TOM BODENHEIMER

November 7, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Bodenheimer: 6/13/39.

Mullan: It's the evening of the 7th of November, 1996, in Dr. Bodenheimer's office in Saint Luke's Hospital, or next to Saint Luke's Hospital, in the Mission District of San Francisco. And we just had a Chinese, or was it Thai--

Bodenheimer: It was Cambodian.

Mullan: Cambodian. I knew it wasn't quite Chinese, a very good small feast. Tell me just a word about the Mission District and the hospital we're sitting in.

Bodenheimer: The Mission District is pretty much a Hispanic area of San Francisco, mostly populated by people from Nicaragua and El Salvador, not so much Mexican or Chicano. It's a fairly poor area, and Saint Luke's Hospital is on the edge of it. The other hospital that's on the other edge of it is San Francisco General. These are the only two hospitals in the whole southern half of

San Francisco, whereas about ten hospitals exist in the northern half of San Francisco north of Market Street.

Saint Luke's is a hospital that was started by the Episcopal Church. It's always been a heavy Medi-Cal hospital, a lot of poor people, which, of course, goes with the neighborhood, and in the past it was considered one of the pretty good hospitals in the city. It's kind of gone down, though, lately, as its volume of patients has gone down, as the volume of patients in most hospitals has gone down, and now it's sort of struggling to stay alive.

Mullan: How many beds?

Bodenheimer: Acute beds, something like 150.

Mullan: And who staffs it, or uses it?

Bodenheimer: The patients?

Mullan: Which doctors, or is there a community of doctors in the Mission?

Bodenheimer: No. It's a fairly open staff of docs. The people who are the big admitters are people who have their offices right around here, such as our own practice. Our practice is the biggest admitter to the hospital. There are also a number of foreign medical graduate doctors, mostly from the Philippines,

some from Latin America, many of whom have their offices in the Mission District who utilize this hospital a great deal, and there are a lot of specialists from all over town who come to Saint Luke's. Some of them have their offices here; some have their offices almost anywhere else in town. Because there are so many specialists in San Francisco, the specialists usually get on the staffs of every hospital they can to find any patient that they can probably find, and their rounds usually consist of going to four or five hospitals every morning, which is kind of a ridiculous life. A lot of the specialists are very good.

Mullan: But increasingly underemployed, one would think.

Bodenheimer: Yeah. Well, San Francisco is a really over-specialty town, and the specialists are always very happy to get a call from a primary care doc.

Mullan: Well, let's go back and talk about you. 1939. Where were you born, and where did you grow up?

Bodenheimer: I was born in Seattle, Washington. About a year after I was born, my parents moved to Washington, D.C., where I lived until I was seven, and then our family moved to Salt Lake City, Utah, and that's where I really grew up from age seven to the time I went away to college at age eighteen.

Mullan: What did your father do or your folks do?

Bodenheimer: My father was a law professor, and my mother was a law professor. They both taught on the faculty of University of Utah. The reason my father went to Salt Lake City was that my father loved the mountains and he wanted to find a job somewhere that had mountains, and Salt Lake City is such a place. It was a very wonderful place to grow up because it wasn't that big. You're forty-five minutes from the best skiing in the world. Lifts cost $2.50 for a whole day, and you didn't have to wait in line the way you do now. You went hiking or camping. It's a very outdoors kind of a existence, which is what I like.

Mullan: And was Salt Lake, other than the mountains, an interesting place to grow up?

Bodenheimer: Well, being a non-Mormon, there's sort of a community of minorities there. Most of my friends were actually not Mormons. Some of them were. My high school was about 95 percent Mormon, but that didn't bother me. I enjoyed growing up there. I have good friends and really have no regrets. I've even thought about going back there, but I don't think I will.

Mullan: As you grew up, what sort of encounters did you have with doctors or medical care, or was doctoring in your world view at all then?

Bodenheimer: Well, actually I decided I was going to be a doctor when I was about five years old, which is kind of ridiculous,

because, number one, no one in my family was--I had an uncle who was a GP, but I hardly knew him. He wasn't a role model. I don't know where I even got the idea, and I didn't have much dealings with doctors. I had my tonsils out and stuff like that, but really I have no idea where that concept came from, and I don't even know whether it was a good idea or not, but it happened.

Mullan: And you stuck with it.

Bodenheimer: Yeah.

Mullan: Did science appeal to you in high school, or is it just a fixed notion that that's what you're going to do whatever? How did it develop?

Bodenheimer: I was much more interested in social science than I was in science. My brother was interested in science, and he's now an astrophysicist. I loved history and that kind of stuff, and also in college I much preferred the social sciences, but it was difficult to get away from this idea, wherever it came from, that this was what my destiny was.

Mullan: Tell me about college.

Bodenheimer: I went to Harvard College. You know, Harvard College had a geographical distribution, so we used to say in

Salt Lake City, "Welcome to Utah, gateway to Harvard." [Laughter] It was pretty easy to get into Harvard from Utah.

College was fine. What I did most of the time was play music and be a grind and study. I play violin, the viola, and I played in the orchestra. I played a lot of chamber music, and I was in Kirkland House, which had a lot of musicians in it. So that was really my main interest in college, was playing music, which I did a lot.

Mullan: What did you major in?

Bodenheimer: I actually majored history and science, which is this funny major at Harvard, but you could do your premed courses, and they'd count toward your major, but you would also do a lot of social science.

Mullan: And your resolve to go into medicine remained solid throughout that time?

Bodenheimer: No. My senior year there was an attempt to deviate me from my path by my advisor, who said, "Your mind will be wasted going into medicine, and you should go into history or philosophy or something like that," and I really liked this guy, and for a while I said I was contemplating the idea that maybe he was right. I still contemplate the idea that maybe he was right, but I guess I'm a fairly conservative person, and I decided that since I had decided this at the age of five, that that's what I

had to do. I don't really regret it. I don't want to sound cynical or anything.

Mullan: Did you write a thesis?

Bodenheimer: Yes.

Mullan: What did you write on?

Bodenheimer: I wrote on some medieval philosophical topic. I plunged myself into Widener Library. I just loved it. I absolutely loved it.

Mullan: And how was medical school?

Bodenheimer: I hated medical school. I really didn't like medical school. The first year I survived because one of my classmates was a really good pianist, and we used to go down to the basement of Vanderbilt hall and there was a little--

Mullan: This is Harvard Medical School?

