ROBERT MONROE

August 9, 1996

Dr. Fitzhugh Mullan,
Interviewer

**Mullan:** Your date of birth?

**Monroe:** June 30, 1931.

**Mullan:** We're in the offices of Group Health of Puget Sound in Seattle. Are these offices distinguished from others? Is this the 15th Street? How do we refer to this complex?

**Monroe:** This is the central campus, the central medical campus, and there's about twenty-some area clinics. We have another hospital complex across the lake in Bellevue/Redmond, and then we use hospitals in the community such as South Puget Sound, Tacoma and Olympia.

**Mullan:** We're on the central campus?

**Monroe:** We're on the central campus.

**Mullan:** And it is the 9th of August, 1996, a beautiful, dry, sunny Seattle summer day.

Tell me, if you would, Bob, a little bit about your background and where you came from, where you were born and grew up.

**Monroe:** I was born and raised in South Dakota. My grandfather was a country doctor in a small community. Two of his sons were physicians, and then I had a bunch of cousins that were physicians.

**Mullan:** Two of his sons, not including your father?

**Monroe:** That's right. My father was a schoolteacher.

**Mullan:** So you had two uncles as well as your grandfather?

**Monroe:** Two uncles, and then I had a cousin on my dad's side who was a physician. So that's always been one of the models for me. Then I went to Texas, to college, to play in a marching band, on a music scholarship.

**Mullan:** Where did you go?

**Monroe:** A little place called Wichita Falls, which had a college called Hardin College, which subsequently became called Midwestern State University. Anything in Texas to be called in the Midwest, I guess, is kind of stretching it, but anyhow they did. So I got room and board and tuition to play in their marching band.

**Mullan:** And what was your instrument?

**Monroe:** Percussion. I met my wife there, who was a fellow percussionist. Music has been a lifetime hobby in our family.

**Mullan:** What was growing up like in South Dakota? Where in South Dakota was it?

**Monroe:** Up in the north central part, a place called Aberdeen, which was at the time the second largest city in the state, 15,000 people. It was wonderful growing up there. I have very fond memories of it. It was a typical midwest community, very heavily into church. We were Methodists, and going to church was a big part of our life. My father had some stature as a schoolteacher. Schoolteachers did have stature in those days, so we were not particularly poor, Dad had a job all through the Depression.

I come from a family of one of seven children. There were five boys and two girls. I'm the third in line. The only one of our family who became a physician, but everyone's college-educated. I have a brother who is a banker, a sister who's a professor at Columbia Teachers. Another brother is a professor at University of South Dakota.

It's interesting that we were definitely in the minority politically. We were quite liberal, and South Dakota was part of the solid North, I suppose, strictly conservative Republican.

**Mullan:** How did "liberal" manifest itself?

**Monroe:** Mainly being Roosevelt Democrats and also believing that the government could make a difference, can make a difference, does make a difference, and that unfettered capitalism is just not good, that the natural vices of greed overcome any of the sort of good things that capitalism can do, but quickly, I think, greed takes over. So that was our philosophy, I think. Although my brothers--I have a couple of brothers that argue with that. My dad did. He was definitely at odds with all his wife's, my mother's, family, who were physicians and were somewhat conservative. It's interesting that one of my uncles was a physician and had a tough time in practice, always dreamed about pre-paid medicine. He thought that was the way to go, that pre-paid medicine would make a lot of sense, and they were talking about that at family gatherings.

I think my uncle have been referring to a report that was almost--like Group Health of Puget Sound if you read that report from the AMA [American Medical Association]. That report recommending prepaid medical practice didn't quite make it through the House of Delegates, but it was written as a result of the Depression or during the Depression. So I think that's one of my backgrounds anyway.

**Mullan:** When you say your family was liberal and in large measure different than the families in the community around you, where did that come from?

**Monroe:** Well, actually the town that I was in, I would say, was a little bastion of Roosevelt Democrats, partly because of the railroad. We had a big division point there. So there was a lot of labor. I think that my dad, who was a history and social studies teacher, was very moved by the Depression and Roosevelt, and that was when he changed, just when Roosevelt came in.

**Mullan:** Changed in the sense of that's when his--

**Monroe:** That's when he became much more liberal, when he felt like the government did have a role and that what Roosevelt did was really save the country, in his view, and I think it was just. I think that religion played a role in it, too, being there was sort of a populism to the Methodist Church at that time. It was a force for that kind of change.

**Mullan:** Were there others in the church that were of like mind?

**Monroe:** Yes.

**Mullan:** Again a distinction from the larger community?

**Monroe:** Yes, I think so.

**Mullan:** Aberdeen was a center because of the railroad?

**Monroe:** Because of the railroad. Nothing existed until that happened. Steam trains could go--every hundred miles there had to be a division point, and Aberdeen happened to be that.

**Mullan:** A division point? A place they could meet?

**Monroe:** Where they would clean off the boilers of the engines. So they'd have a boilermaking shop and a repair shop. Every ten miles they'd have little tiny towns because that was how far horses and a wagon could efficiently take grain. So all those little towns are gone except for remnants of the grain elevators. My grandfather was in one of the small towns of about five hundred. This is where his practice was.

**Mullan:** Near Aberdeen?

**Monroe:** About fifty miles from Aberdeen, very interesting in that it was also the place where Hubert Humphrey was born.

**Mullan:** What's the town?

**Monroe:** Called Doland.

**Mullan:** Was he still in practice when you were growing up?

**Monroe:** Yes.

**Mullan:** Did you visit?

**Monroe:** Yes, we visited him and went with him on his rounds. He was sort of notorious for falling asleep at the wheel of the car, because he was used to a horse and buggy. He would just fall asleep, and the horse would take him home. But in his car, he had a number of roll-over accidents, going off the highway and off into the plowed fields. Fortunately, no one was ever killed. He was quite a character.

**Mullan:** Tell me more about him.

**Monroe:** He went to the University of Michigan at Ann Arbor, and was part of an inbred community in Ohio. He decided to get out of there, came West, and became a booster of this little town Doland. He would meet the train, the noon train, and find out who was there and take them home for dinner and introduce them, try to get them to stay in Doland.

I have his ledger books in which his charges were, oh, like two quarts of cherries. That was a payment. Or a load of firewood, just a number of barter-type things.

**Mullan:** When you rounded with him, or traveled with him, what do you remember about it? Was that an important influence on you?

**Monroe:** Yes. I think it made it seem like it was achievable, that being a physician was achievable and doable. He obviously

had status in his community, was very much loved. There were a number of positive things. And he was a real energetic character. He never swore, but if anything went wrong, he would whistle and say, "Confound it. Confound it." That would be the most that he would ever swear.

**Mullan:** Your uncles, what sort of practice did they have? This is your father's father?

**Monroe:** My mother's father. One of them practiced in a town of about six or seven thousand, and he practiced there for about thirty years. Later he had taken up anesthesia. This community needed it, so he kind of gradually became an anesthesiologist. Then he went to a TB center and worked his last years.

His brother, who, after struggling with general practice, got a job at the state TB sanitarium in the Black Hills, he went out there. Then when he retired from the state, then he and his brother went back East to Fort Wayne, Indiana, and worked in a TB sanitarium there. They both did that in their last years. The one uncle did a lot of anesthesiology, and the other one was more like a pulmonologist; the pulmonary uncle lived to be about ninety-eight, just died about two years ago.

**Mullan:** Did you travel or work with them?

**Monroe:** The one uncle who lived in South Dakota, in Madison, he became the patriarch after my grandfather died, and so we did

visit them. It was never real close like it was with my grandfather.

**Mullan:** As you grew up and went through high school, you said music was a strong factor. Was science and was medicine? Was medicine a goal for you at that time?

**Monroe:** Yes. I wanted to be a physician from the time I was in grade school. There was just one little bit of time when I thought maybe I would do something else. That was in my senior year of high school but I decided not to change. I went out for declamation and oratory. I had won one contest. I thought, "Well, gee, this was fun." But then the next contest, I went up to state, and I lost that, and I thought, "Oh, well, maybe it isn't so much fun." I just now thought of that. It did just play an incidental role.

I think that my father put a high value on studying and getting good grades, and my older two brothers sort of rebelled against that. So it was really easy for me to know where one gets positive strokes by studying hard. So I spent a lot of time studying when I was in school. It was mainly to learn as much as you could, whatever you took. I don't recall myself being really overly interested in science. I got more interested in it the more I got studying it, but it wasn't something that I had any hobbies at. I didn't have a chemistry set or anything like that. I was not interested in that way.

