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Audio File 1

01-00:00:07
MM: This is Martin Meeker recording an interview with Robert Klein on the 15th of February, 2006 for the Kaiser II project. We are in his office at 1950 Franklin Street in Oakland. Let's just start with some of the basics. When and where you born, and I wonder if you could offer a little description of the context into which you were born.

01-00:00:56
RK: I was born April 6, 1943 in San Luis Obispo. Actually, my family is from the San Jose area. I believe 7th generation San Jose but my father was stationed down at Camp Roberts during the war. So that's why I happened to be born in that area.

01-00:01:19
MM: Camp Roberts is just a little bit north of Paso Robles.

01-00:01:21
RK: Right, correct.

01-00:01:25
MM: Interesting. Just as a side, my family is in Paso Robles.

01-00:01:29
RK: Oh really?

01-00:01:30
MM: Yeah. I know the Camp Roberts area.

01-00:01:31
RK: That's actually where my family was living at the time was in Paso Robles.

01-01:36
MM: And so I assume you were born in the hospital in San Luis Obispo.

01-00:01:41
RK: Correct.

01-00:01:41
MM: And then was it immediately after the war that your family moved back to the San Jose area?

01-00:01:47
RK: We went to Oklahoma at Fort Sill and then moved back to San Jose after the war.

01-00:01:54
MM: In what capacity did your father serve?
RK: He was an officer in the artillery to begin with and then he moved into something dealing with the electronic.

MM: And what happened after demobilization for your family?

RK: Well we moved back to San Jose, moved into the house right next door to where my grandparents -- my dad's parents -- lived. My dad went back to work in my grandfather's auto parts house and he remained in the army reserve for a number of years but as soon as the war was over with, he went on inactive duty basically.

MM: Was the work that your father did after the war similar to what he had done before the war?

RK: Actually he basically went into the military right after college. He was in an ROTC program at Santa Clara University. He wasn't gainfully employed before he went into the military.

MM: So he was at Santa Clara University. Does that mean that your family was Catholic?

RK: Correct.

MM: What brought them initially out to the San Jose area?

RK: I wish I knew. My grandfather again, on my dad's side -- I never knew my maternal grandfather. He died before I was born. My grandfather would get back about one generation, so to his parents and then we never found out much more. I haven't really gone back and researched it but my guess is, given the timing, is probably they came out some time during the gold rush, that era. There was a horse thief or somebody back there that people weren't talking about so.

MM: Interesting. So you grew up down in the South Bay in the 1940s and 1950s. I wonder if you could describe what life was like in the San Jose area in the 1950s.

RK: I remember San Jose as being primarily agricultural. The whole valley was agricultural. Santa Clara was called the garden city. The garbage company was the Garden City Garbage Disposal. It was just nothing but orchards basically and some farms. You would drive out to what is now Blossom Hill
Road on a Sunday and I remember doing that with my family. It was almost an all day outing going up there, going up the hill and looking down and seeing all the blossoms and smelling all the blossoms. Later on in the summer, it was a time when all the fruit was being harvested and the vegetables were being harvested. The canneries were in full swing and if it looked like it was going to be cold, the smudge pots were going and the sky would get dark in some areas just because they were trying to prevent frost damage. I spent a lot of my youth either working in the auto parts house, a variety of different jobs there, or in the canneries. I spent time packing pickles and cutting apricots, and also picking prunes. I think all those things made me feel like I wanted to continue with my education.

01-00:05:41
MM: OK.

01-00:05:42
RK: But it was a very idyllic area and then the city manager in the early '50s decided that he would try and attract a broader tax base with clean industry, and he did. He brought Lockheed in and he brought IBM in and the rest is basically history. All the orchards were essentially consumed by shopping centers and housing developments.

01-00:06:10
MM: You speak of the city manager as if you know something about him.

01-00:06:14
RK: Well I remember his name. He was A. P. Dutch Hammond and I just remember reading the newspaper, the Mercury News, I guess is what it was called. This was a big deal down there and at that time I actually thought it was a good idea.

01-00:06:52
MM: So let's just jump forward now. We've got about twenty minutes to talk and I'm wondering -- I don't know what your memories of Sidney Garfield are but one of the reasons that you were placed on this list for interviewing is Tom Debley described an encounter he had with you in which he talked about this project and he said that you know, amongst the people he talked about, he said your face kind of lit up and that you -- that indicated to him that you had some fairly strong memories of Sidney Garfield and the foundation generation, coming in to Kaiser in 1975 in which those people were kind of finishing up their work.

01-00:07:34
RK: Right.

01-00:07:35
MM: And then there was the next generation beginning to move into the leadership positions and you were kind of right there witnessing this.
MM: So what are your memories of Sidney Garfield and that generation?

RK: Well first of all, I have general memories of the generation.

MM: OK.

RK: I, as you said, started at Kaiser Oakland as a staff urologist there in 1975 and I had the opportunity of the subsequent years, because as I moved into more leadership roles, I got exposed to two more of the people who were, as you said, the founding fathers on both the health plan hospital and the medical group side. I was absolutely struck by the real passion and commitment, and also missionary zeal that they all shared around this way of delivering healthcare and insuring people. It was still contagious and you could understand how they were able to overcome many of the obstacles that this organization had encountered in its early years, and it had to be because of not only their talents but their incredible commitment. Now, with Sidney Garfield, that was a little more difficult to detect because he was, from my experience, a very quiet person. He didn't enjoy public speaking. He didn't certainly blow his own horn at all and just sort of quietly went about creating change. That's what I -- I have little vignettes of memories about Dr. Garfield. The Kaiser Permanente Executive Program which was, at that time, down at the Stanford School of Business, where they took up and coming leaders and put them through sort of an accelerated business course pertinent to Kaiser Permanente. He was invited down as an honored guest one evening to sort of mingle with everybody after the day had ended. People had some drinks and they could talk to him in the like. I remember he was very quiet, basically sat over in a corner by himself and if one wanted to talk to him, you really had to go over there and begin to engage him. So here was this fellow who had just accomplished so much who was just so unassuming and again, quiet.

MM: At this point, how did you know him? How did you know of his reputation?

RK: I don't think I can really tell you exactly when I first started to know him. It had to be when I started to get into a little bit more management and leadership kinds of roles where the people who were in those roles discussed Sid. I can't even tell you the exact first time I met him yet when I met him, he always remembered who I was. I was very impressed by that because I really was surprised he would remember. I had several encounters -- not encounters but several times like I did have a chance to see him but it was always brief discussions.
For instance, at this Stanford cocktail party, did you go up to him at this particular meeting and have a conversation with him?

I did go up to him and have a conversation. I don't remember the details of it. I was actually one of the faculty members down there so I was really trying not to occupy his time to allow the students, the people who were in the course, to actually be exposed to Dr. Garfield because I had had pretty good opportunities to at least be able to talk to him. It was more of a -- I don't think that he and I ever really got into serious business discussions. It was more I was there sort of just happy to be able to be engaged at all with this person who had founded basically the Permanente Medical Group.

What did that mean? There's talk and subsequent interviews with other folks who are going to be focusing on this notion of Kaiser Permanente core values which, depending on who you speak with, are two things or three things or five things. What did that mean to you, that he was the founder of Permanente Medical Group, that he was -- what was the contribution inherent in that?

First of all, I became pretty familiar with the history of Kaiser Permanente, so I was aware of what he had done and just again, what his perseverance had been. I also became aware over time that the decisions he had made, while he had a lot of vision and idealism, were also very pragmatic. When people aren't paying you for the healthcare you're providing, you probably need to find something that will work, along with people from Kaiser Industries. I mean, they came up with this pre-payment, which wasn't brand new as a concept but was one that worked very well. And then when you get into that, then prevention starts to take on a whole new meaning. It's hard sometimes to separate the legend from reality but certainly you know, when you see photos of him and his ambulance I guess and the hospital down there, which is I think sort of a really liberal definition of hospital but when you think of that and you see those pictures and you hear about him fending off the bill collectors or the sheriff because he wasn't going to be rooted out of that area, you know you just -- I knew the history real well and then to actually see the person who had done it, all that history reads a little bit like a novel or you could see it as a movie.

Did you ever end up reading the [Paul de Kruif book]?
MM: Because that in fact does read quite a bit like a movie, screenplay or something like that. It's very dramatic.

RK: No, I haven't read that.

MM: As far as understanding his accomplishments, you would have seen it in the context -- and I'm just kind of repeating what you said -- was the notion of prepaid practice and the way which that then develops or nurtures a greater commitment to prevention, the notion of healthcare as opposed to sick care, I guess, is the way it was described.

RK: Yeah. I mean certainly everybody knew that I encountered that Dr. Garfield was actively pounding down the nails in the concrete forums that -- so people weren't hurting themselves, and that became an important thing for him. I think it became -- it was medically the right thing but it was also the financially prudent thing to do.

MM: To what extent were you aware of some of the intellectual work that he was doing after your arrival in 1975, particularly developing this notion of a total healthcare approach?

RK: I really was unaware of it. I became aware of it, I believe, just about the time I became Physician and Chief at Oakland, which was in '86 or thereabouts, somewhere in that timeframe because I was Assistant Physician and Chief before that. First of all, I had to be involved with it because it was going to take staff and it was going to take space, and so there was a need to understand what was intended here. I never thought that I had veto power over it but I did need to fully understand what was happening. So it was, I think pretty thoroughly explained to me what was going on. I obviously needed to be able to represent it to the rest of the medical center too so they would understand because here was this sort of select unit going off and doing different work. Of course there is always the suspicion that they must be doing less work and not fully sharing the burden. So you know, it was important for me to be able to know what was going on and be able to represent it to everybody else.

