BOBBY COHEN

Dr. Fitzhugh Mullan,
interviewer

Mullan: The date is the 14th of June, 1996. I'm at St. Vincent's in New York City, and I'm with Dr. Bobby Cohen.

Why don't we go back to the beginning, and tell me a little bit about yourself, where you were born, what kind of family you had, where you grew up.

Cohen: I was born in the Bronx in a hospital that my mother cannot remember the name of and that no longer exists, 1948, December 13th. I remember it as Fitch-Severterin [unclear], but my memory is faulty. And then moved at age two to Queens where we lived for three years in a place called House Hills, I believe, something like that. It was Metropolitan Life housing project that was built out in Queens just after the war. And then in 1953, moved to Bayside where I lived for the next eleven years. My mother lives there still.

Mullan: And Bayside's in?

Cohen: Bayside's in Queens. Bayside is just on Little Neck. Great Neck is the first suburb out of city on the North Shore, and it was a split-level, a ranch house, a Jewish ghetto that was built by Mr. Post. That's where I grew up for the next eleven years.

My father was an optometrist, and he wanted to be a doctor, but didn't go to medical school, couldn't go to medical school. It's not exactly clear to me. I think there were some financial issues in his youth. He was sent to optometry school in Chicago. He grew up in Brooklyn. And when he was in his late thirties or early forties, he actually contemplated, probably in his early thirties, contemplated going to Italy to go to medical school at that time. I never realized how serious his own thinking was until much later on. And then he didn't do that and instead, went to law school, which he did in the mornings and worked from 12:30 to 7:30.

Mullan: How old was he when he went back to law school?

Cohen: He was in his late thirties, I think. And loved law school, graduated second in his class.

Mullan: Where did he go?

Cohen: New York Law School in Manhattan. And then basically never practiced law. Really liked studying law, did not particularly like the general practice of law for someone who couldn't afford to not earn a living for his family, at that point, of three, my sister, myself, also a generalist.

Mullan: You have a little tradition.

Cohen: Yes, always a physician, with a sub-sub-specialty, or a sub-sub-shtick in AIDS Women and Children, Cook County Hospital.

My mother was a teacher. She actually was my mother full-time until I was seven, I guess, until my sister was four or five. And then she went back to work teaching typing in junior high schools in New York City, mainly in Queens.

I was supposed to be a doctor. That was something that my father understood about me from early on. He was able to, at a very early young age, figure out that my temperament and intelligence was only suitable for becoming a doctor.

Mullan: And you say this with agreement or not?

Cohen: Well, post hoc, I'm very glad I'm doing it, and I think my amateurish, my dilettantish scientist, as well as raconteur, parts both like being a doctor a lot. I think there were probably a lot of other options that one could have considered, but they were not within his plans, which, later on, created substantial conflicts, although one has conflicts with one's father, at least I did.

Mullan: I did.

Cohen: Right. So that was the plan, although it was not a plan that I was invested in at all, I felt.

Mullan: Were you the first?

Cohen: I was the first, I was the oldest child, first son. My sister is three years younger than I am. I grew up in Bayside, very pleasant community, park across the street. For some reason, streets were thought to be safer then. I'm not sure that they were, but the belief was strongly there.

I went to school in Bayside, junior high school in Bayside, went to Bayside High School. And while I was in high school, although I had no thoughts about being a doctor as I can recall now, or actually remember at that time, I did, during the summer of my junior year, take chemistry for the summer at Cornell [University], and my senior year I think I took physics at Cornell. So when I got to college, I went to Princeton [University].

Mullan: These were Cornell summer school courses?

Cohen: Summer school courses, right.

Mullan: And these were of your choosing?

Cohen: I remember them being at my choosing, although I don't remember the--I actually don't remember them being for any particular purpose. Actually, I had a great interest in science at the time. So I think that's why I took them. I'd take a lot of math. And entered Princeton--not to be proud of any of this, but it just comes out, and I'd appreciate it if you won't make me appear to have too much braggadocio. I was sixteen when I graduated high school, and I started as a sophomore when I started at Princeton. I had already taken calculus and chemistry and physics, and basically just needed organic chemistry to fulfil my pre-meds pretty much, which I took. It was my first class, 8:40 a.m., the first, whatever, September, Monday morning, that was. And after several weeks of organic chemistry, I stopped going to organic chemistry. That's not something that I was interested in.

Mullan: You were age sixteen.

Cohen: I was sixteen.

Mullan: Geez. First class, first year.

Cohen: That's right. My plan at that time was to become a higher mathematician or a neurochemist. Those were the only two options. I subsequently became an English major.

Mullan: What happened to the organic? Did you drop it?

Cohen: You know, I stuck with it, although I don't remember sticking with it. And I think Princeton being a gentlemanly place at the time, one could get by with--they were very helpful to students, not that I learned a lot of organic chemistry. I learned very little organic chemistry, and I got some miserable grade in organic chemistry, but my subsequent grades and scores on boards got me through medical school. But I decided at that point that I wasn't going to be a doctor.

Mullan: Tell me about that. You were an English major.

Cohen: I guess I dropped out. Basically I dropped out my second year there. I think I went there for a week or two and then left. I called up my father and said I was leaving. He said, "Don't." Too late.

It's hard to remember the terrible feelings when I was there. I learned that as a doctor that patients have, fortunately, very poor memories for very painful experiences. [unclear] probably the best example. Every other surgical procedure is another example. It's hard to remember bad things. It's a nice thing about being human, at least the physicality of those things. Pain itself is a hard thing to recall, at least for me and most people.

But it was a very emotional, very painful period. It was not all what I thought it should be. It wasn't pleasant. I got little satisfaction from it, after a lifetime of having a short, pre-seventeen lifetime of having great pleasure in my academic achievement and accomplishment. That was absent at that point. I really remember thinking this, that there was too much reductionism around in the world, and that clients seemed to be part of that process. I mean, I just read Coon's Structures of Scientific Evolution and I was sort of happy in the simplistic notion that science was in large measure a group game of experts who actually knew each other and spending their time proving that each other was right through a cascade of normal science, benefitting each other through the process and not moving very far, but being very happy with the established--

Mullan: [unclear]

Cohen: Right. And their tenure. Although I had no idea at that time what "tenure" meant as a seventeen-year-old.

Mullan: So what did you do when you quit?

Cohen: I traveled. I went to California, I did a lot of drugs, mostly marijuana with [unclear], that's about all I did, actually.

Mullan: This was early sixties?

Cohen: Well, this was '66, '67. LSD [unclear] was definitely around then, [unclear] the number-one psychedelic [unclear] in '64, I believe. I drove by [unclear] this weekend, which was the first [unclear] settlement.

So I traveled, and when I came back, I came back to school the following year, and at that time elected to be a sophomore rather than a junior, which I could have been, and decided to become an English major and spent almost all my time with SDS [Students for a Democratic Society]. And that's basically what I did with the rest of my college career, except for the period when I was pretty much thrown out of college for being with SDS, but then being reinstated. Then was readmitted after a brief expulsion.

Mullan: For political stuff?

Cohen: For political stuff, yeah. This was '67, '68, '69, '70. I eventually graduated in '70, although I was initially in the class of '68 because of the year off and a delay in completing my thesis, which was required for graduation from Princeton, which was on the critical perspectives of the proletarian novel Dorian [unclear].

Mullan: So how did you find your way back to medicine?

Cohen: I went from Princeton to Philadelphia, where I was part of a political collective. Actually, the process of leaving Princeton involved a long trip around the country with a group of friends to find a political collective that we would join. The theory that I came out of my SDS experience was that a reasonable way to help politically, which meant to end the war in Vietnam, to help to create a better place which was non-capital, non capitalism-defined, was

through working as an organizer in communities of people more likely to be significant in a dramatic/revolutionary political process.

So I ended up in Philadelphia in a community called Kensington, which still exists. It was a very, very poor, white, Irish [unclear] proletarian community. Most people did not work, people drank very heavily. The housing was, already in the early seventies, probably every fourth house was boarded up. I drove by a couple of years ago and half of the houses were gone, just disappeared through fire and decay, and half of those are now boarded up.

The community was bordered by an African-American community and by a Puerto Rican community to its south, and our group, which had about fifteen people living in a couple of houses, did community organizing, which meant the food cooperative in which we worked very, very hard to provide cheaper food for a community cooperative which mainly was staffed by us. So that was okay. There was a newspaper which I was very active in writing for and editing. A group that worked in local factories, they made most of the money, and their focus was on workplace organizing, independent workplace organizing. A definitely post-SDS concept. There was a women's group, there was significant anti-war organizing, there was an anti-draft part of our group.

I worked in the youth part of our operation which involved the newspaper and talking with young people, helping getting them involved, improved their writing, or, as happened, we spent a lot of time defending the local white drug dealers who were dealing to whites against police oppression in the local park, for which we were eventually burned out of our house in which I lived.

