BELLA HERMOSA

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Dr. Fitzhugh Mullan,
interviewer

[Note: Apparently the first part of this interview was recorded with the voice activation feature on the tape recorder. Therefore, some of the conversation is lost, indicated by [unclear] in the transcript.]

Hermosa: My name is Bella Hermosa, and my name is Villacorta. My second name is Hermosa-Villacorta.

Mullan: We're in Dr. Hermosa's office at Lincoln Hospital. It's the twenty-fifth of June 1996. I've known Dr. Hermosa for many years. I don't think we actually trained together. You were trained when I was still a resident. You helped train me at the time, back in the early seventies. But what I want to do is go back to the beginning and talk a bit about your background and how you came to the United States, how you came to medicine, how you came to Lincoln. So why don't you start telling me a little bit about your background, your bringing-up.

Hermosa: I was born in the Philippines. I was educated there, went to medical school in the University of Santa Tomas. My plan was to work after graduation and get married.

Mullan: What did your parents do?

Hermosa: My father was a teacher and my mother also was a teacher, but she had her own vocational school. So she taught in her vocational school. She taught dressmaking, tailoring and dress designing.

Mullan: Santo Tomas is in Manila?

Hermosa: Yes. Santo Tomas is in Manila, but we were Dumaguete City, which is one of the southern islands of the Philippines.

Mullan: That was your home?

Hermosa: Yes.

Mullan: Could I ask when were you born?

Hermosa: July 6, '40. After graduation, I worked one year as a rotating resident. That's what they call it there, because we have internship as part of the medical school which is five years.

Mullan: You go right from secondary school to medical school?

Hermosa: No. You go to college, but the college requirement could be two years, or three years, or four years, depending on the school. You can take a short college course and then go to

medicine. So I had three years. The title they gave was associate in arts. Then I went to medical school.

After medical school my friends took the exams, you know, the ECFMG exams. I went along with them. I passed, so I decided to come here. Basically, I felt like I was just going along with the current at that time. I was not really directed.

Mullan: Were your parents supportive of your going into medicine, and how typical was it of a woman to go into medicine at that time in the Philippines?

Hermosa: My mother supported me, but my father was against it. When I graduated high school, I told them that I was going into medicine. I completed the pre-med and I was going on to medicine. My father objected because he thought that it was a very expensive investment for a person who might not finish the course or who might not practice.

Mullan: Though he was against it, he did pay for it?

Hermosa: Yes, because my mother was in favor of it. My mother was a frustrated nurse. She wanted to go into nursing. She got sick with tuberculosis before she could go into nursing school. She had the interest.

Mullan: What was at Santo Tomas? What was the male/female ratio? Were there many women in medicine?

Hermosa: Oh, yes. It was like 50-50. The medical school, as well as other colleges in the Philippines, were really open for both men and women. There was not much discrimination against women in colleges. The only courses that had a lot more men were engineering. Nursing had more women, engineering had more men. Otherwise, all the other fields were almost 50-50. The only issue we had during medical school was that the University of Santo Tomas which is the Catholic university of the Philippines practiced segregation between men and women.

Mullan: In terms of the curricular work, the academic work?

Hermosa: The whole school was segregated. The women had their own stairs, the men had their own stairs, and the library was separated into two, the men's and the women's.

Mullan: And the courses?

Hermosa: They were separated, too.

Mullan: On different sides of the class, but the same class?

Hermosa: Yes. The same class, the same teachers, but we were not together. It was interesting.

Mullan: This was through medical school?

Hermosa: Yes. I did not have that kind of experience in grade school, high school and college. It was only in medical school that we got segregated.

Mullan: How about the clinical rotations? Would they keep you separate? Was there much clinical teaching?

Hermosa: Oh, yes. I think clinical teaching started on the third year, continued in the fourth year, and then we had internship. Still, it was completely segregated up to the very end. Even the internship, I think, was segregated. I don't remember having any men in my group when we rotated through the various clinical departments.

Anyway, after that I worked as a rotating resident in a small medical center, and this place had medical graduates from different medical schools in the Philippines. Most of them just stayed there for one year. So every year there was a change of the resident staff. The attending staff were there permanently. It was not really a teaching-type center, it was more like service-type center. And the attending supervised the junior staff who came and went. We only got paid something like thirty pesos a month for that service.

Mullan: Thirty pesos a month is nothing, I gather.

Hermosa: Well, now, the exchange is one dollar. At that time it may have been one to eight. So maybe about four or five dollars a month. But they provided for food and lodging.

Mullan: Was the instruction good?

Hermosa: Well, it was good in the sense that we were supervised directly by very well-trained and experienced physicians. There was one pediatrician, I think two surgeons, one obstetrician/gynecologist, one radiologist, and that's it. That was our teaching staff.

After that, I took the exam, passed the exam, and came here. I went to Kenmore Mercy Hospital in Kenmore, New York.

Mullan: How do your parents, and your family in general, feel? Do they think this was a good idea your coming to the States, leaving the Philippines, or not?

Hermosa: Yes, they thought it was a good move. My father encouraged it mainly because he was trying to get me away from my boyfriend, he was not in favor of that person. My mother encouraged me basically because of her wishes that I should be trained in health care, and I should try and realize that.

Mullan: Did they expect you to come home, do you think? What was their vision?

Hermosa: Yes, they expected me to come home after training. That was also my expectation after my training in pediatrics. In fact, I had everything planned. At that time there was this exposition, World Fair, in Japan. I was going to meet my parents in Japan and then go home with them.

Mullan: What years are we talking about?

Hermosa: That was 1968. I came here '64, took a year of rotating residency before I took pediatrics.

Mullan: What about Kenmore Mercy? Was that a good experience? What was it like? How did you find your way to it?

Hermosa: I applied to a lot of hospitals throughout the country. I really had no basis for choosing one or the other. My basis for choosing basically that they were interested in me through their letters. The rotating residency was important because at that time I had not decided yet which specialty to go to. I chose hospitals willing to pay for my fare, because I had no money to pay for my fare. There were a few hospitals that offered that, and I chose Kenmore because it was New York.