Bodenheimer: Harvard Medical School. There was a room with a piano down there. Every single night we'd go down there and play sonatas, and it really was a lot of fun.

In my second year, I sort of flipped out. I hadn't done that yet in my life, so it seemed like it was the thing to do in

the second year of medical school while taking pathology, bacteriology. You never saw anything like a patient in those first two years the way most medical schools do now a lot earlier. Well, one thing is I got mono, and that was good because I got to stay away from school and not feel guilty about it, but the whole year I really sort of lost interest. I didn't like it. The dean called me in once and said, "We've never had a student who did so well in their first year do so badly in their second year." [Laughter]

But then when we started clinical rotations in the third and fourth years, I enjoyed them a lot more. I found them challenging, and they were interesting, especially going to Boston City in surgery. That was really something, staying up all night, holding retractors for people, taking bullets out of people's stomachs, and stuff like that. I got to meet some really neat people at Boston City. I was at Mass General and Peter Bent Brigham and all those kind of places that was all sort of highfalutin academic medicine. Somehow Boston City seemed like my kind of place. There's a real *esprit de corps* there.

At that point, I was planning to go into neurology because neurology was the intellectual field, and that was me, an intellectual type, and, of course, Harvard had these fantastic neurologists, like at Boston City was Derek Denny Brown. You could go on rounds with him. You wouldn't understand a word of what he said, but you just knew he was absolutely brilliant.

During some of my summers, I did some research in neuroanatomy, mostly electron microscope kind of stuff, and I

liked doing that. And then in my senior year we had some elective time, and I went to Queen's Square Hospital in London, which is a great neurologic hospital, and the person who was in charge of the ward that I was working on at that time was Roger Bannister, the first man to run the four-minute mile. He was a neurologist in England. A wonderful guy. So that was very exciting. And then I spent two months plus a summer in Amsterdam working with a neuroanatomist doing studies of fish brains, and that was a lot of fun, too. So I was all set to be an academic professor of neurology somewhere, and that was sort of what I was going to do.

When I did my internship, and I did it at the Harvard Medical Service at Boston City Hospital.

Mullan: A medical internship?

Bodenheimer: Yeah, straight medical internship, and it was an unbelievable year. I mean, interns think they have it hard now, but we were on every second night for the whole year. You never got to sleep at night. So basically I'd be in the hospital for thirty-six hours, and I'd come home and crash and then go back, and that was okay, because, again, our internship class was just really, really a tremendous class. I think the first resident who was leading the team that I was on was Steve Schroeder. Phil Caper--I don't know if you know Phil--he was in my internship class. It was a great, great class of interns and residents, and

you know, you stay up all night and you feel fine about it because every--

Mullan: Was Beach Conger part of your group, or he was a year or two behind?

Bodenheimer: I know Beach very well.

Mullan: He was at City?

Bodenheimer: No. I don't know if Beach was at Boston City. I visited Beach in Vermont about two years ago, maybe one year ago.

Mullan: I did his oral history.

Bodenheimer: Oh, that must have been fun.

Mullan: Yeah, it was.

Bodenheimer: He's one of the funniest guys I've ever met.

Mullan: Anyway, Boston City Hospital internship group, how was the group?

Bodenheimer: It was great. I really enjoyed that year. Most people went right on to do their medical residency, and somehow I decided I didn't want to do that.

Mullan: You had decided you did not want to do neurology?

Bodenheimer: No, I wanted to do neurology, but I didn't want to do a medical residency. So what I did was, I arranged to go to NIH [National Institutes of Health] after my internship. Most of my internship class stayed on and did their residency. I went on to NIH. And, of course, that was July of '66. The Vietnam War was going on. I didn't want to go to the war in Vietnam. The ways you got out of going to the war in Vietnam are you get some kind of Public Health Service position, and NIH seemed reasonable for me because I'd done this electron microscope work, I could pursue my neuroanatomy stuff. I got accepted in a neuroanatomy lab down there, and down there I went.

That was the year of my major personal crisis, because after spending long nights in front of the electron microscope and cutting all these beautiful thin sections and making all these beautiful pictures, I decided, "Why the hell am I doing this? What good is this going to do anyone?" and, "What good is neurology going to do anyone?" It's wonderful, intellectual work, you know, figuring out exactly where the lesion is, but then you just tell people, "Okay, well, it's in the left parietal area," and "Sorry, can't help you."

I eventually went into a major depression, and I decided I wanted to do something else. I didn't want to do neurology, and I didn't want to be in NIH, but I still had to stay in the Public Health Service for the total two years. Otherwise I'd get drafted.

So one of the people who had been a surgical intern at Boston City when I was a fourth-year medical student in my surgical rotation, we'd become pretty good friends. In the meantime, he had become the medical director for Latin America for the Peace Corps. So I called him up. His name was Andy Horvath. I said, "Andy, can I get into the Peace Corps?" [Laughter]

He said, "Sure. Come on down. We'll talk about it."

I went down, we talked about it, and he basically sort of arranged to get me in. But not only did I have to get in the Peace Corps, I had to get out of NIH.

Well, you know about the government, and there's this crazy stuff that, if you leave a government post, the question is does your slot go with you or not, and people won't allow your slot to go with you, because if they lose a slot, then that's one less budget FTE [full-time equivalent] that they have. So the big bosses of NIH, the personnel types, said, "You can't leave." And that really put me into a depression, and it was sort of nip and tuck.

Andy said, "You know, we're going to assume that you're going to be in the Peace Corps and you're going to go to Costa Rica in June." This was about February. "So we're going to start teaching you Spanish." So at the taxpayers' expense, they gave me a private Spanish tutor whom I spent four hours with every day. She was just fantastic. That was downtown in Dupont Circle. I'd take my bike and bike out to NIH and work there from like one until nine at night. Then I'd bike back home and study

my Spanish and go to bed and get up and do the same thing again. I did that for three months, in the meantime not knowing whether I could get out of NIH or not.

The other thing that was going on was that my wife, my first wife--I'm divorced--she was getting to be a fairly left-wing type, and she was in political science, and her specialty was Latin America. Of course, she wanted to go to Latin America for her own reasons. She actually had gone down to the Dominican Republic, had gotten into all sorts of trouble talking to all the wrong people, and had written a couple of articles which the State Department didn't like. I had to have a security check to be a Peace Corps doctor. Usually it was done by Civil Service Commission, no big deal, and then we found out that it had been transferred over to the FBI. [Laughter] So not only could I not get out of NIH, but it looked like we wouldn't be able to get out of the United States.

