanted to do some international health, so did a Robert Wood Johnson Fellowship at the University of Missouri-Columbia, and achieved--

Mullan: Is this Clinical Scholars?

Kivlahan: No, it was their academic fellowship program in family

medicine. I achieved a master's in public health during those several years, and then left for Africa. I was real committed to doing international health.

Mullan: Tom Dooley.

Kivlahan: Tom Dooley got his mark on my life. That changed everything about the rest of my career.

Mullan: What did you do in Africa? Where did you go?

Kivlahan: I went on a project called Operation Crossroads Africa out of New York City, a non-governmental, non-religious organization, invited by the community to set up a medical project in the community. There had never been any visitors by Americans previously. The major question of the village was, "How big should we make our cemetery" We keep outgrowing our cemetery." Fascinating metaphorical question. "We have no idea how to predict disease or death, and we don't know what to do about it when it does happen." We thought we were just going to go teach doctors and nurses how to take care of that village when we left, and it ended up being my first exposure to population-based health care.

Mullan: Where were you?

Kivlahan: Sierra Leone, about ten hours from the coast, really Tenth World country, no phones, no roads. We were bushwhacking through the jungle to get to our village. People were still buried under the huts. It was very primitive. We had several cases of neonatal tetanus in the first hour after we unloaded our gear, and after working about seventeen hours that day, with people coming from every village all around (I have no idea how they knew that a medical team was coming) we realized that we could die there before we would ever meet the needs. So all of a sudden it became an awareness of, "What is it can we offer during the three- or four-month period of time that makes any difference?" and realized that we could continue treating people with malaria and with worms and with tuberculosis all day, every day, and never get there. And with no public health training, decided to try to figure out some population-based solutions.

We overturned some old building equipment in the community, a couple of old tires that had been left in the community that had clearly sitting water, basically overturned every sitting-water possibility, to try to reduce the malaria incidence. I'd already had malaria twice in the first couple of weeks, and it was chloroquine resistant with 105 fever and shaking chills and delirious and massive weight loss and very weak, and realized

then that we could die here. Lost one of our volunteers who had come with us.

Mullan: What was your team?

Kivlahan: There were twelve of us from the United States, and one of them died in the first three weeks from malaria. So when that occurred, recognized that we needed to figure out a way to prevent some of the catastrophes, and instituted a couple of projects to prevent neonatal tetanus, never saw it again during the time we were there, a fairly simple methodology of delivery and not packing the umbilical cord with mud. Tried to reduce some of the malaria, worked with the World Health Organization to get some fish in the communities, in the rice paddies to eat the larvae. Nurtured a woman who had been making soap for the village but it never really had been ver accepted to use soap, so began using it on all skin washing, etc.

Then did a massive survey of three villages, a community survey to really look at what the morbidity/mortality rates were to help them predict how big to make their cemetery, and then helped them slash and burn the cemetery.

So it ended up with a very serious transition period when we came back from Africa in terms of what I wanted to be.

Mullan: How long had you been there?

Kivlahan: The whole excursion was about a year, traveled throughout Africa, had some other similar experiences.

So when I came back, academic family medicine and teaching felt like, "I don't fit here anymore. I don't know what to do with this." I felt like I had gone from a generalist committed to the individual patient in medical school to the family commitment I had learned so much about in my family medicine residency, to the community, and I tried to bring that back to Jack Colwill and to the department, and no one understood what I was talking about. Even though it was the Department of Family and Community Medicine, I went through a really significant depression about what it is I wanted to be when I grew up, because I was so excited about the opportunity of physicians being the physician to the community and not just to the family. That began my interest and commitment in public health.

Mullan: You'd done an MPH before?

Kivlahan: Right, but it wasn't at a classic MPH school. It wasn't like I'd been to Hopkins. It was an MSPH at the University of Missouri, so the focus was on teaching research and clinical care in family medicine and achieving an MPH at that

time, so a lot of epidemiology, but there was no sense for what population-based health care was all about during that MPH time. So while I had a lot of principles when I went to Africa, I all of a sudden saw it in practice, and the impact of individual care and family care in at least that area of Africa had absolutely no effect on the health status of that population, but when we did four or five serious community interventions, community=oriented primary care, it made all the difference.