The residency program there was run by a person who considered himself a generalist. I don't know what kind of training he had. At that time there was really no postgraduate training for general practice. After school, they just went and practiced. So I don't think he had much postgraduate training,

but his title was medical director of the training program. We rotated through the various clinical departments, very similar to what I had in the Philippines. But of course, there were a lot more doctors.

Mullan: How many would there have been?

Hermosa: The residents were mostly from the Philippines and India. We rotated through the various medical departments. We were evaluated by whoever had the teaching role in that department. In surgery, there were a few people that were assigned to teaching.

After going through these services, my first choice for a specialty was really anesthesia, but at that time I think I only weighed something like ninety pounds. Patients were huge, and I could not lift the [unclear]. I was a member of what we called the cardio-respiratory arrest team. When they called for arrest, we were required to be there in just a few seconds. Although I could get to the place, I could not start resuscitation, because I could not bag effectively. Those patients were just so big for me that it was impossible. In fact, the anesthesiologists there were very helpful. They were pleased that that was my choice. They let me go into the operating room with them and taught me how to incubate.

Then there was a neurosurgeon there who really liked to teach me. I really liked neurosurgery, but somehow I just could not get myself to think that I should be a surgeon.

So finally, towards the end of that rotating internship, I decided I was going to go into pediatrics. A friend of mine (a missionary who I met in the Philippines) was working in Presbyterian Hospital (NYC). She volunteered to help me find a good program. She had friends in the training programs in pediatrics. I was accepted at the Children's Hospital in Philadelphia. I chose Lincoln basically because my interview with Dr. Einhorn and other attendings at Lincoln was pleasant. In other places that I interviewed in, I felt very insecure. I felt the level of teaching was far ahead, and my rotating internship did not prepare me to that level. So I felt that I would be the most uninformed person there. I would have to do a lot of work in order to catch up with their standard of teaching, training, and practice.

I had a friend who went to Case Western Reserve at that time, who advised me strongly not to go there, because she said that she had a very bad experience. She was one of our well-trained cardiologists in the Philippines. She thought she could go directly into cardiology (skip pediatric residency). She was shocked to find the difference in knowledge. She felt she was 30 years behind. So to make a story short, I chose Lincoln Hospital.

Mullan: New York, was that a particular place that you wanted to come in terms of friends or family?

Hermosa: No, I had no relatives here. My decision was based on interviews. Maybe the name New York meant something to me, whereas Philadelphia did not. The interview process was pleasant, I did not feel insecure. Most of the other training programs had mostly U.S. graduates only, hardly any foreign graduates.

Mullan: What year was this that you came to Lincoln?

Hermosa: 1965. I had an interview at Montefiore, and I was interviewed by Finberg, and one of his assistants. I felt so insecure after that. I felt that I should really start at a lower level in order for me to get used to and catch up with material I needed to read.

Mullan: Did Dr. Einhorn do the interviewing at Lincoln, and how was that? Did he make you feel welcome?

Hermosa: Yes. He interviewed us. He had other attendings interview us, and he made it apparent that he wanted me in the program. So that was my choice and I came to Lincoln. I think two or three months out of the year, I rotated to Jacobi Hospital. It was a very pleasant residency.

After that, I was to go home, and I planned to go home, but something came up. My sister decided to come here. My parents were not comfortable with her staying alone. They felt that since I was here already, I should stay to show her around and to

be with her. My sister had no clear plan except that she wanted to come to this country. She felt she was born in the wrong place. She wanted to get out of that place. She completed a degree in Business Administration and was sure that when she came here she'll know what to do. So she came here and she decided to take a course in cosmetology. After that she started working.

Mullan: So you stayed.

Hermosa: So I stayed, and because of that, I had to do something. I took a fellowship with Dr. Sobel.

Mullan: That's S-O-G-E-L? S-O-K-O-L?

Hermosa: Sobel.

Mullan: S-O-B-E-L. And that was at Jacobi?

Hermosa: Yes. That was from 1968 to 1970. My plan was to come back to Lincoln and work here as an endocrinologist. At that time there was this thing that you and I were into, this--

Mullan: Before we talk about the collective, let me ask a little about--when you first saw Lincoln, we're talking how the old Lincoln, the hospital built in 1896, was that off-putting, and giving the sort of war-zone quality of the old Lincoln, both when you contemplated going there, and then the time that you spent

there, how did you feel about it? Was that off-putting or discouraging, or did you get into it and feel differently about it?

Hermosa: Not really. I saw that the building was old but I went in and out freely. I had no idea about violence and whatever crime was happening in the area. I was completely naive. My only knowledge of the criminal activity in the area was from what people told me. Somehow I felt that I should observe this myself. In fact, at that time, we lived in the hospital. We were advised that when we come and go, that we should come and go in groups, or not go alone.

Mullan: You used the subway to come and go?

Hermosa: Yes, we used the subway, but used decent hours and went in groups. As far as I was concerned, there was no major disaster. I personally stayed there for several months. I walked to church on Sundays around the corner from the hospital.

Mullan: One other thing while we're in that same period. As a foreigner arriving in the country, both in Buffalo and then in New York, how do you feel, how were you treated? I realize many people involved in how you're treated, but as a young woman from another culture coming to this country, was it accepting, or was it denying, or was it a mixture?

Hermosa: Actually, I had no problem adjusting. I felt that we were welcomed. There was no welcoming party in the airport or something like that, but when we arrived at the hospital, the people welcomed us, gave us orientation, gave us a lot of time to ask questions and feel comfortable, then asked us where we wanted to live, and whether or not we were comfortable in the rooms that they provided for us and so on.

At Lincoln, it was a little bit different. These rooms were apparently used by the nurses when they had a nursing school at Lincoln. When I came, there was no more nursing school and they used the rooms to house the residents. Most of the residents stayed in that building.