Meanwhile, I was learning my Spanish and all that kind of stuff. So it was a very, very difficult year. But finally it all worked out. We got our security clearance, I got out of NIH, and down to Costa Rica I went.

Mullan: A pretty good experience?

Bodenheimer: Well, it was a great experience, but it didn't last too long. What I did in the Peace Corps, there were 150 volunteers all around the country, and my job was to take care of

them. Well, there wasn't anything to do. I mean, it was a non-job.

So I had this Jeep that they gave me. So I decided, "I'm going to visit all the volunteers in Costa Rica." So I just took the Jeep and traveled. I'd pick the people in the northeast and go up and see all the ones in the northeast, maybe be out for the week or something. I learned more about Latin America in six months than I think anyone could possibly do. So I'd go in there, and these volunteers that are really neat kids. They may not have done anything for the country, but they sure did a lot for themselves, and they knew all the right people in town. So we'd go and have a few beers with this and that person, and I just learned how rural agricultural Latin America works, and it was a real eye-opener.

The other thing I did is, I started working with the Ministry of Public Health, and the Ministry of Public Health was pretty dominated by the United States, as Costa Rica is in general, and they had a lot of programs that were sort of questionable, but I think every country in Latin America has an advisor there from the Pan-American Health Organization, which is the western hemisphere branch of WHO [World Health Organization]. And the Pan-American Health Organization, there's some very excellent people on that in terms of Third World health care. This guy was just phenomenal. We became really good friends, and he sort of taught me like what real health care is in underdeveloped countries and how the Ministry of Health wasn't

doing it. So I just learned an enormous amount there about health in a Third World country.

My wife, in the meantime, was working on her master's thesis on, basically, the role of US AID in Costa Rica and Guatemala, and she was going back and forth from Costa Rica to Guatemala and interviewing all these people. Probably there were five leftists in Costa Rica, and she met them, and probably half of them were CIA agents. It turned out that I got called in by the Peace Corps director, and the Peace Corps director said, "Well, your wife has been doing some things that we don't think are very good, and we suggest that she stop doing those things and learn how to cook tortillas or something." Of course, Susanne, forget that. So one day she had gone to Guatemala, and I went to the Costa Rica airport to pick her up, she was coming back, and we got stopped by the security people, and they went all through her suitcase, and she had a bunch of AID books in there, and they basically said, "You're carrying Communist literature to distribute in Costa Rica." By the next day, we were kicked out of the country.

Mullan: These were AID booklets?

Bodenheimer: Yeah. There was no Communist literature at all. It was a frame-up, basically. It turned out she'd been followed for about three weeks. I was not real happy about that because I liked it down there, and I actually didn't have to leave. They said, "Well, you know, we're only kicking her out. You can

stay," but I went too, which, looking back on it, was probably a big mistake, but I did. So my Peace Corps experience only lasted about eight months instead of the usual two years.

Then I came back, and I had to find another job to finish up my Public Health Service, and so I finally found a job in Washington, D.C., sort of a ridiculous bureaucratic job, and finished it up. Then, at that point, I decided, "I've always been a Western man. I need to go back out West. I've had it with the East Coast. Nine years in Boston; one and a half years in Washington, D.C. I'm not going to go back to the East Coast." I decided, "Well, one thing I can do is go to Public Health School." So I decided I was going to go to Public Health School at Berkeley which was where I wanted to be. So that's what I did.

When I got there, oh, boy, it was '68, '68-'69. The University of California at Berkeley was on strike almost that whole academic year. There was People's Park and Third World this and that and everything you can imagine. So I don't think I did any work, but anyway, I got my MPH, and at that point I decided that I wanted to go back and do clinical work. I didn't want to just be a public health person who never saw a patient.

So I got into the internal medicine residency program at the University of California at San Francisco. That's what I did for the next couple of years.

Mullan: You had, at this point, become fairly politically active yourself?

Bodenheimer: Yeah, I'd become pretty active in Medical Committee for Human Rights particularly.

Mullan: Through college and medical school, you hadn't been particularly active? I mean, your radicalization or your political--

Bodenheimer: Came later.

Mullan: --awareness came, starting with your experiences through your wife and Costa Rica?

Bodenheimer: Right. Yeah. And then, you know, when I came back, I came back from Costa Rica, I think, about February of '68, and April of '68 was the assassination of Martin Luther King [Jr.]. Of course, we were living near Dupont Circle and the block one block to the east of us was burning, and there were tanks in front of our house. It was pretty wild.

Actually, the other thing I did was in between the time I left Washington and went out to Berkeley, the summer of '68, I went down to Chile and spent two months in Chile working in the *Servicio for National de Salud.* I was invited by this guy named Tom Hall [phonetic]. Do you know Tom Hall? He's an international health-type guy. He was an American advisor in the Chilean National Health Service. He took me on to work there for a while. That was also wonderful. I met some great, great people in Chile, who probably died in 1973 in the coup. And I

learned a lot more about community medicine, which was more advanced there than it was in the United States.

Mullan: What form did your political awareness and political actions take in that period? Obviously you became a known figure and remained a known figure on the medical left, if that spectral approach even makes sense in the nineties, but at least back then--I'm interested in how you got from law professors' son in, it seems to me, apolitical Mormon Salt Lake City, to medical activist. What went on in your head? Tell me a little more about it.

Bodenheimer: Well, my parents had always been liberals and believed in the right things, although they didn't do much about it. It was probably my first wife who sort of drew me into politics more than anything else, and in Costa Rica I really wasn't very political at all. I was kind of shocked by what happened, her getting kicked out, and she really hadn't done anything wrong. It was ridiculous. But I think it was when I came back. In a way maybe it was good I came back, that we got kicked out, because when I came back, I sort of got grounded at MCHR. I'm not even sure how, but Sid Wolfe [phonetic] was pretty active in Washington D.C. at that time. It was before he became a became a [Ralph] Nader type and became very prominent. I liked a lot of the people that I met. They were just really interesting people and decent people, and part of it is your role models, your individual role models, that make a difference.