Mullan: So how did you resolve your depression and your quandary? The year now was what? When were you in Africa?

Kivlahan: '85. I tried for about a year to reintegrate into the department and just got increasingly sad every day that I went to work that I didn't feel like I was offering anything, and so I began volunteering at the City Health Department, covering some for the Sexually Transmitted Disease Clinic, and shortly thereafter, the health officer for our health department had a heart attack and retired.

Mullan: The health department being the county?

Kivlahan: The county. Right. Boone County Health Department. So I became the county health officer and practiced half time in

the jail and half time in a comprehensive primary care clinic that I built up at the Health Center, and had heavy exposure to real-life, county-level public health for about four or five years. Continued to teach some and set up a rotation that became the most desirable rotation of the family medicine residency, doing community-oriented primary care, never accepted by Jack Colwill, tolerated but never really embraced.

And that's where I decided that maybe family medicine departments and from what little exposure I knew about general pediatrics and general medicine would never be able to embrace the concept of public health and community-oriented care, and that I needed to leave the specialty in order to find that sense of community.

Mullan: This was when, and what did you do?

Kivlahan: This was again mid- to late eighties now. Continued to work at the health department and then was called by Bob Harmon, who was then the Missouri Department of Health Director, to come down and work in maternal-child health area.

Mullan: By "down," in Jefferson City?

Kivlahan: In Jefferson City.

Mullan: Which is about thirty miles--

Kivlahan: Forty-five miles from Columbia. I did that full time because I felt that he was a good leader, and negotiated an arrangement between the Medicaid Agency and the Department of Health to work on maternal and child health policy, with a rapidly expanding Medicaid program during all of the OBRA and COBRA periods of the late eighties. And I fell in love with it, loved health policy. I still continue to practice one day a week since that time, but I felt very isolated. I was the only physician at DOH besides Bob Harmon.

Mullan: In the health department?

Kivlahan: Yes.

Mullan: So at this point you had left the county entirely?

Kivlahan: Yes.

Mullan: So you were full time with the state?

Kivlahan: Yes.

Mullan: Except the day a week you spent practicing?

Kivlahan: Right.

Mullan: But you felt--

Kivlahan: I felt isolated. I felt isolated from my specialty.

Mullan: It seems you can't win.

Kivlahan: Right.

Mullan: When you're with your specialty, you're not comfortable. When you're with the politicians and administrators, you're out of water. And so?

Kivlahan: I felt that I could no longer go to several important meetings that I had enjoyed throughout most of my career, the Society of Teachers of Family Medicine and the North American Primary Care Research Group. Neither one of those meetings did I feel comfortable anymore, given my focus on community and population.

I followed Bob Harmon to Washington, D.C. to the Health Resources and Services Administration (HRSA), for a short six-

month stint as Chief Medical Officer, again tremendously enjoyed that period of time, would very much have liked to stay longer. Family constraints were such that I returned.

Mullan: This is 1991?

Kivlahan: Yes. Returned to Missouri and again worked on Medicaid policy, especially as it related to an impending managed care movement in Medicaid.

Mullan: This is at the state level?

Kivlahan: Yes. I then was asked by the governor at the end of 1992 to become the Director of the Missouri Department of Health.

Mullan: And you said yes.

Kivlahan: I said yes.

Mullan: Tell me a little bit about the department. What is its scope?

Kivlahan: Missouri Department of Health has 1,600 employees. Two of them are physicians, one is a neonatalogist and one's an

epidemiologist who's never practiced medicine. A budget of $300 million, roughly forty individual categorical programs, five divisions. It's one of fifteen Cabinet-level agencies in the state, does not have the Medicaid agency within it, nor does it have mental health, but it really is all of classic public health and health care for the indigent.

Mullan: In relation to the counties, do they have separate apparatuses?

