JAMES REINERTSEN

Dr. Fitzhugh Mullan

Interviewer

Mullan: Give me your name and spell it please?

Reinertsen: My name is James Reinertsen--R-e-I-n-e-r-t-s-e-n.

Mullan: And your date of birth?

Reinertsen: Born on March 18, 1947.

Mullan: We're sitting in Dr. Reinertsen's office in the Methodist Hospital in St. Louis Park, Minnesota, on the 11th of September, 1996, overlooking a field of marsh grass I commented could be in the nether regions of Cape Cod but in fact is Minnehaha Creek where the marsh is adjacent to Minnehaha Creek. Dr. Reinertsen starts by noting that his principal identity in life is not as a generalist but as a medical subspecialist and that's something we'll talk about but before we do that I'd like to find out a little more about you and where you came from. Did you hail from these parts to begin with?

Reinertsen: No, I was born in South Africa.

Mullan: I noted.

Reinertsen: And spent my boyhood years in that country and my parents were Americans and my father ran a Lutheran school system with a Lutheran mission in South Africa. I did not grow up in this part of the world but came to the United States in my teen years and have lived in the mid-west, on both coasts and eventually settled back in Minneapolis about 20 years ago.

Mullan: Was your family from Minneapolis?

Reinertsen: No my father is from Texas and my mother was from Wisconsin. It was kind of an all American family from all over the place.

Mullan: This was safe Lutheran terrain you were returning to?

Reinertsen: Safe Lutheran terrain to return to. That's correct.

Mullan: What can you tell me about life in South Africa as a youth.

Reinertsen: South Africa was an interesting place to grow up in. I lived in about six or seven places, mostly rural, went to a boarding school which is what every child in South Africa generally did who lived in any kind of rural area. There was

nothing privileged about it. It was a government school, English school system, wore uniforms--gray flannel slacks, white shirt, and green blazers and little caps and had a very disciplined kind of a school setting where we learned reading, writing, and arithmetic and how to get along. In retrospect I find it to have been a very good educational system. Health carewise, etc., South Africa was obviously a divided country. Very good health care system if you had the right skin color and very hit-and-miss health care system if you didn't.

Mullan: Was the Apartheid existence move in place at that time and that was `53 or something?

Reinertsen: Very much so. Apartheid was at its height, as a matter of fact, during my childhood and it was a very evident fact. I mean, my father worked with black educators for most of his life and apart from that, we did live in a city of about 25,000. He had meetings of his faculty and his staff, in our home in a white area, and we would have to draw the curtains and hide their bicycles and motorcycles in the back garage so that there was no evidence that we were having a meeting. Just having a meeting with your co-workers in your own home was regarded as a dangerous activity.

Mullan: And did that have an impact on you in terms of shaping your world, shaping your growth development and consciousness.

Reinertsen: I think it would be presumptuous to say that I was terribly aware in a different way about this as a kid then any other kid was in South Africa. I was a boy and having fun and going hunting and fishing and generally enjoying myself. Yes, I was aware of this. I thought it was the normal way for things to be until I realized this when I got to be about 15 or 16 that it really wasn't that way around the rest of the world.

Mullan: And how old were you when you returned to the States?

Reinertsen: 14.

Mullan: In South Africa did either doctors or medicine or health care play into your experience in any way that influenced you?

Reinertsen: In a very major way. My father and mother died when I was twelve and for three years I lived in--

Mullan: They both died simultaneously?

Reinertsen: In an auto accident. And so then I lived for two years with a medical missionary who was the appointed guardian for our family--my brother and sister and myself. His name was Dr. Erling Hestenes and he was a generalist. A really remarkable man. He ran a large mission hospital in a remote area of

Zululand and at the time we lived with him there was one additional physician there, Dr. Art Hall, and some missionary nurses--three or four of them--and a cadre of trained nurses that he had trained, and they had trained in their own nursing school. They ran the functional equivalent of a 200-bed hospital and did a very good job of it. He had gotten some additional training in ophthalmology and ENT because they were much needed additional specialty skills. On any given day he would round at 4:30 in the morning on the general wards and then go on to a specialty clinic--one day the obstetrics and one day it would be ophthalmologic problems, etc. He did surgery a couple of days a week, including pretty significant surgical procedures and generally did everything there was to do. Including, I should say, when he first came to this area called Hlabisa--right next to Hlultluwe. But when he came there was a sort of dispensary of sorts and he was assigned to build a hospital and he realized that that was something he knew how to do but it wasn't really the point. His first months there were spent designing and building a water purification system for this little village and the people who lived there. That was the most important contribution he could make to their health, not to start doing the surgical procedures.

Mullan: Uh-huh.

Reinertsen: And I don't mean to try to make awkward segues to the subject of generalism but try to think about it, that's getting about as general as you can imagine. He was a sanitary engineer and a water systems engineer. He could design pumping systems and the whole deal for a community in order to get started plying his craft and his trade as a physician.

Mullan: And you lived with him for three years?

Reinertsen: Three years.

Mullan: And did that court medicine into your mind as a career possibility?

Reinertsen: Oh, very much so. I was quite impressed with what he did and how he did it and as much with the spirit of good cheer that he had as he went through this whole process as anything else. There was a man who worked 16, 17 hour days, day after day, and always seemed to be having fun. I can't describe it any other way. That made a big impression on me.

Mullan: And it was decided then at 15 you should came to the States?

Reinertsen: We came back and lived with my uncle and aunt, my designated guardians in the United States. My parents had anticipated that something like this could potentially happen and had actually designated guardians in both countries.

Mullan: Uh-huh.

Reinertsen: My uncle and aunt remained my next set of parents, if you will, for the remainder of my life and are still living, they retired and live down in Texas now. He was a pastor in a small town in Iowa.

Mullan: And what was it like re-entering? Where did you go and what did you do?

Reinertsen: That was really sort of interesting. I had to reform my ways. Despite my interest in the fine science of medicine, I went away to boarding school, of course, all through this time and I had become pretty much of a juvenile delinquent socially. So I had to reform my ways, stop smoking and drinking and riding motorcycles and become a pretty good kid, if you will, in a small town in Iowa.

Mullan: Where was it?

Reinertsen: Humboldt, Iowa. So I did. You fit in as a kid and its one of those things you learn to do very quickly and I adopted the mores of a small town in Iowa and found that to be very good. I went to school, learned American sports, adapted and adopted the ways of my new land as quickly as I possibly could. That's what you do as a kid to survive.

Mullan: Uh-huh. Did the religious environment in which you grew up father, uncle, at the least, play a role, obviously it played a role in forming who you are, but in terms of your values that led you towards medicine. Has that been a factor?

Reinertsen: I can't think it wouldn't have been. I've thought about it a lot, I've contemplated enough even to have given talks about it in my own church. It seems to me that I regard healing to be at least partly a gift that comes from outside not just the things that we do for people with our pills and our scissors, etc. I think that has been part of my thinking about health care and healing all through my training. Recognizing, without really ever consciously doing this until much later in my practice, to tell you the truth. Spiritual health was a big part of why some of my patients were doing well and some weren't. And I was not conscious of this at all, you know, going through my medical school and residency and fellowship training. In fact, I doubt

it was ever mentioned. But I certainly learned my lesson when I started practicing and becoming courageous enough or secure enough in my sense of my doctoring to be able to ask some patients some questions about this and was surprised by the degree to which patients had sort of warmed up to the issue and were waiting to talk about it but never had been invited by any physician. I should say that it did not become--you asked a question, so I'm giving you an answer--it has not become an issue where I have been proselytizing in the waiting rooms and it has been something that I felt out with individual patients from time to time. Every time I have ventured across that line and asked a question about spiritual relationships to the illness, I have found a very, very interesting and effective new place that we can dialogue about. Me in my healing role and the patient in the patient role--it's been an experience that I found very positive.