I think going to Chile made a big impact on me, because I went to Chile before Allende came into power, but there was a huge movement for Allende going on at that time. That was two years before he came into power, and most of the people that I had met there who were activists in the medical school and working on like medical curriculum reform, saying that there has to be much more primary care, rural health, in the medical curriculum in Chile because that's what the people really need. They were getting the same kind of medical education that people got here, which was a lot of specialty-dominated and hospital-dominated. I'd never heard this stuff before, and, of course, it came to the United States around the same time or shortly thereafter, but it was really an eye-opener. These people were just terrific people, and they were mostly socialists and Communists. And then Berkeley, being in Berkeley with all this activity going on, and I worked with the MCHR chapter here.

Mullan: What did the chapter do?

Bodenheimer: Well, mostly the chapter went out and--

Mullan: Political presence?

Bodenheimer: Be medics at riots that year, which is not exactly what I--beat the heat and that kind of stuff, did fine. But then I was interested in health policy at that point and my Public Health School Department was health care administration, medical

care administration, and I began to think more about the health care system and the problems of the health care system. Of course, MCHR was beginning to think about that. It had always thought much more about civil rights and anti-war stuff. The war in Vietnam had an impact on me, too, not personally, directly, but just how terrible it was. Beginning to study about the health care system, the problems of the health care system, I think was a very important thing for me, and that's, of course, what I continued to do and continue to do now.

One of the things that I worked on was what should the health care system look like. [Telephone interruption. Tape recorder turned off.]

A friend of mine and I wrote basically a draft that became MCHR's sort of plan for the health care system, which eventually became the Dellums Bill.

Mullan: Say a word about what the Dellums Bill is.

Bodenheimer: The Dellums Bill was a health care plan introduced in the Congress by Berkeley Congressman Ron Dellums back around 1970 or so, and then introduced a number of times after that, and it was basically a type of national health service, sort of a decentralized national health service, in which there was a single-payer system in which all the money would come from taxes and hospitals would be run by boards, including patients and employees of the hospital. There'd be community health centers that would be run by--community worker control kind of thing was

the word at that time, and it'd be a regionalized system by which he health centers around the hospitals would feed the hospitals for secondary care, and the hospitals would be tied into the university medical centers for tertiary care. It was sort of a rational system, which is almost impossible in a pluralistic sort of economy. So that sort of got me started writing about health policy.

Mullan: I want to come back and talk about your writing, because I think it's been an important thing. Let's walk quickly through, if we can, your vocational history, what you did following your residency training.

Bodenheimer: After my residency, I got an urban coalition fellowship in community health, so I got to stay at San Francisco General for an extra year and work on the development of satellite clinics in the community that would sort of feed San Francisco General, which the administration of the hospital wanted to have done. I actually wrote the grant for a couple of clinics, one of which got funded right away, which is the South of Market Health Center, and the other one got funded sometime in the future, which was Potrero Hill.

Mullan: This was a government-funded community health center?

Bodenheimer: Right.

Mullan: What was the second one?

Bodenheimer: Potrero Hill Health Center, which got funded later on. It's a neighborhood to the east of the Mission District with a lot of public housing projects and so forth. Anyway, the South of Market Health Center started operation just as I was finishing my fellowship, and I went to work there as a clinician, and the medical director there was none other than Beach Conger. So Beach and I worked together there for a while, until Beach left for Vermont. I was a little frustrated with the place because I didn't have a chance to speak Spanish because it was not in a Spanish-speaking area.

So I had some friends that worked in Mission Neighborhood Health Center, which was one of the old Office of Economic Opportunity (OEO)-funded health centers, and they wanted me to come work there, so I went to work there, and I worked there for about four years. It was one of these health centers where there were terrible clashes around the issue of a community board. That's where I got my rude awakening about community boards and how a lot of petty corruption can go on. People up there were always taking these trips around on HEW [Department of Health, Education and Welfare] money, and then at the same time they were saying, "We don't have enough money, and we ought to start charging the patients for their visits," and so forth.

Mullan: So since the community-controlled community boards were a plank in the catechism of the community medicine movement

earlier on, but this experience disabused you that of the simplicity or purity of that concept?

Bodenheimer: Good. That's a good way to put it. Absolutely. So I and some other people got into a fairly major battle with the community board, and I got fired. When I got fired, my patients picketed the health center for about a month.

Mullan: This was South of Market, or this was--

Bodenheimer: This was the Mission Neighborhood Health Center.

Mullan: So this was probably like '79?

Bodenheimer: This was '79. It sort of got put into receivership by HEW. The person who came in to take over as the director was Paul O'Rourke, who is a friend of mine. I don't know if you remember Paul O'Rourke from the old days.

Mullan: I do.

Bodenheimer: And I went to see Paul, and Paul said, "I don't think I can hire you, Tom. You're too hot to handle."

I said, "Okay, Paul. Thanks a lot. Goodbye." And so I had a few little jobs, and then that's when [Ronald] Reagan was about to come in, [Jimmy Carter was already cutting community health centers pretty badly. Health centers had to look for other

third-party money to survive. At that point myself and a real good friend, an old friend of mine from MCHR, Ken Barnes, who was also working in a community health center in Oakland and was also having a lot of trouble dealing with problems there, we sort of thought, "Well, we could just go into practice. What's the big deal? Let's go into practice." So we did. And actually Ken and myself and Sara Syer, who wasn't my wife at that time but is now--

Mullan: When did your first marriage end?

Bodenheimer: It was a long marriage. It ended about 1980.

Mullan: Kids?

Bodenheimer: One kid, the blonde one, Rebecca, is now a senior at Barnard College.

Mullan: And who's the other one?

Bodenheimer: Anna is Sara's daughter, my stepdaughter.

Mullan: Is she the same age, similar?

Bodenheimer: One month apart.

Mullan: Where is she now?

Bodenheimer: She's at Mount Holyoke College.

So basically, Ken and Sara and I looked around, and I had this old friend who was a cardiologist, I called him up and said, "Do you know any practices that we could work at? How do we do this?"

So he said, "Yeah. I heard about this guy who wants to retire. Why don't you call him up?"