Kivlahan: In Missouri, all 115 counties have independent health departments. They are dependent to the extent of about, depending upon the county, between 10 and 40 percent of their revenue comes through the State Health Department from either state or federal resources, but they're all independent.

Mullan: How has it been?

Kivlahan: The best job I ever had. It's fun is equivalent to it's stress level. It has taught me a tremendous amount about myself as a physician and as a person. I've had lots of successes and lots of failures, several very significant challenges to my abilities.

Mullan: Which were, or are?

Kivlahan: One of them was a crisis in the Emergency Medical Series Bureau where there were criminal and sexual harassment activities going on between state and local officials. We spent nineteen days on the top of the fold in the *St. Louis Post Dispatch*. Getting through that crisis was a real challenge.

The second and most significant was that we overspent our Ryan White AIDS budget by a significant amount in Missouri in the last year. We made up the money and all of the financial pieces were taken care of and there was no corruption, but it's created a conflict within the agency around what accountability means for public trust, for public dollars. It took the agency into a new place from what had been a very nice, white-hat public health agency that just did good things for good people, to the reality of the nineties, that you can't overspend your budget and that there will always be people with needs, for whom our society is not funding appropriately. It brought into focus the problem of the uninsured in our state in new ways, and put me in the middle of that in describing the macro questions around what government is supposed to do when we have chronically underfunded services that pretend to meet the needs of the uninsured. What an incredibly awkward position that is re public trust and the dialogue between government and the people it serves. That

created some very significant leadership challenges for me. AIDS funding is .05 percent of my entire budget, but spent about three months in the news. It was on "Rush Limbaugh" (radio talk show). So those were two of the very serious challenges.

Mullan: How do you find the tensions being essentially a professional with the kinds of values and commitments you having working in a highly politically driven environment?

Kivlahan: I don't believe that we can ever separate politics from practice, whether we're at the county level, state, national, or international level. So to me it's just part of the job. It doesn't make me cynical, nor do I enjoy it, but I feel like a thorough knowledge of yourself and a knowledge of your external environment are the key factors in succeeding in that kind of environment. Pretending it's not there or pretending that you can beat it is not a functional way to get the point across.

I've created a reputation for myself that is one of honesty at all costs. I think that goes back to my strong roots as a primary care physicians, in being able to see people through a continuum of issues and needs. It would have been very easy for me to say that it was someone else's fault on the AIDS crisis. On the second day of the crisis, I came forward to all of the major newspapers and said, "It's my fault. We own this. But

here's the macro-level question we're not dealing with as a society, and that is that I can only cover 1, 500 people with AIDS and there are 5,000 in our state."

So I guess I felt that my background as a primary care physician has aided me tremendously in this job in public policy. I know I could have extricated myself from that crisis within a few days by putting it off on somebody else, and instead we made a decision, as a department, to draw the bigger conclusions, have the bigger editorials occur about what this really represents around managed care, around health care system reform.

Mullan: What's the governor like?

Kivlahan: Governor Mel Carnahan, another good Irishman, he is in his fourth year of his first term. He's a strong Democrat, was previously Lieutenant Governor, is an attorney from a rural community. He is one of the most open managers I've ever worked for, gave me only one direction when I cam e to the department, and that was, "Steer, not row." Those are the words he used, and he said, "Let me know if you need me. You can go out pretty far out on the branch and I'll be right there with you." And he's held true to that during all these crises, has been right at my side, extraordinarily supportive, believes in public health. His primary focus is education, but understands health care issues

and actually supported a bill that was nearly as comprehensive as the (Bill) Clinton bill in 1993, and it was in his Governor's legislative package, failed miserably, just like the Clinton bill did, and hasn't' dropped his support of me at all. He believes full in comprehensive coverage for the uninsured and would like to make that happen in this state. It's pretty wonderful working for him.

Mullan: Tell me about the personal side. You got married along the way and had kids?

Kivlahan: I met my husband when he was a resident and I was a faculty. We were doing the Sexually Transmitted Disease Clinic at the health department! Have two children, an eleven-year-old and a seventeen-year-old. Husband is a primary care physician, a family physician who spends half of his time in a practice that we established together in 1993, that is a practice that serves 50 percent Medicaid and 50 percent indigent patients. We're the only two physicians at the practice. There are four nurse practitioners, three nurse midwives. He spends his other 50 percent of the time in cost-effectiveness research.