**Mullan:** You went to Wichita Falls.

**Monroe:** I went to Wichita Falls.

**Mullan:** I want to keep the various colleges' names straight. Hardin?

**Monroe:** It was Hardin College.

**Mullan:** There's a Hardin Simmons--

**Monroe:** He also funded that school, and then he funded a part of Baylor University. His daughter was Mary Hardin Baylor. She married into the Baylor family. So he funded what used to be a girls' Baptist school as part of Baylor University.

**Mullan:** So Hardin was his last name?

**Monroe:** Hardin. He was an oil tycoon from around Wichita Falls, where his main oil strikes were, and he set up all these schools. So we heard about it. It was a real fluke. Our high school band director, to make extra money, taught clarinet at Cook County School of Music during the summer, and this young--

**Mullan:** Cook County. That's in Chicago?

**Monroe:** Yes. Hardin College was getting started, and the college band director used to go up and take lessons from our high school band director, and they got to talking. So he college band director said, "Any of your high school band students that want to come to Hardin, they'll have a scholarship." So a bunch of my high school chums thought it was a great idea, so they went down there, but I didn't. I had my goal set on going into medicine. I came home from work one day in August, and my mother said, "How would you like to go to Texas to school?" And I said that I wouldn't like it. And she said, "Well, they called from Texas, and they need a drummer. Would you go?"

I said, "Oh, there's no way. I wouldn't have time to get there."

She said, "Well, the train actually leaves at 1:00 tonight, and you could actually make it."

I said, "Well, I'm not even packed."

She said, "Yes, you are."

So at 1:00 o'clock that night, I was on the train to Texas.

**Mullan:** What had you intended to do?

**Monroe:** I had intended to stay and go to the local teachers college and then go to the University of South Dakota, which I did subsequently, and then to probably Northwestern, because that's where my cousin went. But it was just interesting how that changed.

Actually, my mother really was the more important influence in terms of my achieving anything. She was a much more emotional, loving, and warm than my father was. So I really was influenced by her. But also I realized that once she'd gone to all that work, I might as well go ahead and go to Texas.

**Mullan:** So off you went to Wichita Falls?

**Monroe:** I went to Wichita Falls.

**Mullan:** What was it like?

**Monroe:** It was pretty terrible at first. It was hot. You know, it's the worst part of--it's the southern part of the Great Plains. It's very much similar to South Dakota except a whole lot hotter, and I had to listen to all those people speak that funny language. But then we kind of got into it.

**Mullan:** By that you mean the accent?

**Monroe:** Yes, the accent and just the way of expressing themselves. But there was a group of us from South Dakota and we stuck together. The college needed people like us to stay there and not go home on weekends and things. So we helped to promote a campus life. In the end, I think it was really a lot of fun. The band traveled throughout the state for the football team. The college put money into a football team and a band. I had

this job for room and board. I was taking care of the band instruments. The instrument truck would take off early, the day before the football games and we would make sure that all the band instruments were there when the band got there. That was a lot of fun.

**Mullan:** And had you been musical?

**Monroe:** Yes. I took piano lessons until I started taking up the drums. My sister went down to Texas to the same college. She was an oboist, and another brother later did percussion at the college.

**Mullan:** Did they have a good music program there, other than band?

**Monroe:** Yes, they did. Several rich oil people had endowed the School of Music and paid people well, to be in the music faculty.

**Mullan:** But you didn't pursue music as a formal study?

**Monroe:** No. In fact, that was one of the big disputes. The college band director really wanted a jazz drummer, someone to play in their jazz band there. I had it in my mind to not do that but rather to study hard and get into medicine. I said, "No, I can't do that (be a jazz drummer)." That was very upsetting to them, because they thought that's what they were

getting, is someone who was going to do that, but I decided not to. And it's really interesting, of that band probably half of them flunked out of college because the demands of the band were so great. We practiced every day from about 4:00 until 8:30 in the evening, and then every third day we were in uniform playing someplace. So to kids who were not disciplined didn't make it.

**Mullan:** Did you enjoy college life? What did you study in?

**Monroe:** I loved it, yes. I took a major in zoology, a minor in chemistry, but it was liberal arts. I took German. I should have taken Spanish. Now I wish I had. German and Spanish. And history, I liked history a lot. John Tower taught us history. He used to be the Secretary of Defense.

**Mullan:** Senator.

**Monroe:** He was a new Ph.D. and a very conservative guy. At the end of that first year--I ran for Student Council. I became sort of like the big men on campus and had a lot of notoriety. That whole college community kind of just took us South Dakotans in, even though we were Yankees. I had a really good feeling about Texas. In fact, I wanted to go to medical school in Texas. But since I was not a citizen of Texas I could not go to a State of Texas medical school. I went to the University of South Dakota.

**Mullan:** So what happened next? How did you accomplish that?

**Monroe:** To go to the University of South Dakota?

**Mullan:** Did University of South Dakota have a medical school back then?

**Monroe:** It had a medical program of two years of basic science. It's been a basic science school since the thirties.

**Mullan:** We're in the late forties now?

**Monroe:** This would be about the early fifties, mid-fifties. I graduated from the University of South Dakota in 1955.

**Mullan:** So that was two years starting in 1953?

**Monroe:** Yes. I graduated from Midwestern University (Hardin College) in June of 1953.

**Mullan:** How was that?

**Monroe:** It was great. I really had gotten single-minded about studying. So I got a place to stay that was just a room. There was another medical student there and a history student. Basically I studied the whole two years, did a little bit of horsing around, but not much. I loved every minute of it, and I

thought basic science was great. I learned a lot. It was nice to achieve that, to learn that stuff, just to sort of say you did it. That was also kind of fun. I made some pretty good friends. There was only thirty of us in the class.

It was fairly brutal, though, in terms of the way the dean treated people. One of my classmates was suspended from school because he was caught in bed with a waitress in town. It had nothing to do with medicine. And I learned later that the dean was having an affair with his secretary. So the whole thing was just so hypocritical.

But the medical school in Vermillion; we did a lot of things. We had to go up to Sioux Falls or Yankton for clinical training. But Vermillion was a very lovely little town. Those towns like Vermillion got started before they had railroads in South Dakota because the Missouri River was the mode of transportation. The river wasn't navigable for big boats beyond North Dakota. So those were actually the main towns. Then the railroads came in and changed the whole face of everything. The river towns just kind of shriveled up. Now these old river towns are great places to live.

I held off getting married my first two years of med school. I remember the dean saying, well, why don't I apply to Harvard for the last two years of med school. The other thing that the University of South Dakota Medical School did is that they flunked out people at the end of the first semester. I remember sitting there in class at the start of the second semester, and the dean came and just dropped letters in front of about eight

kids. They read those letters, got their stuff and left, and that's the last time I saw them. And I thought that was really very inhumane. The school did that so that they wouldn't have students flunk out of the last two years of medical school and damage the reputation of the University of South Dakota Medical School.

But Harvard Medical School wouldn't allow one to be married at that point. So I said no, that I was planning to get married at the end of my second year of med school. Therefore, I did not apply to Harvard for my last two years of medical school.

**Mullan:** Your wife you'd met in Texas?

**Monroe:** In Texas. She was finishing up her degree during my first two years of med school.

**Mullan:** In Texas?

**Monroe:** In Texas.

**Mullan:** Where was she from?

**Monroe:** Right there in that town, Wichita Falls. So I went to Vermillion for the first two years of med school and thought I didn't need much of a social life. So having my fiancee in Texas was not a big hardship as I plunged into med school studies.

**Mullan:** That went for two years?

**Monroe:** For two years.

**Mullan:** An attenuated courtship.

**Monroe:** Yes.

**Mullan:** What happened then?

**Monroe:** I would go down to Texas in the summers, and I hit on this selling of cookware to single women. I'll never do this again, but it was very lucrative business, and I made lots of money. I went down there and traveled the State. I would only show the pots to girls, single girls. I wouldn't call on couples. I'd start out in a little community and go into the soda fountain and meet the girls of the town, talk to them a little bit. Then I'd ask if I could call on them in the evening, and I would go and show them the pots and pans. The girls were encouraged to buy "for their hope chest." They bought not only pots but also silver, china, quilts. Sales were brisk.

This one little town called Midland, Texas, it was a division point for the oil business, and i had about two ten-story skyscrapers filled with women doing clerical work for the oil company and all making good salaries. So one could get rich there. Part of the sales approach was that you were of an

eligible male and a prospective husband. It was exciting at times.

**Mullan:** I would think this day and age it would be just the opposite. I would say a woman wouldn't let a man in there.

**Monroe:** No.

**Mullan:** You'd have a woman selling to women.

**Monroe:** Exactly. But in those days the culture promoted the idea that women would be wives and mothers and not have careers.