So I called him up, and he had this little tiny office out in the sort of southeast part of San Francisco, near Candlestick Park. It was the bottom floor of a house out in the community. It was a working-class community. Across the freeway was Hunter's Point, an African-American community, and on the side of the freeway where we were was kind of elderly working-class and retired homeowners, a lot of Italian, Irish, more white, some Asian and Filipinos beginning to come into the area. I went to see this guy. He was just so happy to see me. He said, "I've been trying to retire, but I just don't want to leave my patients, and if I can find someone good to take this thing, it's all yours." So Ken and I bought the practice for $12,000, and there were lots of patients. This guy, he said, "I want to make sure the patients come back and see you. So the last two weeks of my practice, I'm going to pay you to come in and just meet the patients. I'm going to tell them that they should come see you." So every single patient, said the sane thing. He said, "This is Dr. Bodenheimer. He went to Harvard. He's not that young, so you can trust him, and he's going to be your doctor," and they all came back.

He'd been a doctor who basically--most of his treatments were vitamin B12 shots, estrogen shots, or depomedrol or something. So we had to retrain the patients.

Mullan: This was not located here to begin with?

Bodenheimer: No. It was located about two miles toward the east in this little house in the community. And we got privileges here at Saint Luke's, which was the closest hospital. We started hospitalizing people here. We started learning how to practice in the private world. Sara and I used to do the billing like at ten o'clock at night; we were filling out Medi-Cal forms. We didn't know Medicare from Medi-Cal from anything at that point. We just sort of learned the hard way how to run a small business.

The practice began to grow. We took in Barbara Bishop, whom Ken and I also knew from MCHR, way back. We were all old friends. And the practice continued to grow. When the first HMO came to town, which was Bay Pacific, which then became Aetna, we began to realize that it would probably be a good idea to join up with this thing. And so we paid some money and we joined up with this thing, and all of a sudden we were flooded with patients. Bay Pacific must have gotten us 2,000 patients. When our office got too small, we rented from a GYN group a couple of rooms in what is now this whole office suite. Then we had two offices.

Mullan: This office suite?

Bodenheimer: This one right here, where we're sitting. And we had two offices, and we kind of went back and forth to the two offices, and the thing got bigger and bigger, and we were really, really busy, and the practice just thrived, and that's basically what I've been doing ever since.

Mullan: And you moved it to this locale--

Bodenheimer: About three years ago. We were so sick of having two offices. We got held up. San Bruno Avenue, which was where our office was, became sort of a drug place, and one day someone came in with a big old gun. I wasn't there at the time, but the poor receptionist just was flipped out, you know. I guess this person thought that there were dollars in doctor's offices, which there aren't that much anymore; most things are third-party. That was sort of the last straw. We decided, "We'd better get out of this neighborhood," and a lot of the patients were disappointed, but we moved our whole operation over here. We got the hospital to pay for half of the remodeling and the doubling of the size of this place, because they knew that they had us here, that we admit here, and we were the biggest admitters, and they needed us.

Mullan: So what size? The group's grown to how many, three docs?

Bodenheimer: We now have seven docs and Sara, who is a physician assistant, about three internists, four family practitioners, and Sara. Four of us are women; four of us are men. Four of us are fluent Spanish speakers. We're a very strong community-based practice.

Mullan: And the patient clientele is--

Bodenheimer: Mixed. Right now we're about 60 percent managed care. Maybe about 15 percent of that is senior managed care, Medicare people who have joined the managed care plans. The rest of the managed care patients are working people, employed people and their families. The other 40 percent, a few scattered private insurance people of which there are very few left, workers comp, stuff like that, and the rest is mostly Medicare, Medi-Cal and Medi-Medi.

Mullan: Medi-medi is?

Bodenheimer: Medicare and Medi-Cal, both of them. I would say that we have a cross-section of the world in this office. I mean, we have a lot of Latinos, many, many Filipinos, African-Americans, whites, Indians, Southern Europeans.

Mullan: It's internal medicine entirely?

Bodenheimer: It's really primary care. We don't really differentiate between the three of us who are internists and the four people who are family practitioners. We all do pretty much the same thing except the kids, the family practitioners see kids, and the internists don't. There's really not a whole lot of other difference between them. Ken and I, who started the thing when we were internists, we're sort of internists because there wasn't any family practice when we trained. There's John Cranshaw [phonetic]. He trained as an internist, but he always wanted to do primary care.

[Begin Tape 1, Side 2]

Mullan: This is Tom Bodenheimer, tape one, side two, continuing.

I'd like to ask you a few things about some of the historical developments. Basically, somewhat simplified, you spent the decade of the seventies as a practitioner in a community health center, practicing public medicine to the extent that you were on a public salary and there was some community management, public manager. The last fifteen years you've spent in private practice.

Bodenheimer: Correct.

Mullan: What are your reflections on that, from what you left and what you got and what you see in the two systems?

Bodenheimer: It's funny because all of us, Ken, Barbara, Gary, John Cranshaw, Nicole, we were all trained in public hospitals. Ken, Barbara, and I, who were sort of the major three initiators of the practice, all practiced in community health centers. We all believe in public medicine, we all believe in the single-payer system, and yet here we are in private practice. It's weird. We've always found it weird that we're in private practice. We would all rather be paid a salary; we hate fee-for-service. We don't particularly like capitation.

But there's several advantages to private practice, and even though we're all sort of philosophically and historically public-sector-type people, there are certain things about private practice that we like. Number one, we run the practice. We're partners. We own the thing. There are a lot of small-business things that we have to do that we hate, but we also can do what we want. I mean, we can decide how we want to practice our medicine, decide how we want to put our hours in, work hard enough to make enough money and take care of our patients. We have a certain amount of freedom to be able to do what we want.

Number two, the ability to get good specialty backup, especially ancillary care backup, has been much, much easier in the private sector than in the public sector, partly due to the oversupply of specialists. One thing you can say about oversupply, it may be expensive, but it definitely improves access. If I want a surgeon, I can usually get one within five minutes. I can usually get about five of them within five minutes. And sometimes you need them within five minutes. San

Francisco General wasn't that easy and at the health center it wasn't that easy either, but in private practice, if I want to get a CT scan or an MRI and it's an urgent situation, I can get it like ASAP. So oversupply has its advantages in terms of access to health care. [Inaudible portion] [Tape recorder turned off.]

Mullan: We were talking about community control versus private practice.

Bodenheimer: There is a lot of propaganda that government's bad, but also government in the United States is bad in many ways because the private interests have so much control over it. I think in community control, I think in any kind of governance, there's really a tendency for people to try to use the situation for their own benefit. So then you really have to figure out what kind of checks and balances could there be, or if you have a particularly idealistic group, which I feel like our group kind of is, I would trust my partners to run something much more than I'd trust a group of our patients to run it, I just trust my partners. I think they're generally out for reasonably good things and not particularly out for ourselves. Not a real good answer, but there probably isn't one.