Mullan: At the university?

Kivlahan: Yes.

Mullan: And how have you found balancing motherhood and spousehood with a career of enormous impact?

Kivlahan: Well, here's the rub, Fitz. I'm probably going to leave my job this fall. I'm pretty confident, I'm very confident that our Governor will be re-elected, Governor Carnahan, and I think I could have the role of health officer for the next four years if I'd like to. It is chronically difficult to balance home and family and career.

Prior to this job, I had only been paid 75 to 90 percent time. I never worked only 90 percent time, but that was my reimbursement rate, and I at least had some flexibility to manage home demands. I attempted working 130 percent time at HRSA in Washington, D.C., nearly destroyed our family life, which is why we returned. My husband and our kids missed the trees and the creeks, so we returned to their roots in Missouri. So this effort for the last three and a half years for me has been the first time, really, in our marriage that I've worked in such a demanding job for so long, and it's creating very significant stresses again. I'm confident that when my kids are gone, that will all change. I feel very comfortable about that, but the demands are significant and I've made a decision I've not

announced yet, made a decision to leave this fall. I don't have a job, don't know what I'm going to do, but I know it's really important to be able to spend more time, more mental, emotional, and physical time with my family.

Mullan: Your seventeen-year-old is a boy?

Kivlahan: Both boys.

Mullan: This two-career stuff is a killer, and mostly for the woman, I'm afraid.

Let's go back and pick up the primary care. From your vantage point now, with all you've done both as a layer-on-of-hands and a system engineer, what do you see happening with medical generalism in your world view, state county, nation?

Kivlahan: I think that generalisms new found prominence in our country is real, is here to stay, but it will depend, I think, on several things to make sure that it stays. One of those is a strong evidence-based research foundation. I think that's important for two reasons. One is, it's important for credibility with our specialist colleagues, and two, it's important for our patients. It's important for funding agencies.

I think another task for generalism is to determine where the balance is, not just in numbers, but in practice, between specialization and generalism.

Mullan: We'll flip the tape over.

This is Coleen Kivlahan, side two, continued.

Kivlahan: There was a recent series of articles in the *Journal of Family Practice* two months ago that I was especially impressed by. There were descriptions of the value of specialization and the value of generalism. Neither are inherently good or bad (which is how many of us tend to think of things) but, in fact, it's an appropriate balance, appropriate consultation, appropriate learning strategies between the two that really will maximize the health impact on our patients. I don't feel like we're either there yet on the research foundation, nor are we there in the appropriate balance, and until that occurs, this tug-of-war will continue between whether generalism will last. The debate that hasn't occurred at all yet, is the debate around the real potential impact for the health status of the public; that is the integration of public health with generalism.

It's like the right brain and the left brain for me. In my own brain, I can't disconnect them. When I'm with a patient, I'm always thinking about the impact on their family and the impact

that the remainder of the community has had on what that patient's needs are. I can't disconnect those things, and I think that the physician of the future, especially the generalist physician of the future, needs to have many of those public health skills incorporated into their training.

Mullan: In your judgment they do not?

Kivlahan: No. Absolutely not. We have a new physician who's pending some time with our practice, evaluating whether she's going to stay right now. Her focus is entirely on the individual. On her good days, she thinks about the family. There's no recognition of basic public health principles like communicable disease that might demand that she think about in a broader context, let alone the sense of how the community, its support or lack of support, impinges upon that person's ability to get plugged back into society again and be healthy.

Mullan: As the economic wars wash across medicine, with obviously managed care being the principal battlefront, how is that affecting generalism, in your experience in Missouri?