I went to Northwestern partly because my cousin had gone there and liked it, although it really didn't fit with my political stance. I'd have been better off at the University of Chicago, I think, from a political viewpoint, but I'd never heard of the University of Chicago. Northwestern was a very conservative place to go to school. Loyal Davis was one of my professors, a neurosurgeon and Nancy Reagan's stepfather. I did like Chicago a lot. Chicago was, I thought, a really vibrant city.

**Mullan:** This now was late fifties?

**Monroe:** Yes. So '55 to '57 I went there. Northwestern Med School was all clinical. I found out that the basic science that

I had in South Dakota was great, it was fine, but it wasn't fine for getting into that school.

**Mullan:** How did you feel about the clinical work?

**Monroe:** It was great. I really liked it just as much as--I'd say more than basic science, but still I liked the basic science a lot. But going to all the different places we went, like Saint Luke's Hospital and to Cook County, Children's, there's a very sort of proud history in medicine at Northwestern that we were a part of. I'm sure all the Chicago schools have some traditions, but Northwestern had a sense of tradition that I had not encountered before. A lot of schools in the East, I guess, have that sense as well.

The other thing that we did that I remember real fondly was we spent two weeks becoming midwives. There's a Maxwell Street Maternity Center. On Maxwell Street there's a Jewish market, and so we would live for two weeks over the market and then go out into the homes and deliver babies. One was a junior the first week, and the second week you were the one who taught the junior. If there was problems with the progress of labor, then an OB resident was called and came out to assess the situation. I spent time at Cabrini Green Housing complex. That's when it first opened. We felt absolutely safe anyplace in the ghetto or Cabrini.

**Mullan:** It was black at that point?

**Monroe:** It was black. But the residents were just so friendly to us and so appreciative. We had to think up a name sometimes for kids because the parents didn't know always what names they wanted. I remember giving kids elegant names.

We'd come into the patients' apartments, and we'd always pick a chair that was hard. We wouldn't have a soft chair because it would probably be full of lice and other vermin. You put your coat over the chair, and could sleep if the patient was not in actual labor. There was no vaginal exams done; it was all rectal exams. So we learned how to tell the effacement of the cervix by doing rectals.

**Mullan:** Why was that?

**Monroe:** The OB faculty just felt like vaginal exams would be unsterile, that it would be dangerous and might cause infection.

**Mullan:** Doing vaginal exams?

**Monroe:** Yes.

**Mullan:** Was that the predominant teaching of the time?

**Monroe:** Yes. And back at the university OB patients were followed by rectal exams. A vaginal exam was a big deal. You needed a sterile setup and drapes and things.

**Mullan:** That must be pretty inferential, to try to determine effacement.

**Monroe:** Once it got started, down, descending, plus one or so you could tell quite well the state of the cervix.

**Mullan:** So that was '56-'57. What was your thinking as you approached internship about what you wanted to do in medicine?

**Monroe:** I wanted to be a generalist, definitely wanted that. Otherwise I would have been an internist. Never wanted to be a surgeon. We really could have used some counseling in terms of that. No one ever quizzed me on it, you know, what I wanted to do. I went to Philadelphia General for internship. Part of that is I thought, "Gee, I really need experience. I don't want to have people hovering over me." I wanted to have an experience where I'm the one in charge. It really would have been better for me to have stayed right there at Northwestern and taken an extra year of internship because I knew a lot of professors. In a city/county hospital learning to talk to patients, was difficult because of the educational, cultural, ethnic gaps between patients and physicians. I did get a lot of experience though. It was not critiqued in the way you would liked to have ones work critiqued if one was going to go out and practice medicine in the main stream society.

**Mullan:** It wasn't as educational as you might have liked, even though it was experience?

**Monroe:** That's right. It wasn't as educational as I liked, and I ran into some professors who really exploited the patients. That was very, very disturbing.

**Mullan:** How so?

**Monroe:** I know one of the thoracic surgeons did an esophageal pull through procedure for cancer. The surgeon had never done one before. The esophagus pouch necrosed and the patient suffered a miserable death. I remember having to take care of that patient. And there was a surgical resident being left by the attending MD to remove part of a lung that had a mass duct infection or old TB. The surgical resident did not get enough supervision. The patient died of blood loss. The hospital had a long list of skilled physicians who attended. There was a lot of unsupervised care delivered by doctors in training.

**Mullan:** Was it [unclear]?

**Monroe:** The hospital where I interned was affiliated with several medical schools and had their hospital wards which they supervised.

**Mullan:** Were you affiliated with any one of the schools in particular?

**Monroe:** We were general interns not affiliated with any one school. The last year in Northwestern I did hear a lecture from someone from the U.S. Public Health Service who talked about Indian Health, and at the time we had to choose which branch of Armed Forces we wished to join after medical school. I chose the Navy. The lecture told us that USPHS physicians qualified for a draft deferment.

**Mullan:** This was because of the draft?

**Monroe:** It was called the Berry [phonetic] Plan. If you wanted to be deferred from the draft, you signed up ahead of time with a branch of Service. I signed up with the Navy. But then when I heard this lecture, I thought, "Well, this is for me. That's what I want to do." I met a couple of people from an internship who wanted to do that, too, and so I signed with them.

It was great. We loved Philadelphia. My wife actually turned herself into a medical stenographer and worked at Jefferson Hospital. She was close enough to go to the Philadelphia Orchestra concerts. So she could take a lunch break and go over and see concerts. We loved the museums and Fairmont Park. I don't know if you've ever been in Philadelphia. We loved that city.

**Mullan:** Had your thinking matured about what you wanted to be? Were you thinking in terms of being a GP?

**Monroe:** Yes.

**Mullan:** This was a period when being a GP was not very prestigious, as I recall.

**Monroe:** Right. It wasn't so prestigious. The thing that I felt most about was would I be competent to be a GP? I thought, well, maybe I'd get some experience in the Indian Health Service. I originally was assigned to Gallup [New Mexico] which was before they had an Indian hospital. Gallup had an Indian outpatient service. It was very busy. Between 9:00 and 5:00 on a winter day, we'd see 100 patients with one MD and two nurses.

**Mullan:** This is where?

**Monroe:** This is in Gallup, New Mexico. I did night call at the IHS hospital at Fort Defiance, Arizona, which was about thirty or forty miles away. I had to do my stint of night call. But again you couldn't talk to the patients except in rudimentary Navajo. I kept saying to the Public Health Service, "I want to be in a hospital. Assign me to Fort Defiance." No, they couldn't do that. Finally, at the end of a year of bitching they said, "Well, we'll send you to the IHS Clinic in Ignacio, Colorado." It's just over the line from New Mexico, but you have to go

through Durango, Colorado, to get there. You can't go up through New Mexico except by old back roads if you know them.

**Mullan:** It's southwestern Colorado?

**Monroe:** Yes, southwestern. I served as medical officer to the Southern Ute Tribe, there was an old BIA hospital which had been taken over by the tribe. I had the medical officer's house, which was just a wonderful house to live in. My clinic was right across the road. I still felt the situation wasn't right for what I wanted to do, and I really wanted to get some experience in the hospital with the more seriously ill patients.

**Mullan:** Were you the only doc?

**Monroe:** The only doc. There was a dentist, a couple of sanitarians, three visiting nurses. It was a perfect setup for primary care, which is what I did. I organized an alcoholism seminar while there. I did a health survey of the Ute Tribe, which I did with the help of informants. My nurse was the first Ute to graduate and obtain a nursing degree. She knew everybody in the tribe. So I would just go through the tribal roster with the nurse and focus on health issues. Then I went back through the Department of Vital Statistics and got the death certificates with what people died from. I up with a list of leading causes of death.

All that was a lot of fun, but I had decided that I really should take a GP residency. They were giving GP residencies then, and I was going to go to a small place in Louisiana called Monroe, Louisiana. I had been there selling pots and pans and kind of liked it. So I was accepted through a Meade Johnson Fellowship to go there to get a GP residency.

**Mullan:** This was before family practice had been born.

**Monroe:** Right. It was a two-year program after internship.

**Mullan:** And this was something that was established, that GPs were being trained in a two-year--

**Monroe:** Yes.

**Mullan:** Was this a fairly new phenomenon?

**Monroe:** Well, guys like John Geyman of the University of Washington got their training in GP residencies. There's was a lot of programs in California. In the southern states there were some programs but not much in the northern States.

