ALIZA LIFSHITZ

November 10, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Lifshitz: April 1, 1951.

Mullan: We're sitting in Dr. Lifshitz's dining room, part of the living room, in Los Angeles, on the evening of the 10th of November 1996. She's been good enough to provide me with dinner. Usually the arrangement is that I would sing for my supper, but, in fact, you're going to sing for my supper. [Laughter]

We're in a very, very comfortable and lovely house, on a very warm evening, with a Santa Anna wind blowing, and no air-conditioning, which feels fine to me. She thinks it's warm. For November, it seems fine. Los Angeles is a home of some years now, but it wasn't where you started. So why don't you tell me about your background. You were born, I believe, in Mexico?

Lifshitz: I was born in Mexico City, and I was raised in Mexico City. I went to medical school in Mexico City, and it wasn't until I finished medical school that I came to the States.

Mullan: Why don't you tell me a little bit about your background. From what little you've told me, you're of well-traveled ancestors, and the name "Lifshitz" does not jump off the page as a typical Mexican name.

Lifshitz: That is correct. My four grandparents actually were from Europe. My father was brought to Mexico by his parents when he was very young. He was nine years old, and he grew up in Mexico. It was not until he retired that he moved to the States, when both of his daughters were living here. My mother was born in New York, and was taken to Mexico when she was three months old. So, even though my genes are not Hispanic, both of my parents really grew up in Mexico.

Mullan: The family came from central Europe, from Russia?

Lifshitz: From Russia, primarily.

Mullan: Early in the century?

Lifshitz: The four grandparents. On my father's side, it was in 1928, when they were supposed to have arrived in the United States, but at that time the quota was closed to New York, and they ended up in Mexico City. About a year later, the quota was opened, but it was the time of the Depression. My grandfather had started a business. My father and his brother were going to

school, so it was like, moving to yet another country--they decided to stay there.

On my mother's side of the family, they were born in Russia, but they left--I don't remember exactly when--to live in England for a while, and then New York. And they lived in New York, and for business reasons, my grandparents, on my mother's side, decided to go to Mexico. At the time when my mother was born, my great-grandparents were still living in New York, so she was born in New York, even though my grandparents were already living in Mexico.

My parents' education was in Mexico, and even though they had a European background, they had the identification with the Hispanic culture as well.

Mullan: Was there much of a community of--it would be Russian Jews? Your parents, grandparents, all were--

Lifshitz: My grandparents tended to, I think, congregate more with people from the Russian Jewish community.

Mullan: And there was one in Mexico City?

Lifshitz: It wasn't very large. It wasn't very large, but a lot of people that had--I mean, probably, for the same reason, had been unable to come to the United States, because I don't think that in Russia they had heard about Mexico at that time. They ended up in Mexico, and they kind of helped each other. The

people that arrived there when they were elders had difficulty with the language, and that also made it kind of more comfortable to be with people that spoke their own language. I was surrounded by all kinds of languages when I was growing up, because it was not only the Russian Jewish community. I mean, there were people that had come from Poland, there were people that had come from Hungary, from all kinds of places, so I would be exposed to a lot of languages.

Mullan: Other than English and Spanish, were there any that you used? Did you speak either Russian or Yiddish or anything else at home?

Lifshitz: Well, at home, we really spoke Spanish. With my grandparents, on my mother's side, we spoke English. My father used to speak Russian with his mother, but we didn't speak Russian. We learned French, and when we went to high school, because we went to a Jewish high school, we also started learning Hebrew and Yiddish, which we learned, and we had throughout high school. The other language that I chose was French.

Mullan: Growing up as somebody who did not look or, by last name, seem Mexican, how well were you accepted? What is the Mexican culture like, in terms of its acceptance? In the United States, there's been so much mixing and assimilation of other cultures, including particularly Jewish people from Europe. In Mexico, my impression is, that's much rarer.

Lifshitz: Yes. In terms of sheer numbers, the Jewish community was not very large, and even though there were a lot of Europeans that were not Jews, a lot of Spaniards, a lot of Germans, a lot of Italians. There's even a German school and a French school. When your skin was lighter and your last name was not typically Hispanic, in certain circumstances you were made to feel that you were not exactly like them and that you didn't belong 100 percent.

Nevertheless, for example, when I started kindergarten and grade school, my parents sent me to an American school, because in this American school, we had kids from all over. I had classmates that were Japanese and some of them were American, some of them were Mexican. Different backgrounds, with the idea that what was most important was that we're all the same, regardless of where we come from, regardless of the language we speak, regardless of the religion we choose to follow, and that was the message that I got as number one.

As we were getting to become teenagers, they wanted us to learn a little more about part of the cultural background that we had as a family, and the ancestors, and that's when they decided to send me to a Jewish school. And, interestingly enough, when it came time to go to medical school, the National University in Mexico, the National Autonomous University in Mexico City, was going through a tough time in that, when they were not on vacation, they were having a strike.

So there was a new university, which was a Catholic university, La Salle University, just starting. I passed my exam

to go to the National University, but it was incorporated, this new university, into the National University, so that we would be doing the same kind of program, plus other things. And I went to a Catholic university, although my diploma is from the National University because I had to also present their exams and everything.

Mullan: Because it was on strike so much, that was the reason?

Lifshitz: Yeah. The university is a great place, but the classes tended to be with very many students. They were very large classes, and, as I said, it was a tough time, because they were having a lot of strikes, and this Catholic university allowed me to be in a smaller group setting, utilizing all the facilities that the National University used as well.

And, by the way, they were also going through a change of calendar, so I finished high school, which, in Mexico, you go through high school, six years of high school, and then you go straight to medical school, and it's a six-year program. But because of the change of calendar--they were changing from starting the year in January to starting in July--there was a nine-month period, in which I became a bilingual executive secretary, because my parents wanted me to have a profession, and they were afraid that if I was going to the medical school, I would not finish, and then I wouldn't have anything. It was not customary, when I went to medical school in Mexico, for women to go to medical school.

Mullan: Let's go back and trace that a little bit. Where did the idea of medical school come from?

Lifshitz: I think it was a combination of things. My mother would have loved to have been a physician, and I think that deep down, I must have either inherited that or somehow felt that.

Mullan: Did she tell you that, or how was that manifested?

Lifshitz: No, I learned about that through my grandparents when I said that I wanted to go to medical school, but at the time when my mother suggested that she would like to go medical school, at that time, you know, women did not go to college, didn't go to university. My grandparents thought that my mother was going a little crazy, so it wasn't given a consideration.

My parents were always very much involved with helping other people, in every way, shape and form. I think that medicine allowed that, and I wanted to do something creative, and I thought that medicine allowed me to help people and allowed me to develop that creative side of me as well, because I believe that it is the art of practicing that is based on science.

Mullan: As a child, or as a high school student, was medicine in your mind? When did it firm up that that's what you wanted to do?

Lifshitz: It was in high school. Since you have to decide the fifth year--you know, you have junior high, and then you have to decide by the fifth year, because in the sixth year you have some electives that are sciences. I was initially a little bit undecided between architecture and medicine, because I thought architecture was very creative. Nevertheless, I wanted to work with people, and that's when I decided. My parents tried to persuade me, again, not because they didn't think it was a wonderful profession, but because they were afraid that I was not going to finish.

Mullan: Persuade you against--

Lifshitz: Against going to medical school. They thought I would not finish, and they also thought that, even if I finished, it would be very difficult to practice and have a normal life--what they considered a normal life. They were right. [Laughter] I am very happy I did it.