Kivlahan: We're in early State 2, if you think about them in Steve Shortell's description of the five stages of managed care,

so we're in the early integration phase where the focus is almost wholly on cost in Missouri. So from our managed care viewpoint in Missouri, the uncharted frontiers are managed care's commitment, interest in, or understanding of generalist education, primary care research and community benefit. All of those concepts are very marginally concerns to our managed care organizations. I have been setting up and facilitating meetings between public health, managed care, and primary care specialties to begin the discussion about where the integration occurs and how we can work together in some creative ways, but right now the entire focus is on cost.

I have a state-level National Health Service Corps equivalent in Missouri and have very strong financial commitments, about $6 million right now at the state level, and half of that comes from the Missouri Hospital Association. The hospitals are well aware of the need for generalist training and recruitment and retention strategies.

Mullan: The hospitals are putting up money for scholarships?

Kivlahan: Yes.

Mullan: And what's the benefit for them?

Kivlahan: They can identify kids and docs from their own community who they want to return.

Mullan: And the money goes into the scholarship side. On the payback side, individuals have to find community support of one sort or another.

Kivlahan: Right.

Mullan: Which is there?

Kivlahan: It's there. But who is not awake to that concept at all are the managed care organizations, and we've talked with them on a number of occasions. I think the awareness is beginning to come, but they have a very specific job, and that is to take care of the spiraling costs that we were unwilling to take care of several years ago in a more organized fashion. So they are the slashers and burners of the nineties, and their interest in the long-term commitment to a rational health system is limited only by their ability to succeed in the current marketplace. So I think it's very immature in Missouri. Nationally, my knowledge is that there are very few managed care organizations who have moved into Stage 3 and 4 that really become much more mature, committed to the community, and aware of

the need for physician control and community benefit.

Mullan: Is the presence and the oncoming presence of managed care affecting opportunities for generalists and specialists in Missouri?

Kivlahan: Yes, at this point it's exacerbating the physician distribution problem. Physicians, primary care and specialists, who functioned in rural areas are moving even more rapidly than before to urban areas. We're still in the very early phases of this.

Mullan: Because?

Kivlahan: Because there's a shortage of primary care providers in the metro areas of St. Louis and Kansas City and Columbia.

Mullan: Exacerbated by managed care wanting primary care providers?

Kivlahan: Correct, so the recruitment of current primary care providers is very strong. I think that will turn around. It's the "If you build it, they will come" phenomenon. As managed care reaches into rural communities with our state employees plan

(a Calpers equivalent) our state employees and municipal employees have a very strong (100,000 lives) buying co-op and as Medicaid-managed care moves into rural America and develops health care services that were never there before, we will see improved access. But we're in the very early stages of that, so the distribution problem is slightly exacerbated right now. I think it will be corrected over time.

Mullan: You're a huge medical school state and residency state. As I recall, resident population, you're among the higher in the country.

Kivlahan: We're an exporter, though.

Mullan: I would think. What is the phenomenon going on there? Is it six medical schools you have, with the two osteopath (unclear)?

Kivlahan: Yes.

Mullan: Which is historical accident or historical happenstance. Do you bring people out of state for training and then send them back? What happens?

Kivlahan: The osteopathic schools bring people in from out of state. They're national schools for osteopaths and they move them back out. There is a new commitment from both of those schools to the state of Missouri to train more generalists for Missouri, and they are actively involved in the program we call PRIMO, which is our National Health Service Corps equivalent in the State, that I set up three years ago. So there's a very strong interest from the osteopaths to become part of that program and get the scholarships.

Our urban medical schools outside of Columbia really are profound exporters, in the 75 to 90 percent range, students leave Missouri, and that's the generalists. Specialists are even at a higher rate. Columbia is at about, if I recall the latest numbers, somewhere between 40 and 50 percent of Columbia's medical students stay in Missouri, but only about 27 or 30 percent of those enter primary care specialties.

Mullan: How about international medical graduates (IMG) in Missouri? Are they a factor? Are there many? How are they accepted?

Kivlahan: In family medicine, in the state's family medicine program, IMGs are very rare. In pediatrics, they're very common. In general internal medicine, very rare. In rural America,

international medical graduates are a very important part of primary care service, and frequently the only physicians who will enter some of our communities. In the metro areas, IMG residents are an increasing concern for our own graduates to be able to practice in Missouri.