MM: So you don't think that you learned of it around '81, when you became assistant, or you think it was more around '86?

RK: I really can't tell you.
The reason I ask is because I think it was the first formal proposal came about in about 1980 and I think implementation started around '81. Garfield died, I believe in '84 and then the final report on the project, at which point in time, I think it had become more -- it was 1987.

That's a good timeframe. I was an elected representative in '81 and then became the Assistant Physician and Chief, and then the Physician and Chief, and so somewhere in there I learned of it and I'm not sure exactly where or how I learned of it. I did become aware of it. I know it was a bit of an issue at the medical center. I can recall that for the reasons I just mentioned. I definitely remember getting the report. I got some updates prior to that but that was -- it was really a unit that was pretty much functioning by itself. I can't tell you that there was a huge amount of interest at the medical center in it other than what are they doing and why are they doing it but no one was waiting with baited breath to determine what the outcomes were or anything like that. I think when it stopped functioning, basically the unit got integrated back into the more traditional KP delivery system and no one really gave it much more thought. From my perspective, it was a very intriguing program. One, I had to think that something was right with it because Dr. Garfield was involved in it but the idea of trying to provide care in a team concept and reduce the number of handoffs of care, and to provide even more kind of one stop shopping, if you will, for the members in it and to pretty heavily leverage the physicians was intriguing. When Kaiser opened, the medical center had had a long history of utilizing nurse practitioners. Nurse practitioners weren't necessarily embraced by every medical center but they were at Oakland. So it was not surprising that the unit itself had really only two doctors, who were well respected and were being leveraged by five nurse practitioners and a health educator, and I think a behavioral medicine specialist. That was intriguing to understand how the membership would respond to it although again, our members at Oakland were generally pretty familiar with seeing nurse practitioners and also how the staff and the physicians would experience, and what it would do to outcomes. I think that was a fascinating concept. As I said, I think it was a concept and probably a lot of what Dr. Garfield did was sort of ahead of its time because when the report came out, I remember getting deposited on my desk this three volume report and thinking well, I don't know whenever I'm going to get a chance to read this with everything else going on and I think to some degree, that's why we didn't hear much more about the total health project for some time. I always figured that report, while it was great later on to use as reference material, it was so overwhelming and massive that you'd have to be extremely curious and extremely committed to actually sit down and read through it. When we got to the adult primary care initiative, the total healthcare project, that three volume report became an important document for us to use to try and put together all the best practices that we were aware of and to put it into something that we would actually have as a critical part of our delivery system. I also think the
contribution of the total health project was -- it sowed the seed. I'm sure of this because when we stared to really look and see OK, what are these best practice elements we can bring together, it was a realization that we came to in the '90s that we had probably researched as much as we should what the best ways for delivering care in an ambulatory setting were and that somewhere or another within our own organization there had been kind of in fact, clinical experiment with or pilot with most everything. So we decided you know, rather than continue to investigate this and bring consultants in and the like, let's really put something together where we can utilize all this knowledge that we have. I think that not only was that three volume report important but I think, as I said earlier, that just the project itself, the awareness people had of it and the sort of diffusion of information around it, and just the introduction of the notion of the teams and the leveraging of the physicians and the like, that was something that sort of just did diffuse within the organization and led, I think, to not only openness around the adult primary care effort but also to a lot of what we actually put into that effort.

01-00:24:25
MM: I should probably let you go.

01-00:24:28
RK: Yeah, I'm afraid so, sorry.

02-00:00:10
MM: This is Martin Meeker interviewing Bob Klein for the Kaiser Permanente project. This is tape number two, interview number two. I know last time we probably spoke for about 25 minutes. We touched on a wide variety of issues. We're going to probably spend the most of the period today talking about as much as you can about the total health project and then about the adult primary care re-design and maybe exploring some of the linkages between the two. But before we get to that, I want to cover a little bit more about your career history here at Kaiser Permanente because I know we didn't get a chance to talk about that last time. Perhaps we can start with a brief discussion of your medical school experience at UCSF, how it is that you came to study at UCSF and what your specialty was there.

02-00:01:13
RK: I went to medical school at UCSF. I had applied to many medical schools around the nation and had a lot of opportunities to go to those schools but that's maybe just because I'm a native Northern Californian. When I actually went to UC San Francisco, it just seemed to resonate. It felt good, I liked the people who were there and I guess I got to stay in Northern California. I don't know that that was a terribly conscious part of the decision but it really just seemed to be right for me so that's why I decided to go there. I guess when I was up there interviewing it was sunny. After my senior year in college, I took a clerkship there at the Langley Porter Neuropsychiatric Institute. I think I
arrived somewhere around June 20th and the fog came in June 21st, and I never saw the sun again for three months. If I had known that I may have altered my decision. So I went four years to medical school there and then did my surgical internship there, and two years of surgical residency and then three years of neurological residency.

MM: So how was it that you became interested in surgery as a specialty?

RK: Surgery and then it was urology, and it was basically because I liked doing things with my hands and I liked the immediate gratification it gave. If somebody had a problem, we most of the time fixed it. They were happy, you were happy and you would go to the next thing. So I think that was the main reason.

MM: And what years were you in your medical center primarily?

RK: I was in medical school from '65 through '69 and then I was at the intern and residency from '69 to '75.

MM: But you switch your specialty to urology after 1972 or thereabouts?

RK: Yeah, in about 1972. I didn't really switch. You had to undergo a certain amount of general surgery training in order to be accepted into the urology program. Urology is a surgical sub-specialty so that was just the prerequisite.

MM: And your interest in urology came forward.

RK: Well it's strange for people to understand but first of all, to my mind, the kidney is a fascinating organ, as most human organs are but I became pretty intrigued by what it could do and does, and also, I liked the surgery. At that time, there was a variety of surgery from microsurgery to pretty gross cancer surgery to endoscopic surgery. So we had that kind of variety that was really quite pleasing. Plus, in my medical school and general surgery training, the urologists always seemed to be a pretty happy group of people literally. So that became sort of attractive. There must be something here as opposed to, at least at that time some of the general surgeons were pretty intense.

MM: Did you find that to be the norm across the profession once you became a urologist?
RK: You know, after a while I wasn't noticing any more. I think it was more of the type of people I was exposed, the actual individuals rather than a general statement about the specialty.

MM: From your resume, it looks as if you started at Kaiser Permanente immediately upon finishing your residency.

RK: Right. Actually, I started even before that. About that time, there was a thawing of sort of attitude in the academic circles, at least at UCSF where Kaiser or Kaiser Permanente was no longer looked down upon as some kind of a second rate healthcare organization and the Oakland Medical Center -- Kaiser Center had been looking for a new Chief of Urology. The Chief of Urology who was there at the time was the first urologist ever in the entire Kaiser Permanente organization.

MM: Who was that?

RK: Bill Knigge, K-N-I-G-G-E. He's passed away but he was a USC trained urologist. So they were looking for somebody to take his place and they hired a chief resident that had actually been in the military. He was a chief resident in the military who had been at UCSF, and he brought along with him another urologist who had just finished training at UCSF. I knew both of them and then they established a training program with UCSF, a urology program where the urology residents would rotate through the Oakland Medical Center. I was the first urology resident to do that. I was a junior resident at the time. The surgical experience there was absolutely incredible, just the variety of cases you saw and the training we were getting. I would go back to the urology department meetings at UCSF just bragging about all the stuff I'd done. Everybody was always comparing notes to see what you'd done. I was probably a little too vocal because the next thing I knew, it now had become a chief resident's rotation and I was at, I think the old Southern Pacific Hospital in San Francisco for a while. So that was back in 1973.

MM: So you were rotated out of the Kaiser position because it was too interesting?

RK: I was rotated out of the Kaiser Oakland Medical Center but I went back subsequently as a chief resident and then they offered me the job, and I was delighted to actually take it. I had looked at other things in the bay area but people I had graduated with were all having to find some kind of a gimmick to build a practice. I loved the patients. I loved the people I worked with. I loved -- I mean the patients, I'd take care of a great longshoreman in one exam room and I'd go to the next exam room and there would be a Nobel laureate from
Cal Berkeley. It was just really fun and it still is. I liked the fact that I didn't have to, at that time, worry about whether or not somebody could pay for what I was recommending for them. I liked the fact that I could leave my patients in the hands of my colleagues and know they were going to get top-notch care and I think they could feel the same thing. I liked the facility and I could still be into training. I could be training people. So it was a good match and I never looked back.

You said prior to joining Kaiser as either a resident or as a physician, there had been some professional prejudice. I'm not sure if that's the right word or opposition to Kaiser Permanente. Do you remember any specific instances in which your instructors perhaps at medical school had talked about it?

I can't remember anything really specific that really stood out for me. I hadn't even thought about Kaiser so somehow, I must have had the same bias in my own mind until I experienced it. There were two pregnant pauses I remember in discussing my future with my family over the phone, and one was when I told them I was going to become a urologist. I don't think that's what my mother had in mind, and then the second one when I said I was going to work for Kaiser Permanente and it was like well, but then after a while you'll actually go out and really practice right? So it was still that kind of very much malingering, sort of misunderstanding what Kaiser really was. From my experience, that really was a thawing. It just occurred right at the time at least as far as UCSF was concerned. After that there was a really steady stream of people that almost immediately started to follow.

So were you initially employed here at the Oakland Medical Center?