Again, they told us about the dangers of the place and how to be careful and how to avoid all these problems and whatnot. Gradually as we learned more about the community, residents started moving out and having their own apartments. Some of the residents from Jacobi, you know, the U.S. graduates that came, we became friendly with them. They started advising us as to where we would get apartments, decent apartments, and so on. They gave us further instruction as to where to look for apartments--because I had no idea. I mean, I would have gotten an apartment just across the street. For me that is convenient. But apparently that was not a good thing to do.

Mullan: At Lincoln, did the Filipinos stay together and the Indians hang together? Did everybody hang? Was there any kind of differentiation between country of origin?

Hermosa: There was not. All of the foreigners as well as the U.S. graduates worked together. I did not detect any kind of racial tension.

Mullan: I was looking at the other side. There's a lot written about and talked about how new communities are established in the United States and whether both within your working setting as well as in the larger setting, if helping hands are extended along national lines, or whether they're across national lines. What you've described certainly in terms of the working environment is it was very cosmopolitan and very undifferentiated. As you began to become more established outside of work, was that also an international as well as U.S. foreign community, or were there friends and relatives or others in the Philippine community who were particularly important to you?

Hermosa: Maybe my experience was different from most Filipinos. Most Filipinos I saw wanted to congregate together, wanted to stay in one apartment together. I did not feel the need to be with them all the time. I felt like I was comfortable going with other people, other ethnic backgrounds, other cultures. But when I decided to get an apartment, to rent an apartment, I rented an apartment sharing with another fellow resident who was also Filipino. Somehow it just did not occur to me that maybe I should.

Later on, after the training, people who were working in Einstein and in Jacobi, were driving Volvos and living in Westchester. [Laughter] That was like a standard thing. Drive a Volvo and live in Westchester. So somehow I felt very comfortable with that. I got married; I moved to New Rochelle; I had a Volvo; and I went back to Lincoln to work as an endocrinologist. That was the time that--

Mullan: The chronology of getting married, that's later?

Hermosa: I got married after my fellowship.

Mullan: So in 1970?

Hermosa: Yes. After the fellowship I came back to Lincoln to work.

Mullan: On deciding on endocrinology, and deciding on a fellowship, what was your thinking in regard to that?

Hermosa: Well, endocrinology was one of the areas in pediatrics that I felt I was weak, and thought that going into it would enable me to overcome that feeling of insecurity. I was accepted for a hematology fellowship at Cornell, and also for a dermatology fellowship in NYU. Dermatology just turned me off, because I prefer to take care of the whole human being rather than just the skin. Hematology was also very much interesting to

me and, in fact, in the past, when I was still in college, I was thinking along the lines of psychiatry and cancer. But I had a friend who went into hematology in college, and she was depressed most of the time. I thought maybe there was a reason for that.

Mullan: But the premise of taking a fellowship as a way of advancing one's pediatric career was pretty much accepted among the people you trained with, or not? I'm curious about the decision to specialize or to do a fellowship in the mid-sixties as you did. Not specifically what one, but what went into that?

Hermosa: I felt I was not ready to go into practice. I felt I needed to check out those areas that I was not very secure in, and that if I was going into practice, I wanted to be very sure that I would be confident.

Mullan: You were pretty certain now you were going to stay in the States?

Hermosa: Yes.

Mullan: Did your impending marriage have something to do with that?

Hermosa: Yes, because my husband was an immigrant, and although I had plans of going back to the Philippines, he had just arrived in the country, and he came here to stay in the country.

Mullan: So again up to 1970 and your decision now to come back to Lincoln.

Hermosa: I came back. I worked as an attending. I took care of the endocrine clinic. At that time, aside from taking care of whatever field you were in, we had to cover also the emergency room, we had to cover the ICU--oh, I don't know how often. So that was all right in the beginning, but then I had my first baby, and it became very difficult to take care of a young infant and also meet the demands of the job.

Mullan: [unclear] you slipped that one by me [unclear] my memory.

Hermosa: So I found it difficult to be on call in the ICU and also work long hours. I tried to talk to the administration of the department at the time. I think it was Helen. She also had difficulty making decisions, because things were unstable, and I don't know whether she had the backing of Einstein, but I felt that she could not make a decision. I thought that I'd look for another place to work in, possibly maybe mostly clinic. This position came up at Montefiore Comprehensive Health Care Center.

Mullan: [unclear] facility?

Hermosa: Yes, it's a free-standing clinic. It was funded by NIH, a very well-funded program. At that time it was headed by

Dr. Kitty Lobach and Dr. San Agustin. Later on that program split and Dr. Lobach continued the program over at Einstein while Dr. San Agustin became head of the Montefiore Center.

Mullan: What year was it you went to that?

Hermosa: '72.

Mullan: You were at Lincoln during the so-called collective period. What was that like?

Hermosa: It was chaotic. I felt insecure for myself. I did not feel that my life or my health was threatened, but I saw that there was some degree of violence that I did not expect in a health care setting. However, I understood that this was a political change, and that things like this, mainly because it had to go through committees. Like I said, I think Dr. Rodriguez could not make decisions she needed because of the approval of a certain group of people, a certain committee or something like that. That delayed to me her decision-making, and also affected her running the department because she was sharing it with a lot of other people who were involved in the changes that were going on.

Mullan: These are both the other residents as well as community people?

Hermosa: Right. Which I understood was a change. I understand political changes, but my agenda was different. The service at Montefiore CHCC was attractive. They provided three rooms for each physician. We would work as teams. Patient flow was directed. It was very smooth. Patients appreciated the service. The charts were perfect, (because we dictated it and there were secretaries to type it). So there was nothing that was not legible. They had all kinds of services there. They had five teams for general pediatrics; they had a team for adolescent medicine; they had a team for dental services.

Mullan: Were you doing general pediatrics, or were you doing endocrinology?

Hermosa: General pediatrics.

Mullan: General pediatrics. Going back to general pediatrics, having been train in endocrinology, was that okay with you?