Mullan: The growing competitiveness of opportunities.

Kivlahan: Correct.

Mullan: In rural Missouri, the IMG is an important strut in the structure of care. How much is that a permanent strut, how much is that a rotational strut?

Kivlahan: It's permanent in Missouri. They are incorporated into the community. People who you never thought would be--I mean, that can hardly speak, Missourians who have very strong accents and who are rednecks accept Dr. X from the Philippines with tremendous respect. Its the same phenomenon we discussed before about the DOs and the chiropractors. It's someone willing to come and stay in our community, and they're treated very well. They're the only person in the community with the big house, beside the banker, and they started the country club, very important parts of that community, and usually long-term

residents.

Mullan: In some communities is there an (unclear) the JV is a person for two years?

Kivlahan: Some, but it's really very rare. I approve all the J-1 visas, so we have a pretty good sense for that. I would say I think we approved, I don't know, ten last year or so. It's really a fairly small number who are in and out, and most of those are in federally qualified health centers.

Mullan: If you were looking to a long-term strategy to provide both primary care and equity in services from a workforce perspective, physician, etc., I realize this is an interview in itself, but in terms of most available remedies, what would you reach for?

Kivlahan: I'm a really believer in the primary care gatekeeper concept, so whether it's family medicine, general internal medicine, general pediatrics, and I'm a very strong believer in advanced nurses as primary care partners. I just don't think there's better medicine to be found, not in this country or in any other country. I've watched it, and it works for high and low socioeconomic status folks, it works for ill people, it works

for chronically ill, and it works for healthy people. So if I were kind for a day, my approach would be to provide every citizen with a primary care provider that's accessible and that has good referral patterns, good consultation access to specialty providers when needed, and the four I mentioned would be my primary care providers of choice.

Mullan: What is the future of the generalist, as you see it?

Kivlahan: My hope is that generalist physicians will not only be in the role I just described, and that is the primary care direct practice role, but will also take a major leadership role in two areas. One of those is public policy. It disturbs me greatly to have the medical school dean at the University of Missouri-Columbia run by a cardiothoracic surgeon. I have a great relationship and respect with that dean, and we meet on a weekly basis to talk about public policy issues, but when it comes to truly understanding primary care and building a system that supports it, he's lost.

So training leaders in public policy who are also generalist physicians, who didn't just attain their position because they were a good doc, is a critical strategy, from my standpoint, for assuring the future credibility of the generalist and assuring that the public understands the value of primary care. I guess

that's fairly elitist, isn't it? I also recognize that people in our country will choose with their feet, but I see it regularly in my patients, even when they get insurance, still want to see a primary care provider with that being their first choice. They don't want to shop. They've had enough experience shopping among specialist physicians, that they want to have someone continue to coordinate their care, who understands what is happening when they call at 2 a.m., distressed because their husband walked out, or whatever.

The second area that generalism needs to lead in the future is the direction of our health care system, whether that be directing HMOs, directing large hospital chains, or integrated delivery networks. Training physician executives who are generalists, who are not just retired specialists who don't have enough business anymore and are hungry and are discouraged with the American health care system.

Mullan: So generalist academic leaders, generalist physician executives.

Kivlahan: That a good description, yes.

Mullan: What about the (unclear) that you've identified so eloquently about the smallness of the focus of the traditional

generalist training? That is, under best circumstances, it's excellent training for dealing with the individual and perhaps the family. How do you get the world view expanded?

Kivlahan: I think two fold. One of those is that physicians in training should have some public health principles that are real, that are usable, not that are used in abstract but in fact can be part of a team that understands community health. Just like we believe it's important for physicians to quickly analyze clinical research, I believe that physicians ought to be able to utilize public health and epidemiologic principles in practice. So I believe that all physicians ought to have some training in that are, but I also believe that there ought to be a cadre of physicians who are specially trained to lead and to collaborate in public health efforts in our country.