I was at the Oakland Medical Center as a staff urologist. One of the other things that intrigued me about Kaiser was I wouldn't have to worry about the business of medicine and I wouldn't have to worry about any of the politics of medicine and I could just practice, and that was great. Then I got the attitude that if I'm going to actually be part of this organization and probably make my career here, I had better really get a good understanding of it. Rather than sit around and complain about something, I ought to be more of the solution than the problem. I got involved in committee work, chaired some committees and then became president of the staff and then became the elected representative from the Oakland Medical Center to the board of directors of the medical group. That was right at the time we were incorporating as a medical group so it was back in the early '80s.

Can you describe that process?
RK: The incorporation process?

MM: Yeah.

RK: I came into it when it was --

MM: What was the previous status of it?

RK: It was a partnership.

MM: OK. All right.

RK: It was a partnership and so the idea was to make it a corporation, primarily because, as I recall, we could protect the personal assets of the -- who were then the partners. There were some other benefits to it too. It was an arduous process and I don't remember all the details of it any more, why the physicians were suspicious of going from a partnership to a corporation. I think they really thought that now they were going to be employees of a corporation whereas before they were truly partners in a medical group. It took quite a while to first of all, let them understand what the benefits were of being in a corporation and also the fact that basically, all of their rights and privileges that they had had as partners would carry over into the corporation. So it was such that there was a vote finally of the partners. It passed. It was sufficient passage to approve the incorporation. Bruce Sams, who was the Executive Director of the group at the time believed that that really wasn't a sufficient -- this bare majority was really not sufficient to make him want to go move with such a large task of becoming a corporation without further discussion with the partnership and dealing with what questions and issues that they might have. So to his credit, he basically opened the whole process up again and then I think several months later there was another vote taken and it passed with a pretty resounding percentage of the partners.

MM: Were you in support of the incorporation?

RK: Oh yeah, I was but the task I had was trying to explain all this. I came onto the board as a newly elected representative not really understanding any of this. So I had to sort of catch up and then I had to keep up. As board members, we spent many, many, many long hours working on the issues of incorporation and then many, many long hours communicating back at our medical centers as to what was really going on and that it was really clear that people
understood, there weren't any misrepresentations or misunderstandings or rumors that needed to be dealt with. So it was a very interesting time.

MM: Well it put you in peculiar situations, one being a physician on staff at Kaiser Permanente but then also perhaps by advocating the incorporation status -- I don't want to say the word insurgent but if it's somebody who is seeking to make change in a previously established partnership, that might set you apart from other physicians. I guess you know, how did you approach that and then I guess the second part of my question that might be related to it is during that period of time between the two votes, what was it that was done to bring the majority of the partnership around to change.

RK: I really didn't experience any alienation that I can recall from the members of the staff at Oakland. I think that what I tried to deal with was to be as honest as I could be. If they had issues to take those back and make sure that they were addressed. To communicate as clearly as I could again, to maintain integrity. I don't recall, and I think I would, if it was really a particularly painful process, and it really wasn't. You had to maintain a sense of humor about the whole thing. I think the concerns were, I mean they were legitimate concerns that the doctors had and I think in recognizing that and respecting that, and then trying to first of all verify in my own mind what the reality is with regard to their own concerns and then to be able to address those, bring them back to the board if they were there. They weren't just at Oakland and that was something that again, the board would work really hard on, first of all to make sure that they understood the issues, two that they addressed them and three, that they were communicated back. What happened between the two votes, as I recall, was just there was a lot more communication that was able to go on. Bruce Sams and his staff were really very, very active in going out to the medical centers on a repeated basis. I think at some of the other medical centers there was a lot more hostility toward the whole idea and to those who were proposing it than there was at the Oakland Medical Center.

MM: Which medical centers were less inclined to --

RK: Boy, I don't recall. If you really wanted to dig into that, of course Bruce Sams could tell you but Bill Petrick, who was the general counsel for the medical group I think had just come on as the general counsel at that time and he was part of the dog and pony show that went around to the various medical centers. He could probably give you much more chapter and verse than I could.

MM: I think he is on the slate to be interviewed.
OK, great. He'll be able to give you some real detail on that and probably he'll have a lot clearer understanding of what all the issues were.

Then you were elected Physician and Chief?

Right. Well actually I became -- while I was the elected representative, I got appointed, which required the action of the Physician and Chief at the medical center at the time, Joe Sender, and the executive director as an assistant physician and chief. At that time, I believe the policy manual of the medical groups define how many assistant physicians and chief you could have. It was based upon the population of members you were serving, and so I became Assistant Physician and Chief while I was the elected representative and then when my first term as the elected representative was, which was a three year term, I decided I wouldn't run for elected representative again because I thought it would be better to have somebody else take that role since I was the Assistant Physician and Chief and it would free up the position for somebody else, and that it was a little bit of a conflict to be in an administrative role in the medical group and also to be the elected representative to the board. Subsequently, any concern around that has dissolved but at that time, it seemed to be more of a sensitive issue. I think it was in '86 that I got elected as the Physician and Chief.

So that is sort of like the Executive Director of the Oakland Permanente Medical Group.

Yeah. You lead the medical group and the medical group functions at the medical center and partner with the Health Net Hospital leadership.

How long did you hold that particular position?

Until I think '91. Then I was asked to come down here to the program, to the regional offices as Associate Executive Director.

Now during this period of time in which you became more involved in the leadership and administration of the medical group, did you continue to practice urology?

I did. When I was Assistant Physician and Chief, I was able to practice medicine at least halftime, which is probably the minimum amount that was really needed. I was still operating in the operating room. When I became Physician and Chief, I was still able to practice but I had to really -- I started
to really scale back the kinds of surgeries I was doing because I just didn't have the volume of those cases.

MM: Just to stay in practice really?

RK: Well, yeah. At that time and to a great extent right now, there was an expectation and at that time a requirement that any physician in the medical group was also practicing. It maintained your credibility, it allowed you to sort of stay in contact with what was going on and I think for most of us, we loved it.

MM: And that is the raison d'être of a physician is practicing.

RK: That's right. I still miss being in the operating room and I love -- I still practice. I mean minimally but I still practice. I love going back to the medical center. That's where the action is. You really get the sense that that's where people are really taking care of people who need to be taken care of, and that's what I think -- that's certainly what drew me into medicine and that's what draws people into medicine I think by and large. So not to go back there would be a real loss, so I still do that. Once I became Physician and Chief and certainly once I became Associate Executive Director, I realized that I really couldn't take call any more because if I had to go to the operating room it really would be unfair. I mean, I would picture everybody involved so I stopped taking call. Now basically, and for many, many years, just an office practice urology, which is still great.

MM: Well you speak about your practice and particularly the surgical practice with great enthusiasm yet you went in another direction. What was the draw to go in another direction?

RK: I think the main thing was, and there are probably three things. The main driving force was that I could have a broader impact, that I could actually improve things on a grander scale. It wasn't just myself and a patient or myself and the department. It was I could really be engaged in this more general activity and improve things. The second one, which I think probably just helped with it, is it started to broaden the horizon of what I could see, what I was doing, and I got to be associated with a whole different group of people who were by and large, equally as motivated as I was to make things better, and you could work together with them. It was and is a very gratifying experience and then the third one was somewhere back in the early days of my practice, about five years into the practice or whatever, I realized that about 90% of what I did yesterday, I did the day before and I did the day before and I sort of said gee, do I want to be doing this for the rest of my life. You know,
just every day and I thought to myself, no, and that was more reinforcing. It was saying yeah, I think you're doing the right thing but once I got to that 50/50 split of my practice with the administration, it was a conscious decision, saying OK, I'm going to sort of leave my practice behind or at least the surgical part of my practice and do I want to do that. I decided that it was worth doing but it was a fairly dramatic decision because of having to think of I spent all those years preparing for it and getting really skilled at it and now I say OK, I'm sort of in some ways changing my career. I don't have deep regrets about it at all but I do have sort of every once in a while become a little wistful about how great it was to be in the operating room and what it was like to help people there but for me, I made the right decision I think so.

MM: Well this notion of being able to create positive change in a context that involves more than a single patient or a group of patients is something that I've heard a lot from people in the leadership of Kaiser Permanente. It seems to me it may be different things to different people I've spoken to you know, and so one of the ways in which you were doing work is working on this incorporation status early on. What are some of the other areas that you were interested in working on that you felt like by going into administration you could either bolster or change?

RK: Well I think one of the prime examples for me is when I became Assistant Physician and Chief. I actually led the effort to establish a hospice at Oakland. It wasn't the first hospice in Northern California Kaiser Permanente. I think it was the second or the third. I was motivated by the fact that I had taken care of a few patients who died of kidney cancer and just the incredible effort that it took on my part to try and provide them with the support, and their families with the support while they were in that dying process, just sort of recognizing how woefully unprepared and under resourced, if you will, I and we as basically a healthcare profession were to being able to provide that kind of support. I mean, it's very time consuming and it's very emotionally consuming.

MM: End of life care.

RK: End of life, the number of phone calls you get from somebody because they all of a sudden just become terrified, phone calls from family, just sort of the hand holding, the emotional support, the human support and just thinking you know, we do all this great stuff to keep people alive and to hopefully make them healthier but we're just woefully inadequate when they probably need us the most. And so I led that effort to actually establish a hospice program at Oakland and it's still one of things I feel proudest about because I think it's -- if you're going to have positive impact on people and their families and loved one, it's a wonderful thing. I think that's a good example of the kind of much
more broader change and broader impact one can have, if you get effectively into some of these administrative and leadership roles.

02-00:26:44

MM: Some of the other issues that other people have spoken about, who I've interviewed, talk about interest in for instance, preventive medicine and health education as kind of one of these core themes or values at the heart of Kaiser Permanente, being a health maintenance organization. So the idea really behind that is to maintain health so people are provided with healthcare rather than sick care.

02-00:27:15

RK: Right.