Mullan: That's fascinating. I was actually asking from a slightly different angle which was the impact or the effect that you're religious exposure had on your values in terms of your role in life and whether your decision ultimately to go into medicine was in any extent mediated by or catalyzed, stimulated by a religious precept being your brother's keeper or any other aspect of religious thinking?

Reinertsen: I don't think so. Not consciously anyway. I was the black sheep of our large family--my uncles, aunts, etc. I come from a long line that's either been preachers or educators and that's it. No doctors. So I suppose you could say we were all in public service of some kind. But I think it's a little bit of a stretch to say that it was consciously coming out of some religious background.

Mullan: So you adapted, you became an Iowa non-juvenile delinquent and at some point you headed north for college. Is that right?

Reinertsen: I went to St. Olaf College in Northfield, Minnesota, a Norwegian-Lutheran college that is typical destination for a lot of missionary kids from around the world but also, of course, from people of midwestern or otherwise Norwegian-Lutheran descent from all around the United States and spent four good years there. I was pre-med and more or less focused in on that subject although I would say that again I'm not sure that I got any inculcation while I was there that either reinforced or didn't reinforce the desire to be a doctor. I'd made a decision I wanted to be pre-med and I went in there and did it. It was kind of like you got out the other end and there really wasn't anything there that spoke to the issue was that a good choice or

not. Now you were well down the road, you were in medical school and then you started to find out what doctoring was really about.

Mullan: Did you have second thoughts as you went down the road?

Reinertsen: No.

Mullan: Did you major in a science?

Reinertsen: I majored in chemistry and I had a biology major as well but it was, you know, a classic pre-med course. I took the minimum major in chemistry because my real love and real interest were in other things. I mean I didn't like chemistry so much. I liked literature (laughter) and so I spent all my possible course time I could studying world literature and various other parts of the arts--music in particular.

Mullan: And locked in as you were in pre-med, tell me about your choice of medical school and what that was like.

Reinertsen: Well, I was fortunate enough to be accepted at three schools in Minnesota, Johns Hopkins and Harvard and I chose to go to Harvard. In retrospect I'm not sure why I chose Harvard. It had a fancy name and it was away from where I was. I wanted to

go away, I wanted to see a different part of the world and I kind of tossed a coin between Baltimore and Boston and decided to go to Boston.

Mullan: And how was it?

Reinertsen: Harvard was a fascinating place. I owe a great debt to that institution. I got exposed to some of the most interesting people I could ever hope to be exposed to. My class, my medical school class, was far more diverse than any group of people that I've ever been closely associated with before. So I learned about different perspectives, different ways of thinking, different approaches to just enjoying life let alone studying, working and communicating. And these people, every one of my 150 or so classmates in of themselves, an interesting, fascinating person. Not a boring lout in the bunch. There were people you might not have liked particularly but that's expected. They were very stimulating people to be around for four years and I enjoyed that experience immensely and I think I got a great deal out of it.

Mullan: And as you went through that what texture did your interest in medicine begin to take? What were you thinking of yourself as doing?

Reinertsen: Well, I really thought of myself as being a contributor to the world of research and an academic type. I mean, those are the role models that were right in front of us all the time. The great heroes were the triple threat academicians. You know, the classic researcher, teacher and consummate clinician kind of person. And there were enough of those around Harvard Medical School that you sort of thought well, gee, that would be the ultimate thing you could do. So as I went through my training I did a couple of things a little differently. I did not spend a lot time kind of getting ready to go to my clinical clerkships. The earliest you could go to your clinical clerkships was after 18 months at school and not after a full two years. And I went right from the last pre-clinical class right into three months of my medicine clerkship. And I took my medicine clerkship at Boston City because I wanted to immerse myself into the process of the care, I didn't want to be sort of standing in the backdrop watching others deliver the care. So I was very early in my medical school experience when I went right into the deep end of the pool and to swim. I was just hungry to find out what being a doctor was really going to be like, I guess. I didn't quite drown, I sputtered a few times but I got a lot of my clinical work right done in that late sophomore, early junior year of medical school and then had a lot of time to sort of look around. I actually spent six months or

so doing research in the radiation therapy lab, radiating little mice, as a matter of fact, taking out their spleens and grinding them up and doing strange things to their lymphocytes. I really was tracking on a cancer research track. So that by the time I was preparing to be a senior, I had signed up on one of these plans, I don't even remember the name of it now. We call it the yellow berets plan--

Mullan: CORP--Commissioned Officer Reserve Corps.

Reinertsen: Commissioned Officer Reserve Corps--there you go. I was assigned to go to the National Institutes of Health to do research after I completed some years of my additional training. I got a commission and I was ready to go down to NIH as my next stop after doing some internship and residency.

Mullan: And you did internship?

Reinertsen: UC San Francisco. I wanted another change of venue as people often do after years of medical school and I wanted a general hospital experience like Boston City. So I looked at hospitals that had that kind of a reputation, Harbor General, Parkland, etc., and I chose San Francisco General. It was a nice city and it was a great internship. It was another deep end of

the pool experience.

Mullan: And you decided on medicine?

Reinertsen: I decided on medicine. In retrospect, it seems like all the people who were in our immediate environment, who were revered as great diagnosticians, as clever people, great role models, caring folks, kind of the triple threats were mostly concentrated in medicine and subspecialties. Although, there were many exceptions to that. That was an impression, I think was fairly widely shared amongst my medical school classmates. The smartest fellow in our whole class, a good friend of mine from college days lived in the same apartment with me, surprised everybody by choosing to become a radiologist and many of us, just assumed, that he would become, you know, the next great internist in the world. And it shook up a lot of us, that he had chosen to do that instead of to take medicine residency.

Mullan: Uh-huh. And the notion of becoming a general internist was not, particularly at that point, I know revered much. Was that much on anybody's mind?

Reinertsen: You know, I don't think that any of my classmates--I'm probably wrong--but I can't remember anybody coming up to me

at that point saying that's what I'm going to do. Most of them saw general medicine training as a way towards a subspecialty or a research kind of special interest. It was a necessary path which you had to walk in order to do what you eventually wanted to do. In my case do cancer research.

Mullan: Uh-huh. So you went to San Francisco General. How was that?

Reinertsen: Well, that was, as I said, another deep end of the pool experience. It was a fascinating place but it was in the pre-AIDS era so that San Francisco General was a place where everybody in town who dropped on the street or otherwise didn't have a place to go came when they were desperately ill. A huge patient population. Rampant with tuberculosis, a variety of other infectious diseases. Interesting problems in all the self-destructing behaviors of life. And then an amazing group of people who were just down on their luck or just not quite, just never got lucky, who were striving to make it in the world and got ill and wound up in this place and so it was a wonderful mix of patients and a tremendous opportunity for self-direction and responsibility. Now that's not to say we didn't have any faculty instruction but I can just tell you that it was different there than it was at the University of California. We had a lot more

responsibility and took it as residents.