Mullan: By the police?

Cohen: By the police and then off-duty [unclear]. By the local community who believed that we were Black Panthers, even though we were all white. Although it was true that one of our members was married to a Black Panther who lived in New Haven at the time. But we were viewed as outsiders by the community, which was a very legitimate perspective on their part.

Mullan: By the Kensington community?

Cohen: By the Kensington community, although we had substantial support within the community. We were able to fill the local movie theater when Jane Fonda came to Philadelphia. She did a performance for our group in

Kensington and got local people to fill that whole [unclear], hundreds of people down on buses to [unclear] demonstrations in Washington.

I realized at some point fairly soon that whatever I could do in this community to help, it was not to be an organizer. I felt very distant from the thought processes and aspirations of the people I was working with. I don't think I felt superior to them, although I certainly felt sorry for them. They were in desperate straits and continued to deteriorate, for most of them, but I thought that I could actually be most helpful doing something else.

Mullan: What, in terms of your own ethos and your own upbringing, for that matter, had taken you to that point? Your political activism in college and then your decision to join [unclear] as you did, what brought you there?

Cohen: I was raised with a political leftist perspective. It was mainly couched in homilies or proverbs that were not political in themselves. It was, you know, "It's better to be a sucker than a piper." That's one of the things that my father would always tell me, which was [unclear]. If there was some inequitable distribution of goods, you didn't want to be the part that was keeping it from other people. At least that's the way I interpreted what he said.

I was asked to be a school monitor in fifth grade and was told I had to report certain infractions of whatever the particular rules were. I did, one day, was chased for three hours after school by a guy I had reported, and my father's response was, "What did you expect?" You know, if you want to be a cop, people are going to respond appropriately. This is not what you do. The way to be a good person is not to work for authority to find other people guilty of insignificant or even significant infractions.

Mullan: But your father's philosophy, or your parents' philosophy, wasn't frankly left wing?

Cohen: Well, I think it was not frankly left wing because of the risks as they perceived them. I think they were very risk-averse, both because of their experience of the Depression. My father had a more substantial experience than my mother. They went to City College, which used to be free, and they had homes. Actually, in the Depression, my father's father probably became more successful than my mother's father, who did well throughout the Depression. Some of my mother's uncles were very successful.

I think my father was in study groups. He had a bunch of International Publisher things floating around the house about Marxism, about the Soviet Union. He had been in study groups. He had once had some encounter in

the Army about having a subscription to PM in his locker. PM was a periodical put out during the forties which had a very strong left-wing slant.

The first television I remember seeing was the Army-McCarthy hearings. My father said, "Watch this, look at that. Look at that evil." I guess there were two sort of very evil people. There were several. There was Bobby Kennedy, there was Nixon behind the scenes, there was Joe McCarthy.

Mullan: Roy Cohn.

Cohen: Roy Cohn, right. Roy Cohn was a fascination to my father, as well as evil incarnate. But their friends were not leftist. They specifically did not do that, and that is what became an issue.

Mullan: How much rebellion straight out was there in it?

Cohen: In me?

Mullan: In your pursuing the left-wing avenue you did.

Cohen: Well, I think, in leaving college, you know, in not participating in it, I think there was a fair amount of rebellion. I don't know how one equates that. And fortunately for them, I was away for most of it. They didn't get to see me. I didn't live at home after I was sixteen and a half.

Although I believe most of things I believed then, a little more experienced tactily and strategically, fortunately have lived through the sixties, seventies, eighties, and nineties so far, so I know what it's like to be in this particular mode, this particular era of history, it's not a great one.

It was rebellion, although I'm not sure who made it the rebellion. For example, as I took more leadership roles with SDS and got arrested and got suspended and got expelled, my father would say, "I think what you're doing is right," although we actually did disagree on the national question. He thought class was the major issue. I thought race was equally significant in this country. He really thought that class was. We would have these kinds discussions, but he said, "Let someone else lie in front of the truck," which I disagreed with. I think I expressed my disagreement with at first with fighting and screaming in anger, which was probably rebellious in its nature. Although he wanted me to advance in some class perspective, even though he understood class to be the root of all

problems. He was very proud of me. He'd always been proud of me. He thought my going to an Ivy League school and having all the potential for that, all the opportunities that that would mean, was something that he was proud of and that I should be proud of and take to its advantage.

That was not the way I felt. I hated Princeton. I think that's a total legitimate perspective on Princeton in 1969 was an all-male southern-based, strong southern racist anti-Semitic bastian of clods. Although we did beat [unclear] as SDS in football. I wasn't on the team. So I think there was some rebellion, but--

Mullan: Did he object to your SDS activities?

Cohen: He objected to my SDS activities because they put me in danger.

Mullan: And he was upset with you getting arrested.

Cohen: He was upset with me getting arrested. He thought that I either share that opportunity with other people, or I should let other people take that role.

Mullan: How did you feel about the time in Kensington?

Cohen: I thought that was a very worthwhile experience for me. I think it helped. We did bring a lot of anti-war activity to this community. I think that the mass demonstrations made a big difference in ending the war. Bringing hundreds of people from Kensington for an anti-war demonstration was a very good thing.

I think the ideas of resistance, women's liberation, the political perspective on where power comes from, not that people didn't understand that in some way much more fundamental than I did, was okay. It did convince me, or turns me towards feeling that I was not going to be the leader of the [unclear] proletarian Irish of Kensington. Perhaps if I had been Irish, I could have faked it more.

Mullan: Or had a shot at it, anyway.

Cohen: Some of our group changed their accents to Kensington accents. I couldn't do that.

Mullan: What happened? How did you move from that?

Cohen: It was really after just pretty close to a year that I decided that I would apply to medical school, and then got accepted at Rutgers in New Brunswick, which was a two-year school at that time. And I lived in Kensington and in Piscataway, New Jersey. I was in Kensington every weekend, my girlfriend was in Kensington.

Mullan: The collective had stayed together?

Cohen: The collective stayed together, and just criticized strongly my decision to go back to medical school. They thought it was the wrong thing to do. I think spending most of my time with people who thought what I was doing was not a good idea was very helpful to me in terms of the culture, the socialization of medical school. I was counter-socialized by my closest friends, and I think that was a good thing. It was alienating to some extent. But I think being socialized as a doctor is very problematic.

Certainly my plan on leaving Kensington was to return some day, although I even thought at that time that I would like to be a doctor in Kensington, but I thought perhaps two joined row houses might be a more reasonable place to live than one. I confess that. These one individual row houses in Kensington were a 130-year-old structures which had added on bathrooms on the back of it, and they were extraordinarily small. They were designed as workers' houses for the mills that Kensington supported for the last half of the nineteenth century through the beginning of the twentieth century, as well as for a lot of railroad workers.

Mullan: What was your notion about what you were going to medical school to become? A Kensington doctor?

Cohen: Yes, a Kensington doctor, a primary care doctor in a working-class community.

Mullan: What, in terms of the early seventies, did you define as a primary care doctor? Probably you weren't using the term "primary care."

Cohen: I'm not sure. It was pretty close to the way we took it.

Mullan: Were you thinking GP?

Cohen: I don't think I thought GP, because that represented a number of things which I didn't particularly like. One, once I realized it, it certainly didn't represent any respect within the medical profession, which although I sought not to get for a lot of my time in medical school, I still wanted some legitimacy as a doctor. It seemed clear that you had to be a good doctor, and you had to have some level of training, so I actually thought it meant being a general internist.

I believe some of those words, internist, not specialist, was definitely the thought. Whether primary care was added to that or generalist was added, I don't remember. There was a way that one had to distinguish oneself from specialists. I think primary care was probably closer to what words that I was using in the seventies than generalist. Let me go back and try to remember what I thought through this, because I'm not sure. It was certainly generalists versus specialists. That was the major dichotomy.

Mullan: And you were cognizant of that?

Cohen: Very cognizant of that. There's no question that from the beginning of medical school, this is without knowing anything about medicine, I felt that it was too specialized, that the notion of going to see, as my parent's friends would say, "My G.I. man," was anathema to me.

And so my goal on starting was to be a general internist. I might have used that language too, but it was to not be a specialist, it was to do internal medicine, and it was to work. Initially it was to go back to a community, although when one got into medicine, the notion of working in some public sector quickly became a logical route, rather than being an individual practitioner in Kensington.

Mullan: Let me ask back on the Kensington period here and the political period. Who were your heros, in terms of people you were with or political figures, or were there things that stand out in your memory, people that galvanized you, your thinking?

Cohen: It's a very good question, and I think that I didn't have a lot for a period of time. The ones that I remember were--and they weren't heroes in the sense that I couldn't be like them, were Black Panthers, for example, although I knew there was something unsustainable about those poses on the state legislature steps in the wicker chair. They certainly weren't me. There was something about them which I found very attractive and inspiring.