Mullan: Let me go back, in terms of exploring your political activities and your intellectual development. I sense--and I'm interpreting from kind of threadbare knowledge--that you became

politicized in a sense, at least to be much more aware of political stresses and political factors in medicine and society, during and after medical school, and then judging from your résumé, you began to channel some of that energy into writing about 1970 and have continued, it would seem, as a quite rigorous and regular contributor to medical thinking through your writing since then. Is that chronology about right? Tell me about what it is that you have been doing in terms of your writing.

Bodenheimer: Yeah. I mean, there's no doubt that I've been doing a lot of writing, and if it weren't for this practice, I'd do a lot more, because it's busy, and writing is something that has to be done on the side.

Number one, I like being politically active, but I don't really like organizing. I just don't have the personality for it. I much prefer writing and analyzing. That's number one.

Number two, I love to write. It's fun for me. I write very fast. For me to get up at six in the morning and go to the computer and just write, that's the best thing you can do in a day. If you have to go to work later, that's fine. Get some work done on the computer and it feels good. I really enjoy it, and most people tell me that I'm good at it, so that sort of encourages me to keep doing it. So I've just tried to explore a lot of different topics in health care.

I guess the thing that I did most recently is to write this book with Kevin Grumback, which was just tons of fun. This was not really a political book. It's really a textbook, and it's

fairly even-handed, though sometimes it's criticized for being too liberal. Kevin and I had a really good time. I like to write with other people, but I've had some really bad experiences writing with other people, as I think most people who write have, and writing with Kevin is just a sheer joy because we both think big, and we both like to have a sense of humor about what we write. Kevin is, of course, an incredibly up-to-date and perceptive policy person, and he's more the policy work and knows all of the little ins and outs and follows all the literature better than I do, but I do it to some extent, and we both stick to our deadlines reasonably well, and we work well off of each other's manuscripts. So it's just a tremendous amount of fun and stimulating to work with someone who's so sharp and easy to get along with.

Mullan: How do you characterize your writing? If someone asked you what kind of writing you do, who hadn't read you, what would you say?

Bodenheimer: Basically I think that I'm sort of a popularizer. A lot of the stuff that I do--I don't really enjoy doing original research, what percent of the people who go to the emergency room leave after two hours if they don't get seen, kind of stuff. I'm not interested in doing that kind of work. I like to read literature, read what other people have written, kind of summarize it, analyze it, categorize it, and make it simple. I think what a lot of people say about my writing is that it's

clear and tries to simplify things. That's one of the things we try to do in our textbook, which is to take a very complicated health care system and try to make it as clear as possible. So that's really the kind of writing I do. I think it's sort of on the border between academia and more popular stuff.

Mullan: Do you see it as a political expression?

Bodenheimer: Some of it I do. I think that the textbook was not particularly political especially, although there was an underlying philosophy behind it which we actually put out in the introduction, that we believe in health care as a right. I've written a lot of stuff that is much more political, why we should have a single-payer system and why we should get rid of the employment-based method of paying for health care and articles on the tax structure and how it impacts on the health care system, why we should get rid of the private insurance industry. So some of my writing's pretty overtly political and programmatic, and some of it is more like educational popularizing.

Mullan: How do you decide where to go next, what to write on next?

Bodenheimer: Well, I don't know. One nice thing is that the practice, the medical practice, and the writing are very complementary. There are a lot of academics who write health care policy who have never seen a patient even from a distance.

Some of them are very good, some of them have tremendous insight, but I think there's a particular kind of insight that can be gained by seeing patients day-to-day and seeing how complicated things are. I mean, it's very nice to write about, you know, if you're a medical ethicist, and you're writing about do-not-resuscitate orders, it's pretty easy to write about it until you start seeing patients, then all of a sudden it gets about twenty times as complicated, because everyone's different. You have to figure out what's the right thing to do, given the enormous variety of personalities and people and situations and families and so forth.

So I've tried to incorporate my life in the practice in the writings. The book we did has all these little vignettes, little patient vignettes, to try to illustrate the points based on real patient situations. Given the fact that managed care is such a large part of our practice now and our difficulties with managed care is such a frustrating part of the practice, I've become more interested in writing about managed care now, and I guess the last couple of things I've written are about that and also about the general trajectory or future of where American medicine is going.

I'm also still very interested in the whole issue of financing, which seems to have sort of bit the dust when the [Bill] Clinton health plan went down. No one seems to care about health care financing and the uninsured anymore, and I think that's an issue that still has to be written about and has to be thought about. That's still the number-one crime, I think, of

our health care system and our society is that 40 million people have no insurance at all. That's something that has to continually be brought to the fore.

Mullan: Do you have ambitions for writing? Are there topics you'd like to tackle or forums you'd like to use to communicate globally or broadly or anything in that line?

Bodenheimer: Kevin and I have this series in *JAMA*--some of it's chapters from the book--and we may continue to do some of those. We did another that came out just last month on capitation, and those are just articles that are kind of simple, sort of clinically-based articles about different things that have happened in health care. I'd like to continue to do that kind of stuff.

One of the things that Sara and I have actually thought about is writing a book about this practice, because we started in 1980 and now it's 1996, and there's clearly been a revolution in the health care system, not in the sense of revolution of people taking power, but a revolution in terms of the relationship between providers, who used to be on top, and the payers, who used to pay but were on the bottom power-wise. The payers have now come to be on top, and the providers are on the bottom. Now, that's not the real bottom, but in terms of the power structure of the health care system, I think the doctors and hospitals are in a much weaker position than they used to be in, and the big employer payers and HMOs are in a much stronger

position. We've been through that revolution on the ground floor in this practice, and it would be a very interesting thing to sort of chronicle, almost like a sociology text or something, to chronicle what it's been like to go through this revolution in the health care system. It's one of those things that we, Sara and I, think about every couple of months, then we decide, no, we can't do that. We'd step on so many toes.

Mullan: Tell me your view of managed care, both historically, chronologically, how it visited you, and, secondly, how you see it now.