In out state, it's very discouraging to watch most of the public health "leaders" be RNs with no additional training, or administrators who were good managers or good fiscal managers, and I'm trying to gear them up about what public health needs to look like in the next century and how they need to become leaders in organizing information and assessing their community and in prioritizing, based on scarce resources, where their activities ought to go. Makes it real difficult when those basic principles aren't there. And then to go to the physicians in that community

and say, "I want you to get involved in this community assessment process we now have going in 75 percent of our counties. It's really important that you come and be able to analyze the data we have on health risks in your community and assist us in prioritizing based on evidence-based interventions."

Mullan: Tell me about the role of the advanced practice nurse in the PA in primary care, in particular. Is that useful, advancing, has it reached zenith, and do we have more docs that will fade away? What do you see?

Kivlahan: In Missouri, Pas can only work under the supervision of physicians, so it really truly is an extender. In our state, nurse practitioners can work independently, but in collaborative practice, so I have much more experience with the latter than the former.

My experience is such that nurse practitioners are fully capable of managing most simple and moderately simple primary care needs, and are able to differentiate between complex and simple, and refer appropriately. That saves me a tremendous amount of time for more complicated patients, and given managed care and capitation, which we are under right now in our Medicaid years, I am feel the crunch, which is a fascinating new phenomenon for me, between an upload from the nurse practitioners

of complex patients and a download from the specialists of complex patients.

So for the first time--and I've not seen this articulated anywhere, maybe it has been articulated extraordinarily well and I just haven't read it--for the first time as a family physician, I am feeling very pushed by the tremendous complexity of patients that normally I would have said, "Oh, those five problems? I'll refer to the specialist." And I have extraordinarily competent nurse practitioners who I've worked with now for fifteen to seventeen years and know their clinical skills, and we have weekly meetings and case conferences and readings, and it's an academic practice in many ways, and yet they will never be able to generate a differential diagnosis the way a physician can and understand the pathophysiology of the four medications tat person is on and the three clinical disorders they're presenting with.

So it's a very scary time for me as a family physician, especially a family physician who's not in it full time, and I'd love to hear from family doctors who are in a capitated environment, taking care of a whole new level of complexity. I'm not sure we're trained for that, and I'm not sure the specialists are trained for the kind of real collaboration that needs to occur so the patient isn't at risk in the middle of it all.

Mullan: Fascinating and changing. Twenty years from now, what

are you going to be doing?

Kivlahan: Back when I knew you in Washington, D.C., I would have said, "I'll follow you as the Surgeon General," but now that's no longer an option. I will be attempting to put into practice some of the principles we're discussed. That is, teaching young physicians to understand the value of the community in their practice, attempting to integrate public health and primary care in a way that enhances both fields and hopefully enhances the health status of the community in which those doctors work.

Mullan: In Missouri or in Senegal? Where do you think?

Kivlahan: It clearly will be international medicine again at some point. I think the same issues are operative in most other countries, especially Third World countries, the need to integrate. It's so much more palpable in a Third World country to understand the integration between primary care and public health, the boxes, the lines aren't drawn. So I appreciate and enjoy that environment a lot and probably will spend time there.

Mullan: Anything else you'd like to put on the record here?

Kivlahan: I think my portable vision, the vision that accompanies

me from job to job, what it is that makes me feel like I'm contributing maximally to the world, to myself, to my family, my community, is the ability to work with a high performance team that accompanies me wherever I am, and if it's there, it's a job worth having, and if it's not there, I don't feel any juice when I get up in the morning.

I think that came from my family medicine training. In our Family Medicine Department, we were paired as partners from the start of the residency to the completion. We did three years of a partnership and we were continuously with that other physician, as well as paired with a nurse practitioner, so it really took the three of us to manage the practice all the way through the residency. I left residency looking for that feeling again, and found it in the country health department and subsequently found it in the state health department, and found it in international areas, and have it now. So I think it's that sense of "it's too big to accomplish by yourself," and the best days worth getting up for are days when you feel like you have a role on a team that's making some impact. I think that came from my primary care residency training.

Mullan: Good. You've had an extraordinary carer, from frog hunting on. Thank you, Coleen.

(End of interview)