I think I found [Martin Luther] King [Jr.] quite inspiring. I did not find the early Jesse Jackson inspiring. I may edit out the transcript. He always seemed like an opportunist to me from day one, moment one, post assassination, which I think sells him short actually.

Mullan: But you felt it.

Cohen: But I felt it. In terms of medicine, the heroes were not people I knew, certainly in starting. I don't know when I learned about Horn, but he was a hero.

Mullan: Joshua Horn?

Cohen: Yes. I can't remember when I read his book, which must have been very soon after it was published. I don't remember what month it was published. Whoever published it, I don't remember. I don't remember the date, but it was certainly in that period. And as a doctor, that was certainly a model.

At my medical school, there were no models. There was a nice person, whose name I can't remember, who was starting a family practice program that was not appealing to me. I thought that although I felt, without knowledge, that there was too much specialization and that medical schools and their specialization were part of the problem, I'm not sure. It's hard to remember when one put all these things together.

Certainly that was part of some golden period. It might have been towards the end of it, but it was well within it when medical education equaled NIH [National Institutes of Health] funding to specialists and sub-specialists, and money was flowing, and that's what medicine was. It was to become that. And possibly because that's what medicine was to become that, I didn't want to do that. I thought iconoclasm was a reasonable mode for me to live in.

I also felt, although I think I only read about this later, that a counter-intuitive process was a good one. If everyone was doing one thing, it probably was worthwhile exploring a different direction to try to find truth, because that way lies normal science and counter-intuitively might imply something different or useful, at least something that you couldn't find that was not already implicit in what you had done. It was unlikely that within what was known, we were going to get the answers to the questions that I considered important.

Mullan: You said the first few years you were so connected fairly heavily to Kensington and the group. And the second two years?

Cohen: Second two years, I moved to Chicago, and I finished my medical school at Rush. My sister was there a year behind me in medical school, three years younger, but one year behind.

Mullan: What caused the move?

Cohen: It was only a two-year medical school, although there was a third year available for the first time that year. It's been too many years in central New Jersey. I was not going to spend any more time in central New Jersey. And Rush sounded interesting. It actually sold itself as a primary care school at the time. My sister was there, we were good friends, political, personal. We were siblings. To this day, we are very close.

I went out to Chicago, and we were all--I mean, the zeitgeist was not mine. We were all going to do general medicine, but within a short period of time, it became obvious we were all going to go and do general medicine in Cook County Hospital. And "all" meant eight or ten us or twelve of us at Rush, a bunch of people at University of Illinois, a bunch of people at Loyola, nobody at University of Chicago except the people who were there, the person who was there, Northwestern not particularly. And that was very exciting. I was still slightly estranged from the medical school experience. I didn't understand how to do it exactly.

Mullan: Were you good at it?

Cohen: I was pretty good at it. I was not superb at it. I became much better at it, I think, during my internship and residency. As a medical student, I didn't exactly understand the best way to learn medicine. I think I could have enjoyed my clerkships more and learned more and been better if I had understood. I found it all fairly overwhelming. There was very little clinical experience at Rutgers and I was just started in my clerkship in a hospital that I had never seen before with people I didn't know before. It was a little bit hard, although I did quite well. I didn't get honors in medicine, although I think I would have gotten honors in medicine.

Mullan: You mentioned that you was not only the group of you at Rush, but at other schools in Chicago that kind of came together and headed towards County. How did that society develop?

Cohen: I think there was a central Rush focus. We had a table at Rush, Concerned Rush Students, we were called--CRUSH. And we had a table every day. And actually that was one of my very first days at Rush. I was in my medicine clerkship and I was doing my turn at the table at lunchroom, and my resident, who I'd just met the day before, came down to me and started yelling at me saying, "Your patient is having a G.I. bleed." Now, I didn't know I had a patient at this point. They would have told me. This was my patient. His disparaging reproach to me was an attempt at public humiliation. I was quite intimidated by him as well as annoyed at what had been said.

But Rush was a place where we had Concerned Rush Students, and my sister and Gordon Shiff [phonetic], who had been running the general medicine clinic at Cook County Hospital since a long time already, they were not married at that time, although they subsequently became married.

There was a focus at Rush, and we began a study group with people from Loyola and from University of Illinois. I'm not sure what pushed that. I think there was certainly a desire to find a group of politically conscious medical students who could support each other. It was a reading group that we formed. The reading group read politics, we read novels, we went to plays, we had multiple sexual encounters with the group over the years as we got to know each other. We had parties together, and once the County focus became clear, we had County.

My first encounter with County was at a meeting called by Paul Montner [phonetic]. Paul Montner, I think had been at University of Chicago and was at County. There was a meeting called by the interns and residents, the progressive [unclear] residents that Quentin had recruited who were there at the time.

Mullan: This was Quentin Young, who was chief of medicine at Cook County.

Cohen: Right, the head of medicine at Cook County Hospital. You'll interview him.

Mullan: I have.

Cohen: The subject of this meeting was Quentin's political confusion, as well as backwardness, because of his decision to open up a prison medical service at Cook County Hospital and to require a house staff to work there, as well as by his failure to support whatever the residents and interns wanted to do. There was a leaflet at the time, which I don't have a copy of, but you probably do, which is called the "The Carrot and the Stick." I'm not going to find it. Gordy Shiff may have a copy of it.

Mullan: What was it?

Cohen: It was an attack on Quentin for using the carrot, which I think was giving Bert King the leadership of this unit, this new prison health program with Cook County Jail at Memorial Hospital, and the stick of forcing the residents at County to participate in this thing, using political language, saying, "You must serve the prisoners because they are the most oppressed," probably from Clarence Darrow, from his speeches on prisoners and a lot of other legitimate claims Quentin might have made as to why this was an important thing for us to do. And the feeling that there was no choice or participatory democratic process involved by the residents and interns who had to do it.

I think I went away from the meeting very impressed with Quentin, mildly sympathetic to my colleagues. Quentin at that time was not yet fifty, because I remember his fiftieth birthday sometime after that, and therefore seeming quite old to me. This was 1973, so I was twenty-four.

Mullan: This was your junior or senior year?

Cohen: This was my junior year at medical school.

Mullan: In the interest of time, we should probably move quicker, moving towards your move to County.

Cohen: I went there as an intern. My first rotation was with Jack Rayba [phonetic], who subsequently went on to replace Bert at Cook County Jail. County was an amazing experience, as you've heard from a lot of people. I don't know if I have anything novel to say about it.

Mullan: Tell me a little bit about it.

Cohen: We were going to County. It was very exciting. It was the logical thing to do. It was my number-one choice in my match, as it was for everybody, my friends who went there. I don't remember the numbers when I went there, but I'd say it was about half FMG, half AMG, mainly from Chicago. By our next year, we had recruited a large a cadre from Syracuse who were running around the country trying to find the hospital where they could collectively come and do general medicine, primary care, serve the people, be at County. Extraordinarily exciting.

The attending staff at the hospital were nonexistent when I was an intern. It's not true of all of them, but it was true of most of my attendings. They would come by once a week, every other week, and we would entertain them with a few stories. The resident was responsible. The resident was Jack Rayba. Actually, I succeeded Jack Rayba. He was an intern. I had to read his office service notes, which were perfect in grammar, perfectly legible handwriting.

I had a wonderful resident from Spain. And that was important that the most of the FMGs, or a large number of them, particularly those who were not from India, but certainly include some from India, had a vast experience in the student movement in their country, in South America, in Spain, in Italy, wherever.

I was on strike during my internship, and we struck for paddles for our patients, EKGs available after midnight for our patients, STAT laboratory tech available after midnight. We had no financial interest in the settlement. We negotiated our dollars in minutes, and we went on strike for patient care issues. And that was spectacular. I thought that was great.

Mullan: And the outcome of that?

Cohen: Was that a number of people were jailed for a number of days, Jack Rayba, president of the union. Jack Rayba certainly represented a trend within County, which was people who had tried and then rejected the priesthood as their goal.

Mullan: Had he been [unclear]?

Cohen: Yes. The strike was successful in terms of some of our demands regarding--I don't think we really ever got sheets for the patients. We might have. We didn't get sufficient towels. We certainly didn't get enough blankets, but we did get laboratory studies available and a number of clinical issues that we won. And it was very inspirational.

The difficulty of running a professional strike, a strike of professionals, because people view doctors as people who make a lot of money, we did very well by focusing on issues that we did. We certainly built a house staff union, which generally took good stands, although in the end got the house staff out of jail three years later led by a leftist of a major organization. I'm not sure what she wants me to say about this. I'll edit this later.