Bodenheimer: Let me do the first one first, because that's sort of personal reflections. We have more and more patients that we get through HMOs. We used to be in three different medical groups: Bay Care, which is a primary care medical group; California Pacific Medical Group, which is a big powerful multi-specialty medical group based in the largest hospital in the city, California Pacific; and Aetna had its own IPA. Being in three different medical groups was just ridiculous, because different patients had to go to different specialists with different rules and regulations based on which medical group they were in. We got our Aetna patients into Bay Care, so we're now only in two medical groups, but that's still kind of ridiculous because if someone's in California Pacific and they need an X-ray, they've got to all the way across town to get an X-ray, whereas there's an X-ray machine two floors right above us.

So to some extent, managed care has a lot of very irrational features to it, and a lot of it has to do with when people have to enroll in something, and then they have to only go to the organizations that the HMO they enroll in contracts with. The whole concept of enrollment is a very interesting issue. At this point I think it's sort of dysfunctional that people should have to enroll in things. Why can't they just go? But the way that things are going now, you know, everyone is going to have to enroll in something, and that sets up these irrationalities. There's the usual stuff that doctors complain about, about having to get authorizations to do things that are obviously reasonable to do, and we spend a lot of money and a lot of time getting the authorization. We probably have two full-time staff people to deal with those authorizations, and it just seems crazy.

That's the kind of stuff that doctors are always bitching about, and to a large extent, the medical profession brought managed care on itself. I mean, with all the abuses of the fee-for-service system, you can't really blame the big payers for saying, "Okay. We've had enough. We're going to take over." I don't blame them. It's just that I didn't do it. I didn't abuse the fee-for-service system, so why do I have to suffer?

One thing that always sticks in our face is we feel like we work really hard. A lot of our days are fourteen-hour days, and then we see these radiologists walking out at 4 p.m. and they make four times as much as we do, it's just really sickening. For me, time is everything, so a fourteen-hour day spent seeing patients and filling out forms and all that kind of stuff is less

time to write and less time to have a life, and that whole differential between specialists and primary care docs, I think, is extremely unfair. It's not just money. I mean, it really is time, because we have to work that hard to make a reasonable income in primary care in a poor neighborhood with a lot of managed care, and the specialists don't. Now, I know that specialists' incomes are coming down, and that's fine, but the primary care docs aren't really going up very much, I think. I think there should be a lot more equality, and I'm not sure that's going to happen.

What I think about managed care theory is that we used to have a dispersed health care system where people would go see their orthopedist and go see their gynecologist and go see their dermatologist, and no one would know what each other was doing, and I think the idea of having a gatekeeper in sort of the British sense or the Canadian sense of someone who's sort of your family doctor who arranges for how you deal with the whole health care system, I think that's basically a good idea. I think it's a little bit rigid, because there are people with chronic diseases who would be better off having, I think, a specialty gatekeeper because most of their problems are in their own specialty and there's no need for a primary care doc. So I think a less rigid gatekeeper system, I think, is a good idea. I don't like the word "gatekeeper." I think "gatekeeper" implies you're denying things or something like that.

What I absolutely despise is the concept that the gatekeeper profits by denying care, by shutting the gate. To me, that is

absolutely, unbelievably horrible. Whether it's worse than fee-for-service, where you make more money by doing more things, I can't say. It feels worse to deny things, and I think the whole capitation plus bonus--if people say we're moving toward a capitation method of paying physicians in the United States, that's not true. We're moving toward a capitation-plus-bonus method of paying physicians in the United States. The capitation is okay. I mean, it's not that unreasonable to get a certain amount of money to take care of a bunch of patients, and if they come, you take care of them. If they don't come, you get paid for not taking care of them. It's not that different, ultimately, than a salary. But the bonus part is the problem, when the bonus is usually tied to keeping people away from expensive services and keeping people out of the hospital. Many managed care consultants say a primary care physician's bonus should be 30 to 50 percent of their income because that would change their behavior, that would make them keep people away from expensive services; well, if in a primary care practice your overhead is 50 percent and you're getting from your capitation 50 percent of what your income should be, that means your capitation payment only pays for your office to run, and there's no money for yourself. That means that the only money for yourself is in the bonus. That means that there's a tremendous incentive to keep people away from services that they need, and I think that's absolutely sick. It's got to be fought, and it's got to be banned.

Mullan: Have you experienced any of that? Do you have capitation contracts?

Bodenheimer: We have capitation plus bonus in many of our contracts, yeah.

Mullan: I thought you were dealing only with two HMOs?

Bodenheimer: In California, we have more of a three-tiered system. The HMO pays money to a medical group. Say the HMO gets $100 per patient per month from a big employer, keeps $20 of that $100 per patient per month itself, pays $40 per patient per month to the hospital, pays another $40 to an IPA medical group. The medical group pays the primary care physician $10 per patient per month, keeps $5 for administrative expenses, and puts $25 per patient per month into a referral and ancillary risk pool.

That referral ancillary risk pool, if we order a lot of expensive MRIs, CT scans, send a lot of people to specialists, that risk pool is depleted. No bonus. So it's in our interest not to send people to specialists.

If we hospitalize a lot of people, a lot of hospital days per thousand enrollees, then that hospital risk pool is gone because all the money goes to the hospital on a per diem basis. If we keep people out of the hospital, we can get a big bonus out of that hospital risk pool.

So both with the outpatient and the inpatient risk pools, huge bonuses are possible, and there are physicians who get

sixty, seventy, eighty thousand dollars a year in bonuses, not around here, but mostly in the big medical groups in Southern California. And again, all the managed care consultants say the more money that's in bonuses and the less money that's in capitation payment, the more we can influence physician behavior just to reduce costs. I just think that is absolutely horrendous.

Now, on the other hand, to go back to the fee-for-service system, I think, with that lack of coordination, I don't think that's a good idea either. So the model which I believe in is much more of a kind of group health cooperative, Puget Sound or even Kaiser model, where physicians are salaried, there may be some bonuses but they're relatively small, pay the docs good money and then the docs don't think about money. Doctors should not think about money. We should just do our job. We should get paid decently and then just do it. In the last few years, with this profit-oriented managed care, the extent of doctors thinking about money, I think, has really gone up enormously.

Actually, a little article I wrote for the *Harvard Medical Alumni Bulletin* really expresses, I think, what I believe.

Mullan: Do you have a copy of that around?

Bodenheimer: I could send you one. I don't have one here.

Mullan: I'll give you a pen, and I'll give you a card to remind you.

Bodenheimer: It's a very short little article that just encapsulates it. So, in short, there are certain aspects of managed care that are good, but I think these financial incentives in managed care and the profit orientation in managed care is bad.