Hermosa: In the beginning it was not. I felt like I should be doing endocrinology, because I trained in it. At the Comprehensive Health Care Center, I was allowed half a day a week to attend an endocrine clinic, which at that time was at Montefiore Hospital. I attended that clinic there, but the longer I stayed in general pediatrics, the more I liked general pediatrics. So the year after that, I was promoted to be associate director of the CHCC.

Mullan: Of the center.

Hermosa: Of the center. That was my first administrative position. I had problems dealing with issues [unclear] complex. [Tape recorder turned off]

Mullan: That was your first administrative position?

Hermosa: Yes. I was very naive with administrative procedures, how, at certain levels certain things are done, and I learned as I went along. But there were things that developed that to me were not pleasant, so I decided to leave. I had three months where I did nothing but just sorted out what I should do next. At that time there were ads in the papers, positions at Lincoln Hospital. There were also opportunities for private practice and, in fact, I had offers from obstetricians to share practices, pediatricians to share practices. So I thought I would try going into practice.

I did that for--let me see, from '75 to '78. I had an office here in the Bronx, close to the Bronx Lebanon Hospital. Then I had my other child, my second child. That also interfered with the practice. When a patient calls you and you want to be there, you want to take care of your patients, but you also have a young child to take care of at home. It's just very difficult to be in two places at the same time. So I decided that private practice was not going to work out for me because of my family obligations.

I applied to Lincoln at that time. Who was the person that came after Helen? I forgot her name. She was the director then. She went to Philadelphia afterwards and became commissioner of health. Anyway, there was an opening at Lincoln for a general pediatric position in the clinic. At that time, the position was to do direct patient care in the clinic, direct patient care in the emergency room, plus teaching and supervision of residents. That was my re-entry into Lincoln, which was in 1978.

Mullan: The hospital now moved to the new hospital?

Hermosa: Yes.

Mullan: Tell me a word about that, the new hospital versus the old.

Hermosa: The new hospital was built in '76. It was really pleasant. You cannot imagine working in the old place that was hardly air-conditioned, crowded, and having to struggle to find a parking place; this new hospital was heavenly. When I came for an interview in July, it was very hot, but the hospital is air-conditioned, very pleasant. And to add to that, they had the garage, which was very convenient. The rooms in the clinic were large. At that time we did not have many patients, and we did not have many doctors, so there was enough space for everybody.

Mullan: Was it a similar community to the old Lincoln in terms of who was coming? Did it feel more or less the same?

Hermosa: Same kind of patients.

Mullan: Largely Hispanic?

Hermosa: Right. Somehow, even in the community right now, for example, is like 50-50 black and Hispanic and a few other groups. Seventy-five percent to 80 percent of the patients that come to Lincoln are Hispanic. So same kind of patients. At the time they had Medicaid coverage already. We have something like 10 to 15 percent that have no coverage, and maybe 5 or 10 percent with private insurance.

However, the training program, I felt, had deteriorated. The quality of the residents was very poor when I came back in '78. The quality of the practice was substandard. The service was so poor that if you ordered, say, a CBC, if you didn't go that very moment to get the result, you'd never see the result. The failure rate from the patients was so high, there was no continuity. At that time I wondered how they could have allowed this thing to deteriorate that much, knowing how good it was before. It had deteriorated to the extent that no one was passing the board exams. The pediatric residents--no one was passing the board exams. It was so embarrassing.

Mullan: So both the patient care and the teaching had deteriorated.

Hermosa: Right.

Mullan: At this time, was the hospital still affiliated with Einstein, or had it switched to New York Medical College?

Hermosa: No, it had switched to--at that time they were affiliated with--what's the name of it?

Mullan: Mymonit [phonetic]?

Hermosa: No, it's now OLOM, Our Lady of Mercy. It's a small hospital north of here.

Mullan: I want to say Mymonites [phonetic], but that's in Brooklyn and Jewish.

Hermosa: Misericordia. I could not figure that out--Lincoln was a lot bigger than Misericordia--how it could have been affiliated with that and hope to have that kind of teaching and standard, I don't understand. But anyway, that was their affiliation.

Mullan: The residents were entirely international graduates?

Hermosa: Yes.

Mullan: From what sort of mix of countries? Has it been predominantly one country or another?

Hermosa: No, it was also a good mix. They had Filipinos, Indians, they had Iranians, they had people from Middle Eastern countries.

Mullan: And the faculty at that point was--

Hermosa: And the faculty, they were American graduates.

Mullan: Did Misericordia supply people?

Hermosa: The chief. The chief was from there. I don't remember his name. He was just here a few months when I started, and then he left because New York Medical College came in, came in '78 or '79 they started.

I think it was for the better of the hospital that New York Medical College came in. They started changing programs, putting in their own teaching programs, and installing their own people in key positions, and so on. Gradually--by gradually I mean a couple of years--they were able to bring up the standards. They had a primary care training program which was very well funded, and that was implemented here in 1980, I think.

Mullan: Primary care pediatrics.

Hermosa: Yes. A training program funded at that time by NIH [National Institutes of Health].

Mullan: Probably the Public Health Service. It's probably the Bureau of Health Professions.

Hermosa: Yes. So I was a general pediatrician working mainly in the out-patient department, and doing teaching and supervision of residents. In 1981--and we had developed these teams of primary care services.

Mullan: What did it mean when you had a primary care training program and you were teaching with more of a focus on primary care compared to the old days when you were just training pediatricians? Was there an actual difference in emphasis?

Hermosa: Yes. The residents were required to have 20 percent or 25 percent of their time in the out-patient, in their own continuity clinics. When I was a resident, I thought it was impossible to develop such kind of a program because of the shortage of manpower and residents. Residents were just going through block rotations through the clinic. When they instituted the continuity service, there were problems in the in-patient coverage that was a result of that. Like for example, the ICUs, if the doctors were busy, they could not come down. On the floor, if they were not very well coordinated there, then they could not come down. So that had to be ironed out. But it was

possible. We developed a continuity clinic for each resident. Each resident had two continuity clinics.

Mullan: Or 20 percent time for a day a week.

Hermosa: Twenty percent of their time every year for three years.

Mullan: Are there elements of primary care training that were distinctive?