The president of [unclear] Association should have known better, but was an opportunist, I felt, led a movement to get the house staff out of Cook County Jail because they didn't have CAT scans available on site, because they didn't have arterial blood gasses available on site. I was against that strike, but it didn't matter.

Mullan: How badly was the care at County?

Cohen: I think it was pretty terrible. The senior medical staff and Quentin sought very hard to remedy that, although, as he told at the time, he has pulled in a lot of favors, tried to pull in a lot of favors when he accepted the job, and didn't get that many, didn't get many people to pay back.

Mullan: What was the jail like?

Cohen: Actually the jail was not an unreasonable place to work, as things go. For me, it was a great experience because I felt honored to be taken advantage of by the prisoners. This was the feeling I had. People came there and said they were sick, and if I could do something to help them, even if they were "manipulating me," I felt good about that. In fact, they weren't manipulating me. That was the only way you could get anything, ask for something for a cold or for a more serious problem. I actually always enjoyed talking with the prisoners.

I worked with Jack Rayba. Me, Jack Rayba, and Bert King worked there together for a month or two in 1975. It was just part of the series of amazing experiences that Cook County was. It was certainly a very positive one. We thought very carefully about it. Bert was doing research on TB, TB in jails. He was a very inspirational person. He was very, very smart. He was working in the jail in Cook County Hospital with his MD, PhD, and his humility.

Mullan: You spent three years as house officer at County?

Cohen: Actually four, because I think Quentin instituted a chief residency. I might have been the first chief resident or the second chief resident.

At that time I was totally attached to County. There was nowhere else to be, there was nothing else to do. And chief resident seemed like something that he wanted, which was helpful to me.

[Begin Tape 1, Side 2]

Mullan: Side two of tape one with Bobby Cohen. We have a little aside here of a medical event occurring just as we speak.

Cohen: This is in confidence, and I will edit out the transcript.

Doris Rangle [phonetic] came to me about three weeks ago. I was not her doctor.

Mullan: This being the mother of a close friend who died recently, a close friend of both of us.

Cohen: His son, who is my patient, Arthur, brought her in and said, "Finally brought her in. I've been trying to get her in here for months. You have to help her. She's coughing and she's short of breath, and she has tremendous pain. She won't admit it, and I know she's not going to tell you. You have to know that that's the case, and I'm going to leave now."

He goes out to the waiting room of my office, and Doris tells me that, and I examine her, and I say, "There's something seriously wrong. I'm not sure what it is, but there's something quite seriously wrong. What do you want me to do?"

Because she's a very intelligent woman, and what she thought she had was cancer, she said, "I understand."

I said it's probably cancer. I think I told her that at that point. I don't know. I didn't even have an X-ray at that point, but she had lost forty pounds and she probably had a sixty-pack-a-year smoking history. And she said, "I don't want to go into the hospital. Let's do whatever I have to do as an out-patient. And when I have to go into the hospital, I will, but I don't want to go."

So I got an X-ray that day which showed a right upper lobe pneumonia, Hyler [phonetic] mass, and no bony changes although she had severe osteoporosis, and the X-ray report was, "Can't see bony changes because of severe osteoporosis. Recommend bone scan."

I scheduled a [unclear] bone scan or a tomogram [phonetic] for the following week. I saw her on Thursday, and on Wednesday her pain was too intense, and although I had given her analgesics and antibiotics for her pneumonia, she initially felt much better and then felt worse, and I admitted her to the hospital.

The X-ray was the same as the previous one. The pneumonia was better, but the mass was very prominent. I scheduled, through connections at the hospital, a bronchoscopy the next morning.

The question at that time which I was aware of was, is this tuberculosis or is it cancer. The history was very consistent with cancer and an obstructive pneumonia, although tuberculosis certainly could not be ruled out.

Nonetheless, because she was Doris Rangle, and because we were eager to make a diagnosis quickly instead of putting her in isolation and treating her for possible TB for several weeks, instead we got sputa and did a bronchoscopy. The sputa was negative and the bronchoscopy showed O-cell carcinoma. We knew that by the next morning, and she elected not to get chemotherapy. She's getting radiation therapy. She's dying, but she's not in pain and comfortable.

The call I just got was from the floor that her AFB had drawn out positive.

Mullan: She has both.

Cohen: She has both. This is four weeks later. Part of it's that the primary care doctor is letting the personal get in the way of the care plan, because it was obvious to me and the pulmonary that tuberculosis was the preferred option at this time. One wanted her to have tuberculosis rather than cancer, but it looked like cancer, the bone pain, the history, the mass on the chest X-ray. And there were two hours of diagnosis of pulmonary cancer, O-cell type, by definition metastatic, although we sometimes pretend that it's not.

Mullan: But it improves the prognosis a bit.

Cohen: No, well, she has O-cell cancer.

Mullan: Right, but [unclear]?

Cohen: Oh, no. In fact, I don't think it improves it a bit. It just creates a management problem for the hospital that she's been around without treatment. Although she's been in a single room, she was certainly coughing a lot when she came in, and she will have to be in an isolation room. People will have to wear masks. And I think, in retrospect, we should have done everything but isolated her until we were sure. Although we got the sputums back and they were negative. We had multiple sputums which were negative, so she would not have been isolated.

Mullan: Let's get back to your story. Cook County Hospital. What happens next? We're in 1975?

Cohen: 1975, 1976, 1977, 1978. I'm a chief resident. Actually, I had a relevant encounter as a resident, in which I had a patient who did not have a primary care disease, or generalist disease, although I recognized that and failed to recognize it. A young woman came in with a pleural fusion, and the fluid didn't show anything, and no one had a diagnosis, and I thought we had to do a thoracentesis. The pulmonary service, which was taking its time in helping me take care of the patient, did not want me to do a thoracentesis, and I didn't understand their logic and why I shouldn't do a thoracentesis.

A thoracentesis was performed and the patient had a complication of the thoracentesis. She had pneumothorax and became shocky, although she recovered. The head of pulmonary medicine decided that I should be thrown out of hospital for this--Whitney Addington [phonetic].

Mullan: This was thoracentesis that you performed?

Cohen: That the house did perform. It could have been me. I don't actually think that I did it.

Mullan: It wasn't the pulmonary service?

Cohen: It was not the pulmonary service. It was my feeling--you know, we had no attending support at all, and it was my feeling at the time, and it continues to be my feeling, that when you're the patient's doctor, you consult with specialists and you take their recommendations or not. One is foolhardy to not take recommendations when one is way out of one's area of knowledge and expertise, but the request for a consult does not imply that you are going to do what the consultant says.

That's not the way Whitney felt, Dr. Addington, and that's not the way Quentin felt, because it came up to a hearing, because he called for my immediate termination from the house staff. It's just an attitude, but it does reflect a feeling that I had, and I know Bert and I teach together and have for the past eight years, and that's the way we approach it. And that's the way I approach medicine, too.

At that point, there was no question about me being a generalist and not a specialist. If I was going to be a specialist, I would have been an infectious disease specialist. I found that the most challenging. I think I have an aversion to doing too many procedures, so I wasn't interested in the financial rewards of being a proceduralist. But I also found the intellectual work of infectious disease very interesting. There was a model specialist at Rush, a guy named Stu Levin, who is now chair of medicine there, has been quite a while, though he was head of infectious

disease at that time. And the way he taught and the way he thought made me find that to be very appealing. But I didn't do that. Instead, I did a chief residency.

Actually, during my chief residency or in my first year as an attending, I then became an attending at Cook County Hospital. I had two job offers. I had one from San Francisco General Hospital working for Dick Fine [phonetic], which I only got because Quentin was having trouble getting his budget together and not promising me that I had a job. And so I said, "Quentin, I have a job in San Francisco unless you give me a job here." "Okay, you have a job." I'd been asking him for months and it wasn't really a question, but for some reason I thought I had to move Quentin at that point. [unclear] in County and that's the only thing I wanted to do.

During my first year as an attending, I did get the assignment of writing a grant for a primary care residency program, and I was the first person among anybody I knew, certainly the first person anybody who knew me knew who would use Federal Express. This was, I think, 1977. It could have been 1978.

Mullan: Did you get your grant in?

Cohen: I got the grant in. It was not funded, and I think that was a very legitimate decision on the part of Washington because I didn't know what it meant to put together a primary care program. I had no assistance.

Mullan: [unclear] Federal Express.

Cohen: But I knew that Federal Express was the way to get a grant proposal in. It was a long night, and my sister and my friends helped. I don't remember Quentin actually helping that much.

Mullan: Was she at County as well?

Cohen: She was at County. At that point she was probably a chief resident at County. We actually had the program for the CPC which the chief residents run and a resident would prepare. I was the chief resident, she was the resident. She was presenting. It was actually, in 1978, a case of CMV pneumonia in a drug addict. They posted the real diagnosis at that time. I think my sister became pregnant soon after, or may have been pregnant at the time. The child came out very premature, but is doing well.