02-00:27:16

MM: And different ways in which that can manifest. I guess I wonder how that value or that ethic was taught to you or how you've learned it and then how that related to the work that you did in an administrative capacity.

02-00:27:37

RK: Well, to be honest with you, as a urologist, I think the whole notion of prevention wasn't something I was really thinking about. It really is not something urologists get very much involved in. I mean, you can more now but certainly then it wasn't anything that I was even aware of. I became aware as a practicing urologist that there were educational facilities at the medical center that I could refer people to but it really still wasn't a big part of my practice. I don't think it was until I actually -- it was somewhere. I don't know if it was when I was Physician and Chief or when I actually came down here as Associate Executive Director that I really became a real -- I saw it in the larger context of what primary care could do and what we could do as an organization. I think it was David Sobel who actually headed up our health education function here for many, many years who I think really brought to my full attention and comprehension the fact that the primary provider of healthcare in the United States is the individual and it's not the healthcare profession itself, that people, by and large, want to make informed decisions and participate in their own healthcare and as I thought about it, realizing all of the over the counter medications and self help books and of course then with the internet, the number of sites on there for sort of helping people manage their own health. The fact that people generally first seek advice from their loved ones and their neighbors around their health and how they're feeling and conditions and what they should about it made me really realize that we really need to partner with our members even more than I would partner with them in an exam room but to partner with them on a much broader scale to really empower them to really manage their own health and make informed decisions around it. The Health Wise Handbook was brought to my attention when I came down here a year or two afterwards I guess, as something that would be worthwhile for us to promote and assimilate into our own practices. I definitely, very actively supported that and that's grown. At
that time also, I did have a vision for what I was calling telemedicine could be at the time, which was really the idea of using a variety of interactive communications, including the internet, to promote healthcare and now of course, I think we've really kind of come to much fuller fruition there with the Thrive campaign.

02-00:30:42
MM: How so?

02-00:30:43
RK: Thrive?

02-00:30:44
MM: Yeah.

02-00:30:45
RK: Thrive is interesting. It's either the brilliance of the people who are supporting it from Kaiser Permanente or the advertising and marketing company, but it really I think resonates with who we are as an organization. It's not this notion that if you're sick, come in and we'll take care of you but it's the idea that we're really committed to you being as healthy and as active as possible, and that we do do it in a team concept. There's a lot of resources to support our members and our physicians and staff in providing care. It's just got such an upbeat, positive connotation with it and it sort of catches people's imagination. I understand and I've been told that it was the Farmers Market at Oakland that actually stimulated thoughts of the marketing or advertising company that this was -- I think it was great. You know, they could see that this is really what it was all about and now of course that's mushroomed dramatically, and it's starting to impact things much more broadly than just Farmers Markets and thinking in terms of not only the food served in hospitals but the food served in a lot of different places, exercise, the whole works. I mean, I think it's been wonderful.

02-00:32:24
MM: Were you involved in any way in the creation of this campaign?

02-00:32:26
RK: I was not involved one bit. I cannot take any credit for that at all. I wish I could but I can't. It's sort of neat because I've only sort of felt, rightfully or wrongfully, that if you advertise as much, at least in our industry, as much for your own workforce as you did for people on the outside. It was a way to get a message across to your own workforce. I think that the people in the organization are wearing their Thrive buttons because they want to, not because somebody said you should and buying Thrive kind of merchandise. But I get people from the community who are not Kaiser Permanente members coming up and saying gee, I really like what you're doing. I can relate to that. I think that Thrive is almost like the Nike swoosh that they've got that identifies what organization you're talking about.
An enduring logo.

Yeah. We'll see. You'll be able to interview in the future and you can see what happens, but I would predict it's going to be pretty enduring.

Well it's definitely had an impact and maybe as this project goes along, it will make sense to perhaps interview some of the marketing professionals involved in it.

Yeah, because we went through a lot of other stuff before we finally got to the Thrive.

Well you know, this is something that I hadn't thought to ask you about but what was -- and I'm not sure if this is anything you've ever encountered but what has been your interaction with marketing, in particular marketing Kaiser Permanente?

I can remember sitting at the meeting table at Oakland as the Physician and Chief, meeting with marketing representatives who were kind of developing I think a national campaign at the time. I think it was J. Walter Thompson, I'm not sure.

This would have been when?

Back in the late '80s.

OK.

I can't remember. We had a couple of them. Good People, Good Medicine. Again, it was all built upon what probably focus groups and just other information they were able to get from the market of where we needed to put some emphasis, and so the Good People, Good Medicine relayed some of the human side of Kaiser Permanente, which was looked at as a large institution that just sort of got you know, a conveyor belt move through. And then we went to I think Different From the Ground Up which was again, trying to show that we really were different, and we're different than any other managed care organization, which I believe in my time -- my memory of exactly what the calendars were doing at the time is a little unclear but I think this was right about when we were getting into the managed care backlash in the early '90s. So, Different From the Ground Up. Those things never caught
on. If you're a person out in the community, you'd still have trouble figuring out what that all that meant. The good people could miss. OK, yeah but Different From the Ground Up, I don't think that ever really quite got people's attention, as we were trying to differentiate ourselves from other HMOs if you will. I think again, it wasn't really until Thrive that I think everything really took off.

Was there ever any -- because I know that this was you know, in the 1980s which roughly was a period of time in which advertising and marketing really became important in the medical care field, especially with the emergence of television advertisements about pharmaceuticals and so forth. Do you ever remember there being discussions about the wisdom of pursuing a marketing or advertising campaign --

Yeah.

-- and ways in which to do it and ethical versus non-ethical?

Well I remember the board discussion about when the AMA basically lifted their restriction on physician advertising. There was a discussion about whether or not we should advertise or not. It's all sort of vague memory right now but I think for a while we said we shouldn't be and it was probably the wrong thing to do but ultimately, as there was a lot of advertising going on I think, as the competitors were advertising, I think we believed that we needed to probably advertise. I don't think there was every any question that it would do anything but accurately represent who we were. I think as time went on, we started to see some of the advertising that was being carried out in the community and some of it was so outlandish that every once in a while you thought maybe the AMA had been right in their restriction. That sort of holds even today. For a long time and right now I can't remember why but we wouldn't put Kaiser Permanente on the side of the building. So you could drive by a Kaiser hospital or medical office building and you wouldn't even know it was Kaiser Permanente. We'd have signage outside but you wouldn't have major signage on the building like we have now, and that was a big step forward. Finally people agreed to put the signage on, I think because it was again, I think getting over this idea of we don't need to advertise and we really can stand on our own for what we are and people will know. But as other hospitals and medical centers began putting signs on the sides of their buildings, sometimes almost right next to ours -- you know, the Samuel Merritt Hospital down and almost across the street from the Oakland Medical Center had hung their signs out and Providence Hospital did, I think and Peralta did. People started wondering why don't we have a sign on our building. If you could see it from the freeway that would be great. So there was, you're right, there was that sort of evolution in our culture in terms of
should we advertise or not. Even something as simple as putting a sign on a building was a big deal.

02-00:39:22

MM: I know that we touched on this a little bit last time and I'm wondering if we could just kind of revisit it, and that is the Total Health Project of Sidney Garfield. You were a staff urologist at the Oakland Medical Center at the time that this was going on. Do you remember encountering it in any way?

02-00:39:44

RK: I think I was able to demonstrate in the first interview, my sense of timing there was a little -- it also gets smushed together some. Just general recollections is first of all, I think there was a question on the part of the staff there, the physicians there, as to whether or not the people who were working in total healthcare were actually working as hard as everybody else because they had all those extra people there. So there was always that is this really right or not. I do recall as a general recollection, having patients who were in the total healthcare and calling either Terry Alyone (sp?) or Mel Weiner, who were the two doctors there and you know, just conferring with them as I would any other of my colleagues. I know it was generally communicated as to what the model was. The Oakland Medical Center was a good place to do it. Not only was it I guess the home base at the time for Sid Garfield, but it had been one of the medical centers that had really embraced nurse practitioners and so this whole concept of leveraging the physicians with nurse practitioners was one that I think at least had some conceptual acceptance at the medical center. But it really wasn't, I think, until I became Assistant Physician and Chief or Physician and Chief that I got to understand a little bit more about what it really was all about, and that it really was an attempt to see if you could improve the satisfaction of the members by being able to provide them with more sort of one stop kind of shopping, with health education and the like all located in the same building, same module really and with their medical records, at least their outpatient records, finding all their medical records there in the module or the unit and also to determine if it actually had any impact on health and what it did for the satisfaction of the people who were working there. At that time, at least from my memory, it was a pretty novel idea. It certainly was nothing like mainstream Kaiser Permanente was, where at that time it was basically individual physicians practicing in medical offices without really the kind of I think teamwork and mutual support that was possible. It wasn't there at the time. So I think, to Sid Garfield's credit, and I don't know where he got the seed of an idea for this, but to his credit, he was able to launch it. I think as I mentioned last time, I personally believe since I again, I was the recipient of the two or three volumes of outcome information and description of the project. That was one of the reasons at least, that it did not go forward. It didn't expand at the time but rather close down was that it lacked really any effective executive summary where you could say wow, this really accomplished this. This is a very compelling argument to go forward. I don't know even if it had that kind
of a compelling argument but the reports were so dense, it was sort of hard to find that information. After the total healthcare project stopped, everybody who was in it just got re-assimilated back into the normal "Kaiser" practice.

02-00:44:36
MM: You mentioned two perhaps goals of the project and that was increasing patient satisfaction and also increasing the satisfaction of the providers but undoubtedly, there was a third goal of maintaining costs or cutting costs --

02-00:44:51
RK: Sure, sure.