Mullan: And you spent three years there?

Reinertsen: Three years.

Mullan: And did you like San Francisco?

Reinertsen: I liked it a great deal. My wife and I had no children at the time and it was like one long date.

Laughter.

Reinertsen: We had no money but that didn't seem to matter. We just, you know, ate out three, four times a week, went to shows, it was just like one long date.

Mullan: You got married along the way? When was that?

Reinertsen: Got married after my first year in medical school.

Mullan: You met --

Reinertsen: We met in college. In the orchestra, as a matter of

fact.

Mullan: And what did she do? What does she do?

Reinertsen: She was a teacher then and she is teaching again now. But in between when we went to San Francisco, she's a Latin and English teacher, she taught in Boston, San Francisco she went into the banking world and became a very successful banker with the Chartered Bank of London and then left that to become a Mom and raised our two children, did a variety of volunteer things and now after much prodding from the rest of the family, because she really is a wonderful teacher, she is teaching eighth grade English again, full time here in Minneapolis.

Mullan: She didn't get tempted back into the world of high finance?

Reinertsen: No, she realized that she could make a really good contribution here and I think is very proud of her work. She should be, she does a nice job.

Mullan: So at the end of three years in San Francisco you had the NIH waiting for you.

Reinertsen: Yep. And by this time I'd also decided that cancer care was not the clinical outlet that I was interested in. I became, I realized that my interest in cancer was simply because I was doing immunological research and that would seem to be a hot bed of work. But the clinical outlet "cancer care" as I experienced it during my residency was not as exciting to me as some other areas so I said what else can I do with an interest in immunology? And it turns out that I went to NIH and negotiated my way out of Paul Terry's lab and into a lab in the arthritis and rheumatism branch of NIH because I could use my immunologic interest there and said "Well, maybe I'll find out if rheumatology is a clinically interesting discipline." It was about that conscious a decision. I had not disliked rheumatology in my residency. I'd certainly not liked what I saw about cancer care and a lot of the terminal struggling that was being done with patients. It seemed to me anyway, a very futile kind of struggle. So that's what had turned me off on oncology as a discipline.

Mullan: The life and culture at NIH certainly the Corps folks who spent time there many have succeeded to leadership roles throughout the country in medicine, I think at NIH they often look at that as a (unclear) at least for young investigators since the Vietnam situation and post-Vietnam situation steered a

lot of folks into the lab there that might not have gone otherwise. How did you feel about it? What was it like? How do you look back on it?

Reinertsen: It was a very important experience for me because I discovered that I did not like the research environment that I got myself into, and therefore, began to question the whole idea of an academic role for the rest of my life. Without going into a lot of detail, I wound up in a lab where I realized I couldn't ask questions that were important, if by important you mean the answers would change things for the better. But I could ask for questions answers to which would be publishable. And it bothered me. It bothered me a lot. So I did a little of that, I mean I was a good soldier, instead of asking questions to which an answer might be really important (high risk, high reward questions). I wound up doing some studies that wound up being publishable.

Mullan: Meaning that the results might be trivial but they were another step down the path that others were interested in and therefore they were of publishable interest? I understand the concept, what were some examples?

Reinertsen: I think the questions being asked were questions

that no matter how the experiment turned out the answer could give you--you could generate a paper from it.

Mullan: Uh-huh.

Reinertsen: Whereas if it turned out that it was something that worked that would, in a therapeutic kind of a way, that would be useful information and if it didn't work you'd go back to the drawing boards and nobody would ever know about it. I was not comfortable asking these questions that sort of were designed for academic advancement rather than for better results for patients.

Mullan: Uh-huh.

Reinertsen: To be very blunt about it and I was also--I became aware of--and this was maybe very isolated in this lab--I would hate to tar the NIH with this particular brush because I don't think it would fit at all. But in my particular lab I was not particularly happy with the level of data integrity that was there. So after six or eight months I left the lab and I sought refuge with a wonderful mentor, John Decker, who was the administrative leader of the arthritis branch at the time and I think was eventually the clinical director

Mullan: Director of the Clinical Center.

Reinertsen: Wonderful man. And he said I understand and

Mullan: What was he doing then? I'm sorry.

Reinertsen: He was the, I don't know what his title was, he was the director of the arthritis/rheumatism branch, ARB, and it was about that time I think it changed to NIAMDD but that's a whole other matter. And he put me in the hands of Jack Klippel. And Jack so--

Mullan: Klippel?

Reinertsen: Jack had just come back to NIH and was one of the younger research directors there and was not in a lab as such doing a lot of research but was more involved in clinical research protocols and Jack and I did some interesting studies on genetics and family influence and a study on whether or not dogs caused lupus or not in humans. It was wonderful. It was interesting to me because it was relevant. The questions that might have to do with public health, a variety of other things and I had a great experience but it--the whole idea of doing bench research as a lifetime pursuit just kind of faded away and

I realized that my real interest, and probably my real skills quite frankly, were in relating to patients, thinking about the patient in a context of the human systems and social systems that those patients worked in. I found myself doing a self-assessment that said you know, I don't think I'll be very good at doing research the rest of my life. As an academician and the triple threats, I would have been a great teacher, I think it's a skill I've got, I would have been a good clinician, and I would have been a lousy basic researcher--is what I learned. Partly because I didn't like the machinations you had to go through to be successful in research.

Mullan: Uh-huh. So you finished out your two years and headed back west?

Reinertsen: I came here to a large multi-specialty group practice at the time called the St. Louis Park Medical Center. I'd actually been sniffing around this place for a couple of years before that, I'd come here at Christmas time to visit my wife's family and just on a lark I knocked on the door of the medical center, at the time there was about 100 doctors, and asked to interview with somebody and just find out what it was about and I wound up spending almost two hours at the end of the practice day with a physician named Bud Green. He had been one

of the founders of the organization. He opened my eyes to an interesting thing I'd never thought about. All my life in academic medicine I had had this picture of the practicing physician out there in the community that was somewhat distorted. I don't know whether I thought of them as not quite as bright as the academics or what but it was certainly that flavor that was transmitted by the academic environment. But here was a man who was brilliant. A wonderful physician. Had all the tickets and tools and had done all the wonderful things that you could imagine is practicing in a setting, and he had an ethical and community commitment sense to him that was really noticeable. And it was really clear that it infected and infused the organization by the kind of people that had chosen to become part of it. It made me realize that nobility of purpose didn't have anything to do with these academic centers necessarily. You could find them there, to be sure, but that it was not an exclusive property, that there were noble physicians working to really better their communities and to improve knowledge and to deliver excellent care to teach others. Working in settings that were not academic. I later described it in a paper that I wrote about the organization called "Not Quite Private Practice." Because there was a tremendous academic commitment within the organization to research and teaching that was very meaningful and was very attractive to me. So I had a place that I could go

that wasn't quite selling out the academic environment, if you will and going off to drive a Porsche, you know, and be a rich, private doctor. I had some guilt about leaving academia and this organization filled the bill beautifully for me. So I joined and became a practicing rheumatologist.

Mullan: Two tracks. One, tell me a bit more about what sort of historically the context of the St. Louis Park Medical Center was at that time. Had it been formally enrolled in the ranks of the prepaid or managed organization? I mean, was that extended in Minneapolis at the time?