Mullan: So your time as an attending--

Cohen: Attending was for two years, and attending at Cook County Hospital meant that I did two clinics in the general medicine clinic, and loved it. These were my patients that I had built up over the previous three or four years, and couldn't get any new patients, but had a lot of patients who were my patients. This was Chicago. I'm sure 70 percent of them were black women from the South, in their forties or fifties, with hypertension and diabetes. Syndrome X. We didn't call it at that time. And they were great. I took care of some of their children when their children came to the hospital with endocolitis [phonetic].

The clinic was a very difficult place to work. I think I was actually offered a job. I think Ron had the job at some point, Ron Chanski [phonetic], of being the head of the clinic, and he took it, although it was a job without authority to do anything. But I loved County.

Mullan: Is this the Fantas [phonetic] Clinic?

Cohen: It's the Fantas Clinic, the general medicine clinic at Cook County Hospital.

Mullan: And what was it like at [unclear]?

Cohen: It was very decrepit when I was there. It subsequently was rebuilt. A new Fantas Clinic was built, a so-called Fantas Clinic, before. It was fairly decrepit. We had little cubicles with curtains. They were the size of a desk, an examining table. The examining table was certainly the length of it. The amount of room it took to maneuver between the desk and the examining table, which were parallel to each other, was the size of it. They were at low levels, so there was no privacy. Certainly no sinks in the room. There were public sinks in the corridor outside of the curtained cubicles. There were some wonderful attendings around by that time.

Mullan: So, primitive as far as the amenities go.

Cohen: It was very primitive in terms of amenities. It was very primitive in terms of laboratory tests getting back to us in any timely manner. Consults--I don't recall them being very easy to obtain. Any complex procedure required admission. CAT scans would take forever, X-rays would take forever, blood tests could take close to forever.

What Cook County Hospital's clinics represented to the patients there was the county, which was this place where they could go for free. Previously they had needed a letter from their alderman to come to County. Basically, and we understood it, but I didn't understand it as much as I do now, it was free drugs. There was a pharmacy which dispensed medication. That was what the clinic was about.

Mullan: As opposed to some other doc where you wouldn't get free drugs.

Cohen: Right.

Mullan: So you spent two years there. What next and why?

Cohen: As well as working as an attending, which meant attending on a floor for twelve out of thirteen four-week periods every year, that's what an attending physician is. I thought I was the luckiest person in the world to have this job, but it was actually a very difficult job. At some point I began working--Bert asked me to basically replace him on a project on the epidemiology of epilepsy among prisoners, which was funded by the Surgieski [phonetic] Foundation, which was some money that was supposed to be for cerebral palsy that ended up going for epilepsy to a lot of friends of a man named David Hunter. All the people on the committee that allocated the funds got the funds. They were good people, though. There's Merlin Sessor [phonetic], there was Quentin Young, and a bunch of other very nice people around the country. Bert organized the project studying epilepsy among the prisoners, and when Bert left to go to New York in 197--I'll think it out on the transcript--I took his place on the project.

At this point, I was beginning to realize that I needed something like a career. I thought of it as a shtick at the time. I had never thought of that before, but it began to surface in my mind. I didn't want to be a specialist, which was a career move. I wanted to be a general internist, and I thought that that actually meant at that point becoming an administrator. I asked Quentin, and then Quentin left. I think he had successfully changed several clauses in the constitution, that he had beat the County board in a number of fights, and then after fighting successfully, not being fired on many occasions, he quit. We were all terribly upset, recognized that that's not an illegitimate thing to do. There's something not quite as valedictory which he could have said at any moment, or his tenure, preceding seven or however many years it was, but he chose it for his political purpose. At that point, nothing had really changed, but he didn't want to do it anymore. I didn't respect him as much as I do now for that

decision. And then he put someone else in, he was pretty much able to choose his successor, and he made a mistake in choosing the chair.

But I asked that person for a job as the director of general medicine. It was the job that I wanted. That would have been in 1981, spring of '81.

Around January of '81, I got a letter from Bert King asking me if I wanted to come to Rikers Island--a letter, not a phone call. I don't think I had ever gotten a letter from Bert before, and he sent me a letter telling me it was a great place to be, and that I should really consider it, I should come back and see it, he would love it if I would work with him.

Mullan: Rikers Island being a New York City prison?

Cohen: A New York City jail, an island close to LaGuardia Airport, which had most of New York City's jailed prisoners on it. I tried to negotiate a job at County and was unable to. I was actually in competition with Ron Chanski for such a job. I don't think either of us really got it, actually, got the job that we wanted.

So I went to New York. I miss County terribly to this day, County being a tertiary care institution, but for us, we thought we were doing primary care and general medicine. And we were. We were working in the clinic, and we were taking care of people in hospitals. It was very hospital-based, but we were totally committed to the general medicine clinic. That's what we did. Quentin's motto was "Every admission is a failure in out-patient care." He was wrong, but it was a good slogan.

Mullan: So you came to Rikers in '81.

Cohen: In '81, and I worked there for five years.

Mullan: What was that like?

Cohen: That was a spectacular job. My mother and her friends thought I was the only doctor on Rikers Island, and I was actually within nine months replacing Bert as the director of a program of 300 to 400 medical staff and five clinics and a pharmacy program in it.

Mullan: Three or four hundred medical staff? Wow.

Cohen: Yes. It was a $25 million budget.

Mullan: That's not physicians, that's--

Cohen: That's everything, nurses, nurses' aides, pharmacists, laboratory technicians. It had a lab.

Mullan: How many prisoners at any one time?

Cohen: Today there are about 21,000. When I was there, there were about thirteen-some-odd thousand.

Mullan: All on that island?

Cohen: All on that island. I'm not sure. There were thirteen on the island when I was there, there were another couple of thousand around the system. I'm not sure if that 20,000 is just the island. It may be the whole system.

It was an amazing job. We were delivering primary care. It was the beginning of the HIV epidemic, which was centered in jails and prisons, among other places.

It was a managerial job, running a large primary care program, huge detoxification methadone program, with my boss 20,000 miles of conscious distance from where I was.

Mullan: [unclear]?

Cohen: [unclear]. With Bert looking over me, looking over for me. I think I actually reported directly to him for quite a while there.

Mullan: Was he in St. Vincent's already?

Cohen: No. He was special assistant to Carl Isador [phonetic] at Montefior. Bert was at Rikers and previously and continuingly at Sermak [phonetic] where Bert had worked before. That's the Cook County Jail medical program.

Stewardship was a concept that we had, and so Bert's responsibility was to replace himself, that's why he asked me to come from Chicago. Although I felt then, and I feel now, I'd always said it, and I'm consistent, if nothing else, on this position, it was very terrible that we were getting so much money to expand capacity to incarcerate more people. It was, administratively and primary-care-wise, a very stimulating process. It's a lot more fun to do administrative work in medicine when there is cash. When there isn't, one is forced to consider to find cut-backs as innovation. That's bad for the soul.

Mullan: Let's get your story up to the present.

Cohen: Five years on Rikers Island. At that time I was not practicing medicine, except for two months a year when I attended at one of the public hospitals in the Bronx, North Central Bronx, with Bert King. We co-attended for two months a year.

Then I spent most of the time negotiating contracts with the city, as well as expanding a program creating a mental health program for prisoners on Rikers Island. It was a spectacular job with very little supervision. I had the hubris and the skills to pull it off pretty much, particular since I had Montefior backing me, and there were no competitors. It was a special position to be in. Others have been there; very few aren't today.

I falsely felt after that experience that I could actually work, since I had been negotiating against the city and winning on behalf of prisoners for five years, that I could take that experience and work for the public hospital system and negotiate in their behalf with the city. There's a naivete to that proposition which is embarrassing to me at this point, but I didn't know better.

I applied for a job at the New York Times. It was actually decided at one point I had to leave Rikers Island. I don't remember the day, I don't remember what it was, I just had this feeling that I had to leave this. And I actually applied for a number of jobs.

Mullan: Was it professional burnout?

Cohen: It wasn't burnout because I loved the job. I just thought I had to do something else. I had been there every day for five years in the jail, and I loved it, and there's nothing else that I knew I wanted to do, but I thought I had to something else, and decided to leave. I didn't feel burned out. I think I could have easily have felt burned out if I had continued with this feeling. Actually I hate the word. It's a totally legitimate word, but I don't like it. A lot of

people would say they're burned out. I don't think they're burned out. They may have some problems with their job or their lives or whatever.

Mullan: But you had a sense it was time to move?

Cohen: I had a sense it was time to move, and I wanted to move. I had applied for a number of jobs which I never got interviewed for, one job being to run the AIDS program for the Health Hospital Corporation [phonetic]. I never even got a postcard acknowledging my application. I applied to be the director of New York State Department of Health physician in New York City. I didn't even get an acknowledgement, didn't get an interview.