Mullan: The Catholic university that you went to--in your class, what percent were women?

Lifshitz: At the National Autonomous University, the percentage was very, very, very, very low. I can't tell you exactly the numbers, but I can tell you that in my group, when I graduated, in my group there were only three women, even though it was a small group.

Mullan: Three of?

Lifshitz: I think that there were twenty-eight of us. Because we started with fifty, and then when we started clinics in the third year, there were only twenty-eight left.

Mullan: So you're talking, something like 10 percent were women. Was that typical?

Lifshitz: That was in my class.

Mullan: Was that typical?

Lifshitz: No, it was less when you take the National--

Mullan: Less than 10 percent?

Lifshitz: Yeah, less than 10 percent.

Mullan: And now we're talking seventies? When did you graduate?

Lifshitz: I graduated in '76.

Mullan: Let's talk a little bit about medical school in Mexico. What was it like, and when was it that you switched from National to Catholic?

Lifshitz: No, actually, I started in the Catholic. It was incorporated into the National Autonomous University. The way it happened is that I took the entry exam to both of them, but it was a new school that was going to be using the exact same curriculum as the National Autonomous University. We were going to actually have the same professors for the clinic rotations, and the diploma was going to be from the National Autonomous University, because we were complying with everything, and we were also going to be taking the written exam which they took, in addition to an oral examination, for which they invited professors from the National Autonomous University to quiz us. It was quite exciting, quite a challenge.

Among the things that we had that were different from the National University is that they increased the number of requirements, and one of the classes, for example, that we had to take, was medical ethics, which was given by one of the priests, which was fantastic. As a matter of fact, he asked me if I would help him with a mass when we graduated. He knew I was Jewish all along, and I told him that I would be delighted to do that, but that I wouldn't know what to do. And he said that he would tell me what to do, and I helped him, and it was just wonderful, a wonderful experience.

Mullan: That's great. Medical school, as I understand it, in Mexico, is somewhat less clinical. It's five years, six years?

Lifshitz: It's six years.

Mullan: How does it break down?

Lifshitz: It breaks down, the first two years, you have basic sciences, and even though you do have some rotations in which you sometimes visit hospitals, like an introduction, it is not about doing things the first two years. It is about watching people while you're learning your basic sciences. Once you go through your basic sciences, the third and the fourth year are your clinical years, and then you go through your clinical rotations.

The fifth year is what they call a pre-graduate internship, meaning that you cannot get your diploma after four years. You have to do that year, in which, when I was there, there was no choice in terms of straight medicine or straight surgical, because it was pre-graduate. You rotated, and you had peds, and you had psych, and you had medicine, and you had surgery, and you had OB/GYN, and that was for a whole year. For practical purposes, you functioned like an intern here, but with the supervision of the postgraduate intern and the residents.

Then the sixth year is the social service year, and the social service year, the greatest majority of people go out to underserved areas, little towns, where there's nobody, really, and they have to provide health care for those communities during that year. They get paid for it, but pay is very minimal, but it really helps these communities, which otherwise wouldn't have anyone.

Then after that, you can get your diploma. You have to, obviously, take an examination. You get your diploma, and then

you can choose to practice as a GP, or you can choose to get postgraduate training.

Mullan: In terms of the first five years, the both basic and clinical science, you've had an opportunity to work in and around medical schools in this country. How did they compare to what you've seen in medical education here?

Lifshitz: One of the things that happens when you go to a medical school in a Third World country is that you do not have technology as easily available. So the clinical aspect, the history-taking, your skills, in terms of trying to get to the diagnoses with your questioning and your exam, are by far more emphasized. The way you take a history in Mexico is more the French style, which, even the way in which you write it down--like here you start with chief complaint, then present illness, and then past medical history, family history--the order is a little bit reversed. You start again with chief complaint and present illness, but then you go on to family history. It's different, and it's very descriptive. I remember that my histories and physicals used to be so descriptive that someone told me that they didn't have to see the patient, because I had described it. But it was part of the teaching. The style was different. It was very clinically oriented.

I think that probably in terms of basic sciences, it is more emphasized in this country, and in terms of technology. When I was in medical school, of course, we didn't have MRIs, because

they were not even available in this country at that time, but the technology that was available was not available for everyone. You didn't have as many machines, you didn't have even things like, for example, disposable needles and syringes to draw blood.

Here, it's always been, you get a new one, you know, a brand-new one, you open it, that's it. Over there, we used to sterilize syringes and sterilize needles, and sometimes the needles were so worn out that it was hard, and it hurt to try and stick the person. Sometimes, depending on where you were working, you might have a pole to hang your IV, but sometimes you would use something from the window. You had to improvise. You had to be very creative with what you had and what you could do.

There were, like everywhere in the world, people who could get their medications, people who could not get their medications, people who had the sophistication to understand what you were doing, and the ones that didn't. But because it was much more widespread, the "have-nots," it was not unusual to spend more time explaining to them, or trying to find a way in which maybe you can call the intern that is at another clinic to see if they had some extra bottles of whatever.

It was, I feel, a little more humane. I believe that here, science and technology is fantastic and I think it's extremely important, but on the other hand, there is a certain coldness and there is a certain fear because of the way the patient-physician relationship has been established through the history of lawsuits and lawyers getting involved. I do believe in protecting the

patient, but sometimes, if you go overboard, that can actually I think, deter from care.

Mullan: Tell me about your social service year. Where did you go for that?

Lifshitz: When I was doing my internship, there was one physician who had been trained here in the States, in Boston, who was an internist, and whom I really respected very, very much. Even though the pre-graduate internship is pretty grueling in terms of the schedule, I always felt that he was someone that was up to date, and was always reading the *New England Journal of Medicine*, and I always found a way to spend a little time and get interested in some of the projects that he was interested in.

So he was doing some clinical research with psychiatric patients, and I started doing a little bit of clinical research with him. So, for the social service year, he requested if I could stay to continue doing that. I ended up staying at the hospital and working with him, so that we continued with those projects. He was also an endocrinologist, and the studies that we did had to do primarily with endocrine disorders in psychiatric patients. It was a time when, universally, they did not check patients that were depressed, for example, for thyroid, for hypothyroidism, so that's one of the projects that we had. It was fascinating, because I had a chance to experience clinical research beyond what you're exposed to in medical school.

Mullan: What was the prevailing attitude, both among your classmates and in the medical school setting in general, about specialism versus being a GP, which I gather was the dichotomy of choice? Describe for me what the dichotomy, or what the attitudes and options were in the generalist/specialist opportunity.

Lifshitz: When I was going to medical school in Mexico, the availability of residency positions for specialty training was not humongous. It was not by any means as restricted as it is now, meaning, that at that time, if someone really wanted to get any kind of specialty, they might have had to maybe wait a year or so, but they could have gotten it. Nevertheless, the striving to become a specialist was not really that great. Being a GP was something that a lot of people felt very proud about, and a lot of people that came to the National Autonomous University and rotated through the same hospitals that I rotated through actually ended up going back to the places where they came from, and a lot of them were not from Mexico City. They came also from large cities, but there were not very many good medical schools.

There was the military school; there was a school in Monterey, which was very good. The school in Guadalajara was really looked down upon. It was the school where the "gringos" went, when they could not get into a medical school here. That, I understand, has changed, and I think that they have really done a lot in terms of the quality of that university, but when I was in Mexico, it's one of those universities where, you know, people

preferred not to go if they were Mexican. So that we had very many people coming from all over Mexico, ready to go back to where they came from.