Reinertsen: Well, let me give you a little background. It was formed as a eleven physician multispecialty group in 1951 when such things were regarded as socialist if not worse and it had grown dramatically through the years. It was in 1971 that it, as an experiment, formed its own prepaid health plan. Mainly because the doctors, these idealistic doctors I was describing, thought it was terrible that most insurance coverage didn't include physicals and preventive services. The pediatrician stirred up the group and said let's do one of these prepaid things so that we can give preventive services to patients without them having to pay for them. And so that prepaid plan actually, because it couldn't be owned by the clinic, it was

started under a separate organization, it grew up over the years, eventually went through adolescence, moved out of the house and did its own thing. It's now what's become HealthPartners--a big HMO in this town. After mergers with several other organizations.

Mullan: This is not Group Health. This was the physician--

Reinertsen: This is not Group Health. Group Health was the other piece that became HealthPartners--this was Med Center Health Plan. Yes, at the time I joined the clinic Med Center Health Plan probably had 40,000 members, I don't know exactly, and it grew very rapidly to become well over 100,000, 150,000 by the mid eighties.

Mullan: Let's come back to that theme. I'm very anxious to understand better why this phenomenon took root so much more effectively here than elsewhere. But let's walk on through. The other is a personal theme. At that point what did you see yourself as a clinician and when you went to work for the St. Louis Park Medical Center as you did, is that right?

Reinertsen: Uh-huh.

Mullan: What were you doing?

Reinertsen: I had just completed my rheumatology boards having done two years at the National Institutes of Health as an alleged fellowship in rheumatology. And you have to understand that that's a very strange fellowship. I didn't see a single case of acute gout but I saw 400 cases of serious lupus. I mean, it's very distorted. And so I actually went into practice thinking I knew what I was going to do in practice and my schedule was booked out about six or eight weeks the first day I came in. They'd been waiting for me to come. I was the second rheumatologist in the group. And I will tell you that I learned all the rheumatology that I really learned mostly in the first six months I was in practice. It was really scary. How little I really knew about clinical care after that kind of a fellowship experience. But the first day I was there I had a 19 year old kid show up in my office with septic hip, I mean it was a really deep end immersion experience in clinical responsibility. I had only one other experience like it which I ought to mention to you. It was during my residency. My former chief resident, when I had been an intern and that dates me by when I call it intern, but anyway, he had been chief resident when I was an intern and went up to a small practice in Eureka, California, with three other general internists. When I was a third year resident he

said, "Would you like to switch with me for six weeks or so?" I'll come down and do your nephrology rotation and you come up here and fill in for me. I like to get back to the city and kind of do some academic things and get another booster shot of education." So we went to the residency committee and asked if we could do this and they thought this was the most bizarre thing they'd every heard of. Is it possible we could lose our residency accreditation. I went up there and in the six weeks I filled in for him as a generalist in Eureka, California, I learned more medicine than I learned in the other three years I'd been in my residency. I mean, I saw incredibly sick people and there was nobody else but me to take care of them. I will never forget being on call the first night up there in this farm house, like 15 miles from town and get awakened with that call when you're sort of still half asleep and the ICU nurse says in this little hospital, you know, Mrs. Johannson (phonetic) or whoever, needs a pacemaker. You know, she's gone down into complete block or whatever she was saying and I in my sleepiness said, "Well call the cardiac fellow." There was this long pause and then she said, "Uh, Dr. Reinertsen, up here you're the cardiac fellow."

(Laughter)

Reinertsen: And you know, that was a real, real, deep-end

immersion experience as well. I value that immensely. Here, coming to this clinic, I learned a lot of clinical care in six months on the job. I don't know whether my experience is atypical or not. My guess is that there are much better clinical experiences than the NIH for training. I sure hope there are. But I was allegedly a board-certified rheumatologist at the time.

Mullan: So walk me through rapidly your clinical experiences. I'm anxious to get to your management experiences. How did things develop for you?

Reinertsen: Well, I had a full practice, as I said from the day I walked in. I enjoyed it. I spent a lot of time working on getting better at it. As the years went by I got more comfortable with my skills and as I indicated earlier I started to kind of explore other ways of approaching people with chronic pain problems and rheumatologic problems. I suppose the great epiphany events came in a couple of instances. One where I had a patient who had very mild lupus but it was not the main problem and she had gone through a divorce and you know, had an ulcer and had a whole variety of very stress-related illnesses over the course of six or eight or twelve months. And she kept kind of "woe is me, I'm never going to get over this" sort of approach to life. And one day in my office, I'd gotten to know her pretty

well over six or eight years, I finally got a little exasperated with her and I don't remember exactly what I said but it was pretty much like "your going to have to decide to get up off your butt here and get on with life already because I'm not getting anywhere with you just trying to treat everything that comes in. You've got to make a decision." And I kind of scolded her a little bit. As a physician I had never done this before in my life. I thought--and she got very mad and stalked out of my office. And I thought oops, it was a negative reinforcement for actually being honest with her about how I felt about what I thought was not a medical problem, it was a different issue. And about five years later she showed up on my schedule again.

Mullan: Without having been there in the interim?

Reinertsen: Right. And I was scared. I thought she's going to come and sue me or tell me something terrible. And she walked in, she looked like a million dollars, was dressed in this fancy suit, had rings all over the place with large rocks on them and she said, "I know you remember the last time I was here when I was really mad" she said. I wanted to come back and apologize to you. She said, I stormed out of here after saying some really bad things to you and I fumed for weeks afterwards and I finally said, "I'm going to show him." And I went out and I started work

on that stuff and well to make a long story short, I started this company, I just sold this company for five million dollars. And she said, "I came back to thank you for giving me a kick in the butt."

(Laughter)

Reinertsen: And, you know, it was a reinforcing experience--I'd not done this technique very often--but it made me realize I could be a human being with these people, I didn't have to always be behind my doctor's shield.

Mullan: Uh-huh.

Reinertsen: And there were times when it was okay to step over the line a little bit. And I started doing it a little bit more and it actually turned out to be something that I indicated earlier that opened up a lot more interesting dialogue with patients.

DR. REINERTSEN - Tape I - Side 2.

Mullan: Your work during these years was principally in rheumatology? Were you doing general medicine as well? This

story sounds more like general medicine than rheumatology per se.

Reinertsen: Rheumatology is a large dose of general medicine. In our clinic, we do take generalist responsibility for a number of our patients. We were the person they would call--my definition of being a generalist or primary care physician is that if somebody--that your patient would call for help anytime of the day, nights or weekends with any problem, you'd be the person they would call. I did fill that function for many years. For a large number of my patients. Others of them I didn't. For a variety of reasons. I would be sharing the responsibility with somebody else, a primary care physician usually, or could only have been in the role as a temporary consultant.

Mullan: So how did your medical life evolve then moving from clinical medicine to more managerial activities?

Reinertsen: Well, that's a long story but I'd been asked early in my time at this large clinic to take a role as a medical director of a small venture that the clinic was starting--a health improvement company called Shape (phonetic) which sold personal health counseling and fitness and stress management and nutrition advice services to individuals either as part of executive physicals or in corporate settings in large groups,

etc. I wound up eventually running a little company of six employees. I had to learn what it meant to make a payroll every month, I had to learn what FICA tax was, I had to learn about business controls--it was a great learning experience for understanding the complexities in managing a business enterprise.

Mullan: What year was this?