And then there was this ad for vice president of medical operations, Health Hospital Corporation, and I saw that ad just a few days before I was scheduled to have lunch with Martin Trikowski [phonetic]. I had lunch with Martin Trikowski, a spectacular lunch prepared by his archivist, librarian, special assistant, and cook, Dorothy.

Mullan: Is this Dorothy Lemmons [phonetic]?

Cohen: Yes. We talked, and he was interested. We had met a number of times, although he had left Montefior just as I came. We'd always have a brief talk about what was going on at Rikers. He said it was very dear to his heart, and I believed him. I'm not sure there were many other things that were dear to his heart, but I think Rikers was. He was quite isolated in the decision. Every other major medical center in the city had been offered Rikers, and he was the only one who would take it.

o I talked to him and my application to Jo Bluford [phonetic] who had run the whole social medicine pr Montefior, and before she took my job, the job that I eventually got at Health Hospital Corporation, she had run that program for a number of years under Martin Trikowski.

So I had lunch with Martin, I sent my application and resume to Jo Bluford, and lo and behold, I got called in just a couple of days. And it was just based on my resume, I'm sure. I interviewed with Jo. I don't think she asked me what I wanted to do in five years, a question I never ask anybody, a question people had asked to them, I was vetted by the city. I didn't realize that this was actually a [New York Mayor Ed] Koch appointment and not a Health and Hospital Corporation appointment.

At that time, my appointment was blocked by an obstetrician/gynecologist whom as the chair of the Medical Affairs Committee in the Health and Hospitals Corporation.

Mullan: Somebody from Columbia?

Cohen: From Columbia, Bruce Barron [phonetic] who said I was not skilled enough to do this job. I think he was astute enough to think that I might not be the right person for Koch to have in this position, but he blocked it, and I don't know if Martin had to call Koch or if Jo just threw her connections through Stan. Breznov made it happen.

I did have a very successful interview with Victor Botnik, who was the chair. This was his last act, I think, as the chair of Health Hospital Corporation before he was ignominiously kicked out of city government for having forged his college credentials on his application. But I think the last thing he did was interview me, and he liked me. I got this job.

Mullan: What year is it?

Cohen: This is 1986. I was replacing Dan Light, who has also been in social medicine, designed to train primary care practitioners. And as you know, it trained some primary care practitioners and a lot of leading administrators. I think they really were training administrators. I think that's what they were doing. Even Neil Cowlman [phonetic], he was an administrator when he was my roommate in medical school.

Mullan: This is Rush?

Cohen: Rush, and he went to Montefior and I went to County. So I replaced Dan Light, who had been a close friend of Jo's, who'd been through social medicine and was dying of AIDS, and had been in that position for a long time, unable to function because of his illness. Jo had a lot of difficulty replacing him while he was alive. One can understand that. I don't begrudge her all in that decision. It was still a very difficult job to fill since it had been Jo's job before. And when I tried to remove some of her staff, they got promoted to her specialist [unclear] from my purview.

So I went there committed to go into primary care, which was Jo's commitment and was a minimalist initiative of the Health Hospital Corporation. It was portrayed as a massive initiative. I think it totaled at least $5 million out of the $2 billion budget, and didn't accomplish a whole lot.

A whole lot of people were hired to develop primary care programs because of Jo and her commitment was absolutely genuine. She continues in the primary care business, although I'm not exactly sure what she's doing now.

My understanding is that when last heard from, she was trying to privatize the three-thirty clinics, which may be an advance, but I know it's not.

I worked for two years at Health Hospital Corporation responsible for ambulatory care, AIDS, women's health care, another $5 million initiative, home care, long-term care, medical staff malpractice, quality assurance, and whatever, these giant jobs at a central bureaucracy which is running hospitals which don't care what the central office is saying anyway, and operated under separate political patronage.

Mullan: It sound like a very difficult time.

Cohen: It was a very difficult time. It was the end of the Koch administration, and he didn't realize it was the end of the Koch administration, but it was year ten and eleven on the Koch administration. Understandably, Koch felt that after being there for ten or eleven years, everything had to be perfect, because he had been in charge for ten or eleven years. It obviously wasn't, but I was not allowed to raise questions about things not going right. I couldn't raise them to Jo about her programs. I couldn't raise them beyond the confines of our small meetings about there being problems.

My theory was that my role and the role of any leadership in Health Hospital Corporation was to develop public support for the role for public hospitals, as hospitals and as massive providers and major providers of primary care in New York City. The only way to do that was to show that there was a tremendous need, and we didn't have the resources to do it. We were not allowed to say that.

Mullan: This was budget busting or something that you did?

Cohen: This was budget busting, and Koch was committed to cutting the budget for Health Hospitals Corporation and Dinkins and Guiliani did after him. Was the decrease in budget due to a big slowdown in the economy of the northeast [unclear] New York? Yes. Was it due to tax cuts? Yes. Could something different have happened? I think so, but I wasn't able to accomplish anything there. I grew increasingly frustrated. I was not that good at in-fighting within bureaucracies. I thought my job was to do what I just described my job as doing, but as I later found out, the job of the vice president is to create the position of a senior vice president to fill. I didn't know that, and I didn't achieve that. I learned a tremendous amount about health care, about health care policy, about how the city works.

Then when I decided to leave that job at the wrong time, because anybody who left at that time was deserting Koch, it was the end of his administration, but he was running again, so you really had to stay on at that point, I left. I asked that my present from my staff be a stethoscope.

Mullan: From your staff to you?

Cohen: Be a stethoscope because I had decided that I should go practice medicine, and I did.

Mullan: This now is 1988?

Cohen: 1988. I took a couple of months off. I left in June, I paid for my own way to the agency. The agency was going to pay, although it was complex in terms of city politics about paying for overseas travel. I went to Stockholm for the Second International AIDS Conference, without a title. Then came back, went to Welthly [phonetic] for a month, and then came back and tried to figure out how to start practicing medicine again.

And, of course, Bert King told me there was this excellent internist who had general practice, but was also doing a lot of work with HIV infection, who I should talk to and his name was David Kaufman. I talked to him and I joined him. We're associates. There was no partnership, there wasn't then, there isn't now, but I rented space and staff from him and started practicing on 14th Street in the Village, between 8th & 9th Avenue.

I was practicing general medicine. That's what I wanted to do. I was intentionally joining David because I wanted to participate as a physician. I wanted to help as a physician within the epidemic. I felt consistent with my narrow ideological prism that the role of an internist starting practice in 1988 was to take care of people with HIV infection. I had had experience in the preceding seven years being quite involved in HIV policy of knowing that the specialists, particularly infectious disease specialists, had no interest in HIV cure. The only one in New York who did was Jerry Freedland, and Montefior refused to allow him to work because he'd had his picture on Newsweek, and they didn't want it to be known they were an AIDS hospital.

Mullan: What was the name of your partner?

Cohen: David Kaufman.

Mullan: And where was David from?

Cohen: He's from New York.

Mullan: Did he go to University of Chicago?

Cohen: No. There's a number of David Kaufmans in town, there's a urologist, there's an internist.

I was actually quite excited by the notion of general care and HIV infection. One, because it was so important. I knew a lot about it. I had been on the Hastings group, which formed some of the basic policy which became national policy on confidentiality and against mandatory testing. I had been quoted while I was at HHC as personally stopped mandatory testing from happening. I think Ron Bear [phonetic] said that.

Mullan: That is so or it's not so?

Cohen: It is so. I mean, I wish I had had more help. I think it is so. I didn't believe that they should be mandatory testing of people. Everybody else did, including the Commissioner of Health.

Mullan: That was Steve Joseph [phonetic]?

Cohen: Steve Joseph. That's not true. He didn't want--but he wanted more routine testing. He actually was against mandatory testing. He wanted testing to be much more easily done.

Mullan: So you're in practice.

Cohen: I'm in practice. Then in February or December or January, Bert asked me if I would be medical director of the AIDS center at St. Vincent's Hospital. I agreed to do that. It was 1988, It was a difficult time to start a new practice in general medicine. Most people who had indemnity insurance went to specialists to better define what they thought their diagnosis was. There were a number of very good internists in the city. A lot of people knew me politically from my work at Rikers and in the city, but people didn't know me as a doctor. It was a very slow process, and I was very interested in AIDS. Of course, a very, very close friend was asking me to do it, and I would

be working for him, and I had a principle at that time that you only worked for people that you knew, and I continued that principle. One is privileged to be able to do that, and I recognize that. I don't hold other people to be able to do that goal because it's not attainable for most people, not because I'm any better at what I do than they are, but because being a doctor gives one considerable privilege.