Hermosa: Yes. They were required to teach a definite curriculum. They had to develop a general pediatrics curriculum, they had to assign responsibility as to who should teach this particular subject. There were courses that were taught by specialists such as cardiologists, for example. They had their own curriculum. The specialists had their specialty whereas general pediatric topics were taught by general pediatricians. So in addition to seeing patients and supervising the residents in the clinic, the general pediatricians were now involved in the teaching, the giving of the lectures, didactic teaching, making rounds, and participating more in the direct teaching of the residents. The ratios between general pediatricians and specialists improved. By that I mean there were more general pediatricians and less specialists.

Mullan: In terms of what people did when they graduated from the program?

Hermosa: No, in terms of the teaching faculty.

Mullan: The faculty itself.

Hermosa: Yes. In the past, we only had a hematologist, a specialist in infectious disease, and other specialist and maybe a couple of general pediatrics. Now there were more general pediatricians, maybe half the pediatricians were specialists.

Mullan: It was like half and half. Half were general pediatrician, half were specialists.

Hermosa: Yes. The residents now were informed that this was a primary care training program, and that they were expected to go into primary care after their training.

Mullan: Did most, or did they continue to specialize for the most part?

Hermosa: Most of them went into primary care. I think the problem and influence in the decision-making as to whether or not they stayed in primary care or they went into a specialty was if they were going back to their country. If they wanted to practice neonatology in Indian or Pakistan, then they were decided on that. If they were staying in the country, the issue was how much was the pay. Because if you become a neonatologist,

you make twice as much as a general pediatrician. That was the major issue, but most of our graduates when into primary care.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Hermosa, tape number one, side two.

You were saying most went into practice in the South Bronx.

Hermosa: Quite a few came to work either with the Department of Health, or opened their own solo practices in the area.

Mullan: What percent do you think would have returned to their countries, what percent would have stayed in the States?

Hermosa: Maybe about 10 percent would have gone back to their country.

Mullan: Mostly in the States?

Hermosa: Mostly in the States.

Mullan: And of those a significant number, you think, stayed in the South Bronx, or in the Bronx, in the area?

Hermosa: I can't say how significant, but through the years, maybe two or three would stay this year, and two or three would stay another year. They would work say, in Union Hospital, open

their own practice, or work for the Department of Health in this area. Those that stayed in general pediatrics but went out of the South Bronx, went to places where they had offers for conversions of visas, like some areas in Tennessee, some areas in Alabama. So they stayed in places in the country where their services were needed, and in turn their visas were converted.

Mullan: How did things develop then through the eighties, both in terms of Lincoln and your role here?

Hermosa: In 1981, the chief of OPD here, the pediatric OPD chief, died. Before she died, she recommended me for the position. So I was appointed director of pediatric OPD. I took care both of the clinic and the emergency room. The chief of pediatrics at that time was Dr. Grohisch. In addition to being chief of the OPD, he asked me to be associate director of the department, because he felt that if he had one person taking care of in-patient and out-patient, that the administration would be easier, and there would be communication and better implementation of the program, and he was the primary investigator for that primary care training program. So not only did he make me associate, he also made me responsible for the coordination of the primary care training program. There was a director of residency, but my job was to see to it that the elements that needed to be implemented in the program were implemented.

So we had this, and this is what I did for all of the eighties. We started thinking about faculty practice in the mid-eighties, 1985, '86 and, I think, '87, we started our faculty practice. All the attendings in the department as well as the hospital, formed a group practice and billed for services rendered directly or indirectly through residents under their supervision.

Let's see. What other changes were there? Managed care came around 1992. We implemented that. At that time I had, let me see, about ten or so attendings, a few in each team. When we started implementing managed care, it pulled away the supervisory role of the attendings from the [unclear] teaching program. So instead of them, providing two sessions per week in direct patient care, and the rest in supervision and teaching, with managed care. They were expected to give direct patient care 60 percent of the time, and 20 percent of their time was now supervision and teaching. Because of that major change, I had to ask for more staff.

Mullan: This is Medicaid managed care, for the most part?

Hermosa: Yes.

Mullan: That was because Medicaid wouldn't accept residents doing the principal care? Why was it that the attending-level faculty were so much more hands-on at that point?

Hermosa: That was what HHC wanted to do. They wanted to move the direct care of patients from the residents to the attendings. They felt that doing this would improve the quality of care for the patients. They wanted to start moving away from having--

Mullan: Total resident dependency.

Hermosa: Correct.

Mullan: Did they decrease the number of residents?

Hermosa: At that time, no.

Mullan: But you needed more attendings to do what--you asked for more attendings?

Hermosa: Yes.

Mullan: Did you get more attendings?

Hermosa: Yes. I did not get enough, but I had a couple more attendings. Then I had to ask the director to see if any of the specialists would help to supervise the residents at the clinics. Supervision is a requirement for billing. There were some residents, like PL3s who did not need supervision. They could handle the clinic. However, because of the faculty practice, and because we were billing, the requirement of the Medicaid program

was that every bill had to have a note in the chart to show that you saw the patient, and that you supervised the resident that gave the service. So in order to do that, we had to have sufficient numbers of attendings to supervise and check every single patient that came into service.

There were quite a few changes during that time, too.

Mullan: The impact of that as you saw it, did that improve quality? Did it increase expense? What was the outcome of those changes as you saw them?

Hermosa: A major change was the movement of patients from caseloads of the residents to the caseloads of the attendings. There was a point where the residents lost all their patients, because now they had to compete with the attendings for the patients. If you ask a patient who they wanted to be their doctor, they would choose an attending rather than the resident. I was concerned that the managed care was going to destroy the program, but as it settled down, and as some changes came about, for example, the managed care administration in Albany allowed residents to be part of managed care, but they set certain requirements.

Also, as we learned more about managed care and what kinds of rules and regulations we had to comply with, we started to understand that patients can really be seen by residents, even when they belong to certain attending caseloads.

Mullan: How did you work that? The resident would see the patient; the attending would stop by, or the attending would sign off?