02-00:44:52
MM: -- in some ways.

02-00:44:53
RK: Right. To this day -- I mean, I may have known at one time but I don't recall any of the really outcomes from it. You can certainly talk to people who participated in it and they will tell you it was a great way to practice. But I think that they didn't represent a critical mass and we're not that vocal, I think, in trying to really promote it further. So I think it went into hibernation for a while.

02-00:45:38
MM: You mentioned hibernation. Why did you choose that word?

02-00:45:41
RK: Well I think as the '90s started to roll out and there was a lot of criticism of the HMOs and managed care, and there was also a lot of pressure being applied to really curtail rate increases. There was a lot of competition on the market for market share. We began to look around as an organization, realizing that our current practice model probably wasn't sustainable or at least it needed to get improved. We needed to figure out how to do what we were doing and do it for not necessarily less cost but no real cost increases and also, we needed to do things to improve our levels of service and quality. So we began to formally pilot some healthcare delivery models. I can't remember. There were two or three different models that we used at the time, which one was I think using a lot of chronic condition management within a few modules. One was to use teams and there was another one that I think was the blend of the two but I can't recall very clearly right now. As these pressures mounted and as we started getting more learnings from this pilots, we actually came to the conclusion that from those things, those pilots, from the total healthcare project and just from other sort of home grown experiments, if you will, that had been carried out in this organization, that we probably had at our fingertips all the information we really needed to be able to design some major modifications to our delivery system. So that's actually what we embarked on and engaged a large number of people in essentially coming together for many weeks to take all the information that we had at hand and to design something, which again would be sort of those same kind of functions that we talked about with total
healthcare. It would contain costs, it would improve quality and it would improve the satisfaction of both the members and the staff. A good part of that model was sort of the team-based concept. It's a broader concept of team but it was a team-based concept of delivering care and highly leveraging the physicians. A lot of dependence upon chronic condition management programs, a lot of outreach to patients and members. We made a distinction between members and patients. Patients were people who were contacted because they've got some kind of a problem. Members are people who seldom come in in any given year but they were just as important. We started to look at things in the broader concept also that yes, there was the team that was there which was jointly responsible for a defined segment of our membership and then that the specialists were actually just an extension of the team, and the needed to think in that way to be able to support the primary care team, knowing that also patients would want something different than necessarily just coming into the doctors office, recognizing that office visits were sort of a very, very poor indicator of whatever, productivity and that what we were really looking for is the happiness and health of the people that team was taking care of and it didn't matter if people came in for an office visit or not. So the concept of telephone appointment visits, the concept of group visits also came out of that ambulatory, adult primary care project. So when I say it was in hibernation, I think that for whatever reason, the total healthcare project was sort of ahead of its time, as Sidney Garfield often was but the seed was sown and there were other seeds which were variations on the theme that sort of got sown also. So there was this epiphany at one point saying you know, OK, we can actually see the fruits of these plants and now we can move forward with something. I think today a lot of what we have in the organization in the way we're practicing medicine, you can see it's been an evolution but all these concepts have just continually grown and gotten refined. I think now what we're looking at is how we can more aggressively employ technology to support the same thing. You can use technology to proactively monitor and proactively reach out to members for preventative services. You can do it for chronic condition management programs. You can do it just in terms of being able to have the team or the individual physicians communicate more effectively with the patients. I mean it's a real enabler for that.

02-00:52:30

MM: Was there ever a point at which these dense reports, these conclusion reports on the Total Health Project were actually on the table or being circulated amongst those who were interested in what became the adult primary care design?

02-00:52:45

RK: Absolutely. There were just reams of paper and still reams of paper representing analysis that we really went through. It was a very rigorous process with a lot of resources devoted to it. A good part of it was to actually understand all of those -- the total healthcare, other pilots that we had -- to
really fully understand them, to reach out into the community, to look at their other best practices we could identify that other organizations were carrying out, that the literature supported these things, and then to start to do the number crunching to say OK, if we were to do this what would it mean in terms of resources, what would it mean in terms of savings. At that time reengineering was real en vogue, the whole concept of it and the real focus of this was to improve our service levels, to improve quality. I was the one who established the parameters for the group that was going to be engaged in this.

MM: The parameters meaning the staff that would be on?

RK: No. What we were trying to get out of it.

MM: OK.

RK: What we did, just briefly, is we brought about 90 different people together. We brought all the chiefs of medicine together. We brought people from other specialties together. We brought people from reception, nursing, labor, just a broad variety of people. People from emergency departments. We established this notion of -- I think it's still called big medicine I think, which meant that it wasn't just what was occurring in the medical departments but there was internal medicine adult care that was being provided in the emergency departments and the like. So we sort of had to get our whole arms around all of that. Still we get startled every once in a while when somebody talks about big medicine but that's what it actually was referring to. We brought those people together and said here's an opportunity. We've got a wealth of information and we've got to make some changes. What we want to do here -- and I can't remember the exact metrics that I established but you know, we've got to improve service, improve health, and I think I said we had to cut costs in the whole model when we're all through by 15% or something like that. I actually didn't believe that we were going to be able to do that but I believe that any reengineering work worth its salt was going to resolve in some efficiency and some cost savings. I wanted to have a parameter there so that we weren't improving service and improving health at the same time by just throwing more resources at it because that wasn't going to get us where we needed to be. That group really worked hard but they did very much digest all of the work, including the total healthcare project. The total healthcare project was very influential. Again, you can see sort of what came out of this whole effort as an example of just that fact, that total healthcare and teams, leveraged care. The intent of total healthcare, I think one of them and certainly with adult primary care is that you diminished the hand offs, because we recognized that that's when quality can suffer and also service. The quality when you're having to transfer care from one person to another and so the idea of team care was that there really wasn't that formal transfer having to occur
and it was actually the team that was accountable to begin with, and they could provide a lot more of the services within the team than previous to that because they would have behavioral health and they would have health educators and physical therapists. Basically the behavioral health and physical therapy, that's where a large number of the referrals were being made out of medicine, musculoskeletal problems and the like. So if you could actually house those services at least at the primary care level in the primary care departments, that would improve not only service levels -- people didn't have to go running all over the medical center to get their care -- but it would also improve the quality.

02-00:57:31
MM: So would you say that there was a fairly direct line between total health and adult primary care redesign, particularly in relation to the concept of leveraging physician time and teamwork?

02-00:57:45
RK: Sure. Actually, we had the people on the projects of adult primary care who could actually really go back and sift through the findings from the total healthcare project. I know that with the adult primary care, I know that total healthcare was pointed to on more than occasion as proof of concept. It's already been shown it can work and I think that was really the whole premise that we even undertook adult primary care. Again, we demonstrated to ourselves what can happen. We really have the makings of the model right in front of us. We should stop looking any further and as I said, we still looked into the community to make sure we weren't missing anything but it was all homegrown. You could certainly trace a direct line there. Things that people looked at, people people talked to and that very, very much impacted what we were doing at the time with adult primary care. I've thought this for a long time, it was again, this incubator. Those of us who had been around total healthcare and at all exposed to it, knew it had happened. We knew that it worked and it was just a matter now for it to come of age. What would have happened if Sidney Garfield had never had total healthcare I can't tell you but I don't think we would be where we are today. I can't prove that but I don't think we would be because where exactly this notion of team care came from, where exactly did the notion of leveraging physicians in a way that total care leveraged it. If we hadn't had that, would we have it today or would we have had it as part of adult primary care? I don't know. I fortunately don't have to wonder because we had it.

02-00:60:17
MM: OK. I think I have to change the tape here.
An interesting thing from your perspective is though it must be organizational memory and how the history is represented. I mean, that's just a basic concept with history in general, is how people account for things or recount things.

Yeah, you're right. How are certain stories told. One of the things I'm interested in uncovering and I think this will be a theme for next year is this kind of notion of what are the values, what are the ideas that make Kaiser Permanente unique. You know, a lot of these have been articulated over the past 50 years or so but you know, came into being and were, by a certain measure, solidified by the 1970s. What is the process by which individuals who become deeply involved in an organization learn those ideas or learn those values and to what extent are they taught explicitly, to what extent do they just sort of permeate the atmosphere and then what do individuals do with them. How do they interpret them?

Yeah. It is interesting. I was thinking, as you were saying that I thought you know, I mean I think within Kaiser Permanent or within the Permanente Medical Group at least, I mean my initial response to that would have been well, the values of the organization are just so consistent with the values of people who are in healthcare. It really is doing what's right for the patient or for the member, that it's very easy to adopt that and really just sort of become part of the culture. I know the problems that we've had in expansion so it's been very, very hard to develop the culture and develop a critical mass to support that culture. So it's a lot more complicated answer than I would have as a knee jerk response or just saying thoughts. It's almost a no-brainer saying we did the right thing and the right place to be for people and healthcare.

I guess something that I'll kind of want to get into more but I mean, just along that idea of the notion of the culture of Kaiser and then what comes from it, you know, I think it's no accident, if you will, that total health emerged from within this context of prepaid group practice, non-profit, the idea of preventive medicine as the main theme and then the adult primary care initiative. Also it's an idea that would naturally emerge from that confluence of ideas and then in the history of Kaiser, you also see Morrie Collen’s project on the multiphasic health testing beginning in the 1950s and the 1960s that I think again, might -- if anything can naturally emerge from something else, it seems like that's a logical trace. There are also other projects around the system. I know Vince Felitti in San Diego was doing some work on testing and having that influence in improved care that might have been done also in a group setting, which kind of brings me I think to this one question, the one that I was trying to remember anyway. My brain went bland. And that is this notion of group practice. I think the way that it was conventionally understood
in the context of Kaiser was that group practice was really hospital care, that it was the kind of healthcare that individuals would get would be the kind that you would get in the hospital. So they would benefit from specialists as opposed to you know, a family practitioner or a general practitioner back in the earlier days in which they kind of had to be a jack-of-all-trades.