I want to say that during all of this time I continued doing a lot of work around prisoners, around prisons. I worked as a medical expert testifying on behalf of prisoners, and increasingly working for courts monitoring medical care in prisons under court settlements. I did that work while I was at Health Hospital Corporation. I actually started doing that work while I was at Rikers and continued that.

By the time I started my practice, just around that time, I was appointed as the auditor of medical care under a compliance agreement at Greenhaven Prison in New York state, chosen jointly by the state and by the attorneys for the prisoners. So I was actually doing that a fair amount of the time. I didn't want to be doing it all the time, because it involved a lot of travelling, and I also felt that if you were an expert for hire and that's all you do, then you become very vulnerable [unclear].

I was concerned that my livelihood depended on doing this kind of work, that it would change the way I approached things in a bad way. I think I really am self-conscious as I come off saying what I do. I always know that's a problem with being an expert and being a paid expert.

So I continued doing that, and then I started this practice, and I worked as director of the AIDS Center at St. Vincent's Hospital, which was the largest AIDS center in the city, although when I started, it had one clinic a week, and was all focused around in-patients, because that's what there was. There wasn't any out-patient capacity.

There was no interest on the part of the Infectious Disease Department in AIDS. It took the leadership of the department--in twenty-five years he won't know that I'm saying this about him--but it was terrible, actually, it was very sad because this was a central place.

Mullan: 1990?

Cohen: This was 1989, actually. It was the center of the epidemic in the world, St. Vincent's Hospital in Manhattan. That contributed very little, certainly nothing from the Department of Infectious Diseases.

So I worked for the hospital. I worked for Dr. Lambert King, vice president from medical and professional affairs, and I expanded the program dramatically. It was easy to do because everything we did brought in money. The hospital was paid time and a half for every new admission under the New York State AIDS Center guidelines.

So a day's rate would have been $800, they would get $1,200 for every bed that was there, no DRG, and the outpatient rate was spectacular. It was four times what the basic Medicaid outpatient rate was. So Medicaid patients in the AIDS Center were gold as far as the administration was concerned, and I was able to expand the program dramatically.

I wasn't able to do everything I wanted, but we needed to be funded, also, and although there was regular increase in our budget, it wasn't as much as we needed for an actual epidemic, as well as to fund the research that needed to be done.

I was at that time uninterested in getting drug company research. As you know, the drug company research runs this epidemic from a practice perspective, as well as from a research perspective. When I was the head doctor at the general medicine clinic at the Cook County Hospital, I spent most of my time when I wasn't seeing patients or teaching [unclear] residents, throwing detail people out of the clinic. This was a principal position that I had my whole life, and I continue to this day, that the drug companies took over immediately. And everybody who does AIDS research is on many, many payrolls of the drug companies.

Mullan: Deleteriously so?

Cohen: Well, I think deleteriously so in terms of being objective about what you find. I think deleteriously so in terms of the cost that care has--

Mullan: Is it substantially different than that of antibiotics, with cancer drugs?

Cohen: It is substantially different because since the academy had no interest in it, they became a much easier market, and they took it over. It's not every specialist, every senior specialist in every field cannot be, if he or she wants to, on a drug company payroll, not that most of them aren't, but the AIDS drug company, [unclear] research of AIDS relative to other research, certainly for a hospital like this was dramatic. There were just so many [unclear] diuretics one could put out. I think it was substantially different in the price of these drugs.

Mullan: Have you continued in this job to the present?

Cohen: No. I stayed in that job for about two years. I left it for a number of reasons. My practice was getting larger, and that's really what I had wanted to do.

Mullan: Your 14th Street practice?

Cohen: Fourteenth Street practice. The Department of Medicine finally hired a new full-time chair and [unclear] had been in Chicago, she was the head of critical care at Chicago Medical School, and was certainly Bert's pick to be chair. He looked at [unclear] budget and saw where all the money was, and all the money was in my budget. He had no budget, essentially.

Mullan: This is general medicine?

Cohen: This is all medicine. There was no budget. The only budget that there was, the only salaried faculty he had, other than the half-time division directors, all of them had private practices, were program directors in infectious disease and pulmonary and in TI, all of whom were paid for by the AIDS Center budget. There were no full-time staff except for the AIDS Center. And so, understandably, Eric [Grakow] wanted this budget in his department rather that in Bert's department. And Bert said, "This is what Eric wants. It's not what I necessarily want, I know it's not what you want, but talk to him, he's a great guy. I'm not going to say no to him. You can say whatever you want, but I'm can't." I wouldn't have asked for him to turn him down because chairman of medicine is a much more important position and St. Vincent's Hospital needed a chairman of medicine.

Mullan: Let me put in another tape.

[Begin Tape 2, Side 1]

Mullan: Bobby Cohen, continued.

Cohen: So I continued as director of the AIDS Center under Eric, and that became an increasingly difficult position for me because of what I had actually accomplished as director of the AIDS Center. What I had set up was a large out-patient program staffed only by attending physicians. I let residents who were very interested do electives there,

which they arranged on their own, but I had no house staff in the clinic because I felt that based upon my own experience as a house officer and my experience with house officers at St. Vincent's and the way house staff programs are run, there will be very little supervision for the house officers, and that these patients were going to keep coming to the clinic for years, and I did not want them to have a different doctor every month.

This was something I tried to push on Sol Farber. He was very interested in my perspective on medical education, Sol Farber, chairman of medicine, provost of medicine, and dean of medical school at NYU for the time being. Nor was any other Department of Medicine interested. But my notion was that you had to learn to be a doctor, but the way you learned to be a doctor was not by playing doctor, although you had to play doctor, but certainly in a primary care setting--I think Jo Bluford in the social medicine program was much better at that, where you had lots of time in the primary care clinic. You had five clinics a week, and you had real attendings and you had very few patients, very expensive model, and you're an expert on it, so I won't talk about it.

But what I established, because I had to bypass it, because I couldn't establish that, I didn't run the Department of Medicine, was a non-house staff out-patient program with board-certified, on some rare occasions board-eligible physicians, most of whom were just general internists, a few of whom were actually from the infectious disease program and had I.D. boards. They were all full time and they were all attending physicians, and they followed their patients in the clinic, and they followed them on admission, seven days a week, twenty-four hours a day. And that program continues to this day.

Mullan: Which you moved back out of?

Cohen: I moved back out of it, but I established that program and I'm very proud of it. And when that program was threatened by Eric Grakow--this will be read twenty-five years later and not for current dissemination--he said [unclear] would have to run every case, than have a closed order book. Your attendings can be advisory, but house staff would run the care. I said, "It can't be that way."

He said, "It has to be that way. It has to be that way because I have to tell the new medical students who are potentially interns and residents that's the way it's going to be because we have to get them in here, and this is going to scare them away."

Eric was quite successful at getting a very excellent program in residency and internship. I think he was wrong in thinking I was going to scare them away. In fact, the house staff loved the fact that the attendings would

take primary responsibility. They had less responsibility. It was a very successful program, but I left when Eric came because we had conflict over these issues.

Mullan: This was a couple years ago?

Cohen: This was after two years there, so this was in '91.

Mullan: We've got to bring it up to the present.

Cohen: Okay. I left in '91. I had several things happen around '91. My first child was born, and I went back in practice and developed a practice in general medicine. Initially, it was majority HIV because I was known as an HIV specialist, as a generalist, as almost all the HIV doctors who have staff, who had taken care of thousands of patients at St. Vincent's Hospital and all over the city have been. The creation of AIDS care has been the creation of general medicine.

Mullan: That's New York-wise?

Cohen: Certainly it's true in Chicago, it's true in New York, I believe it's true in San Francisco, except it wasn't [unclear] because of [unclear].

Mullan: [unclear].

Cohen: Well, actually it was oncology. [unclear] is an oncologist. Infectious disease said, "Oh, shit. We don't want to deal with this. These patients are all going to die. This is going to tar us with this thing we don't want to do. Let's get rid of it."

Mullan: Do you think that will be maintained, that this is a unique generalist disease, with all of these ramifications that have terribly specialized systems and [unclear]?

Cohen: Well, it has certainly continued to the present day, and that's been--I haven't talked at all about what it's like to be a general doctor, but one part of being a general doctor, it's great to be able to practice medicine both in-patient and out-patient, and you can do that. I think that people who go into traditional infectious disease have not gone into it because they wanted to see patients in their offices and get called, except for emergency consults, and they have fellows to do that because they can't imagine a world without fellows. So I think it could well continue, although it may be that given the oversupply of specialists, that the current generation of infectious disease-trained physicians may have to do it because there's no one else to do it. In particular, if they undercut generalists in some carved-out arrangements with the medical managed care, they may end up with it. That could well happen.

Mullan: So you are now in practice full time, most of the time?