Reinertsen: This was in 1979--one year after I came to the clinic, but more intensively 1980, '81, '82, '83, '84. I was really spending up to about half of my time eventually as the president of this little company that was a venture of the clinic. And so that was my training ground. I had no, absolutely no formal business training but then when it was needed--somebody was needed to be the president of our research foundation, I was asked to take that added responsibility and then in 1986, just a couple of years after that, our clinic in one of its periodic cataclysms, which happens in clinics like ours, decided to relieve its current leadership of responsibility and asked me to be the chief executive of the clinic which was another deep end of the pool experience administratively speaking because at that time we were 275 doctors in a complex business and a very difficult marketplace and so I've been doing that ever since.

Mullan: And then the Park Nicollet Clinic became the name of the corporate structure somewhere along the way?

Reinertsen: Park Nicollet Clinic became--was the next iteration of the St. Louis Park Clinic. As of 1983 we merged with the Nicollet Clinic and then in 1993 merged with Methodist Hospital to form something called Health System Minnesota. So we had a fully integrated care system of some 400 doctors, 30 doctors' offices. We take care of close to 20 percent of the people who live in Minneapolis and its suburbs and provide a comprehensive set of services for them--everything except solid organ transplants, in-patient mental health, and long-term care. We do just about everything else ourselves.

Mullan: Uh-huh. But back in 1986 that's when you took on the CEO role? You'd been president of the Park Nicollet Medical Foundation prior to that?

Reinertsen: Prior to that, I was.

Mullan: Which was more of a--

Reinertsen: It's the research and education organization within the family of organizations that we have. It does about now 13

million dollars a year of funded health services research, chronic disease education, professional education--it's where our residency programs and fellowship programs are housed, etc.

Mullan: But it(unclear) CEO

Reinertsen: Of the clinic.

Mullan: And how was that and how did you do with swimming out of the deep end of the pool on that and does that continue?

Reinertsen: Well, I'm still occasionally going down for at least a second time. But it's been a wonderful learning experience. Some of my gratification that I used to get from a hug from one of my patients--I now get when I see a dramatic improvement in a care result, for let's say like myocardial infarction survival or breast cancer diagnosis. My gratification comes in seeing a control chart of improved performance on some care outcome. I've begun to realize that that's an important role as well--to be able guide and steer a system so that its physicians and nurses can work together in a team to make care better--and I drive home at night now and instead of a nice hug and a feeling I've done a good job for a patient--I can go home with a nice feel thinking that I've done a good job for 300,000 patients.

Mullan: Do you remain clinically active?

Reinertsen: I continued to practice for years in a consult role only. I couldn't really continue any primary care responsibility for any of my patients after 1986. Although it's a tribute to their tenacity and to my reluctance to give up the relationship that a certain number of my patients persisted in regarding me as their primary care doctor through all of those years. Until I finally had to say this isn't working anymore. As of January 1, 1996, I am no longer in practice. That was a very hard thing for me. I remember writing a letter to all of my colleagues saying that I was officially not going to be practicing anymore after this time and thanking them for their support and seeing my patients with me all these years. It took me hours to write this letter because I couldn't see the screen, I was bawling so much. It had taken me two years to make the decision and I'd never let the emotions come out until I wrote the letter. Then I realized how many emotions there really were around this. I really liked what I did and I had gotten to be, I think, really good at it. It had taken a lot of work to get there and it was really hard to stop.

Mullan: What has impelled you along this different course and give it a little texture--as I look at your bookcase you clearly

have studied the art of management. Why and what's it been like and why did you make the change of course?

Reinertsen: I think it has less to do with my physician role than it has to do with just a personal drive that I've always had to lead things. I don't know that I can describe it other than to say when opportunities have been there to lead, whether its the trumpet section of the orchestra or the organizing for the development of the float for the fraternity, or what, I've always--despite my best desires to steer clear of leadership roles in many instances gotten sucked into them in one way or another and I find, now that I know myself a little better, almost 50 years old, I sure hope I've learned a little bit about this, I found that I can't fight that. I mean its something that I have within me so when there's a need that seems to be identified for somebody to step in and take a leadership role, I have wanted to step in and do that. Especially if nobody else has sort of filled that vacuum. And this is something that I sensed that had happened here and I periodically get that reinforced. Its a dangerous thing because if it's a self-deception and nobody else wants you to do the leadership job then your kidding yourself and everybody else and it soon becomes apparent. So far I haven't gone so far from my roots, if you will, that separated myself too far from my colleagues. I regard

myself as their servant in this matter, by the way, I think that's a really important part of this. I'm trying to make this the very best practice environment they can have. So that they can do their work really well. So they are my customers rather than somebody I order around. In fact, I would delude myself severely if I presumed that I was ordering them as clinicians in any way. I have very little direct authority in that respect.

Mullan: The taking on of this strikes me in having something in common with what you characterized as your first exposure to that position at St. Louis Park Medical Group back some years before--the keeper of the culture of nobility or idealism or principle within a system. Is that true and how has that developed for you? I mean, you talk about your colleagues being customers, but give me a little more context of what its been like to be a physician manager in a system like this and how you kept nobility in it.

Reinertsen: Well, I really appreciate your asking that question because that's really part of the joy of leading an organization like this. I mean you temporarily get custody in the leadership way of an enormous asset--a culture that's very special. A group of people who share common values and has struggled one way or another to bring those values through different generations and

across different kind of marketplace challenges, etc. But those values have flowed almost like a river current through all of that and you temporarily, as the leader of the organization, get to be sort of at the front of the boat on the river current but if you weren't there somebody else would step up. That current is really what flows through this organization in a very powerful way. It's a wonderful thing to watch. We have articulated those values in something we call the diamond, if you can imagine a figure with four points on it. On one point we write the word care, that's technical care excellence defined by professional standards and patient outcomes, etc., research activities would fall in there. The second point of the diamond is service which is what was the patient's perception of this whole experience. Whether or not the care was excellent usually has little do with that, it has more to do with caring and service and timeliness and a variety of other dimensions. And the third point of the diamond is stewardship. A peculiar value of this organization all through the years, even back in the fee-for-service era, the doctors in this institution didn't want to run up the bill on people. They were very conservative in their practice style. They generally didn't drive big fancy cars and show a lot of flashiness in that respect.

And so we had a very conservative practice style. We define stewardship now in terms of total cost per member per month for

enrolled populations, etc. And finally, the last point of the diamond is joy. (After Deming's statements about joy and pride and work). How do you create professional satisfaction? As one physician said, "I wanted this to be the kind of place that I can recruit my grandchildren to work and feel good about." That's the joy and pride in work part of it. Everybody has slightly different things that give them joy in their work. Those are the values that I am sort of a custodian of. But not me all by myself. I can articulate them, I can hold them up from time to time but what the physicians really want me to do is to take a look at that value set in the diamond and if people go out of bounds on that value set to nudge them back in. There needs to be some organizational discipline around that in order to tend to that particular value set and not let it go to seed. By the kinds of people we hire in, by the kinds of policies we develop, by the kinds of systems we put together--what nurtures those values is really the question.

Mullan: In preparing yourself or reinforcing your skills in this leadership or custodial role, you've not, I gather, as some have done, gone back and sought further degrees--a masters in business administration or what have you. But you have done-- Let me put it differently. What have you done to educate or re-educate or advance your education in this area?