Mullan: And were they planning to become specialists?

Lifshitz: Some of them were, but I would say that the vast majority didn't. The other issue that I'm sure had something to do with it, was the fact that a lot of the people that went to medical school, like a lot of the people that went into other professions in Mexico, were people that came from poor families, and actually, even though education was not expensive--and it's still not expensive, if you compare it to United States standards--it might be expensive for someone that has just enough to eat, because everything else is expensive. But when I went to medical school, what you had to pay the National University was the equivalent to about, I think, fifteen dollars a year. I mean, you had to buy your books and stuff, but it was really very inexpensive. So a lot of people that did not have a lot of money were kind of eager to start helping their families or to start a family themselves.

Mullan: So they would be ready to go back and not do more training?

Lifshitz: Exactly.

Mullan: My understanding is, then and now, that the default specialty is being a GP. In other words, if you don't do more training after your social service year, and you go into practice, you go into practice as a GP.

Lifshitz: That's correct.

Mullan: Anyone, essentially, who goes on for further training, is becoming a specialist.

Lifshitz: Exactly.

Mullan: So that the specialist-generalist division is not only one of clinical proclivities, but it's one of advanced training and rudimentary training.

Lifshitz: Exactly. And I do have to say that people that went beyond being GPs did look down on people that were "just GPs."

Mullan: Tell me about that, just to understand the mind-set. That's what I'm anxious to hear about.

Lifshitz: When you finish medical school in Mexico, you don't become a "god," like it used to be in the States, (because it's no longer that way). But it used to be that when you went to medical , school here, it was something very, very, very special. In Mexico, if you went to university and became a doctor, it was

great. If you become an accountant, it was great. If you became an architect, it was great. And everyone has a prefix before their name, so it's not just Dr. So-and-so, it's "icenciado" for other careers, or "architect," or "accountant."

So everybody had something that would basically describe them, and being a physician was not something necessarily above the others. Some of the people that elected to stay at the GP level in some ways felt that, yes, we needed specialists, but the ones that wanted to go beyond that were in some ways elitist. They had, I guess, in some ways, an ambivalence about, yes, it would be nice to learn more, but why do you need to learn more if you can already take care of people? And we don't need as many specialists.

The other thing is that you did not have the pyramid-type situation in Mexico. So if you wanted to become a specialist, once you started, you knew that you were going to finish. You didn't have to compete for that position. And like here, the academicians always felt that they were the best, and anybody who was not in academics was not good enough. And the people that were in clinical practice always felt that the ones that were only in the lab and doing research really didn't know what was happening in the real world.

Mullan: What were you thinking about at that time? How had you envisioned your career as you left medical school?

Lifshitz: I was thinking about specializing, because I felt that I was not really ready to see patients and to have that responsibility in my hands--without a little more supervision--although I did want to see the person as a whole. So I knew that, eventually, I wanted to do primary care. I like clinical research. I like the scientific side of it. So it was exciting for me to combine both. But I saw myself as someone who would always see the patient as a whole, so that I would not like to be, for example, the super-specialist of the right hand.

In terms of coming to the States, it was not something that I set off to do when I was going to medical school. When I was working with Dr. Manzano, who is the physician that I was referring to earlier, since he had trained here, he said, "You know, you should go get your postgraduate training there, because there are certain opportunities that are available there, that you wouldn't have here. And then you can come back, and I'd love for you to come back and work with me." So that was my idea when I came here.

Mullan: How did you pick New Orleans?

Lifshitz: It was very interesting. I didn't know much about the matching. . .well, I didn't know anything about the matching program. I knew I had to take the ECFMG to come here, so I took it to see what it was all about, and I passed. So I thought, "Okay, you passed, you finished medical school." This was during my social service year. So I said, "I guess I should probably go

and interview at a couple of places, and then choose which one I want to go to." As it turns out, it's not that easy. This doctor that I was talking about earlier had trained in Boston at the Joslin Clinic and also--I've forgotten the name of the other place, because I went to the Joslin Clinic. Joslin is affiliated with--I don't remember the name of the hospital right now. . New England Deaconess. The New England Deaconess.

So I decided, I respected him so much, he had gotten his training there. I wrote a letter to the New England Deaconess. I didn't hear anything from them, so I went ahead and I called them, and I asked to speak with the head of the education department, whatever.

Somehow I got through, and he said, "Well, did you join the matching program?"

And I said, "What's the matching program?"

He explained to me what it was, and he said, "Without the matching program, we really can't even get you an appointment to come visit us, because we won't take you."

I said, "Well, even if I were to join the matching program, I would like to see what you're all about, to see if I'm interested in matching with you in the future. Is there a chance that I can come visit?" I guess he realized that I was so decided, that he gave me an interview. I went there, I went for a visit, I liked it.

But then I learned a little more about other things, and I hadn't written to any other place. Actually, several of the physicians that had trained with Dr. Manzano were living in New

Orleans at that time, and at Tulane there was an endocrinologist and a hypertension specialist who were clinical pharmacologists, and they had an excellent program at Tulane.

So what I decided is, "Okay, what I'll do is, I'll go, start with them, while I learn about the other hospitals, and apply to the matching program, because I don't want to take just whatever everybody else doesn't want." I wanted something good. It was a two-year program. So I started with them and committed to one year.

At the beginning, I was participating as a fellow in the program, but I wasn't getting paid because the opening was not funded by the university. After I had been there for four months, I started getting paid because they thought I was doing a great job. The peso had devaluated in Mexico, and, financially, things got a little tougher, so I started getting paid. I decided to stay there for the second year, to complete the program, because I was enjoying the program and was really happy with the education I was getting and the opportunity to complete a fellowship. And then at that time I learned about the different residency programs and hospitals, the matching program and what I had to do to apply.

Mullan: But that was not formally a residency.

Lifshitz: It was a fellowship. It was actually a <u>fellowship</u> at Tulane and the reason they ended up granting me the fellowship position was because I had the pre-graduate internship, the

social service. I had worked with this doctor that they knew. So that I had really had two years of clinical training before starting the fellowship.

Mullan: But then at the end of that, you decided to go back and start a whole new medical training?

Lifshitz: Internal medicine. I wanted to be an internist. No matter what, I wanted to be an internist. As I was getting close to finishing my internal medicine training, and I actually requested Stanford as my number one, and Ochsner Medical Foundation as my number two, because during my training in clinical pharmacology, I had met a lot of physicians at Charity Hospital who were from Ochsner, and it had what I thought was a very good program. LSU was also there, but I really liked Ochsner.

Stanford didn't even give me an opportunity because I was a foreign medical graduate, and Ochsner took me right away, because I had met several of their physicians and there was a relationship. It was great training. At that time, clinical pharmacology was something that was not being done in Mexico, so I thought, again, I wanted to go back to Mexico, and I like to start things. I thought it would be wonderful if I could start a clinical pharmacology program in Mexico, with the government, at the C'entro Medico, which was kind of like the main general government hospital in Mexico City. Starting a serious clinical pharmacology program, and then do it all over Mexico.

I had spoken with the people at Tulane, and they were really very eager and interested in helping me, but when I went to speak with people in Mexico--at that time, I looked very young, I was a woman, and they listened to me very attentively, and when I finished, they said, "It sounds very interesting. Obviously you're Mexican. You went to medical school here, so you can come and practice any time, but the studies that you've done abroad, we really cannot recognize."