In the meantime, I had gotten friends with the county health officer in Durango, which is close to Ignacio, Colorado, where I went after leaving Gallup. I went to Durango to visit the Health Department. There I met this maverick doc, Art Warner in Crown Point, New Mexico. Art had been at Indian Health Service and had

been fired because he was too pro-Indian. He was very much promoting keeping the Indian culture and then grafting a few things on that would help, how to make life healthier. He was a pediatrician. When he got out of medical school, he had been interested in health care co-ops, so he rode around the country and tried to find out if there was anybody doing anything in health care co-ops. He met an MD in Elk City, Oklahoma, who said, "Well, why don't you go to Group Health in Seattle." So Art had gone up there and spent one year in Group Health Seattle as a GP and then went back to school and did his specialty work becoming a pediatrician.

He talked to me about what I was going to do after IHS and said, "Why don't you go to Group Health?" At the time, Group Health had decided that they couldn't function as a multi-specialty group without generalists but in their opinion generalists were not adequately trained to do primary care. So Group Health set up an additional year of training for generalists. This was about '54, and that training was in rheumatology, outpatient orthopedics, gynecology, some of the surgical training, a little bit of ENT outpatient work, some neurology outpatient work. The training was a year of one-month segments in the above specialties then the trainee was qualified to be a generalist in Group Health. I said, "That is the kind of training I like."

So I went up to Seattle and interviewed and thought, "Well, yes. This would really be good. I would like that." But then I

didn't hear from GHC so I accepted the GP residency in Louisiana.

Somebody from GHC in May of 1960, called and said, "Well, Robert, we haven't heard from you. Are you coming to GHC or not?"

I said, "Well, I wrote and said I would come but no one from GHC has offered me anything."

They said, "Well, we want you to come to Seattle and be a GP at Group Health."

So I canceled the GP residency in Louisiana, and I went to Group Health. But by the time I got there, Group Health had grown enough so they couldn't afford to have me take this residency program.

**Mullan:** They needed you to go to work?

**Monroe:** Yes.

**Mullan:** Hold on a second. I'll turn the tape over.

[Begin Tape 1, Side 2]

**Mullan:** This is Dr. Monroe, tape one, side two.

So when you got to Seattle, it was, in fact, a working job, not a residency?

**Monroe:** What they decided to do is that you could take half days off and rotate through the various subspecialties, especially dermatology--that was a big one--and outpatient orthopedics. That was another big one. Actually, those were the two main ones. Gynecology if you needed or wanted it. ENT. I did feel like derm and gynecology were important. So in the course of a year, you might have a week or two that you spent rotating through the various specialties.

The other thing that we did is, we would save up cases for orthopedics and have them double booked when the orthopedist could come and see the patients with us. This was called "circuit riding." We did that some in gynecology and other specialties.

So the whole emphasis from the specialist's viewpoint, it was, "What does this generalist need to know that will make my job as a specialist a whole lot easier and more efficient. S o that the cases I see are properly triaged?" We developed quite an *esprit de corps* and a feeling among each other of mutual respect that I thought was good.

The other thing the generalists did then is that we ran the after-hours care service because the specialist did not feel competent to see cases out of their field.

**Mullan:** Did you feel like a competent generalist now? You've had a series of experiences which you described as unsatisfactory from a training point of view.

**Monroe:** Yes. At Group Health there was an internist cardiologist who was very supportive of GPs, and I would say I learned a lot from him from the hospital inpatients that we had together. This internist round and call you up after and say, "Well, how come this patient's still here? What are you planning for this patient?" You could call him up and talk over cases with him. I thought that was really good. I found that doing OB--once again, I was learning a lot from the gynecologists and obstetricians. That was really helpful.

**Mullan:** Tell me just a quick word about the history of Group Health so we have that as part of the story, Group Health of Puget Sound.

**Monroe:** The germ of GHC got started from a physician who cared for loggers in Tacoma, Washington, before World War I. He wanted to make his clients to be able to get his services the whole year round. He started charging them a monthly fee

**Mullan:** He was a logger?

**Monroe:** He was a physician for loggers. His clientele were mostly loggers. I guess I misspoke. So he started this pre-paid practice and gradually developed into the Western Clinic of Tacoma, where he did most of the prepaid practice early on. Then they expanded to Seattle in about 1938 and formed the Medical Securities Clinic. And then the war came, and the clinic was

heavily into taking care of people in war industries. Then in '45, the bottom fell out of that. But at the same time there was a lot of political uproar here in Seattle. People wanted to have health care, and so some people organized a co-op to get health care. In the meantime, the doctors from Medical Securities Clinic were out of work. The two groups got together and said, you know, "You've got the vision. Here's the docs."

So the docs came together with the co-op founders and formed Group Health as a co-op. Then the co-op bought this little hospital (which was just recently torn down) called the St. Luke's Hospital. Then the group bought an apartment house and had it renovated into a clinic. Then they ran into the fact that the docs couldn't belong to the county medical society because they weren't ethical according to by-laws of the County Medical Society. Just the whole idea of that practice was unethical. So the co-op sued the medical society for restraint of trade. If you couldn't belong to the county medical society, you couldn't belong to the state society. If you couldn't belong to the state society, then you couldn't be eligible for Hill-Burton funds for the facility improvements. Plus it was harder to recruit. So they sued the county medical society and lost the case here locally, but then in the appeal they won. Subsequently in the Supreme Court of Washington, they won. That was about '53, '52. That marked the beginning of growth and to become more accepted in the community. But the co-op always were very heavily union, pro-union, pro-labor, very liberal group.

**Mullan:** Were their clients mostly labor unions?

**Monroe:** Yes, labor union or sort of liberal activist types who believed in the idea. So they had a board, and like anything that's run by a board, there were times when things didn't go right. The closest the group came to disbanding was when the board interfered with medical staff decisions on hiring a doctor. The medical staff didn't like the guy, and he had a lot of support on the board, and that got worked out.

**Mullan:** When you got here in 1960, how large an operation was it?

**Monroe:** About 50,000 patients.

**Mullan:** And how many physicians?

**Monroe:** There was probably fifty or something like that, maybe a few more.

**Mullan:** How did you feel about what you found? I'm a little confused, because you came under one premise, that is, you were going to be a resident or a trainee, and you were pressed immediately into service, and your teaching opportunities were limited.

**Monroe:** Were less.

**Mullan:** Did they pay you more?

**Monroe:** Yes. When you were a resident, you would take a reduced salary.

**Mullan:** They didn't bring you here under totally exploitive circumstances.

**Monroe:** No.

**Mullan:** You just got here, and their needs were different.

**Monroe:** That's right. In fact, they offered--they didn't say I couldn't do it. They just said what they preferred.

**Mullan:** So you found a fifteen-year-old organization that was anomalous by American medical practice standards.

**Monroe:** Yes. I was turned down for membership in the Academy of General Practice.

**Mullan:** Because you were at Group Health. When would this have been?

**Monroe:** This would have been 1960. And then the next year, membership of the local Academy of General Practice offered me a membership.

**Mullan:** A medical practice group?

**Monroe:** Yes. In 1960, I wrote the National Academy of General Practice and they said, "Yes, you can belong." But local academy, they said, "No, you can't belong and practice at Group Health." But the next year they changed their mind as I stated above.

**Mullan:** This is the family practice group?

**Monroe:** The family practice group, or actually it was called the general practice group.

**Mullan:** This is the Academy of General Practice.

**Monroe:** The Academy of General Practice.

**Mullan:** So in terms of what you found, doctors, colleagues, clinical standards, political attitudes, what was it like? What did you think of it?

**Monroe:** I thought it was exciting. Once I got here and really started getting into it, you know, practice was very absorbing. I was assigned to a clinic off in the south of Seattle called Renton Clinic. They had no pediatricians, and so my practice was 50 percent kids, and I had a chance at a lot of OB. That is interesting, now that you mention it, that I did sort of

entertain, "Should I really become a specialist, because I think the practice at Renton did not fully meet my need to feel totally competent. So I got thinking, well, gee, maybe I should go into internal medicine.

**Mullan:** This was after you got here?

**Monroe:** Yes. So there was that kind of undercurrent going along and always feeling like, you know, I could learn more, I would be better if I knew more.

**Mullan:** What was the attitude at that point within Group Health and within the larger community about GPs?

**Monroe:** I think that there was acceptance of generalists in Group Health. I think there was a realization that there was a niche, but I think there was also a sense of limits. They needed help, you know, with what a family physician or a general practitioner could do. I wasn't involved in those, because a lot of those were surgical, and the local Academy of General Practice, their conflicts were around procedures. The kind of procedures that they wanted to perform were D&Cs and Cesarian sections plus some others.