Hermosa: No, we had already this arrangement of attendings supervising the residents with every single patient, and writing a note in the chart. So basically, the attending was as familiar with the patient as the resident. There was not a patient that came in and out without an attending knowing about it.

Mullan: So that the use of the attendings became more prominent, but you established a balance between attendings and residents so that the teaching program was not destroyed.

Hermosa: Yes.

Mullan: But the number of residents was somewhat reduced during this period?

Hermosa: Actually, the reduction in the residents only took place this year. There were plans of reducing, but it did not happen until this year.

Mullan: In terms of your residency class size, what had it been through the eighties, and what is it now?

Hermosa: Through the eighties it gradually increased and got to as many as sixty, sixty-two residents.

Mullan: Over three years.

Hermosa: Yes.

Mullan: So you were taking in about twenty a year.

Hermosa: New ones?

Mullan: New.

Hermosa: Yes, twenty.

Mullan: What is it now?

Hermosa: Right now it's been reduced to around fifty-seven, I think.

Mullan: So a slight decrease.

Hermosa: Yes. There are plans to reduce it farther the following year. I think the reduction is to take place in three years, a gradual reduction in three years.

Mullan: What is driving that? Is that policy that they think there are too many residents? Or is it cost?

Hermosa: Mainly money. The city health system is not willing to fund the residency programs anymore and, I think, also because the monies from the federal government, the funding of this is also running out.

Mullan: From your perspective, will that be more expensive if you lose residents? What is the role of residents in terms of patient care today? Are they the bulwark? Are there less so than they were in the past to patient care? Will it cost you more if you lose residents?

Hermosa: Yes. The city hospitals will have to pay more if they lose residents because, as it is now, the cheapest service they have are the residents. Say, for example, the resident is paid, say, $40,000, $45,000.

Mullan: Is that what they're being paid these days?

Hermosa: Yes, I think the lowest is something like $35,000.

Mullan: Intern starts at $35,000?

Hermosa: Yes. But they work twenty-four hours every third or fourth night. If you had to replace that person with a nurse

practitioner, say, a physician's assistant, you will still have to hire somebody to supervise that person. The amount of money will be almost double. If you hired a junior attending to do the job of a resident, you have to double the price of the resident, and still not get the twenty-four hour service.

Mullan: So the resident's a good buy.

Hermosa: It's a very good buy. It's an excellent investment.

We had the primary care training grant which ran out, and the state took over. The State up-weighted reimbursement to our services. We had that for three years, and then somehow we didn't qualify anymore for up-weighting. So right now that's what we have. We have managed care; we have a primary care training program; we have very few--several--specialists. Maybe a couple of them full time, but most of them part time.

Mullan: The part-time ones come and do teaching or consultations?

Hermosa: Right.

Mullan: But the principal focus of care is generalist primary care?

Hermosa: Yes.

Mullan: Even when you hospitalize children with oncologic problems or pulmonary problems, they're hospitalized here. The general service takes care of them, but the specialty services consult on them? Is that the way it works?

Hermosa: Not to that extent. If the patient came through the emergency room and is a newly diagnosed leukemia, for example, the emergency room would consult the hematologist, oncologist right away. Usually that patient is admitted to tertiary-level care, which is maybe the ICU, in which case the specialist becomes the primary physician for that patient until everything is stabilized, and the specialist gradually becomes the consultant, and the generalist takes over the care of the patient.

The specialists in the past were very reluctant in giving away this service, but more and more they are forced into it because they are also expected to increase their productivity in their own field. Plus we require that children have comprehensive care, and if they are not willing to give comprehensive care, they are willing only to do their specialty, then they should give up that part of the patient to get comprehensive care from a generalist. So now they are forced to assign or refer the patient to a general pediatrician, even when the patient goes to the specialty clinic regularly.

Mullan: Let me ask some big-picture questions about the last fifteen or twenty years of your career, which have been divided,

as I understand it, between patient care, teaching, and administration. Between the three, what has been the most satisfying to you, what has been the least satisfying to you? What feelings do you have about those pursuits?

Hermosa: I think it's only satisfying to me because of the mix. If I had to do direct patient care all the time, I would get bored. If I had to do administrative work all the time, I would also get bored. I think the mix is the key. You don't get bored, because there's always a change. During the week, there's time to see patients, and you have set aside time yourself to do something else.

I also got involved with quality improvement and quality assurance, and joint commission requirements and surveys, state department surveys, and that kind of thing. So I have no time to get bored. I am very busy, and there are plenty of fields that I am into that is very interesting, and I have opportunities to learn all these other things that are developing in the health care field. It has been very pleasant. I enjoyed my job very much.

Mullan: Do you miss endocrinology?

Hermosa: No. No. Every now and then I feel that there is something that I expect myself to know, and maybe I have not kept up to date with what is going on in endocrinology, and I feel sorry for myself for not being able to keep up, but there's just

too many things to keep up with, especially in general pediatrics. I mean, it's very difficult to be current in all the fields.

Mullan: As you look to the future, let's talk about it on two levels: one, the system as a whole, secondly, your own ambitions for what you'd like to do. Let's first talk about you and where you're headed in terms of the system, and in terms of your practice and your career. What do you see over the next number of years for yourself?

Hermosa: Actually, I have resigned this position. I'm working here until July 16. Then I have a similar position over at Staten Island University Hospital. I think it's a private hospital. They're developing a primary care program that is in private practice setting. The service right now that's there has a teaching program with residents who are rotating down-state. They would like to have their own residency program, and they have asked me to take care of the out-patient department, as well as be the associate director for the department in order to implement this primary care training program.

Mullan: Do you look forward to that?

Hermosa: Oh, yes. To me it's a challenge to be able to get practice in private, a private practice-type setting. I was told that I have to standardize the quality of the practitioners.

Because they did not have their own training program, their standards of practice is really not developed, and there are doctors who are very good, but there are doctors that are not that good, and they would like to be able to see that everybody functions at a certain level.