MM: Perhaps a master of none but then it seems that the notion of what group practice is or can be perhaps begins to change with innovations like total healthcare, adult primary care in which you bring in people like nurse practitioners or so forth. Did your understanding of what group practice meant as a main component of Kaiser Permanente healthcare change and if so how?

RK: Well, I think that when I started to practice within the medical group, I basically took a lot of what was going on just for granted. I mean the fact that I could have a curbside consult with somebody and not have to worry about the fact that you know, I really could be sending that person over for a visit to that specialist or whatever or primary care physician because that was a revenue issue for that particular physician.

If you were providing a curbside consult, you're not going to get paid for it and really could -- not only was I practicing in a group of urologists but it was a larger group and there was never any barriers to essentially being able to get ideas, share ideas or get information, share information about how to manage a particular problem of a particular patient. So that was --

MM: OK, yeah.

RK: Or non-medical incentives either.

Exactly. It was so there was never a problem. At the time when I joined, that whole notion of group practice, at least in the outpatient setting, was a little bit confusing to me because if I wanted to talk to a patient's primary care physician and that physician wasn't there -- on vacation or sick leave or whatever -- I would find there would be nobody covering for that patient. So it was like well how do I find out or how do I discuss the case with the patient or to who do I refer the patient. They have a medical problem they need to be seen for even though they're seeing me in urology. You'd end up sending them to urgent care or to the emergency department or something, which wasn't a very satisfying answer to that. So I think what started to happen with total healthcare, and I can's say this is the absolute beginning because I don't know
that it was, but it certainly extended from total healthcare and into adult primary care is you really had a team that was taking the accountability. So if a person wasn't there, it was not nearly as significant because there was a team there to back it up, and I think that was one of the reasons for having the medical records on location for total healthcare was that you had access to the records of everybody who was being taken care of by total healthcare, not just your own recollection of your own patients. I think that was a real important step forward. I think what we were able to do -- I'm sure it was able to be done with total healthcare but certainly with adult primary care was something which was hard for any of our competitors to imitate, and that was to bring a whole group of people together who could provide care really without consideration as to what the payment mechanisms were going to be. So you could bring physical therapists in. You could bring a behavioralist in. And we didn't have an uproar from the psychiatrist department that we were taking patients away from them. They were actually happy to have the care being delivered at the unit when it was the appropriate place for it and basically the same thing for physical therapy. So it allows one to have a lot more of this idea of a group practice and it started to extend the notion of group practice from just being a group of physicians but a broader group of other healthcare providers who could come together and function as a team. I think the whole concept of group practice continues to evolve for us. I think just being able to identify with everybody in the group. I mean, these were my associates and that we all have the same objectives in mind and that we all basically hold the same values is a very, very powerful thing.

**How was it then that your competitors were unable to do this? So I guess I don't understand the mechanisms of that.**

**Well first of all, in the community, the people don't generally have physical therapists and behavioralists available to them and again, if you are going to be providing -- there's always the issue of who's getting paid for what and so, if I, as a practicing physician out there or as a group more specifically, started to say I'm not going to refer people to psychiatrists any more but we're actually going to provide a lot of that service right in our own units or physical therapy, we're going to provide that in our own units, there's somebody who's ox is getting gored out there because they're losing the referrals, pretty much so in the fee for service community. I mean, referrals are how you live if you're a specialist of any kind. You take a lot of time and effort to nurture referral patents and have the people referring cases to you.**

**That's what golf is all about, right?**

**That's right, I guess the Wednesday afternoon golfing. I mean, to just give you another idea of what group practice is to me, I mean when I was a new staff**
urologist, I mean we were getting a lot of referrals from medicine and pediatrics that we said you know, they don't need to be seen in urology. This person's got a simple bladder infection. They can get treated for it and they don't have to come to urology to get treated for it and the like. So we were able to and the chief of the department was able to engage in a fairly effective educational program. You know about this is what an appropriate referral is. This is how you treat these kind of conditions because they don't need a referral, because you just can't tell people well don't refer. I mean, you've got to give them something they feel comfortable with in terms of being able to take care of the patient. Now in the community you wouldn't be doing that. You wouldn't be saying don't send these patients to me. You'd be accepting them and sometimes you probably say under your breath that geez, this is crazy. So that whole issue of not having to worry that you're taking money out of somebody's pocket because of what you're doing is something that we don't have to worry about basically. Again, I think it supports the whole concept of group.

03-00:12:42 MM:

I mean in essence then, the fewer referrals that go to urology, the more healthy the organization?

03-00:12:48 RK:

Well it’s not the fewer referrals. If a condition can be cared for effectively by a primary care physician, for the most part that's what's most desired by the patient or some people just say no, I need to see a specialist, only a specialist can take of me but it makes the most sense in terms of the utilization of the organization's resources because you're not referring people who don't require expensive interventions be it just a specialist. You're keeping the care where it belongs and that's why even in a prepaid system, that's why prevention becomes so dominant a concept too. First of all, if you can keep people healthy and help them stay healthy, that's to their advantage, that's to the organization's advantage because of prepayment and then if they do need care, you want to be able to provide it in the most appropriate and cost effective fashion. So where the care can be provided in primary care it's generally going to be more acceptable to the patient. It's less hassle of running around to see other people and it's you're being taken care of by somebody whom you know. So we made a big effort, I know in adult primary care to say that if you as a primary care physician or I as a primary care physician picked up the phone and talked to one of the specialists and got advice and then I went back to the patient, I would actually say you know, I just talked to the orthopedist and this is the advice I got, this is what we're going to go with. So the patient knew that they had actually had the advantage of a specialist in that situation but they didn't actually have to go to the specialist. Again, that's just another concept or another way of looking at group.

03-00:15:11 MM:

Well in considering the historical trajectory of group practice, there is, I imagine, for the physician, the acceptable notion that I am engaging with my
colleagues, many of whom are specialists in a different area than I am as we pursue a better practice in medicine but that arrangement perhaps, some would say, would begin to shift dramatically when you bring in more physicians to the group. I guess how did you confront that possible stumbling block?

RK: The only stumbling block that I recall, and it wasn't a major one, would be people saying are we going to need fewer physicians because obviously -- and it's not fewer physicians in the future so we're going to need fewer of us who are here right now.

MM: So a fear of layoffs.

RK: Yeah, although I don't think people ever thought they were really going to get laid off, although I think that may have been a concern in the back of some people's minds. I mean, we were able to demonstrate pretty effectively that what we were really doing here was trying to ease the burden. One of the things that would happen would be ease the burden on the current medical staff, who all felt overworked and also that we were going to pave the way for additional growth. So this was in many ways a way to grow the membership and actually then grow the number of everybody who we would have in the organization providing the care. Maybe it's selective memory but I don't recall that as being -- it's something we had to address but it wasn't, I think, a major stumbling block.

MM: In some of the literature about the redesign, it mentioned there were, in addition to the total health, which actually hadn't really been mentioned much as far as I can recall, but there was discussion of precedence that influenced the redesign within the system in Orange County and Colorado and Georgia. I wonder if you can talk about what was going on in those places and to the best of your memory how it influenced what you came up with here.

RK: Again, it's probably selective memory. To be honest with you, I do recall, now that you bring it up, I believe in both Colorado and in Georgia, they were working with the team approach also but I don't -- you know, I knew at the time because we would talk about what the differences might be and what their approach had been but I don't remember the details of it any more.

MM: OK. And there was also -- and this may be something else that didn't hit your radar but there was a rather well regarded report by the Institute of Medicine regarding thinking about primary care. Do you remember running across that and if it had any influence?
I don't remember the details of it again but I do know that not only had I read it but the people working on the project, the physicians for instance, some of the chairs or the chiefs of medicine and the like were very aware of it, and it did have an impact but I can't tell you what that exact --

You had mentioned that there was a core group of people who were for instance, studying the total health and the various documents. Do you remember who some of those people were?

Yeah. Let's see. Sally Retecki. I think Patty West [Belson?], who is here right now, was also involved in that. Boy, a number of the people who were in what's now QOS, Quality Operations. There was loads of people but those are the two who stand out.

So those two individuals might have a sense about what it is that they were looking at and how it was translated?

Yeah, Sally would. I think the other people who would, the people who were co-chairs of the chiefs of medicine. Paul Feigenbaum, who is down here now, Mike Getzell, who is now an assistant of PIC I think in the GSAA mainly at Hayward. They were both very much really engaged in this and helping lead it. They weren't doing the analytic work but Sally and Patty and others were very much engaged in the analytic work. Sharon Eastman, who is not here. She's retired. She was the project manager for it and she would have a good recollection probably also.

OK. So if I was interested in following up this issue, those might be some good people to talk to.

Yeah, yeah.

You know, I think that we've covered this a little bit but maybe just to kind of get it more distilled. In the most broadest sense possible, what was the impetus for the redesign and then what were some of the very specific goals that you had hoped to achieve.

Well, the impetus was I think the understanding that if we continued to go with the practice model that we had that it was going to continually drive our rates up in an environment where we couldn't afford that, that our service levels needed to be improved. We thought we were practicing good quality but that we could provide even better quality. That our primary care
physicians were feeling absolutely overwhelmed. We had taken some interventions to try and help them but they were still really feeling under the gun. When you penciled it out, you either had to make, to allow them -- and we just started with primary care. The whole idea was to go right through the whole medical group with every specialty and essentially redesign the delivery model but that if you penciled it out and said if we're going to be able to essentially curb the cost increases that we were experiencing and going to be able to provide these kinds of levels of service, you would be adding to the patient load of each one of the internists, which was already at what they were believing, I think rightfully so, was sort of at a breaking point for them.