**Mullan:** You weren't doing that anyway.

**Monroe:** I wasn't interested in doing that. I would actually have agreed with the specialist that I thought that those were the kind of things that should be done by a specialist. Once I did join the academy, their interests were getting money for doing procedures which I wasn't interested in doing. There wasn't a lot of political talk about primary care or the kind of things I wanted to do. It was mostly about making sure they got paid properly. I would say there was a conflict with pediatricians here at GHC. Some of the pediatricians had trouble with general practitioners doing pediatrics, and the general surgeons had a little trouble with GPs doing any kind of hospital care.

**Mullan:** These are territorial matters.

**Monroe:** Territorial things. But to think, should we be here? I didn't sense a hostile environment generally at GHC.

**Mullan:** I don't want to put words in your mouth, but as the sixties unfolded, and you do have this two years after the Peace Corps that I want to come back and touch on, but for the moment, talking about your early experiences with Group Health, what today we call the generalist concept or the primary care role in the system, it sounds to me like it was not well developed. There was a certain number of kind of utility player GPs that were thought to be helpful for the system, but there was nobody in the front office saying, "We should design a system which is X

percent generalists and Y percent specialists," or anything like that. Is that fair?

**Monroe:** No, it probably isn't quite fair. Like this internist I met, he felt very strongly that we needed to have more generalists, and we did talk about percentage. I can't remember whether it was before or after the Peace Corps, but we did talk about what should the percentage be? Should it be 50 percent? Should it be 80 percent? So that percentage was talked about. But I think you're right. Then also, the specialists did design this program for training generalists at Group Health, recognizing that it was not efficient to have the subspecialists trying to care for patients who were not screened.

**Mullan:** This was a program of rotating through certain specialties.

**Monroe:** Yes, that year.

**Mullan:** Tell me about the Peace Corps period.

**Monroe:** Of course, we were very pro-Kennedy and very strongly politically in favor of that. When the Peace Corps was mentioned, I wrote them a card and said, "I've just finished the Public Health Service. If you need physicians, call me." They called after I'd been here a year. It was the usual thing from Washington. They call early in the morning there so they wake

you up at 5:30 here. At that time I felt like I couldn't do it because I had been at Group Health only a year, and I thought I should give Group Health a little more time. But I said, "Well, call me in six months." And so they did. In six months they called me.

So I went into Washington and interviewed with a whole bunch of people, including Sergeant Shriver, and came back and decided to do it.

**Mullan:** What was "it"? What were they offering?

**Monroe:** I was going to go to Ecuador. At the time I went there, I interviewed with all the proposed people and directors who were running the various countries, and South America looked good to me, and I decided, "Well, let's do it." I had also gotten my wife pregnant with the third child, and so I took off in March then and went to Washington and helped organize the Peace Corps medical program. It was just so interesting. The new Kennedys had just started, and there was this new Peace Corps. Everybody was sort of running around, staying until all hours, nobody really working efficiently, you know. It was just all this hype. Everyone was really hyped up.

I did a lot of--oh, I forget. We were trying to decide what to do about hepatitis, and so I called medical people who were doing research in hepatitis and asked them what we should do for the Peace Corps. So then decided, "Well, we can give them gamma globulin." That was great. It was kind of fun and exciting.

Then I went to Puerto Rico to be with the first group and to start learning Spanish.

Then my wife and I came back to Washington and stayed at Bethesda. We were at Bethesda quite a while. In Ecuador, the Peace Corps rep and myself were the first ones in the Peace Corps there. It was fun.

**Mullan:** How long were you in Ecuador?

**Monroe:** Two years. And my son was born there. We lived a year in Guayaquil, and then a year in Quito and I mostly traveled, about--well, probably half the time checking up on volunteers, organizing medical care for them when they got into trouble, sort of a morale-builder. Our home was kind of a converted hospital for those people who got hepatitis and amoebic dysentery and all those things.

**Mullan:** It was mostly dealing with the volunteers, as opposed to the Ecuadorian health system itself?

**Monroe:** Right. There was some, but they were very jealous of that, very fearful of--

**Mullan:** "They" being--

**Monroe:** The Ecuadorian medical establishment.

**Mullan:** That you would muscle in?

**Monroe:** Yes. I mean, those Third World countries are just so short of money and so overstaffed in training physicians that very few physicians had full-time jobs as physicians because there were no resources. So they would really be fearful. [Tape recorder turned off.]

**Mullan:** You were going to say about being in the Peace Corps?

**Monroe:** I had decided that maybe I should specialize, and so I started applying for internal medicine programs, and actually at the Mayo Clinic, and then I later got accepted at Staten Island for the U.S. Public Health Service Hospital in internal medicine. I visited there on a dreary February day, and I just thought, "God, there's no way." I just sort of felt it wasn't fitting. I mean, it wouldn't fit. And so that's when I really became convinced that I really would stay at Group Health. I wanted to make my career here and do what I could to become successful. And that was a relief, to just sort of decide that. and in some ways it really left moot the training questions. I guess the kind of training that I had in mind was what some of the ER docs had. And especially I think in traumatology a little bit more. That's an area that I wish I had become more skilled in.

**Mullan:** What was the job at Group Health? What did you come back to?

**Monroe:** To practice, to do a general family practice, do OB and Peds and take care of families.

**Mullan:** You pretty much settled in as a full-time Group Health general practitioner?

**Monroe:** Yes. I also took up trying to contribute outside of the practice on the medical staff from the viewpoint of trying to make the system work better. A friend of mine who was a Peace Corps physician in Nigeria, Dick Smith is his name, he was in the Medex Program and came by and was talking about the Medex Program and I said, "Hey, we need that at Group Health." We were having all these young docs come stay for a couple of years until they decided what specialists they wanted to be, and then they'd leave. So there was a huge turnover of physicians. So I envisioned that the practice of the future would be a few people like myself and a bunch of Medex or physician assistants who would take care of most of the routine care.

**Mullan:** In today's lingo they would be physician assistants.

**Monroe:** Yes. And so we convinced Dr. Smith to expand his program. He was going to do it only for rural areas. So he expanded his program for us. And we took four of the first Medex class. And then almost simultaneously up comes this family practice thing. We had applied to a general practice residency and actually had just gotten approved to have a general practice

residency in Group Health, and it was going to be based on an internship year which was going to be required, then a year of outpatient rotations much like we were already doing with new GPs.

And then the Family Practice Movement came out, and so they converted our applications to family practice. We were actually the first ones to have an approved family practice residency in Washington. I was chief of the Family Practice Section during this time. That was when I became involved with FP training.

**Mullan:** So you preceded the university in terms of having approved family practice residency?

**Monroe:** Yes. I remember going over to the university. They said, "We want someone from Group Health to come over and talk about general practice, family practice." So I was on this med school committee for the family practice pathway and I described what it was that we did at Group Health. That was heavily influencing to them, because I remember the docs saying, "Oh, yeah. That's exactly what we had in mind." Before I went over, I was just talking to our group saying, well, what is it that we do and that we contribute, and so we were beginning to kind of develop this idea that we would take care of most of the patients' needs with appropriate specialty backup.

**Mullan:** Both of those programs, the medics program and the family practice program, were started in the late sixties, mid-sixties?

**Monroe:** Yes.

**Mullan:** What became of each of them?

**Monroe:** The general practice program, of course, was abandoned once they came up with the family practice program.

**Mullan:** You said you were approved for a family practice program.

**Monroe:** Yes, so we started off with six residents. Then I had a chance to be the first director of the Residency. I felt still a little uninterested in the political side of Family Practice, so we had another person to be the clinical director of residents. He got a Federal grant, so we doubled the program to twelve. Then he left. By that time, I had decided that I did want to be here in the Residency.

**Mullan:** So how long did the family practice residency continue? Do you have one yet today?

**Monroe:** Yes.

**Mullan:** How about the medics program?

**Monroe:** The medics, they're sort of physician assistants.

**Mullan:** That's continued on.

**Monroe:** That's continued on not as a training program. But their number was increased by hiring them on at GHC.

**Mullan:** Are there other residencies or teaching programs formally based here?

**Monroe:** Not formally. There was some training for nurse anesthetists.

**Mullan:** In terms of your practice when you got going, tell me a little bit about what sort of practice it was, who your patients were, how you got patients. How does it work with Group Health?

**Monroe:** In the sixties, one of the ways that we got patients was--you know, there were just so many of them, the patients would sort of stick with us, but we couldn't see them all because our panels were too big, and, in fact, the young MDs would leave to go into specialty training, that would enable us--of course, with growth we'd hire more docs, and a lot of them were just temporaries. So there was this big group of patients building up that didn't have a doc because their docs left so much. and so these patients would say, "Well, who doesn't leave?" "Well,

Monroe seems to be staying." So you'd have this huge group of patients. There was no way that you could see them all.