So at that time, my heart was broken, and I decided, "Okay, what do I want to do?" Obviously, I always had this special love for endocrinology, because my mentor had been an endocrinologist. So I was accepted at NIH [National Institutes of Health] to do a fellowship, and it was going to be on the effects of the neuroendocrine system in psychiatric illnesses, which is something that I did during my social service time, and it was quite interesting, and I thought I should pursue it further.

But what happened at that time--my sister was already living in San Diego, and I come from a very tight family, and throughout this whole time, I would speak with my parents once a week, and they would come visit me, and whenever I had a chance, I would go visit them. My father was starting to think about retirement, and they started saying wouldn't it be nice if the whole family lived in the same place again. I told them that, if I found a good endocrine program in San Diego, I would move there. I was lucky to be accepted under Dr. Gordon Gill at U.C.S.D., where I ended up doing my endocrine fellowship.

Mullan: What did your father do?

Lifshitz: He was an engineer by profession, although he also finished the Conservatory as a pianist, but that was just a hobby.

Mullan: He worked for an engineering firm, or he had his own firm?

Lifshitz: No, he started working for someone, and when he was in his mid-twenties, he started his own business, while he was still helping his dad in his clothing business. My grandfather was also an engineer, by profession, in Russia, but he could not work as an engineer in Mexico. He had started something to do with shirts.

So my father was helping him. He was teaching. He was finishing the Conservatory. And then he decided that he wanted to start his own company. It was not a large company, but it was <u>his</u> company. When I said that I wanted to go to medical school, my father was dying for me to go to engineering school and work with him. I only have one older sister, and she was totally artistically oriented, nothing scientific, or anything like that. My father knew that I could become an engineer because I was the one who always helped him around the house. But I could not picture myself as an engineer.

Mullan: So you hooked up with them in San Diego?

Lifshitz: Exactly.

Mullan: And did a year of endocrine there?

Lifshitz: Exactly. At UCSD. And then basically, as things happened, I met someone, I got married, and moved to Los Angeles. And by that time, I had already decided that I was going to stay in the U.S., in the sense that I felt that there was a huge need in the Hispanic community because the availability of Spanish-speaking, culturally sensitive physicians was really limited for the number of people that were living here. I've always liked to get involved with the community. It was either the American Diabetes Association or it was the AIDS Commission.

Mullan: Before we go on and talk about what you did, now that you're grown up and going into practice, the years between '76 and '80, when you were in training, and essentially still had a twin identity, or a dual identity--Mexican and American--what was your feeling about the reception that you got in this country, both in terms of exams, in terms of institutions, and in terms of fellow physicians, and the medical structure? Were you well-accepted, were you not well-accepted? What was it like to be an international grad, arriving in the system?

Lifshitz: It's kind of a dichotomy, but I must say that I've always been an optimist and I've always looked at the good side. For example, not getting an interview at Stanford because I was

an international medical graduate was a big disappointment for me, because I felt that I should be valued as an individual. Other than that, I felt that I had been well accepted.

There are always people who are not very accepting of people that are not identical to them, just like in Mexico, a different skin color, or an accent, or Hispanic, or Jewish. There are always some of those people. But I would say that, overall, the reception was good, and I think that at that time, a lot of the people that I interacted with had had very good experiences with international medical graduates.

New Orleans was not a place where you have tons of international medical graduates, but you had several international medical graduates that had done a very good job. The head of the nephrology department at Ochsner was an international medical graduate, so that they had had good experiences, and the competition was not as fierce as it is now, so that, given those two factors, I think that, overall, the reception was good.

There were still some people that felt that somebody that did not go to medical school here could never be as good, no matter how much they tried, because those four years were not like you do it here. But there were other people who were open-minded, and actually welcomed the approach of someone that came from a different place.

Just to give you an idea, my first grand rounds was on a case of amoebic amebic abscess, which was like a big deal, and I was sitting there thinking, "Hmm, this is interesting. Grand

rounds here. And I've seen so many." Those are some of the differences. I had the experience with parasites. Some of the things that came to my mind when we were seeing some patients, as a first differential diagnosis were not necessarily the same as those that the American-trained physicians always thought about. And I think that, the longer I stay here, the more I realize. And now, obviously, Chron's and diseases that I hardly ever saw in Mexico, come to mind because I've been exposed to them. But I think that having had a different background and having had those experiences enriches everybody.

[Begin Tape 1, Side 2]

Mullan: This is Dr. Lifshitz, side two of tape one, continued.

How about the flip side of it? As you moved towards making a decision to stay in the United States, did you have any second thoughts about Mexico, either in terms of opportunities that you might be foregoing there, or obligations that you might have had there, based on that's where you were educated, and that's where you started your medical career?

Lifshitz: I have to say that I always felt very close to Mexico, and I was very grateful to Mexico, and I felt very Mexican. When I came here, I wouldn't have even considered becoming an American citizen, because my background, my identity, the way I grew up, my culture, was Mexican, even though if you look at my

background, it's not 100 percent Hispanic. Nevertheless, I felt that loyalty.

When I went back to Mexico and I wanted to give back, and they rejected me. I never felt like I was angry or upset at Mexico. I always felt I would sometime be able to help and communicate with them, but I felt that I had a bigger opportunity to help people here.

Had I gone back to Mexico in the situation which was originally planned, which was, with my mentor--he really wanted me to go back and work with him, and I respect him immensely, and he's in private practice--I would have immediately been able to go back to work with a group of physicians which we had put together and that were, and are, highly respected. He was very well established. I would have been able to really go back and move up, earn a lot of money. It would have been a lot easier, a lot easier. I kind of felt that there were more things that I could do here with people that needed me more. The people that I would have been seeing in Mexico were people that could see any doctor they chose. Here, I could see people that maybe other physicians wouldn't see.

Mullan: Tell me about that. Your career from 1982, '83, why don't you sort of give me a synopsis of how it's developed, in terms of your practice settings.

Lifshitz: Initially, since I got married in Los Angeles and I wasn't quite sure exactly how I was going to practice, there was

an opportunity. It was a time when all the clinics, the emergency clinics, were kind of appearing everywhere. The walk-in clinics, not emergency clinics.

Mullan: Urgent care?

Lifshitz: Urgent care, right. So I had the opportunity to work in one, with flexibility in my schedule, and I was moonlighting at Kaiser, and also at Olive View. The clinic started doing a little bit better after a few months and they asked me if I would be interested in being the medical director. So it was a challenge, and I still hadn't decided exactly what I wanted to do. I knew that private practice was not what I really wanted to do, and being in that setting allowed me to see a cross-section of people. I was at that medical clinic for two years.

Mullan: At this point, you were seeing yourself more as an internist?

Lifshitz: Yeah. Oh, definitely. I've always seen myself as an internist. I mean, yes, I have my background in clinical pharmacology. During the time that I was in endocrinology, I did basic research, but I decided that I needed to be with people, too. It's wonderful to come up with all the analysis of everything that you've gathered, but the actual everyday working with cells. . .contact with people was something I missed

immensely, so that I knew that I could not be just a basic scientist. I needed to be with people.

During the time that I was in this clinic, it was working well. But I was limited in the sense that even though I was the medical director, everybody who walked in there had to have some way to pay. So there was this part of me that wanted to help people that couldn't pay, and being in that setting was not a way in which I could do it. I mean, I had to be on my own to be able to do that, or to work in a government setting where basically a lot underserved people would walk in.