Cohen: I have a part-time arrangement with the Department of Medicine. I still have two clinics, and I still see new patients in the Infectious Disease Clinic, and I follow those patients in the hospital, and I still work part time as an expert usually for federal courts monitoring medical care in prisons, although I most recently testified in a case involving charging prisoners for care, which is all about primary care. This was a test involving the Rand Insurance experiment, and what it means to charge co-payments for people who don't have money and are sick, versus people who don't have money and aren't sick versus people who have money, etc., etc. It's a big movement in prisons and jails right now to charge prisoners for care.

Mullan: Charge them against their rate?

Cohen: The jails, it's being charged against nothing because there are no jobs for those people in jails, and most prisons there probably aren't jobs for a lot of people. It's charged against their commissary account. All of the systems say if you don't have a commissary account, then you'll just be charged, you'll just have a negative balance which you'll have to pay back. And they argue that that doesn't deny care, but the cash nexus of care has everything with care, as we have seen in this country.

Mullan: Tell me a little about your personal life.

Cohen: I married at age forty to Mattie Delone [phonetic], who I met at Spafford Juvenile Detention Facility. She had a public health degree and was monitoring the Montefior contract at Spafford, which I oversaw, Spafford being a juvenile detention facility. We have two children. She subsequently went to law school, and after our first child was born, our second child was born when she was in law school, and she is now working for children's rights, developing a litigation around medical mental health and foster care as it intersects with juveniles in the juvenile detention systems throughout the country.

I'm on the board of the Fortune Society, which takes the social work for ex-prisoners, and I'm on the board of the Housing Works Day Treatment Programs, which provides medical care and will provide residencies for very poor ex-drug addicts who hopefully are under treatment for tuberculosis and have HIV infection.

Mullan: Your parents are still alive?

Cohen: My father died when I was a resident at County, a very specialized hospital.

Mullan: How did he feel? I was curious.

Cohen: He wanted me to be an ophthalmologist. He was quite proud of what I was doing.

Mullan: Good, good. And your mom?

Cohen: My mom wishes that I had an easier life. I'm not sure what she means by that. I think it has to do with--if I worked less hours, that I had more money, but she knows how happy my sister and I are doing the kind of work that we do, and I think she's very pleased. Particularly when I got married and had children, then she became really, really happy.

Mullan: For a primary care doctor like yourself, money is less plentiful. Has that been a problem, an issue?

Cohen: It's not been a problem for me. We could use another bedroom. My wife went to law school rather than earning money for a period of time. Almost everybody I know lives to their limit. I had a series of jobs where I took lower salaries each time because I wanted the job. So I never approached medicine in terms of maximizing my

income, or I would never have gone into general medicine, because that obviously can't be done that way unless you become involved in administration with your own chain of clinics.

I think that doctors in general care can earn a living. Managed care has actually helped. For people like me who just came in to practicing private medicine, it's actually a way to build up a practice quickly and make a reasonable income. My partner's account has been cut 30 percent per encounter by managed care, and he has sped up his already very fast practice almost 30 percent. I can't see [unclear] as fast as he does. He's a year a older than me.

Mullan: Where do you see generalists going in this country? Is this the golden age where the generalists finally get appreciated or is it a mean time when the skills of the generalists are being used to ration care?

Cohen: Both are happening, the second more than the first. I think that patients are beginning to understand the value of having a generalist physician. I hear that all the time. I think that's part of it. I think, pleasurably, that people like me as a doctor, and part of it is that they've never had the experience of having a doctor available for lots of problems. When they call their specialist, they can get appointments in three weeks. We work very hard in my office to be available as quickly as possible. That's a very difficult thing to do. Plus it causes us to run late every day, but since I take care of a lot of sick patients, I expect people to be honest in their triage complaints over the phone, we see a lot of patients urgently. I think that it enables people to practice primary care medicine in a financially possible way that wasn't possible before, although the chances that managed care will squeeze those dollars is very likely. Certainly all the money to date has come out of doctors. It's beginning in New York to come out of discounted hospital rates, but most of it has come out of a 30 percent decrease in physician salaries.

Do I think there should be a 30 percent decrease in specialist salaries? No. I think there should be a more than 30 percent decrease in specialist salaries. I was about to say that there is a possibility, but only through a transformation into a national health care program. I don't think within managed care, proprietary managed care is developed anything's going to happen other than doctors being sped up and patients begin to hate it and everybody hate it. I sort of hope that happens, because that will lead to the next change. It's certainly going to be volitional on the part of the companies who are making fortunes right now off of managed care.

Mullan: Do you see that kind of dissatisfaction manifesting itself?

Cohen: Yes, although New York is a new market, as they say, so I don't see it often. I have a thousand anecdotes which you have, which are not particularly relevant right now, although the patient I had the other day who has uncontrolled urinary frequency with a fibroid which is pushing her bladder into one-eighth of the space that it requires and has been followed by U.S. Health Care. A gynecologist said, "Well, if you're not bleeding excessively, it's not causing too much pain, there's no indication for doing a hysterectomy or removing the fibroid." Let alone patients with cancer being forced to go 400 miles away for their indicated bone marrow transplant.

Yes, I think it will result in it. I think it's slightly resulting in it right now. It's very complex. I like talking to patients. I am not interested in maximizing my income, although I am not immune to maintaining my income. I would not like to stay in a substantial 30 percent cut in my income working as hard as I do now, because I just don't want to see patients any faster. It's not that I want to work less hours, I just don't want to see more patients, because I like to talk to patients. I mean, you have these [unclear] all through your interviews, I'm sure, but it is a great privilege to be a generalist.

Part of it is just being a doctor, but it's particular being a generalist because people understand that they can talk to me about anything, and they do. That's the way they think. They do think that there is a relationship between how they feel and their psychological state and their medical problems. They want to talk about all of it. I talk about their sexuality, and I talk about their children, I talk about their mother-in-laws, I talk about medicine, I talk about how I think about medicine, how they think about medicine, and I particularly talk about what they do. And this is after long-term patients, it's after knowing them for a long time, but with those patients who I know best, we are having the same conversations two minutes after they've walked into the room.

That's the great privilege of being a doctor, and I think I'm relatively good at opening up. I introduce myself as Bobby in the waiting room, and I dress as I dress, which is without a tie or jacket, not to criticize people who do--you're not going to have to wear a uniform after January, but it's the way I'm more comfortable. And I think in some ways it breaks down a little bit of it.

The point I made at the beginning about my friends not liking the fact I was in medical school, I think that's something that was good for me because I don't want to get too much authority or distance between myself and patients. I prefer it when they listen to what I say rather than when they don't, and that's common among an educated population, particularly with HIV infection, in particular with a lot of people I deal with. They want to be in charge. I actually would prefer to be in charge, but we work it out. But it is an incredible privilege to just talk to people as a generalist and not just be focused on their particular problem, even if they have AIDS.

So I think for a doctor, it's a great thing to do. For patients it's great also if they have doctors who have the time to do it. To this point I don't believe that there is any criteria for admission to medical school, the training program, that has anything to do with someone's personability or ability to conduct a sympathetic interview. I think it is still based upon the chances that they win a Nobel Prize, nothing to do with anything else, period.

There is a much greater interest on the part of medical students right now becoming generalists, but I think that's because they know that there's nothing else they can do. It's nice to see. They get enthusiastic about it, and when Bert and I teach on the floors as we are just at this moment, we made several spectacular medical students think about general medicine because we can talk science and we can talk other things. I think generalism is a political statement about medicine. I think it should be a statement against the academy, which is getting off the hook because, since it has nowhere else to go, it's going to adopt generalism as its philosophy when it is as far from its philosophy as anything.

Mullan: Do you mean academic medicine?

Cohen: Yes. You're trying to change that, you've worked hard. Bert is trying to change that, he's worked very hard, and there are some primary care people at very high positions in some departments, but that's not what they really think medicine is. I think they think a generalist is the LMD that I was taught about when I was at Rush. I think it was the academy that taught us how to spend ten days working up hypothyroidism as an in-patient when I was a medical student at an excellent medical school, that developed insane lengths of stays and incredible unnecessary testing. It was the academy that taught us this as the standard by projecting specialist care onto every simple problem. I think that if the academy does not recognize that, that will continue to be a great problem. Because although they can easily adapt to it, everybody adapts to it. The only thing anybody is interested in nowadays is primary care.

But in general, when you're training general internists and general med-peds, family practitioners, I think the academy, except for the cash flow that you provide or others provide, there is no real interest in it. I think they always thought that was psychiatry's role to do the sort of touchy-feely stuff, and medicine had to do with molecular biology. I think they still believe that. It has a lot to do with molecular biology and it is amazing molecular biology, but practicing general medicine and talking to patients is a spectacular job, a great privilege.

Mullan: Maybe this is a good place to end. Great.

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