**Mullan:** In Group Health, does everybody have a primary care physician?

**Monroe:** A gradual development. The medical staff finally just said, "You know, you really need to panelize patients." And so it was done. As the patients came in, they were assigned up to a doc, once we realized we needed to do it.

**Mullan:** How large a panel would a person carry?

**Monroe:** Originally it was around 2,000, maybe slightly more. That's been whittled down so that it ended up being about 1,400.

**Mullan:** For a generalist?

**Monroe:** Yes.

**Mullan:** And the communities from which Group Health draws its clients?

**Monroe:** Very heavily working class, but also lots of university professors, teachers. And the co-op member, unaffiliated, that group bought the individual plans. That's where the leadership

has come from for the consumer. That's eventually shrunk as far as percentage-wise. So it's mostly now offered through business.

**Mullan:** So once upon a time it was individuals buying into--

**Monroe:** Once upon a time there was at least 50-50 individuals buying in.

**Mullan:** Fifty percent being individuals, 50 percent being health plan members of some sort.

**Monroe:** Right.

**Mullan:** Today it's predominantly various health plans?

**Monroe:** It would probably be like 80 percent health plan, 20 percent co-op. It's hard to know, because some people have the co-op membership but they actually have it paid through their work. Co-op membership gives you a vote.

**Mullan:** And does it give you benefits beyond traditional health services?

**Monroe:** The co-op membership is for consumer governance.

**Mullan:** And as the thinking of Group Health developed, I gather what you're saying, at one point it wasn't quite so clear that every patient, every member, needed a primary care physician?

**Monroe:** That's right. We would see the patients. It was sort of like you need to be seen by the doctor. Okay. Picture that. Here's the doc. He's going to see you. That was the way it started. But people like myself who were staying in primary care began to realize that that just was not workable, that you needed to have patients assigned to a doc, and we needed to feel more and more responsible. And patients liked the idea of having their own doc. So somewhere in the late sixties we began to institutionalize that. And that would be the question: who is your doctor? We kept trying to make that the norm, and now it is. It is the norm to have your own Doc. We always used to sort of feel "holier than thou" because Kaiser didn't do it that way; you see whoever is available that day and not see the same MD over time.

**Mullan:** As opposed to having continuity.

**Monroe:** As opposed to having continuity. So we early on valued that, and I think the family practice residency has also helped to solidify that. That was one of their main things, and it was one of their main questions about Group Health, could and do you have continuity, and how do you ensure that. I think that helped. That helped to reinforce the idea of the panel.

**Mullan:** Do many of the residents stay in Group Health?

**Monroe:** Until we stopped growing, yes. My goal was 50 percent, and we easily reached that.

**Mullan:** Fifty percent would stay?

**Monroe:** Yes.

**Mullan:** Over the years, what percent of your time do you spend clinically?

**Monroe:** When I started with the residency, I'd always been 100 percent and just did the administrative stuff outside. then with the residency I became 50 percent practice and 50 percent teaching. I've always felt that in order to remain credible clinically one needed to practice at 50 percent.

**Mullan:** That's pretty much where you stayed over time?

**Monroe:** Yes.

**Mullan:** And the residency was your principle avocation. Were you involved in medical administration and issues of other nature?

**Monroe:** Yes, kind of back and forth, helping get the Medex program started. Then I was chief of the Family Practice Section, on the executive committee. Then when I left the residency and became less involved and went into geriatrics, I became the lead in geriatric medicine.

**Mullan:** When was that?

**Monroe:** That started about in 1987, '88, 1988, probably.

**Mullan:** One of the major issues that comes up a lot in the policy base today is that word "choice," and whether an individual is getting sufficient choice or choice at all as they move towards a health plan or health option. What you describe, first of all, is a situation at Puget Sound where continuity is valued. Was there, and is there, any ability for a new patient, or even an ongoing patient, to exercise informed choice, like, "I'd rather have Dr. Smith than Dr. Jones"?

**Monroe:** Yes, and that has grown. Originally you could choose anyone, and then certain doctors got overloaded with certain so many patients so then the docs said,"No, you can't be that free. You've got to make sure that the burden is shared," because some docs are going to work more quickly. They're going to get negative, reverse incentives and stuff. So then the other side was, well, you can choose anyone you want if the panel is open. Then I think the free choice thing became more and more, and so

now there's a membership person who helps you to decide who your best bet is, sort of keeping in mind that the doctors' panel size and keeping in mind the patients' wishes. So now I'd say there's a very active plan to try to get patients attached to their doctor.

If they're not happy with the doctor, they either can change--one of the things at Group Health that we've always had to do is, if a patient gets mad at you or if you get mad at a patient, they're still stuck with the plan, so you have to try to negotiate. So patients who initially said, "I don't want to see that doctor again," sometimes the doc said, "Gee, I didn't realize that's how it came across," calls this patient up and kind of clarifies it, clarifies the issue, and says, "Well, okay. I see your point." Especially if it was over some sort of style. If it's over a sense that the patient is aggrieved about competence or that they missed a diagnosis or something huge like that, that it is probably best that a change in MDs takes place.

The Complaint Department of Group Health is really important, because it does lead to resolution of the issues. Sometimes that is a time when, it's a missed opportunity if the patient just leaves and you're right on the verge of some sort of resolution that could be very helpful to their health problems. So the Complaint Department here is a stressful place to work in, yet it's been entry level for a lot of our administrators that are now in high positions.

**Mullan:** How have you felt about your work over the years? What stands out as high points? What stands out as low points?

**Monroe:** I have this overall just really good feeling about my career with Group Health. I've really enjoyed it, and I've found many opportunities to do things that would have been harder to do had I not been in Group Health. I have been able to have a nice mix of clinical work with administrative work and also have felt like the amount of time that I've been able to have free and so forth are benefits of being in Group Health, having close association with physicians daily, not just being one-on-one with patients, but having this whole supportive cast and somebody you can call up and talk about a question with and there's no barriers between us.

And then having a role in training the new docs as they come in. I've seen them assume positions of leadership or going off into the community and being sort of advocates of the way we practice and the way we're organized. So I think that's just been really exciting.

I think the low points have really been few until recently with this change in the medical scene. What really disturbs me is the medical staff, which has really been, I think, the place where the germs of change have always occurred and that's where people have stepped forward to meet the challenges, I fear that there's this victim sense. Too many of our docs are feeling victimized, rather than sort of saying, you know, "What do we

have to do to change and meet this new challenge?" It's starting to happen, but it's not happening as fast as I'd like it to.

**Mullan:** If you looked at the evolution in American health care from the moon, from Mars, you would say, "Gee, we had a solo practice fee-for-service system, and by God, we're moving to a managed care system that features organized groups of physicians, and by God, Group Health of Puget Sound was there before anybody else. They must be in their glory days." And yet that isn't the case.

**Monroe:** No.

**Mullan:** Group Health is struggling.

**Monroe:** Right.

**Mullan:** Why?

**Monroe:** I think we've become inefficient. I alluded to it a little bit earlier, that we can't have it both ways, can't have all these perks, all this time off.

**Mullan:** Tell me about it just to get that on the record. What is it that the culture of Group Health has nurtured?

**Monroe:** I think we have nurtured getting sufficient manpower, making your day humane against production. The production has always been relatively on the low side compared to our colleagues in the community who are seeing sometimes forty patients a day, and if we see twenty-five patients a day, we feel like we may be overworked. And we also want to take time off for family, allow for personal growth. This means that somebody's got to be there subbing for you when you're not there, and you've got to sub for them when they're not there. So it takes more docs. Yet if salaries have stayed the same or increased, then we're relatively overstaffed in the community, and I think that's part of what the issue is right now, is that we have become too fat.

Whether the way out is to have more nurse practitioners and PAs, physician assistants, that probably is one way, but it's not the whole thing. I think that when we allowed our family practice section to be excused from after-hours care--you can do after-hours care for extra pay, but as a group to no longer have that as our responsibility, I think that's been a mistake.

**Mullan:** What is the pay range of family physicians working today in Group Health?

**Monroe:** The range, starting is probably like seventy or eighty, and it goes up to about a hundred and twenty-two or twenty-three thousand.

**Mullan:** And if one takes on night call or other responsibilities, that--

**Monroe:** You could get up to 10 percent more salary or something like that.

**Mullan:** Does the fact that Group Health finds itself in this difficult situation after years of being an outlyer and a potential leader in the field feel bad to you? How do you feel about what has happened to your practice?