But it coincided that, about a year and a half after I had started working in the clinic, someone invited me to go for an audition for a television program, and I thought it was the craziest thing. I was not interested, but my friend, who is a psychologist, was very interested in going, and asked me to go with her. And they selected me to host a thirty-minute program, in Spanish, where people would call in with their health questions and I would answer. I really didn't know what it was all about. I thought it was all a joke. This is Hollywood. I went to the interview. And I ended up being the host of this program, which I started doing at lunchtime. It was on an ethnic channel, and it was thirty minutes of a call-in, live program. That was the start of my media career.

Mullan: What year was this?

Lifshitz: This was 1986. What I became fascinated with was the fact that people would call with all kinds of questions, and they would write me letters, and I did not have enough time to answer the letters on the air, so I ended up on weekends, writing, you know, answering letters. I felt so bad for these people. So I said, "Okay. The medical clinic where I'm at right now does not allow me to do what I want to do in terms of helping people. If I end up in a very rigid structure, like a government position, I won't have the flexibility to do a program like this, so I have to find some way to combine it." And that's when I decided, "Well, I think I'm going to have to start private practice."

So I started private practice. I still do not like it. I do not like the administrative part. I do not know about billing. It's terrible but as long as I have enough to cover my expenses and, hopefully, bring some money home, I'm happy. I'm never going to be rich. But I have the ability, which has been decreasing because of the changes in health care, to see someone who might not be seen somewhere else, or to see their grandmother.

Mullan: So what is practice like? We'll come back and talk about your show-biz career, but how has the practice developed? Are you on your own?

Lifshitz: I'm on my own. Yes, I've always sublet space from someone else, because I have always wanted to have the flexibility of being able to move to a different place if a

situation changes. At the beginning, I was moonlighting because I wasn't getting enough income from my private practice income. I just had an answering service, and I would make my appointments myself. Quite interesting. I started without any knowledge in business--I still don't have knowledge in business--and it was a mom-and-pop operation. I mean, when I look back, it's amazing that I survived, but that's a very long story.

Mullan: What have you got now?

Lifshitz: Right now, I have two people working for me. I'm still subleasing space. The place where I'm at right now, there are four other physicians and myself, and each one is in solo practice. I'm the only one that speaks Spanish, in terms of the physicians in the group, but the two people that work for me are bilingual.

About 50 percent of my practice is Hispanic; 50 percent of my practice is Anglo. Because of the AIDS epidemic in Los Angeles and the fact that, at the very beginning, a lot of physicians did not want to see AIDS patients, and especially if they were Spanish-speaking, they were more limited in terms of the physicians that might be able to help them. I started going out to the community to talk about HIV and AIDS, and I started getting a lot of referrals for HIV. Many were Medi-Cals, didn't have any other kind of coverage.

My practice is very eclectic. I get the lady that lives in Beverly Hills and her housekeeper. I get a prostitute, an IV

drug user, an alcoholic, and I get a lawyer. They all sit in the waiting room. Every time that I've moved--because I've had three offices since I started, meaning that I've sublet from three different people, and all of them have been wonderful. The main reason for moving from one to the other has been financial, in terms of how much I've had to pay for the place, or the help that I would get--the support that I would get. But they've all known that my practice is very eclectic, and that they could have anything happen in the waiting room. Like one guy that came in drunk, and we had a little scene, and we had to call the police. But, you know, it happens.

Mullan: More women than men, or mixed?

Lifshitz: I would say about 60 percent women; 40 percent men. I have a lot of teenagers also, which I love. I love teenagers. Because I've been in private practice since '86--in practice since '84, if you consider the clinic being practice, and the moonlighting--I do have patients that I've been following for a long time, and I'm starting to get to know their families. That's the kind of medicine that I like, and that's in some ways what is very distressing to me about managed care.

Mullan: What is that doing to your practice?

Lifshitz: First of all, it is limiting the number of patients that I can see for free, because I still have to pay rent, and I

still have to pay my staff. I don't just work because I like it. I do need to make a living. So it's limiting that, and I don't like it.

Mullan: Describe to me how it limits that.

Lifshitz: It used to be that anybody who was Medi-Cal, that called my office, would get an appointment without any problem. Anyone that was seeing me and I was taking care of them for free--if they had a relative or whatever, a friend, that was sick--they knew they could call and I would see them. Now I have to limit that, because the reimbursement rate for Medi-Cal is so little, sometimes it's ridiculous.

Mullan: So is it Medi-Cal in particular that's pinched you?

Lifshitz: No. It is managed care in the sense that the idea of managed care is that you have to have a certain volume of patients to be able to get a certain income a month. I cannot see a patient in 8 to 10 minutes. I am not a "volume" doctor. To practice good quality medicine, you need to spend time to talk with your patients, to examine them. I have never had a problem in terms of having patients, but if your HMO practice grows to the point where you have a lot of people, that can be a lot of money, but I do not believe in treating patients differently, whether they're HMO, whether they're cash, whether they can't pay, or whether they have indemnity insurance. Even a patient

that comes to my office is treated exactly the same. Where I have to look at the difference is: do I have to send them to this certain lab because they're HMO? Do I have to get an authorization, or can I get him medicine samples for this? This is very time-consuming and the paperwork and bureaucracy is frustrating.

Mullan: If I understand, you've signed up with a number of HMOs, so you're a provider.

Lifshitz: There is only one organization, which is a Physician Hospital Organization, which has several contracts with HMOs, through which I am working within the HMO system. It is Cedars-Sinai Health Associates.

Mullan: But the reimbursement that you get for those patients is more modest than in the old days when you could charge indemnity insurance, so that gives you less margin to play with in terms of treating poor patients?

Lifshitz: No, it goes beyond that. It's not only the money you get. It's the paperwork and the bureaucracy that you have to go through.

Mullan: But how does that curtail your treating?

Lifshitz: Because I'm spending longer hours, and the longer hours are not being reflected in necessarily better quality of care or more patients. Most of the time it's paperwork, and it's not only the HMOs, it is also the other insurance companies, in which you have to fight--you know, write letters to get paid for certain things. So in that sense, the changes in health care have done that. When you get less reimbursement per patient, you do have to limit the number of people that you can see for free.

Mullan: In terms of HIV-positive folks, how have you felt about treating them? You've mentioned it's been an important thing to you. How many do you have? How do you stay abreast of the confusing domain of HIV therapies?

Lifshitz: Well, I would say that right now, probably about a fourth of my practice--it used to be a little bit more.

Mullan: So that really makes you an HIV practitioner, for all intents and purposes, right? Because that's far higher than the ambient population.

Lifshitz: Exactly.

Mullan: So people are seeking you out because they know that you're competent and available and interested in HIV?

Lifshitz: And interested, exactly. And if you think about it, when it comes to HIV, obviously, being an internist, I do not see myself as a know-it-all. So I try to go to meetings, read journals, ask questions of people that I trust, learn from the cases that I have. But if I have someone that has an opportunistic infection that requires hospitalization, for example, I will ask an infectious disease specialist to see my patient as well. So I'm not really an infectious disease specialist. Of course, there are certain things that become pretty standard that you follow.

I do believe that HIV eventually is going to become like diabetes or hypertension, where the primary care doctor can take care of most of the problems, and it's just when you have something special that you need to get a specialist. Emotionally, it's very draining, because you get a lot of young people who die, and that is very draining.

Mullan: Are you seeing more intravenous drug use related to HIV disease, or gay-related disease?