Reinertsen: As I said, I had the school of hard knocks running a small business and during that small business education because the product that we offered was education and consultation, I had the opportunity to speak literally world-wide to over 500 audiences of hard-nosed business folks, their families, etc. I had a public speaking tour experience which gave me a great communications kind of internship. As it turns out that's very important in leading large groups like ours because your communications skills and your ability to emote with audiences and connect with large groups of people, it is not absolutely essential, but it helps a lot. And then when I became CEO of the clinic I realized I needed a little more education and instead of going to formal education, I joined a group of chief executives of non-health care companies. There were about eight of us and we met for a full day once a month to learn together. We acted as sort of an informal outside board for each other's company, brought our toughest problems to each of these once-a-month sessions and would get advice from the others about them. And then we'd bring in outside resource people to help us with specific learning activities. Did that for several years and it was a very useful learning experience. Mostly what it showed me was that I actually knew a lot of this stuff, after years of being on our board, and that most of the tough problems were people problems. It wasn't some secret handshake that MBA's

learned, it was people judgement. For example, who would be the best person really to do a job? They aren't popular but they can get it done. You give them the ball even though they are not popular. Those kinds of judgements are just as much the case in a linen services company or a company that makes parts for a computer as they are in the health care services. Those are the tough ones. I learned a lot from that experience. I did take a 13-month course on Fridays and Saturdays once a month to kind of give me a once over the top of basic business skills that was offered by the management group, Medical Group Management Association. I took that fairly late in my career after I'd been CEO for a couple of years and I found I didn't learn much. I--most of what I learned I knew already from just working with the finance committee and CFO, I learned fundamental accounting and a little bit of reading that I did. And I knew non-profit accounting better than the books did because we'd done it for all these years. Some of basic skills I just learned by doing them.

Now, I will say this, a lot of physicians who want to become managers in health care will say "Well, I'll go get an MBA and then I'll come back and my group will want me to lead something." So they go get an MBA and they come back--but the group never wanted them to lead anything and never will. They never had the mantle of leadership given to them in that intangible anointing process that happens in a group that says " We will allow you to

lead us." Leadership does not happen because you have three letters after your name. And most of those people end up being disappointed and going someplace else leaving their organizations.

Mullan: The transition of the question of what the sub-culture of Minneapolis first understand the role of Methodist Hospital and Health System Minneapolis, you are, as I understand it, a multispecialty integrated service system which includes a hospital that essentially contracts or provides care to insurers of various sorts. You don't have an insurance product per se.

Reinertsen: We do not have a health plan--we contract with health plans. We're the doctors and nurses and clinics and surgical centers and pharmacies part of things. We're the care delivery system would be the best way to describe it. For about 20 percent of the people who live in Minneapolis suburbs. Now that 20 percent doesn't all come to us as enrolled members. Some of them come to us as a one-time visit to see a dermatologist and then we never see them again. Others of them see us for every bit of their care. We have 196,000 people who are enrolled as members in our system through one or another kind of a health plan. About 160,00 of those we bear full capitation risk for. We've been doing that for 25 years and understand how to do it in

a way that I think is very effective. We're about 50 percent primary care and 50 percent specialty care. The number actually gets to 60 percent primary care and 40 percent subspecialty care if you count ob/gyn as primary care. That's the definitional question that I prefer not to get into most of the time. Just gets me into trouble.

Mullan: And go back and pick up this question of what happened in the Twin Cities area that has made the preeminence of managed care or managed systems or the prominence of managed systems much greater and earlier than it has elsewhere in the country. Why is that?

Reinertsen: I can think of a couple of influences. One is the groupiness of the Twin Cities and the upper Midwest in general. There are a fair number of large organized groups that had already developed so that the competence to manage a comprehensive set of services for a population of people as opposed to seeing people one-by-one in a doctor's office and then go to another doctor's office and basically being thrown into a totally new system with a new chart, a new system and all was something that had been developed here over many years. Park Nicollet, Mayo Clinic, you know, Marshfield, there are a lot of these upper midwestern clinics and a lot of smaller versions of

the same. So group practice wasn't such a foreign thing. That's point number one. Point number two--the large companies in this area were not very happy with the traditional indemnity kind of insurance even back in the sixties. And there was a seminal series of conversations that occurred in companies like General Mills and others where they said let's try some different models of purchasing. Out of that came a lot of customer pressure to think about pre-paid models and this and that and although there had been Group Health here in town for--since the forties, the next thing that happened was St. Louis Park Clinic saying "Well, let's try it. We'll do a little one of these things." And that in turn stimulated the Hennepin County Medical Society--the physicians who weren't really part of groups to say well, we're going to do one too and they started Physicians Health Plan. Now, that leads to the third--that was back in the seventies--that leads to the third factor. In Minnesota non-profit health plans are the only option, we don't have a for-profit model and I think that the fact that they were not for profit and therefore that much of care dollar got turned back into actual care as opposed to profits going off to Wall Street had a lot to do with the successful growth of these plans and customers, patients, companies went into them and found that they got good care. There wasn't any doubt about that. So they were high-minded, good products and finally I would say that the thing that made

this work here better than elsewhere was that there already is a conservative style of practice in the Twin Cities compared to many other cities you might be in. I mean people read about the Lubbock, Texas, or wherever it is where everybody who had walked down the street within a mile of the hospital has had an angioplasty--maybe I'm not speaking of the right city there but some city in Texas I read about in the Wall Street Journal a few weeks ago. The point is that Minneapolis has been a very conservative practice style town in general and that it made a natural to implement some of these things. People were more used to collaboration, cooperation and kind of working as teams. There's a little midwestern, upper midwestern groupiness to this whole culture.

Mullan: Scandinavian in origin?

Reinertsen: There's a lot of drivel about that but you know the single largest ethnic group in Minnesota isn't Scandinavian. It's Irish.

Mullan: Is that right?

Reinertsen: Well, you know, everybody came to work on the railroad and the lumber yards.

Mullan: Managed care around the country is a controversial issue, I don't need to tell you, and in many circles, particularly in physicians' circles it's an anathema. Is the experience here instructive of a maturing system in which the medical community makes peace or is this anomalous?

Reinertsen: Well, there are tensions even in Minneapolis but by and large the managed care world here is far less rancorous than it is in many other parts of the world. And the reason is, at least for systems like ours, that we have organized ourselves as physicians so that we are not just providers contracting to deliver care to somebody else who designs the care, but we have cherished and retained the role of being both providers and architects of the care. We have said we are not going to give that up. And what did we have to do to achieve that? A group like ours, now 400 doctors, has had to develop the central nervous system and backbone and apparatus to actually manage the care for ourselves in a professional way. We do this for ourselves rather than have somebody else do it to us. I mean I can give you many examples. Some years ago one of the major insurers in town started--decided to have this program where you had to call a nurse on a telephone every time you did any of some 20 different kinds procedures and she had a protocol that she would look at in a computer, you weren't allowed to know what the

protocol was but you would say why you think this person needed the procedure and then she'd tell you whether you got the jackpot or whether you didn't. If you said, "Well, tell me what the protocol says so I can understand it," she wouldn't tell you. Your supposed to go back and guess, you see. Well we thought this was onerous and wasteful and we looked at our data and realized that we could back to the plan because we had the capability to analyze ourselves and our data. We basically said to the plan, "Here is our current performance on these 20 conditions. We're already better than the goals you have established with this program. We wish to have an exemption from this nonsense." And they said "fine." Now the point was that our conservative practice style and our culture and our internal systems ranging from compensation systems to a common medical record, which by the way is one of the great quality improvement and excessive utilization management tools of all time, in other words if you're practicing with 400 other doctors and any one of them has access to your chart when he sees the patient next for some purpose, it's like having a good chief resident looking over your shoulder all the time. You're under some peer pressure to do a real good job and document it. And I think that has immense value. Those kinds of systems have made it so that we have earned an exemption if you will from some of the more demeaning aspects of managed care. I will say something about this, long

ago I think there were some little experiments in the Twin Cities with what I call micro capitation--putting small, small groups of doctors on risk for care rendered to their populations of patients. It's generally a bad idea and it's caused immense angst and pain amongst doctors all over this country when it has been used. The HMOs in this town learned that lesson very quickly and just don't do that anymore.