**Monroe:** Well, I feel worried, partly out of selfishness because this is where I get my medical care, and I feel worried that some big change will occur that will make us not appealing, to my vision. So would we not make it? Would we be bought out by some other company that would just come in and be much more impersonal? The areas where I see us really sort of on the cutting edge is in organizing care for diabetics, for making sure that preventive care needs are met, anti-smoking, with our guidelines and pathways, treatment of illnesses and knowing what's important and what's the most cost-effective thing to do, evidence-based care. Those are the things that I think that we're really beginning to take a lead in doing. At the same time, we're pricing ourselves out of the market. I think that's the shame of it, is that all the stuff that we're doing because of our long-time stability and our records and patients over the years, we're losing that opportunity.

**Mullan:** There are those on the outside who might argue that there's a sort of welfare state existing here which is anomalous and atypical, a welfare state for physicians that isn't realistic and isn't supportive in terms of the perks, in terms of the backup, etc. Fair? Unfair?

**Monroe:** I think there's a point. I think there's a real point. I think that we need to get leaner, and that means either have fewer physicians or lesser pay, or lesser paid people taking care of more people. Where that comes from, we found out that if you eliminated the days off per month or per year, that you could add I forget how many new FTEs that you could add without increasing, the budget and there's just a lot of areas where that could happen and still maintain a humane practice. I think there's plenty of room to change and still keep the things that made us want to come here, which were some of the perks.

**Mullan:** It's argued by many physicians today that the last thing they want to do is be swept up in a managed system for whom they become "just"--in their language--"just" employees, and they're fighting that. Legally they're fighting that. Sociologically they're fighting it every way they can. As someone who has been an employee physician working in this setting for many years, are the physicians who are here anomalous in what they're looking for to the extent they're content, or is there a message to the physician community as a whole about what you have here at Group Health, as a physician who's worked in an HMO for thirty years?

**Monroe:** I have never felt like I was just an employee. I feel like I'm a member of Group Health medical staff, and we contracted through a health cooperative, and I've never felt constrained by the fact that I get a salary. I feel I have a lot of power and control in the GHC community.

[Begin Tape 2, Side 1]

**Mullan:** This is Dr. Monroe, tape two, side one, continuing.

**Monroe:** But I think an individual physician who feels that way, this may not be the right spot for them. The way you deal with it, I feel, is that you get active, you get active in one of the committees of the med staff or co-op.

**Mullan:** Of course, hear many arguments, a lot of which are not rational at all, but you do hear some that are not unreasonable. But it is less a sense of having a board up there, but it's working within an organization in which hours are determined and formulary is predetermined, and many of the options that physicians have felt were important to their individualized practice of medicine are constrained, I would think, under this setting.

**Monroe:** Yes, I think that's true.

**Mullan:** Again, is that something which can mix ultimately with the mainstream medical community? As you've observed yourself and your colleagues, you clearly feel it's a special place. Is it a special type of physician that can work under these circumstances, or does it have generalizability to the medical population as a whole?

**Monroe:** That's hard. I'd like to feel like that has generalizability, but I really don't know whether it does or not, because I've seen physicians leave for those reasons that you've mentioned. They don't like it. On the other hand, I feel like they're one against many when they get out into the community. Sometimes we've heard them sort of say, you know, really Group Health wasn't so bad. At least we have a say in how the organization changes and how they do different things. But I think that people have left us because they didn't like the idea that they couldn't always hire their help, that they couldn't pick a day off exactly when they wanted and would have to negotiate those things.

So to the extent that that's the way the outside is, if the majority of medicine people have all this power to individually influence their daily life decisions, then maybe Group Health isn't the right place for them. But as I see our residents getting into communities, they feel like things are so frightening and that there's such poor coordination of care that they really admire and feel nostalgic for us, for the way we

practice. But again, they're a special group that came to us. So I really don't know.

**Mullan:** What about patients voting with their feet? My understanding is that staff-model HMOs are not prospering in terms of the competitive wars of enrolling patients. Is that true of Group Health?

**Monroe:** It's my understanding that growth has really tapered off, and it's slow. I think that it's monetary. I think loyalty to Group Health is very much based on what's the best deal.

**Mullan:** In other words, they can get better--

**Monroe:** They can get a fairly similar package for less, and I think that's at issue now, not choice or things like that.

**Mullan:** What's bandied about in sort of a general deliberation is choice and that the group- and staff-type plans look to the consumer, particularly to the more high-rent consumer, the folks who are used to indemnity insurance, that the constraints on being able to get just the right plastic surgeon or whatever turn them off. So that having flexibility in your product, allowing individual flexibility in a product is appealing, and that the absence of flexibility for the Harvard Community Health Plans and the Group Healths is putting them at a disadvantage. Do you see that? Were you seeing that in your patients?

**Monroe:** I never have experienced that.

**Mullan:** But then you're seeing patients who are enrolled and presumably content.

**Monroe:** Right. That's true. I have been really shielded. I've had patients for thirty years. So that's not changed. I just don't know the answer to that.

**Mullan:** Are Group Health doctors, as a whole, content with lower salaries than their analogous colleagues in the community?

**Monroe:** I would say that their salary scale right now is satisfactory with all Group Health physicians, but that there was ten years, fifteen years, where there was really agitation to bring salaries up. What I hear is that our salaries are now comparable to the community.

**Mullan:** But at a time they were not.

**Monroe:** At a time they were not, and the family docs were generally satisfied. Certain of the subspecialists, orthopedics, cardiology, mostly surgical, were very dissatisfied and very heavily lobbied into getting salaries raised.

**Mullan:** And within Group Health, where you had now not freestanding people of the community but colleagues on a medical

staff where I would imagine the pay differentials, whichever you were talking about, were a factor of maybe as much as two or three? The family docs are making a hundred, were there people making two hundred and three hundred thousand within Group Health?

**Monroe:** There were very few.

**Mullan:** Making that much?

**Monroe:** Yes.

**Mullan:** Were there surgeons making $200,000?

**Monroe:** Yes. There'd be some neurosurgeons would be close to $200,000, and the guy who's head of the lab. It's interesting, though. We used to have what we called lifetime earning concept. Have you ever heard of that? That's where everybody in their lifetime, every physician, is equally valuable to the co-op, but some people had to take training longer before they could start to come to Group Health, so they had a shorter time to earn the same amount of money that a family practitioner might have. So a neurosurgeon would come after eight years of training, and would have a proportional higher salary at Group Health, but over his lifetime would earn would earn almost the same as a family doctor who started six years earlier.

**Mullan:** If he's making twenty thousand more than the family doc, that sounds like it makes sense. If he's making double or triple--

**Monroe:** Yes. It started to break down as the market force of supply and demand came into play. In the sixties and seventies, that was the philosophy behind the Group Health salaries.

**Mullan:** That makes good sense, but by and large, that's gone way out of whack. There is disgruntlement among generalist physicians about the differential between what they're recompensed for their labors and what their proceduralist colleagues are recompensed for theirs, and that's fairly clear. You don't have to be a PhD in economics to think that a factor of two or three difference for what are similar hours and not dissimilar training is, at some point, unfair. Within a tight medical staff, are those issues played out, and how?

**Monroe:** Yes. Primarily the way they're played out is by salary scales, by comparisons to the community, saying why we can't recruit, we don't pay the right salary. So there's sort of reality checks for those people who disagree, "We're sorry. We agree that it's not fair, but we need the type of cardiologist or we need that type of gastroenterologist, and this is what it takes to get them." And so if we're going to have to pay that once we get them, the people who are already here need to be on that salary scale. But it's a task force of the medical staff,

including some of those specialists who aren't making enough money who are on the committees, and then that's how they resolve that.

**Mullan:** In many sectors today where organized managed care is progressing, there are oft-stated sentiments that residents coming out of standard training programs in medicine, in pediatrics, in family medicine, aren't well prepared to work in managed care and that they really need re-training or focal training when they go to work for a managed care organization. These are coming more out of highly organized systems like Henry Ford in Detroit or Harvard Community Health Plan, where there is a sentient assessor of young doctors, as opposed to independent practice associations or whatever, where who knows? As you've observed doctors coming to work for you and as you've trained physicians, is that an issue? Is there something there that is curricularly different, that ought to be taught?

**Monroe:** Yes. I have thought that there is sometimes. In fact, that was one of the things we were always taught about having our residents program, if any, is that they can practice in a large setting a lot easier. The biggest problem, I think, though, has been more having to do with primary care, most of the subspecialty-trained people who never really dealt with primary care that could really handle a lot of issues. So I've seen it more as an issue between primary care and specialty, rather than HMO or un-HMO.