Lifshitz: The greatest majority in Los Angeles is through man-to-man. But in the Hispanic community, you also have a lot of heterosexual. More than coming from IV drug use, it comes from extramarital, or previous encounters, man-to-man, but then, because of the cultural differences, it is not well-accepted. Homosexuality is not well accepted among Hispanics, or sometimes they believe that they have to fulfill their role by getting

married and having children, and then they really have to go outside of that environment to fulfill their other needs, and that's the way in which it gets passed on.

Mullan: Are most of your HIV patients male, or mixed?

Lifshitz: The greatest majority are male, because it's still predominantly male in Los Angeles, but I have several women. I would say that about 60 percent of them are Anglo, and about 40 percent of them are Hispanic. You tend to see more new cases in Hispanics in Los Angeles, as opposed to Anglos, because Anglos have, in some ways, heard the message and are protecting themselves a little better. This is reflected in the statistics where it's plateaued. Although with the younger population, I'm not sure, with the teenagers.

Mullan: Where do you see your practice headed? Are you going to be able to maintain a solo practice, or are you going to get bought up or consumed in somebody's integrated system?

Lifshitz: I'm not ready to work for an HMO. I'm not ready, again, because I do treasure the flexibility that I have--not only in terms of the patients that I can see, the time that I can spend with them, but also in terms of the other interests that I have, so that I do not see myself right now working for an HMO.

I do not believe that the future of practice, the way I like to practice will be feasible for me. I believe that there will

always be solo practitioners that will do very well, this is universal. Other countries, where they have socialized medicine and other systems, there have always been physicians that have been in private practice and have done very well. I don't believe that my future as a solo practitioner, doing all the things that I like to do, is necessarily feasible. Group practice is something that is appealing to me. I'm also a little tired of covering, being on call every day, weekends, so it would be something nice. But I would love to be in a group practice with people that have the same philosophy and the same ethics that I do. That is, I am not against making money. Obviously, we all like money, and I like to live comfortably. But I want the group that I join to feel the way I feel, that the patient comes first, no matter what--a payer or the non-payer. The patient comes first, and you have to work within the constraints of the system. I mean, it's just like if an HMO patient does not have coverage for removal of a little skin tag, I'm not going to fight for that. That's cosmetic, that's not going to harm the patient. But if the patient has something medical, which might be expensive, but that he really needs, to receive adequate treatment, I'll fight for it.

Mullan: What about your role as a primary care provider, as they say these days? Is that changing? Both in terms of how you're treated or what attitudes your patients have, as well as how you see yourself, is that changing, or is that unchanged?

Lifshitz: I've never seen myself as better or worse than any other physician just because I've chosen to be a primary care doctor and not a super-specialist. I never wanted to be a neurosurgeon. I was very happy being an internist. I feel I've been an internist all my life, and in terms of the perception of other people, I know that the super-specialists have always looked down on us. Right now, in some ways, there's this competition--which is very uncomfortable--in which they look at primary care providers as the gatekeepers.

Mullan: How does the gatekeeping function, to the extent you're doing it, impact on you? Do you find patients are disgruntled, or other physicians treat you differently, better or worse, worse or better?

Lifshitz: Because my practice has never been based on physician referral, I've always interacted with other physicians as colleagues. They've never made a big deal about trying to get me to send them patients, or vice versa. So I have good relationships--it really hasn't changed.

In terms of patients, there are a few patients that do not like the system, who might be unhappy, in spite of the explanation sometimes about the need to get the authorization for a referral, when it is indicated, or the fact that I can treat an otitis externa or an otitis media, and that an ENT referral is not necessary. If the person doesn't get well, obviously I refer them. But I am qualified to treat many problems that HMO

patients think require a referral. I think that if you establish a good physician-patient relationship, that is not a problem. The problem is when you don't have the time to do that, or when you have patients who buy a Volkswagen and want to get Rolls-Royce treatment. And then no matter what you do, they won't be satisfied. If they were accustomed to seeing a specialist for anything and they now want their PCP to write them a referral whenever they call with the flu, they won't be happy with the response. Many times I have to spend a long time explaining the system and what they're covered for, and what the mechanism is. So in a lot of ways in HMOs, the perception of the public right now is that sometimes the primary care provider is the adversary. And this perception is obviously a barrier in the physician-patient relationship.

Mullan: But are you experiencing that resentment from patients?

Lifshitz: From some patients, sometimes, yes. Very frequently you get calls from people who have never met me, that say on the phone to my assistant, "I'm looking for a new primary care doctor because the one that I had before was not providing me with the care that I wanted. I want to know the referral policy of the doctor, and if I will be seen the moment I call."

I've had patients who have wanted to come and visit me to get to know me before they actually sign up with me--which makes a lot of sense--but, financially, I can't afford to do it. At the beginning I said, "You know, it makes a lot of sense." But

if you're already limited in terms of the time you have to see the patients that you are taking care of, you can't just spend forty minutes with someone who wants to get to know you, and frequently wants free medical advice in the process--advice for which you're legally liable.

So I'm not loving the way the system is going. I don't believe that physicians are the enemies. I do not believe that primary care providers are the enemies. And, by the way, I have a lot of respect for anybody who does anything--from cleaning the street to being President of the United States--but I do believe that there are certain differences in terms of the ability of someone to perform certain tasks. And I do believe that education and experience allow you a certain ability to treat certain things better than when you don't have them.

I'm not in any way implying that anybody that has more schooling is necessarily better than someone that does not have schooling. There are good doctors and bad doctors, just like there are good accountants and bad accountants, and good lawyers and bad lawyers. But I do believe that in the financial race and the problems with resources, sometimes we are disregarding certain differences. I mean, if it were not necessary for someone to go to medical school to prescribe medications, and psychologists could prescribe medications by just becoming therapists, then why do we have psychiatrists? If optometrists don't want to go to medical school, for example, but do want to prescribe, and ophthalmologists only need to go to medical school to do surgery, then why do we have the system that we have? And

why are we switching away from it? Training and education do matter.

I don't believe that the switch is because we have found that we can provide better health care by letting people do certain things that they didn't do before. I think that what we're saying is, "Well, if we just have this much money, then maybe we won't do a great job, but that's all the money we have." And then, you dress it up as though, "Oh, it works. It's just as good." I think that there's a little schizophrenia in the system.

Mullan: I know you've been active, increasingly, with organized medicine at the state and national levels, and in Los Angeles, too. *LACMA Physician* is a publication of the Los Angeles County Medical Association. "What does the Hispanic patient expect from her gynecologist?" What was the answer to that? [Laughter]

Lifshitz: You know, it was very interesting. When they asked me if I would write that, I said, "First of all, I'm not a gynecologist. Second, I think that Hispanic patients expect what other patients expect, and that is concern, caring, respect." And the gist of what they wanted me to write in that article was the fact that due to some cultural differences, for example, if a Hispanic patient goes to the doctor and the doctor doesn't touch them, it's almost like they didn't really go to the doctor. It's kind of like part of what's expected. And sometimes, for example, with an Anglo patient, it could happen that if you

become too touchy-feely, they might feel that you are going beyond your limits.

Mullan: The expected role.

Lifshitz: Exactly. And yet these are some of the cultural differences. So I talked a little bit about that--and there are some differences--because of my upbringing. Some things that, I have to say, I did not understand, having grown up in Mexico and gone to medical school in Mexico. Until I came to the States, I did not realize the differences between the way men and women were treated, in terms of the opportunities in work settings and stuff like that. I didn't believe that there was any kind of discrimination while I was living in Mexico.

Mullan: In Mexico?

Lifshitz: Yeah. I mean, so what if I was in medical school and the men wanted coffee. I served coffee. Big deal. You know, what's the problem? I never saw it any differently, because that's the way I grew up. It wasn't until I came here that I started realizing that there were some differences.