Mullan: Why because you can't control the risk and somebody gets hurt?

Reinertsen: Actuarially it's really bad. Secondly it puts a tremendous distrustful element in the room when a doc and a patient close the door and say, "Now, what's wrong with you?" and get into this professional interaction. You've got this other force in the room that says "This doctor will earn more money if he withholds care from you." Now, if there's any element of that in that dynamic--

Mullan: That does not exist in the larger systems? That does not exist among 400 docs?

Reinertsen: We specifically exclude it from the doctor. We have no incentives at the individual doctor level that say to the

doctor you actually make more money if you withhold care from anybody. We just don't--

Mullan: You don't design your system--you don't allow that kind of design in your system?

Reinertsen: I'll tell you what we've done--we've basically said we want our patients to trust our doctors to make the best judgements they can on their behalf. And that's what we ask the doctors to do. We pay our doctors a marketplace salary by their specialties and then we adjust that salary based on three things--up or down by maybe 15 percent total. The three things are the amount of work they do on behalf of the patients, I mean this is still America and people value the work ethic and say if you see more patients and work harder, you can get paid more. The second thing is we ask all of our patients "What do you think of your doctor?" in a formal way and if the doctors really build robust relationships with patients they can earn more money.

Mullan: How do you measure that?

Reinertsen: Patient satisfaction surveys that are specific to the doctor. Very useful instrument we've used over 15 years. The third question we ask is, we ask the nurses and doctors who

work around that doctor "What kind of a micro-environment does that doctor create around themselves?" Does it create joy in work or does it the doctor leave a trail of tearful and angry behind him or her every place the doctor goes.

Mullan: How do you score that?

Reinertsen: Questionnaires.

Mullan: This is annual?

Reinertsen: Uh-huh. And that's how we--we don't have any portion of their pay which is dependent on whether or not they skimp on services for people or whether they provide too many services. We eliminate to the best we can both of those things from the individual (unclear). I think this is a very important lesson for--

Mullan: Profiling does not exist or is not used?

Reinertsen: Profiling of the kind the plans use--it does not exist or is not used. We do provide individual doctors feedback on performance on things like are they getting mammograms on their patients, etc., only as a way of learning from them.

Feedback should be for everybody to learn how to perform better not to punish people or otherwise create fear and we use feedback wherever possible as a learning tool rather than as a policing tool.

Mullan: The fact is that you haven't highlighted, in this part of the discussion which intrigues me, the absence of for-profit plans or competitives in your arena. Is that a key factor to creating environment for managed care function in a more gentile and less rapacious (phonetic) way or not?

Reinertsen: Well, I've heard this conversation going on all over the country. I tend to be a proponent of the not-for-profit model simply because I think it's a matter of ownership and the ultimate needs of owners. In a not-for-profit model, when it's operating perfectly, the owner is the community and so the community looks for a return on investment which is measured in health and health services. If the owner is an investor from Wall Street, the owner's looking for a return on his investment in terms of dollars. Now you can have both of those things, you can have both profit and a return on health and the argument from the for-profit is well, if you don't get a return on health you'll never get the return on dollars. It's right to a certain extent. You may get profits for a while and then you won't get

them anymore. Which is actually one of the risks of for-profit--that you'll just get in for the short haul and then get out when you've made your billions as many have. Whereas in the for-profit, you in there for the long haul and the community really does care--

Mullan: Not-for-profit.

Reinertsen: Not-for-profit--the community really does care whether you get--what you give them a return on their investment in terms of health. I--ours is a not-for-profit system. I asked one of our board members one day, I said, "If we need to make about 10 million dollars of operating profit a year in order for us to stay on track towards being what we call an A credit" (phonetic) which is a long-term goal of ours.

Mullan: A credit?

Reinertsen: A credit. It's a measure of credit--worthiness. So it's kind of a financial target that's a solid baseline requirement. That, by the way, for us is about a two percent profit margin for a system like ours. Pretty slim. I said, "What if we were to make 20 million dollars some year. Would that be twice as good?" This is a business man. And he said,

"Well, of course." And I said, "Now, you're a board member of a not-for-profit." I said, "Think about that for a second." And he started by saying, "You know, I suppose it would depend on whether you achieve the 20 million by running up the bill unnecessarily on the community or whether by skimping on services that were really needed or a variety of other means." What I'm basically telling you is that our not-for-profit system does require that it makes a profit and I think that's also true of not-for-profit health plans. They need to make a profit. But at a certain point after they've achieved some basic minimum financial targets and their current profit level is in the neighborhood of one or two percent in Minnesota, after that they need to return the investment back to the community in better health or reduced premiums. I think that discipline is alive and well in this State.

Mullan: I think you've made the point that I've been including which is the not-for-profit extra structure which surrounds the sundry plans and the sundry systems in Minnesota is as the character does because it doesn't have full profits competing (unclear). I mean, for instance if you took United Health Care, based as it is here I gather but not practicing here, and dropped, you know, took away the proscription from that and let them loose in this marketplace, do you think it would not have a

major destablizing effect?

Reinertsen: Well, I don't think they could compete right now on the price side unless they decided to come in and buy the business at a loss. The not-for profits are doing a very efficient job--so I'm not sure what destablizing there would be. It would have been a lot different if the for profits had been here all along. I think there would be a lot more anger, rancor, harsh words, wild accusations. The managed care demon would be much more brightly painted in Minnesota now than it is.

Mullan: Though this is a fascinating discussion, time is real short. Let's go back to what I started with which is the issue of the generalist and you indicated at the outside that you had thoughts about the trials, tribulations and joys of generalist practice and where that's all headed in this world we live in. You want to do some of that?