Mullan: As the system is changed, managed care, quality assurance, increase in primary care, etc., what, as you look back and forward, about the changes in the system do you like and make you optimistic? What do you not like and make you pessimistic?

Hermosa: What I like best is that the country now recognizes general pediatricians and general practitioners, and is giving them the financial support. I think the financial support is key to the change, because if specialists make twice as much as generalists, then no one, not even U.S. graduates, would like to go into general medicine, because they need the money to pay educational loans. There was really no incentive when generalists were earning something like $35,000, and specialists were earning twice as much.

Mullan: Generalists are making it.

Hermosa: Yes. But worse than the generalists are the other specialists in Lincoln Hospital because they are earning less.

Mullan: Oh, they are?

Hermosa: Much less than the generalists, because their salaries were not increased even when the managed care salaries were increased.

Mullan: What sort of specialties are suffering that?

Hermosa: Cardiology, nephrology, endocrinology, and all of that.

Mullan: Really. They're making less than generalists?

Hermosa: Yes.

Mullan: These are people going out into practice?

Hermosa: Right. I don't know if they will do better if they were to practice their own fields outside Lincoln Hospital. It's very difficult to try and get them up to a certain level, just as we had tremendous difficulty moving the generalist up. I had to really fight for them to be in managed care, because that was the only way I could bring their salaries up. When it finally came through, when they approved the managed care positions for all my generalists, some of them had like doubled their salaries. That was how much they had to climb up. They had very low pay.

Things I don't like. Basically, the reduction in the number of residents, because the transition is going to be painful for the city. I don't know whether other states and other cities are going to be hurt as much, but New York City is going to be hurt

tremendously by this change. The number of patients that can be cared for is going to be limited. The waiting time for service for them is going to be longer if there is no residency program. This is easy access for them, even if they have to go through the emergency room.

Mullan: How do you feel about managed care as a movement? Physicians, as you know, are terribly divided about it. As you've seen it come to play here in the Bronx and New York, how do you feel about it now, and what do you see as its impact on the future of medical practice?

Hermosa: I think it has a very strong impact in the quality of care of patients.

Mullan: Positive or negative?

Hermosa: I think it's positive. I think they will be able to put the emphasis on preventive care, and because of the gatekeeping-type service, before a patient is sent to a specialist, for example, or before a patient can decide to have any kind of procedure done, it will have to be reviewed by--

Mullan: You're certainly talking in terms of Medicaid managed care, which I certainly agree. If you manage the Medicaid dollar, you'll get more mileage out of it. It's been poorly spent in many ways in the past.

Hermosa: Right.

Mullan: Generically, do you feel that way about managed care? I mean, in the commercial sector, that it's--and I don't mean to challenge you, I'm just trying to tease it out.

Hermosa: I'm trying to figure out, say, for example, if I belonged to a plan, I, as a patient, belonged to a plan, I may not like the idea of having to talk to a nurse if I wanted to see my doctor, or if I had something that needed attention. But in the long run, I think it is good for the general public to have that kind of different levels of care. As a physician, I was against being limited to a group. Also, because I am a physician, when I get sick, or my family members get sick, I have an idea more or less as to who I should consult, and I would like to retain the choice of who I should go to.

But when you look at the plan, and if you have in the plan a listing of people that you have some kind of trust, then to me that is just as good as my choice of a physician. For example, if I had to see a gynecologist, and in this plan you have these names, and I have a way of checking as to the quality of these people's performance, that would just be as good as my own choice outside the plan. As it is now, what is happening is that the plans are getting the choicest physicians, and the good physicians, even those in private practice, are joining the plans. So they're coming together in some ways that I think is good for the health care industry.

Mullan: What's going to happen to Lincoln?

Hermosa: If they don't sign the agreement--

Mullan: The agreement being--

Hermosa: College, and that is in question right now, because they cannot agree [unclear].

Mullan: Explain a little more just for the record.

Hermosa: Every year there is an agreement between HHC--

Mullan: Health and Hospital Corporation.

Hermosa: --and the college.

Mullan: In this case being New York Medical College.

Hermosa: Yes. New York Medical College.

Mullan: In affiliation. So there's some question now as to whether it's going to be renewed.

Hermosa: Yes. Both parties are being obstinate. They have their own demands. HHC here, the administration of the hospital here, would like the college to sign a contract eliminating the

OB service. They would like to get the OB service elsewhere. The college will not allow that. The college has residency programs in OB. They have students that need teaching in OB, and they will not agree to have contracted out OB. So that's where it's at.

Mullan: So if it splits and Lincoln goes solo as a city hospital, will it be able to maintain both teaching and services?

Hermosa: There are ideas floating around where the physician group here can incorporate themselves and go into contract with HHC as far as practice is concerned, and then solicit. . .

Mullan: Managed care contracts?

Hermosa: No, training with, say, a college.

Mullan: Contract for training.

Hermosa: Yes, contract for training. Because they can train residents. They have been doing it. So if the New York Medical College is not interested in keeping their residents here, then they would like to see if, say, Columbia University, or any other universities who--

Mullan: So there's at least ideas about a free-standing city hospital with a fairly stable staff that would contract for teaching activities.

Hermosa: Right. Some people think that this is very naive and that maybe it's bound to fail because we are not businesspeople, we are physicians and, therefore, we are not ready for this. Some people feel very strongly that they can handle it, that they can do it. Coney Island apparently is doing this now. I think they're losing money, but apparently their service is going in that direction.

Mullan: How has your career in medicine affected or intertwined with your personal life? Has it been good, taxing, difficult? How has that all developed?

Hermosa: I think the key to my being in this position is that my husband supported me to do this job. There was a time when he did not agree with this administrative position. He thought that it would be better for me to remain as a general pediatrician, because I could spend more time with the children and with the family. I disagreed with him, mainly because I felt that if I stayed in that position, I would be very bored. I felt like I needed a challenge, I needed some problems to be solved, and things like that. I was able to convince him that I would be a happier person if I did this.