Mullan: Because there were differences in Mexico?

Lifshitz: Exactly. Meaning Latinos and the role of the Latina. And the role of a woman. And the role of a woman physician. And

then you come here and you start looking at some differences, and you realize that there are differences that you had never noticed. When you are in the middle of the forest, you only see the trees around you. And that's one of the beauties of coming from another health care system, from another country, from another culture, so that you can see some of these differences.

Mullan: Perspective.

Lifshitz: Exactly. And what happens. . .I don't believe that only Hispanics should treat Hispanics, or only women should treat women. That would be very narrow-minded, and I don't in any way believe that. But I do believe that we can learn from women how to treat women. I can learn from men how to treat men. I can learn from Chinese how to treat Chinese patients, and I think that that's one of the great things about America.

Mullan: The International Medical Graduate Conference within the AMA [American Medical Association], the IMG organization, I don't have the name right. What is it called?

Lifshitz: This is interesting. It used to be FMGs, and just like with "blacks" and "African-Americans" and "Hispanics" and "Latinos" which became kind of "politically correct," they switched it to IMGs, which is international medical graduates. It's the same thing.

Mullan: And what is the IMG section?

Lifshitz: Well, they're trying to get a section right now. It started out as a task force, actually, and we are kind of in the second wave of a task force that became an advisory committee and now is a caucus. They're trying to get a section, and the main reason why all of this has happened is because, again, with the financial changes and the competition, the IMGs, which at one point were needed and appreciated, now are not needed, and a lot of people believe that it would be great if they could just disappear.

When I was invited to be part of the IMG Advisory Committee to the AMA, in all honesty, at the very beginning I wasn't thrilled with the idea. I felt that I was pretty much mainstream--that I had been able to accomplish a lot of things--and that I didn't know why it was needed. Nevertheless, as I learned the issues, I understand why it's needed right now.

Mullan: Tell me.

Lifshitz: The reason it's needed is because, just as I said earlier, in terms of my application to Stanford, it was a disappointment, but it was not the end of the world. It's just that once you are an IMG, it doesn't matter what you do. You're always an IMG. For most people nowadays, being an IMG is like being a second-class citizen, and the opportunities are not the same--so much so that there are some insurance companies which

are advertising, obviously not in writing, because it would be unconstitutional, that they only have "good" doctors. That all of them are trained here. I do believe the training here is excellent, but I do not believe that anybody who is not trained here could not be just as good or even better than a lot of the people trained here.

The perception has been, I think, more emphasized as competition has grown, because there was a kind of an open-door policy for anybody who wanted to come in. And financially, in some areas they needed physicians because it was cheaper than having even nurses. They started allowing international medical graduates who might have not come in under different circumstances. But, because they did not have enough people to fill those positions, they let them in.

So it's a combination of things. But what I find very unfair is that there is a perception that is being perpetuated without the background. For example, there was someone at the California Medical Association who came to present to the board, who said that the Board of Medical Quality Assurance (which recently changed its name), which is the organization that overlooks physicians' work, wanted to request that IMGs get an extra year of training. And when she presented that, I said, "What data are they basing this on? Is it that you have more malpractice insurance claims? Is it that you have more patients complaining? Are you having more complications from the patients that are being treated by these physicians? We are physicians.

We should have scientific data. It's not 'I feel this should be.'"

And she says, "Well, actually, no. All that data, malpractice claims are the same for the American-trained and international-trained physicians. Patients don't complain more. No, it's just that "they feel" that with the changes in Medicare and the changes in the number of residency slots and the specialty positions and this and that and whatever, that IMGs should not have the same opportunity."

Well, I think that we need to separate a few things. I do not believe a non-American citizen who wants to come here, either to go to medical school or to do training, necessarily has to have the same opportunity as an American citizen, because I do believe that countries need to protect their citizens first. But I also believe that if someone has actually fulfilled all the requirements, has passed all the exams, has proven that they have complied with all the requirements, have been working here, have gotten post-graduate training here and have been taking care of patients here--providing good medical care--and are legally here, deserve the same protections as American-trained doctors. And, some day, they should be acknowledged as good physicians--physicians just as good as any other. I've been in this country since '76, so it would be nice, if my performance has been good performance, or, let's say, not worse than someone who was trained here, that at some point in time I might be considered as good as an American graduate.

Now, if we're talking about limiting the number of new international medical graduates that are coming to this country because of the situation, the ways things are now, residency position competition, that's a different story.

Mullan: It isn't clear to me when the hot topics and tough topics of IMG politics and policy are discussed, that within the IMG community there is a distinction between protecting the rights of individuals from abroad who have trained here and are now part of the system, and future generations who would like to train here, but aren't yet part of the system. Is that a meaningful distinction in those discussions?

Lifshitz: You can't talk about the IMG community as a community that has a unified voice. That is not the case. You have different opinions, depending on who you ask. The advisory committee felt very strongly that the United States was a country that was built on immigrants--you know, most people in the United States are immigrants. Whether they're first-generation, fifth-generation, or tenth-generation, they're immigrants. Very few people actually have their roots in the United States. And they feel that competition should be for the best qualified, and that competition should be based on merits, not on place of graduation. I believe that there is some merit to that.

A lot of the IMGs are American citizens, born and raised here, and the government gives grants for American citizens to go abroad to medical school. So there's a discrepancy here. If

medical schools outside the U.S. are so bad, why does the government pay Americans to go to them? Now, if the training of international medical graduates is so terrible from the perspective that some people have, then they should not fear the competition, because the "best" doctor will prevail anyway. So it's a very difficult and very hypocritical situation.

Mullan: But surely the IMG community, in practice in this country, looking at the growing numbers of physicians and the diminishing demands for physicians, must be concerned about the future.

Lifshitz: I'll tell you something. Whether you're an American graduate or an international medical graduate, you're a physician first. I mean, regardless of where you trained. It doesn't mean that you're not a physician first.

Mullan: I'm even talking about just the pure raw economics of it. As a physician in practice looking at a large body of physicians in practice and many more coming along, wherever you're trained, you must have similar concerns. If you can cast your mind on that, the question is how to slow down the production of physicians. What does the international medical graduate practicing physician feel about that?

Lifshitz: It's very mixed. A lot of international medical graduates would love to see more people from their countries

train and go back to their countries, because it really helps other countries. Some of them would like them to stay here. I believe that we need to find a way in which we can find a balance. And that is to the benefit of everybody, not only physicians, but just people living in the United States. But when you're talking about a surplus of physicians and you're opening more osteopathic schools, and you're not limiting the number of students going into medical school, there's a problem right there. It's not only the IMGs.

[Begin Tape 2, Side 1]

Mullan: This is Dr. Lifshitz, tape two, side one, continued.

Lifshitz: I think that we will look at the situation with physicians and the work force and the economics. We cannot look at IMGs as an entity, isolated from the whole picture. We have to look at IMGs as part of a puzzle, and if we're going to attack it, we have to attack the problem from all the different sides, not isolating it to one group. It's easier to isolate it to one group, because you can keep a hell of a lot more people happy.

Mullan: Not talking about people in practice, but about future generations, and you have an indigenous production capability, U.S. medical schools, allopathic and osteopathic, and then you have large numbers of people coming from abroad, and if you want to recalibrate and decrease the number of people entering the

workforce, does it seem, to you, discriminatory or unfair to say that from a policy point of view, where we should diminish the input, the throughput, is from the folks coming from abroad, rather than from U.S. schools? How does that seem to you?