Reinertsen: I think the interesting challenge for the generalist is actually is that there are a whole series of roles and responsibilities that the generalist has had from the beginning--managing literally everything that comes in the door and managing it yourself and not delegating a great deal of it. As medicine has marched on and new sophistication and new knowledge has come

into it that's been added and added and added and added to (unclear). You had to do all the things you always did, clean out ear wax, etc., and be responsible for managing, you know, methotrexate therapy and polymyositis and now the next thing. And understanding all of that has become a real challenge so enter the specialist, basically, start having special knowledge in one of those areas and really being able to drill down in depth into those. So I see two interesting issues for the generalists. At the interface between the specialist and the generalist, more and more in systems like ours the specialists--the subspecialists are seeing their job as not to deliver all of the services in the area of their specialty but to see to it that the whole system does a really good job of caring for the problems in that specialty. Whether they personally deliver the services or not is not the issue. Some of them they will personally deliver. In rheumatology, as a case example, my field, a really serious Wegener's granulomatosis (phonetic) and polyarteritis now those I could argue that most generalists would be happy to turn those patients over lock, stock and barrel full time to a rheumatologist who would really make that part of a rheumatologist's work. But the rheumatologists also need, in our system to spend a lot of time training and equipping the primary care physicians and everybody else to take good care of gout so that if a case of gout--acute gout--ever finds its way to a

rheumatologist's office it's kind of a failure of the upstream part of the system. Rheumatologists love to see acute gout, it's a lot of fun. We can fix this problem and act like a hero but the problem is that it's also, it is eminently manageable in the generalist office so we need to make sure that the generalist's office is equipped with compensated polarized light microscopy and people in the office capable of reading it, people who aren't scared to tap into funny joints and take out a little bit of fluid and look at it. Training and developing that capability is an important part of the rheumatologist's job. Now, if the primary care doctor takes on that responsibility the next challenge is if the other end of the interface of the primary care doctor. What is there about a primary care doctor's life that doesn't require 12 years of post-high school education to deliver? And that's when the generalist starts to have an interesting challenge in the concept of generalism. Most generalists that I talk to have said that is they could organize their practice anyway they could with no personal financial risk to them, they would jettison a good deal of what I would call--they would call--routinizeable work.

Mullan: Get rid of the ear wax.

Reinertsen: Ear wax, strep throat, routine UTIs, a variety of

other things and physicals. Much of the preventive exam they would regard as doable by somebody who was really good at it. Mayo Clinic did this year's ago, they had technicians do all the proctoscopies. I don't know if you know this or not. If Mayo could figure that out then most primary care offices probably could too pretty soon. If it's a well-designed system, this works. What that would focus the generalist in on doing then and many of them have talked to me with great anticipation about this, if we could take some of the routinizeable services and have them well delivered in our offices by capable support staff with our back-up and supervision, they wouldn't be working in patients between the physical exam and the strep throat. Patients like an older man with weight loss and abdominal pain gets five minutes in between the routines and a woman with a headache in the setting of a new divorce gets a very short visit in the setting, squeezed in between other stuff. They would spend 30 or 40 minutes with those people and they would listen and they would examine and they'd think and they'd counsel and they'd diagnose. They wouldn't just sort of see them and say "Oh, shoot, I don't have the time to work you up, I'm going to do a bunch of labs and send you to a specialist." Many of the primary care doctors that I've talked to in that context have had tears in their eyes when they described this wish that they have. They want to feel like they're doctors again. And when I've

asked them, "Why don't you just do that? I mean, why don't you just organize it that way?" These are all doctors out there practicing in our community. They have said because I'd go broke.

Mullan: Hold for a second while I put in a tape.

Mullan: This Dr. Reinertsen Tape 2, Side 1.

Reinertsen: These doctors basically said, "I'd go broke if I do that." It's because they largely work in a piece work fee-for-service system that pays them only if they see patients in their office. And so they haven't had the freedom to innovate in the ways they know would be better for care and ways in which they would actually be getting more joy as doctors on a day-to-day basis.

Mullan: Where do you see that heading? Is there a remedy for that?

Reinertsen: Well, one of the ways to do this would be to put physicians more and more on a compensation system that doesn't place them at personal risk for innovation. That's what piece work does.

Mullan: Personal risk for?

Reinertsen: For innovation. Where the physician would say, "Look, I'm going to organize my day the best way I can think of for the patients that I take care of. Regardless of what I personally wind up having to do in that role." That's what Dr. Erling Hestenes did back in South Africa. I mean, he's one doctor with a 200 bed hospital. How's he going to organize his day? He had a cadre of nurses that did an enormous amount of work that doctors normally do and each person he trained. He was freed up to do that because you know he had a salary--one salary from the mission office which wasn't very much. That's why Mayo and Park Nichollet and a variety of other larger systems like that over the years have put physicians on salaries. Because it frees them up to collaborate, cooperate, do new innovative things without any personal risk to their incomes. I think it's going to be a big issue for the generalist physicians because many of them get dispirited over the years when most of their practices income depends on other things that they have to crank through in order to generate an income. When what they'd really like to be doing is spending more time holding somebody's hands through a life crisis or diagnosing and working on a tough problem of lymhadenopathy (phonetic) in a young man, or whatever it is.

Mullan: I have heard a complaint in well triage systems that the level of acuity of responsibility that the generalists inherits is so intense that it is really a very, very tough job. In other words, whatever you may think about the routine aspects of care, if you mix those with very sick and very acute problems there is a kind of balance. When you triage out the simple problems then you're left with the complex sicknesses, it can be a very grinding job.

Reinertsen: I think there is a balance issue there and my guess is that we won't ever get that effect with the triage. I hope we don't. And the physicians in our group have said much the same thing that they like to have an easy problem in their days here and there just so that they can kind of take a deep breath. They also don't like a full day that's full of boring, relatively minor problems because they don't get to sharpen their skills as physicians the way they'd like to.

I haven't talked at all about another issue with generalism and I know time is running short but I could tell you that I believe that we'll divide into two forms of generalists--one that works mainly in an office setting and one that works mainly in a hospital setting.

Mullan: Hospitalists?

Reinertsen: We have done this here and we have a cadre of hospitalists who actually come in for two weeks out of every three months--the other two and a half months they're in the office. But they are hospitalists for two weeks at a time and they have self-designated themselves as hospitalists. They chose that as opposed to a pure out-patient role. About one-third of all the generalists in family practice and internal medicine chose the hospitalist option. And it turns out that it was fun because the ones who were really good at it chose it. And the ones who had realized, and this is something important to mention, they'd realized maybe many years ago that they weren't entirely comfortable with their skills in the hospital but they had had previously no honorable way to withdraw from the hospital and the people were so sick in the hospital that they couldn't really take good care of them any longer but they had no honorable way to say that to anybody. Now, with this model, they can choose an honorable option to be a clinic out-patient physician and many of them have and their lives are a lot better as result. And quite frankly, the best people at taking care of people in the hospital are doing it which is better for our patients.

Mullan: You haven't used the word nurse practitioner or PA at all. Is that because they're not prominent in the Twin Cities area or you don't think they--you've talked about support staff--

Reinertsen: We have nurse practitioners and we have PAs. They have thrived in a few of our office settings and in other settings they aren't evident at all. It's largely at the individual desire of the physicians. I just don't think we have enough experience with specific subsets of physician assistants to know whether or not one or another form of them is going to be better or not. We use nurses a lot in roles as triage nurses and as telephone advice nurses 24 hours a day giving guidance to patients based on information provided to them by doctors. But--

Mullan: You're not persuaded the NP or PA as we know it today is the solution?

Reinertsen: I've heard it said that people believe we'll have nothing but PAs and specialists at some point in the future. I don't think that's going to happen. I think if we carefully use the model I've described for you, you take the generalists and you move some of the generalists' activities into what was heretofore been specialty areas by providing systems to do that like I was describing for rheumatology and jettison some of the

more routinizable activities of the generalists to some other support staff people. That's an incremental step that I can predict very confidently that's going to occur at least in systems like ours.

Mullan: Great. It's been terrific. I'm sure there are other things that we can go into but given the hour, we better cut.

Reinertsen: Thanks a lot.

Mullan: Good, thank you Jim.