He has cooperated with me and helped me in doing the job to a lot of extent. I don't have a computer here. Most of the people here are now very, very knowledgeable in computers. I took a master's program in the college that I did not finish, but I learned a lot about computers, but he does most of my work with computers. He types for me, he makes my slides, he was beginning to develop a network between the office and the house when I decided to change jobs. So now he has to wait until I get there, then he can develop the network so that he can download my work from the office and I can access my work from the house, and so on. So to a lot of extent, he has done a lot for the family and for me.

Mullan: How old is your son?

Hermosa: He is going to be [unclear] years old.

Mullan: You have the two, a son who's almost twenty--

Hermosa: Twenty, and my daughter who's twenty-five.

Mullan: Going back to your home and your roots in the Philippines, have you remained close with your family in the Philippines, and do you go back and forth often?

Hermosa: Not as often as I would like, but now with the E-mail, it's very close. My husband communicates with them almost every

day by E-mail, because it's cheaper than telephone calls. My side of the family reside in an area which is not as developed electronically as Manila. But my husband's side of the family is mostly in Manila, and most of his relatives have computers and they communicate through E-mail very easily.

Mullan: Do you go back often?

Hermosa: Yes. We went back February 1995. We plan to go back again January of '97.

Mullan: He has been back himself.

Hermosa: Yes, he's been there.

Mullan: In terms of your journey as an international medical graduate from back in the sixties to the middle of the nineties, how has that changed or evolved in terms of the winds you feel blowing in the system in general, in terms of acceptance, integration, non-integration, and so forth?

Hermosa: I think, to a certain extent, I have been a part of the Filipino group of physicians, and to a certain extent, non-physician community of Filipinos. I've not been that active in that area, maybe because I really don't have that much time to spend or socialize as much as my friends have. So I think to a certain extent that has hurt the development of my children,

because they have not been exposed to a lot of Filipino children, Filipino community, and culture, and all that. But I think they are better adjusted as a result. I did not concentrate in just socializing with the Filipino groups. I see myself as a little bit different from that, in the sense that I have a variety of friends.

Mullan: Your identity is less Filipino than somebody more integrated or more cosmopolitan.

Hermosa: Right. And I have accepted a lot of things that most Filipino families would not accept. I have tolerated this development, like for example, when I see my children do certain things that are not acceptable in our tradition. Other Filipino families object very strongly. My husband had a very difficult time accepting all these changes.

Mullan: Back on the theme of medical practice. The level of acceptance at the various places you've worked, you as an international graduate or as a Filipino, is it changed over time in one direction or another, or is it different with different communities of people? Do the patients, for instance, that you treat at Lincoln, who were predominantly Puerto Rican, what is the dynamic between you and them in the regard to the extent you can distinguish it, your being Filipino?

Hermosa: I don't think the patients here see the physicians as Filipino, or non-Filipino, or Indian, or whatnot. They recognize that if you are a physician, that you are a caring physician. They may not know much about what you know or recognize the quality of your service, but they understand a caring person as opposed to a person who does not care. I don't think I have any problems being accepted by the patients. If I were to practice in another community, I think they would see me the way I project myself, as a caring person.

There was only one instant, I think, during my fellowship that I had a problem with a patient who did not want to see me because he said he was Dr. Sobel's patient. I was only the fellow, and she wanted to see Dr. Sobel. So I explained this to Dr. Sobel, and Dr. Sobel said, "Well, we'll talk to her and we will let her understand that before she can see me she has to see you." After that, I really did not have any problems. But of course, I did not practice in Scarsdale, so I cannot say whether or not they would have accepted me there as much as they have accepted me here. But here I have no problem.

Mullan: With physicians trained in the Philippines leaving in large numbers to come to the states and elsewhere, is there any question one way or the other? Do people in the Philippines think that that's good, or do they think that, "Gee, our people should stay here and shouldn't go abroad"? I'm sure it's probably part of a larger question of people going abroad in

general. Was there any sense about that when you were leaving, and has that changed over time?

Hermosa: When I was leaving, there was not much in way of government regulation or family holding back people from going abroad. It was the "in" thing, it was the right thing to do, and families were proud that the children were being accepted in training elsewhere in the world, and therefore that was a sense of pride for the families as well as for the government. Then when a lot of people were leaving, the government started saying that maybe this is not such a good thing. So they started developing their own teaching programs, and in the mid-eighties, they had already good training programs in the Philippines.

One of my classmates in medical school never came here to train. She's an ophthalmologist. She trained there. She now practices the state of the art. She comes here maybe once a year to update her knowledge and technique. When I went home in January last year, I went to her office. She has everything computerized the way most ophthalmologists here have their practices computerized. She makes diagnosis based on whatever number she enters into the computer, and she determines how much, what angles, and things like that, and she demonstrates this to her patients. She is very well trained, and she never trained here.

Mullan: I thought you were leading up to saying the government is now attempting to discourage physicians leaving the Philippines.

Hermosa: They are not attempting to discourage, they are just attempting to attract people in various places.

Mullan: So that they don't have to go abroad to get good training.

Hermosa: Right.

Mullan: That's been somewhat successful?

Hermosa: I think so. The second generation (children of my classmates), who are now physicians themselves, are staying there and training there. I know of some who came here to train, but they have gone back and have worked there. Some of my friends who came here and went back, and came right back to the United States. They came back because at that time the state of the art of practice in the Phillippines was still behind. It was very difficult for them to adjust. Even just having a disposable needle can make a lot of difference. Here they're used to having disposable needles. They don't have to worry about having to sterilize needles and having to use needles that are not as sharp. When they went back there, they had to struggle with

that, to have the right equipment. They could not practice what they learned was the right way to practice.

Mullan: Which was discouraging.

Hermosa: This was discouraging. It was very difficult for them to readjust there, so they came back. Now they are staying. A lot of them who came here are going back and staying.

Mullan: You've had a fascinating career, and you've really been very generous to share it all with me. Is there anything else that we haven't touched on that you'd like to comment on?

Hermosa: I don't think so.

Mullan: Thank you.

Hermosa: Thank you, too.

[End of interview]