Mullan: Diabolical.

Bodenheimer: Yeah.

Mullan: Primary care. Has it arrived? Is it going to stay? Or is it going to be crashed on the rocks of new technologies and patient belief in sub-specialty medicine?

Bodenheimer: Well, see, I've never been one who's rah-rah primary care. I believe in primary care. I think it's great. People need it. But a lot of those pro-primary-care people have sort of an anti-specialist tinge.

Mullan: I heard you complain about the radiologist going home at four o'clock. I mean, that's not prejudice. That's fact.

Bodenheimer: That's fact. Yeah. The specialist pay can get you down. But I need that radiologist, and that radiologist is absolutely necessary for my ability to practice medicine and the well-being of my patients. I need that radiologist. I need that interventional cardiologist that maybe puts too many stents in

the left main coronary artery, but, you know, some of those stents save people.

Also we fight over the capitation dollar, because since there's only $40 per patient per month for outpatient care, you know, the more of it that goes to specialists, the less of it goes to primary care. We had a huge, huge fight last week here between the specialists and the primary care docs, in which the primary care docs are getting their capitation payments cut, and we went to the specialists, and we said, "We're getting ours cut; you've got to get yours cut, too," and the specialists walked out of the room furious. It's sad.

Mullan: Who was doing the cutting?

Bodenheimer: Well, Bay Care Medical Group's doing the cutting. Bay Care's in bad financial shape. But in terms of medical care part, it's a cooperative venture between primary care docs and specialists. So I don't think primary care docs have arrived. I don't think we have that much power. I mean, there are certain groups in Southern California who have learned how to use the potential power of getting the capitation dollar, because if you get the whole capitation dollar and then you pay it out to other people, especially if you're unethical and not thinking about the patient, what their needs are, you can keep a lot of that dollar. But I don't really care about that part, who's in power and all that kind of stuff.

I would like to see us all be salaried and working together in the same organization and just not think about whether I'm going to lose money by sending someone to a specialist or not. With the specialty capitation, I mean, you see some ridiculous situations come up. If the primary care docs are capitated and the specialists are fee-for-service, then the primary care docs don't want to send people to the specialists because it will cut into their bonus. The specialists want as many patients as possible, but the minute they decapitate the specialists, then the specialists don't want to see any patients, they want to send them all back to us. And all the primary care docs want to send all the patients to the specialists to get them out of their office, because it won't cost any more money to send them to the specialists who've already been paid by their capitation.

So you have these ridiculous situations like the one in a southern California multi-specialty IPA. They capitated the specialists, and the number of coronary angiograms, that had been something like 120 per 100,000 patients, and the minute they capitated the specialists and the specialists wouldn't make any extra money by doing more of them, it went to like 26, an 80 percent drop in coronary angiograms. Well, I don't know which number's right, maybe it's somewhere in between, but the fact that economic incentives could make people change their practice that drastically doesn't speak well for the medical profession.

Mullan: You've mentioned on a number of occasions the growing supply of physicians in San Francisco. Is that palpable? What

is happening to people's practices, both generalists and specialists, in this heavily doctored area?

Bodenheimer: A lot of specialists are getting hurt, and some are leaving.

Mullan: What does "hurt" mean?

Bodenheimer: Their incomes. I've heard of people's incomes going down by 200 and 300 percent. Gynecologists who used to make $400,000 are now making $75,000. A lot of it has to do with this whole channeling, deselection business in managed care. The primary care docs learn to channel their patients to the low-cost specialists, and then what happens is that the specialists who don't get the patients, two things can happen, either they get deselected and locked out of the contracts or their income goes down so low that they just leave. The problem is that it doesn't necessarily correlate with quality. It might. Some of the bad doctors are getting driven out, but some of the good doctors are getting driven out.

Mullan: Do you know people who've left?

Bodenheimer: Yes. Or people are retiring early, and, of course, if you make a lot of money, you can retire early easier than if you don't.

Mullan: Give me a couple of minutes or a minute on your view of the future. Where do you think the system's headed? What's likely to happen?

Bodenheimer: I think we're going to have an oligopoly, a small number in each metropolitan area of big health care conglomerates, which will probably be HMOs plus hospitals plus medical groups all together in one sort of big vertically integrated company or maybe virtually integrated through contracts. They're not that much different in terms of how it looks to the patient.

I don't know what's going to happen with access to care for people who don't have any insurance. It doesn't look real good right now. I think it's going to take a while.

I think that some of the excesses of HMOs making too much money, the CEOs of HMOs making too much money, and hopefully some of the excesses of capitation-plus-bonus payments will be mitigated by regulation, which I think would be good. I don't know if we're going to move in the direction of more of a group or staff model, Kaiser model, which I think is a much better model than this sort of dispersed IPA model that we tend to have here on the West Coast. I hope that we'll move in that direction so that rather than me being in three different medical groups and having to send different people to different specialists, that we're just working in one system.

I would like to see a system in which there are small offices of primary care docs that are feeding many larger multi-

specialty polyclinics, but I'm afraid it may look more like big huge offices, which I think patients have expressed they don't like that much, and I think it's going to get very big, conglomeratized, oligopolized, and maybe more rationalized, and there may be some cost savings involved, but I'm not sure it's the kind of health care system that I would like to see.

Mullan: In summary, as you look back from your earlier days as an activist and your now days as a medical practice leader, are you hopeful or disappointed, frustrated? How would you describe your response or emotions about watching what you've been through, looking back to what you've been through?

Bodenheimer: Personally I'm basically a happy guy. So that's important. But I'm not happy about what's going on in the country in terms of the health care system, but I think also I think a lot of other things are happening in the country that are much more important than what's happening in the health care system that will impinge on the health care system. I think there's sort of an apathy of people, a potential for very bad interracial problems surging again as the economy gets worse over the next twenty, thirty years. I can see really bad things happening in this country. I sort of feel like it's an empire in decline, and I'm sort of glad I'm not going to be around to see it, and I hope my kids are not going to have major problems with it. I think that's going to overshadow particularities with the health care system. So I'm not super optimistic about the United

States. Maybe I'm too pessimistic, but that's sort of where I'm at right now.

Mullan: Anything else you'd like to add?

Bodenheimer: No. I don't have a thing to add. I shot my wad.

Mullan: It's a good place to stop

[End of Interview]

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