03-00:22:38
MM:

What was the load?

03-00:22:39
RK:

I don't remember, to be honest with you, what their panels were at the time because there have been so many numbers over the years, but it was a lot. I don't know how many they had but we thought that if you're going to really make this work, you would have to have the physicians with the ability to handle about 3,000 on their panels and if you said that, then it got to a point well how do you do that? You can't do it by having them have to see every patient one on one through office visits and the like. So the idea was to again, leverage them to come together as teams also for the service and quality aspects of things. One of the things that had to happen was that the physicians had to be able to spend more time in the office. So that was when we introduced the hospital based specialists because not only did we think it made a quality issue but it also was you know, if the physicians are spending a fair amount of time in the hospital all the time on call or whatever then they're not available to their patients who need them in the outpatient setting. So that occurred. The idea was to say OK, how do you really get to that point where they have a manageable group of patients but it's probably a larger group with the leverage, the active outreach, the telephone appointed visits, the group visits, all those things. The utilization of other types of providers to provide chronic condition management because that's a lot of what a primary care physician is engaged in doing. That was sort of the impetus, that was what made us feel that we had to move forward with something different and the metrics were -- you know again, I don't remember the specific metrics but we were going to improve by X percentage points the care experience of our patients, the members, the quality measures for how we were doing with the chronic condition management programs and the like, and that took a lot of work to get those in place because there was skepticism if we could really make those work and whether or not they would be effective. And then there was, as I mentioned earlier, we needed cost containment and actually wanted to drop cost out of it. I think those aspirations in terms of panel size of 3,000 or whatever it was were overly aggressive because I think we envisioned at even more effective leveraging than that was occurring required a different mindset on the part of the physicians because they would have to actually be
doing a lot of desktop medicine and delegating to other people on the team; the medical assistants and the nurses alike, some of the actual things which the physicians were normally doing in the office setting. And then there were just other things that started to come in that could actually increase the workload of the physicians, various regulatory requirements, various business requirements, just stuff that started to -- trying to comply with the HETUS measures and the like just started to add to the workload. So I think that was probably one of the -- if we went back and looked at it again, we probably would have said well, let's be a little bit more realistic and a little less aggressive on this but to make it all pencil out, that's the way it had to work at the time, and it really was not bottom line driven. There was definitely costs in it but it was primarily, how do we make this a manageable load for the physicians and actually accomplish all these other things like care and service. One of the things that had to accompany it is we really wanted to get more toward looking at outcomes. You become a lot less concerned about how a physician cared for his or her panel. It was the outcomes you were looking for. If they could figure out ways to really efficiently care for that panel of patients, what we didn't want to do was reward them giving the more patients. We wanted to say hey you know, if you can put your feet up on the desk for a couple of hours do it, but we're going to monitor how satisfied the members of your panel are and we're going to monitor the quality. So we put a lot of effort into getting what we now have. It's called the member patient satisfaction survey but back when it was introduced, it was introduced with a lot of controversy. I remember getting up in front of a large group of chiefs and saying you know, what we have to do is we've got to meet the reasonable expectations of our members, and everybody wanted to modify that. With all these expectations, you can't you know -- the expectation, that doesn't matter and most of them are not unreasonable. The vast majority of them aren't unreasonable. That took a lot of effort to get that survey in place and to develop some credibility around the survey. Those are the kinds of things that had to accompany any kinds of these practice changes. You had to be able to get much better at measuring outcomes.

03-00:28:24
MM: So from what I understand, the main study happened in late '95 is that correct?

03-00:28:30
RK: Main study for which?

03-00:28:32
MM: The redesign, the kind of articulation of that.

03-00:28:35
RK: Yeah. I think it began in '95, maybe '96 even.

03-00:28:44
MM: And then rollout was planned for '97?
RK: The years sort of --

MM: I mean sort of roughly, so you're talking about --


MM: OK. So during that period of time between the initial articulation and introduction of what you hoped to accomplish and then rolling out, there was a period of time in which you had to implement it, which included convincing the medical group for instance, that this would be a good idea. What were the strategies that you used to approach that?

RK: Well, the very first strategy was to go to the Board of Directors and indicate to them what the situation was we as an organization, as a medical group were in and the fact that we needed to have some significant change, and that we actually had the knowledge, the information to accomplish the changes in terms of what were the options we had and what kind of model could come together and to suggest that we actually go through this process of bringing a group of people together to really spend concerted time working on it so this didn't drag out for years, as people were sort of an hour a month or whatever, two hours a month trying to put the thing together. So that was the first thing and so the board did approve going forward with this. I don't think anybody on the board, including myself, probably fully grasped what this was really going to mean and so I think there were times when larger groups of individuals would question what we were doing but basically we brought that group together. It was a broad based group. The key people who had to be really engaged in this were the medicine family practice chiefs. I think one of the advantages of all this was that this practice model was being designed by the people who were actually going to have to practice it and the people who were going to have to lead it locally. I used to say, this wasn't designed by academicians. It wasn't designed by consultants. This was designed by the people who actually are going to live it, and that was one of the real values of it. I think that was one of the keys to really being able to move forward with it because you had people there who were actually almost to a person. There were a few people who were still skeptical when they had gone through the process but we had people who had really, over the time, they had struggled with it. They had asked the questions. They had struggled to find the answers and it had really become part of their effort. Then, with the change effort, it just took a lot of communication. It took a lot of leadership resolve, not to vacillate and waiver around it. It took resources. What we did, with a great deal of effort but what we did was to say you know, we can't have people learning this new way of practicing, learning how to do it -- understanding it and then learning how to do it in their spare time or we can't say well about an
hour, your lunch hour, is the time when this will all come together because we put a lot of effort into how do you function as a team. So we actually funded a lot of training for physicians and staff to be able to actually learn how to do these things and I think that was another element that helped accomplish this. We never really had a vision that adult primary care would suddenly be implemented and we'd all sit back and say whew, finally we did that. It was one that will always be just part of the evolution of how we practice. So as I look back at it, and you say well, did you get it in, was it successful? You know, I'd say yes, we got it in, there's a lot of stuff. We've got team based care right now. We've got very effective chronic condition management programs. We do do group visits. We do telephone appointment visits. The whole notion of internet visits sort of builds on that and you know, we have hospital based specialists in place. I mean, there's a whole lot of stuff that happened but there's a whole lot of stuff that could have still happened and is still happening as it relates to it. So it's just again, it's just part of our progression and progress as an organization, bettering how we deliver care.

03-00:34:22  
MM: As one of the main architects of it, what in your evaluation are some of the areas of the design that are yet to be included, that there's a realistic chance that there could be implementation or there really needs to be?

03-00:34:38  
RK: I don't know that this will ever happen but at least the idea was that at that team base level is that we would actually have a fuller accountability at a team based level, which might include even budgetary accountability within some limits so you had more measurement of performance at that team level. You could measure referrals just to compare it to others and the like. So I think that was one of the other things that was planned but just didn't happen. The rest of it you know, as I said, we really didn't want to stop with adult primary care. The idea was to go through the other specialties and I still believe in my own mind that there are real opportunities for improvement there. Again, it basically relates to leveraging physicians. What we want is to have the people that we're paying to do jobs doing what we're paying them for and to their highest level of training. We may still have the situation in some places but the whole idea of sometimes being understaffed so the physicians actually have to room the patients, I mean if you step back from that just a couple feet, you realize that's really not why people went to medical school and not why you hired them and not why you pay them. Having physicians have to wait around because there isn't an exam room for them to use doesn't make a whole lot of sense. So one of the models, a redesign that occurred up in the north valley was around ophthalmology, and they were able to show very effectively that you could really leverage ophthalmologists. You needed to give them additional exam rooms, I think it was three per ophthalmologist and that the ophthalmologic text and the like could basically take the history. They could do a lot of the pre-work and then the physician basically was able to come in with all that information, perform whatever examination they needed
to do, tell the tech you know, maybe write the prescription or tell the tech what follow-up was needed; they need an appointment for this, they need this test, whatever it is, the tech would actually complete all that work. So the quality of time that the physician spends with the patient is very, very high quality but it's not a long time. I used to get in trouble in some groups for mentioning this but I think it's a lot like what really effective dental offices do. If you ever go into a dental office, the dental technician or whatever comes in, updates your history, takes the X-rays if you need to have them. Somebody else cleans your teeth and the dentist makes a cameo appearance usually but he or she can sit down and say how are you? Is everything all right? How's your kids? You get that real connection but you've spent very little time with that dentist. It's the same thing with a lot of stuff that we do. The traditional medical model is the doctor goes in and takes the history and does everything, fills out the paperwork, enters it into the computer, whatever the case may be and as a matter of fact, what you really need that physician for is a lot different than all of that kind of activity. So I think there is still a great opportunity for that. So that was the plan. It was a very ambitious plan as it turns out, to be able to sort of march through each specialty but we started with adult primary care because that was where we would get the most return. That was where we have our greatest impact, greatest interface with our membership and we figured that was the place to start.

So this notion really of leveraging doctor and doctor time must have been a challenging one for a lot of doctors. I mean, if you look at the plans for the adult primary care project, the most ambitious, optimistic ones for its rollout and maybe into other specialties you know, it certainly didn't hit those marks although as you noted, there are some considerable legacies of the project. Just from your vantage point, what were some of the main stumbling blocks that got in the way of the full evolution of this project, implementation of it?