**Mullan:** I'm not sure I understand what you mean.

**Monroe:** In other words, that residents who come out like in pediatrics or in cardiology have no conception of what family practice can do and what they're capable of doing. And so there's this learning curve where they have to learn. Since we're a primary care base, they have to sort of learn what it is that we do and that they're doctors to patients but that they're also consultants to family practitioners. So that's what I see as the biggest problem in Group Health, is that it takes these specialists a while to learn how to work with us because we're primary-care based.

On the other hand, I actually say that, you know, one of the things that family practice has done is focus on preparing people for the marketplace and how to make money. If you can't thrive business-wise in practice, it doesn't matter how smart you are; you can't provide medical service. So there is a difference, though, between our residents and, say, a resident from a fee-for-service training, even a family practice. They see it when our residents come to them to practice there, and we see it when they come to practice here.

**Mullan:** How do you characterize that difference?

**Monroe:** For us, it would be not being aware of the cost of medications, not being aware of the need for formulary. It would be not communicating as well with their specialists and other

colleagues. And for us, when our residents have gone out, they call up and say they're used to helping to deal with the patient's problem over the phone and that doesn't bring in money, so they haven't learned what they need to do in order to make money. And when they come to us, they're not aware of what costs are, they're not aware that they're generating cost, that productivity isn't necessarily all great. But the real gaps, I think, are between just lack of knowledge in primary care and--

**Mullan:** On the part of the specialist.

**Monroe:** On the part of the specialist. I think that there's a lot easier interchange between our HMO-trained family practitioner and private-practice trained practitioner than there is between a subspecialist and an HMO.

**Mullan:** You referenced that the patient does have a say. I'm not familiar with how Group Health works in detail, but is that a presence in the examination room, where a doctor's aware in a way that's different than other practices that the patient does have a role in governance and is potentially a potent force?

**Monroe:** It is for me. I feel like I'm a doctor for that patient and I'm also a doctor for the co-op, and so I'm kind of charged by the board, or by the medical staff, to use the resources well. I don't have my pay reduced or increased by any decision I make with a patient. So sometimes there will be a discussion with the

patient about a treadmill or where they want a mammogram every year. We'll talk about that when we make the choices, and the reason we don't do them is because they would be too expensive for the value. You have to be careful about that because some patients don't like that. But some patients come to Group Health with that--especially among that twenty percent co-op, they're very open to that kind of discussion.

**Mullan:** The question of a patient being dissatisfied with you and reporting you or you getting in trouble with a patient, is that part of the environment at all?

**Monroe:** I think more and more, especially recently, that patients are upset with--you really want to know that. But there's always been this complaint. I can remember a patient leaving my office and we've had this interchange, I'll call the Complaint Department right away and say, "You may be getting a call from So-and-so. I just want you to know that this is my side of it, of what's happened."

**Mullan:** It's very, very interesting, what you've done. I want to ask two more questions about your career. One is about the career as a whole. You've expressed values starting from your Rooseveltian growing-up in South Dakota as a populist set of values, which, looking at it from the broad view again, seems to make sense where you've found your practice home. Is that fair? In terms of your values as an individual and the values you've

been able to pursue as a physician, these are not typical values of many physicians in America. Is the place that you've found to practice them one that you consider unique, or how do you feel about the melding between your personal values and your career?

**Monroe:** I feel at ease about it. I think the area that could have changed my life would have been the sense of competence to do general practice in an unprotected setting. I think family practice in Group Health is a somewhat protected setting. We have at our fingertips all of the various specialties and back-up, and, in a way, I think that was what I finally came to terms with. I'm never going to feel totally as competent as I would like to feel, but I certainly feel very competent in Group Health, and, I think, family. I looked at a couple of rural practice sites, and I wouldn't be married to the same person if we stayed there. So yes, I think there has been a compromise, but I'm content with it.

**Mullan:** Was there any kind of mid-career correction for you? Many docs reaching their fifties who have run hard at something for twenty years go through a kind of mid-life crisis or course correction of sorts, and some leave practice or do other kinds of practice. There seems to be consistency to what you've done. Were you aware of that kind of intervention?

**Monroe:** One of the things I hit on is survival, how to survive in Group Health. And what I finally decided was the way to

survive, and this probably was because I was already doing it, was do other things besides medicine, besides clinical, one on one, do other things, and that's how you survive, because I found that to be quite clinical was too hard all the time. At Group Health there was too much going on, and I think you get burned out.

**Mullan:** So what you're saying is, do other things.

**Monroe:** That would be like being chief of your section or residency director, teaching residents in geriatrics, committees. There's just a lot of things that you can do, and that way it gives you some time off. Your real satisfaction usually comes from your one-on-one practice, but some longer term satisfactions and some breathing room from the press of clinical activity comes from some of this other stuff.

**Mullan:** You've been an HMO physician for many more years than most physicians in America, all of whom are looking at the question of being an HMO physician to some extent today. If you had a message or a parting shot that you could pass along based on your experience, what would it be?

**Monroe:** To me it's that the physician has the power to make this thing work or not, and we should exercise that power by being involved.

**Mullan:** Tell me a word about your family. You've mentioned your wife along the way and that she went back and got training as a medical transcriptionist. I think you have three kids?

**Monroe:** Three boys.

**Mullan:** Tell me a little bit about your wife and your kids.

**Monroe:** My wife is now a professional musician. She does percussion, what's called historical percussion. She plays flutes and harps and recorders, and does performing and teaching at workshops which means renaissance and medieval. She doesn't do anything medical, although she did write a book on how to organize an AIDS care committee. A lot of her musician friends died off with AIDS, and so she was very active through our church--we're Quakers--in organizing care for people with AIDS.

Then I have an older son who--they're all musicians. The older one decided to have a job. He works for the state as a driver's license examiner. And then my middle son is a music theater composer, conductor, and lives in town. My youngest son is a jazz percussionist.

**Mullan:** The one they were looking for back in Wichita Falls.

**Monroe:** Exactly. Very good. He's very good.

**Mullan:** He travels, or he's based here?

**Monroe:** He's here, but he travels some. Our family hobby was music. We played in local symphonies, so our family, instead of playing soccer, we would go to the symphony rehearsals and concerts, [unclear] percussion instruments. It was fun.

**Mullan:** Have you continued to play?

**Monroe:** We do a lot of playing of early music now.

**Mullan:** You as well?

**Monroe:** Yes.

**Mullan:** Percussion?

**Monroe:** Percussion, recorder, flute. I took a sabbatical in '86. That's when I stopped being residency director, I took up the baroque flute, so I play that. I may be taking up the viola de Gamba here in the next few months.

**Mullan:** Did you see Tous Les Matins--

**Monroe:** Yes.

**Mullan:** That soundtrack is great. You mentioned Quaker. How did you evolve from Methodism to Quaker?

**Monroe:** We were very impressed with the way the Quakers dealt with the Navajo Indians. So we became interested in it.

**Mullan:** This was in Durango?

**Monroe:** Gallup. So we kept that in mind, and then when we came to Seattle we started attending Quaker meeting and liked it, and then when we came back from the Peace Corps, we joined. In fact, I had thought that I wanted to teach residents using the Quaker business meeting as the way to do it, which is very much into consensus. You talk things through. One person standing in the way of a decision can scuttle it if they feel strongly or they can stand aside if they want. So it takes a lot of effort. The first few years, that was basically the model. It still is somewhat the model, but it began to drive people kind of nuts. But I still like the idea of listening to every person as much as you can, and then, as a group, you decide what you're going to do. It was very much empowering to them. It was not the chief coming down and saying, "This is the way it is." You know, call schedule. What's the call schedule going to be like? They plan the call schedule. They deal with the problems. It attracted a certain kind of resident who really liked that the consensus way of decision making.

**Mullan:** Has religion been important to you in terms of your medical work?

**Monroe:** Not really. I think it's been more just sort of political and social and philosophic.

**Mullan:** Sounds like it is compatible.

**Monroe:** Yes, very compatible with medical work. We didn't go out doing any missionary things, and I don't feel evangelical. Most Quakers don't.

**Mullan:** No. On the other hand, the building of community, which Group Health has been, in a sense--

**Monroe:** Yes. It fits right in with that. People have sometimes referred to the Quaker Mafia in Group Health. [Laughter]

**Mullan:** There's more than yourself?

**Monroe:** Yes.

**Mullan:** Anything we haven't touched on that you'd like to comment on?

**Monroe:** No. It's been very good, very interesting.

**Mullan:** I appreciate it. Thank you.

[End of Interview]