I think probably there were a couple of things. I think to really have something like this be really successful, you really need support at every level of the organization and I think conceptually, the folks from a health plan of hospitals who really were going to fund it, I mean if you're going to get down to it, my impression was at least a good number of them understood what was trying to be done. They were skeptical about whether or not we could do it and it would have the benefits which we said it would have and, therefore, they were reluctant to fund it. We finally, after a long time, got some pretty good funding for it but I think that was one of the -- the Regional President for health plan hospitals, I remember said to me, he said you know, I've been out in the other regions in this prior role. He said, trying to get people to do this. He said, now I can't believe I'm sitting here saying you know, we can't afford or whatever. So that was one of them. We had a change in medical group leadership at the time and I think --
Ah huh. So the direction sort of changed there. You know, I think there was skepticism or just resistance to the idea that we had to have a huge project to accomplish all this, that it was consuming so much resources that we should be able to make changes with less kind of resource commitment than we were committing. So I think those things were probably -- with more time and with more persistence, it would have gone further more rapidly but I also stepped back and looked at it and maybe there's some pride of authorship here or something like that but when I step back and look at it, it just seems to me we really got almost all of it. It took a little longer and it took a little bit of a different course necessarily than was mapped initially but I don't think anybody in our organizations questions team care. I don't think anybody now questions hospital based specialists. There may be some but not a lot. I don't think there's anybody who questions certainly our chronic condition management programs. I know there's pretty broad spread utilization of telephone appointed visits and group appointments. I think there is very much more of an understanding of you know, you really need to meet the expectations of the members and the member patient satisfaction survey is now part of the fabric of the organization. When I look at it, it basically may not have been quite the course that was charted but it's there.

In all but name right?

In all but name, yeah. It's sort of a dirty name because I think people associate it with this huge project.

But what are the politics of that because I know that the name is not used any more even though, as you argued, the elements of it are in place.

Right. You know, Robbie wanted to do away with it as a name, just figuring it was a big project and he didn't want to carry any baggage around with that, which I can't fault him for but I think that's really the main thing. Many of the people who worked on it, they still every once in a while come to me when something happens and say yeah, that's adult primary care.

Interesting.

Or my God, we finally got -- this is a few years ago. We finally got just put into the agreement between the medical group and health plan hospitals, the full year to year funding of our chronic condition management programs. You know, what a triumph and that goes right to adult primary care.
Are those the disease management institutes?

Well they're not disease management institutes. It's actually the formal programs we have, which are basically to keep registries and to have formal outreach programs and in-reach programs to patients with chronic obstructive pulmonary disease, congestive heart failure, diabetes, asthma. So it's managing these chronic conditions but they're managed in such a way that there is minimum physician involvement in it really. There are protocols that people are utilizing. There's people, either nurses or pharmacists or whoever, who are responsible for really being on top of it on a day to day basis. They communicate back to the primary care physician but the primary care physician doesn't have to be doing that hands on, OK, you need to increase your medication by X amount or something like that.

So the asthma clinic -- 

Or now you need to get a blood test.

So the asthma clinic in the hospital, is that something that was an outcome of this?

I don't know quite what you're referring to in terms of the asthma clinic.

It's like an allergy/asthma clinic.

Probably not I suspect but these are more -- it's proactively monitoring the condition of the patients and where they are in terms of needing a variety of things; needing the tests. Are they getting feedback saying gee, I'm having more shortness of breath, well let's do this. It's again, following protocols. Coumadin management, the anticoagulation management is basically done by pharmacists whereas some years ago, I mean the physicians had to manage each one of those patients. They would get the blood work back and have to call the patient and modify their dosage maybe. Now that's just done, pharmacists will do that and they do it better frankly because that's what they're focused on and that's what they're expert at. So that's the kind of thing that we're talking about.

You had mentioned there was a leadership change in the medical group. Did the redesign program have anything to do with that or was it just a retirement?
RK: You know, it's hard for me to answer that. There was a lot of dissatisfaction and unrest among the medical group. It had to do with one, there was a lot of change occurring and there were some changes that frankly were difficult for people to understand and accept. We had that eleven elevenths or whatever it was called where essentially, physicians, if they wanted to maintain their full income, had to work eleven units rather than ten, and that was I think viewed very negatively. I know what the intent of it was but it probably just didn't work very well so there was a lot of dissatisfaction with that. There were hard times in general in healthcare at the time because there were real again, constraints being put on premiums, what we could charge people.

MM: They began to lift shortly thereafter.

RK: It did. It began to lift. There was a heavy influence of outside consultants in the organization at the time who basically said you had to do whatever you had to do to increase market share, which meant basically you had to really keep your premiums at rock bottom or below. So that put some significant constraints on resources. That's I think part of what led to, especially the primary care physicians, feeling so overwhelmed. You could increase the number of physicians you had but not adequately. So there was just a whole constellation of things that were occurring. How much did adult primary care impact that? I really don't know. I'm sure it had an impact. It was a change and I'm sure that was not something that everybody would embrace but I don't think it was any one thing. Harry Caufield was reelected. He basically, at least conveyed to me, I mean his decision to step down was for personal reasons, not for anything else but he didn't have to step down. It wasn't a forced change in leadership.

MM: And then how was the decision made about succession after Harry?

RK: Well, the medical group has a formalized process that it goes through for succession. There was a nominating committee and the nominating committee nominated, I think or was in the process of nominating a number of people and so they nominated people and went through the normal process of those folks going out and basically campaigned and then were voted on. That was the process. I think it was a surprise to people that nobody on the executive staff decided to run, and I don't know how successful any one of us could have been if we had run because I don't know if we carried enough baggage around that people just wouldn't vote us in. I think that's a possibility. I know at least a few of us decided not to run just because we had seen -- I had seen at least and I think others, the personal toll it had taken on Harry Caufield and just said you know, I don't think that we really want to undertake that kind of real disruption to your personal life and the toll that it would take on us to
actually run for that office. I think at least a few of us had given it very serious consideration but eventually said no.

MM: It sounds like you didn't have any regrets regarding what you talked about, the difficulty of the decision.

RK: You know I don't. I think I had actually thrown my hat in the ring when Harry was first elected and I think at that time it was the right time for me because it was just the right time in my career. I mean, I had probably the full energy level and optimism level and commitment to it, and I think that would have been the right time. I think after seven or eight years of being in the position I was in, which was trying to lead a lot of change and being sort of in the crosshairs of everybody as a result of being a leader in that. Yeah, I was relieved that I didn't have to do that. In some ways I mean, I still would like to have seen what I could have done but I'm not that curious to think gee, do I really wish I had done it and quite honestly, Robbie's done a great job. I think if he had come in and there had been some real difficulties and we were floundering, I may have had some different thoughts but you know, he really has done a terrific job and so I have no regrets at all.

MM: Well I know I've kept you a little bit loner than I anticipated but I wanted to see if we could actually get through the complete interview so I don't have to bother you one more time. One last question, and this is just kind of asking you to comment on an observation and that is you know, from my perspective, learning about Kaiser Permanente, there is something -- I don't know if it's something inherent or if it's something about the individuals involved in the organization that bring certain ideas to it but it really has shown itself to be kind of a wellspring of new ideas about the delivery of healthcare. I'm wondering if you would tend to agree or disagree or modify that statement and you know, in the event that you do have some agreement with it, what is it about the organization that enables that kind of new vision?

RK: That's an interesting question. Well first of all, I think I mean, there really is a legacy. I don't know exactly what impact it has on people's day to day thinking around this but there really is a legacy of innovation. I think most of us at least, I hope the new physicians are but those of us who have been around a while really understand a lot of what that innovation really was. Yes, Sid Garfield didn't start the first prepaid practice but he was one of the firsts. I think another thing is that there are not the constraints that one might have in another working environment inasmuch as the physicians and others in the organization can actually be looking at how to actually provide care better, how to actually work better without having to -- and it's promoted, it's supported. The people who are actually successful are recognized for being successful. It's not something which is put down. I think one of the challenges
we've had is that there hasn't been a dearth of ideas. How do you actually get them to be seen? How do you spread the light or whatever so that the people can see it and how do you support then the adoption of those changes. Maybe that's just the advantage of being in an organization that has a similar approach to things because if you can prove that something is a good idea, a sound innovation then in general, I mean there's support to actually get it rolled out. Sometimes it takes a lot of heroics -- I will admit that -- of the person who is really the champion but those things again, do get out and they do get rewarded. We have, since the day I joined the organization and before that, I mean there is access to research funds if you can prove your case that it's something worth funding. You'll get funded, you'll get time to do it. So in one way or another, the whole idea is nurtured. I can't say it's the primary focal point of everybody's activities but there certainly is room for it, for the innovation and again, I think people get rewarded for it. I don't have a real clear cut answer for you as one thing versus another. Some if it's just got to be plain old cultural and the fact that we can give people some time or they have the time to do it. I mean, not that people don't work very, very hard and work long hours but probably compared to physicians in the office practices in the community, at least in these days, I mean, I think that's a real survival mode out there and you probably don't have a whole lot of time to do things that are terribly innovative, except where they turn out to be sort of survival kinds of innovations.

03-00:58:01
MM: Interesting.

03-00:58:02
RK: And a lot of them you would never hear about because there's no either interest or way of spreading them. Here you can spread them ultimately and there's a lot of good examples of where those things have gotten spread and accepted. Then there's just some great people doing it. I don't think the organization can take credit for the fact that Ernie Bodai got the breast cancer stamp approved by Congress. That's just sometimes people, you've got to give credit where it's due and it's the individuals.

03-00:58:38
MM: All right then. The light is flashing so I think that you need to go.

[End of Interview]