Lifshitz: Well, I believe that we have two issues. One of them is--and I understand, I'm following you very well--and the way you state your premise, at first glance it would seem as though it makes a lot of sense. The problem is that the United States could still probably train, and I'm not saying train with the idea of having them stay here, but train a large group of international medical graduates who could go back to their countries.

Mullan: If we were talking about a legitimate exchange program.

Lifshitz: Exactly. And that is something--a policy--that could be implemented. I know that there are loopholes. The government has utilized the loopholes because they've needed the IMGs, like, for example, in underserved places. And what they do is that they offer that, if they go work there, then they can stay. You can't say you have to shut this door 100 percent and not allow people in, when I think also the United States benefits from the exchange of people coming from abroad. It's just that you have to establish a policy through which people who meet the requirements can come to train, and then go back, and close the loopholes.

And if they don't want international medical graduates because there's a surplus of physicians, then they should not be producing as many American graduates while still having American citizens go abroad. Thank God we're not in a dictatorial country where the government speaks, and everything's done. But there are ways in which the government can influence things, and there's no question the market forces are what's going to determine what will end up happening. Obviously, if you start producing so many physicians that they end up in Mexico, Argentina, Spain, driving cabs, because there's no place for them to work, more people will elect not to go to medical school.

On the other hand, we also have to look at the broad picture, look at what's happening, also, with the population. We cannot always project, with statistics, what's going to happen twenty, thirty, forty, fifty years from now. The population is aging. We're having a more diverse population. There might be a need for some things that we are not necessarily projecting right now.

So, am I in favor of opening the door to anyone that wants to come here? No. Am I in favor of continuing the status quo? No. Am I in favor of fair competition? Yes. Am I in favor of looking at the problem the way it <u>is</u>, with all its multiple facets, and attacking not only one, but all of them? I'm in favor of that, and I'm also in favor of doing things in an incremental way, with some pilot studies.

Again, if we are really scientists, we have to have some data, not just prejudices or opinions. Some things we can

predict, some things we cannot predict, but we have to have the data that backs it up. And if you look at some of the data, excellent data from places that are excellent, they don't all come up with the same projections. So that means that there is a margin of error, and in some ways, everybody is trying to protect their turf.

Mullan: Tell me about the Advisory Committee on IMGs. You chaired it for three years?

Lifshitz: I chaired it--I think it was two and a half years or three years. I don't remember exactly.

Mullan: How did you become chairperson, and what was it like? What were the interdynamics, interpolitics, between different groups?

Lifshitz: Well, it was a diverse committee because there were representatives from different groups. In the international medical graduate community, there have been groups that have been more active than others, and that includes the Indian physicians, and the Pakistani physicians. Some of them are people whom I respect immensely and that are fighting for things that they really believe in. Some people fight in ways that we like. Some people fight in ways that we don't like. Their styles may be different. And this is not exclusive to that community. But

they have been the most vocal and they have been the most active.

On the advisory committee, we had representation from them as well, and they tended to be very vocal. And they had a lot of experience from past situations that they had tried to resolve. For example, there have been cases in which someone has been denied an interview because they have a foreign, Pakistani or Indian name. They were treated as international medical graduates when, in fact, they were American graduates and American citizens who just happened to be born from Indian parents. You know, examples like that, actually enlightened a lot of us who had not really heard of those things. They believe very strongly in fighting for merit, given somebody's merit, rather than where they trained. And the committee felt, and the AMA shared this feeling, that, if rather than saying, "If you are an international medical graduate, we will not grant you an appointment for an interview." If you said, "If you are African-American, or if you are a woman," that would really create havoc. So why does it not create havoc because it's this group? And if you look at it that way, you know, you should be given the opportunity.

The way the greatest majority of the people on the committee felt was that, the moment you are an international medical graduate, you're already put kind of at the bottom of the list of applicants. If someone who is an international medical graduate competes with these other American graduates, and as it turns

out, the people that are interviewing feel that this person is more qualified, that they should allow that person to go forth.

On the other hand, people who would basically feel differently would say, "Well, Americans have invested a lot of money in the education of this person going through medical school, and if they've invested that money, then they should be the ones that can get the residency training, as opposed to someone that we didn't invest any money in educating." Or someone can say, "That's great. You can have people that don't cost you, are very qualified, and can perform, which, rather than trying to shod them away, you should be happy that it didn't cost the taxpayers the education." I think that the advisory committee felt, overall, that that was the case.

Personally, although I do believe in the premise that competition should be based on merit, I do believe as well that we are asking the United States to be what it's always been--and that is, the country of opportunities--to open the door to anyone who is qualified, even when other countries do not do the same. Mexico didn't do the same for me. Yes, I could go back to practice, but what I have done here would have not been recognized. Would that have translated in me not being able to make a living, or do very well? No.

Mullan: But what about the brain drain, just to put it in very simple terms? Within that group, and I'm asking now not alone for your opinion, but from the discussions that are abroad and in the IMG community, it's fine for physicians from all over the

world to say, "We want an opportunity to make a new start in America." But the fact stands that in many cases these are the most intelligent, best-trained people, the elites, or people who have benefitted from the educational systems of their countries to en masse, and when you talk about Indian or Pakistani physicians, the numbers are very substantial, to up and leave. And that's not alone the United States, it's England, Canada, Scandinavian countries. I know the arguments, that in India the opportunities, they've got a good education and a rich education in terms of a lot of people, and the opportunities to have a sophisticated medical practice and make a good living are limited. So I understand that conditions at home may not be what they would like, but is there no concern that there is an obligation to the country that sired them, that supported them, that educated them?

Lifshitz: I think in terms of the feeling that they would like to give back to their countries, in one way or another, a very large percentage of physicians do that. There are tons of physicians who go back to their countries and provide care at no cost. Who send journals and equipment and a lot of things that they would not be able to get if not for the group of physicians which is organized and lives here.

Mullan: Money.

Lifshitz: And money. So I don't believe that there is a divorce, necessarily, in terms of helping. It is a different kind of help. Can the United States absorb anybody that wants to come? Of course not. Nor should it have to. But I have never heard of international engineering graduates or any other profession being singled out as, "Well, if you did not go to an American school, you should not have the same opportunities." And the reason is that the competition is not ass strong.

Mullan: In medicine, it is true that, if you don't have American graduate medical education, you're singled out. In medicine we've already, for better or for worse, for state licensure purposes, established a pretty much uniform requirement of graduate medical education in this country. So I think it's different than engineering and architecture and others. Engineers and architects apply through their quotas from whatever country. Their licensure, though, is not dependent on training in the United States, whereas in medicine it <u>is</u> dependent, so it's a bit different there.

Lifshitz: Right. But even if you meet all the requirements--and obviously you're very knowledgeable about this--but if an ophthalmologist has been a professor of ophthalmology at a university for twenty years, has been recognized by his peers in one state and wants to move to another state, they might not grant him a license to practice ophthalmology in the other state because, when he went to medical school, he didn't get the ten

hours of psychiatry or the ten hours of public health. That, to me, is not right.

We all know that American medical schools are not all the same. Some of them are better than others. And we know that not every American graduate is a superb physician. There are good ones and bad ones, just like in the IMG community. So, sometimes, certain requirements are not really set up in a fair way. And I'm not saying that it should be identical, because there are some differences, but there has to be a time and there has to be a way in which things are fair. If I wanted to go practice somewhere else, I might have problems.

Mullan: What is your guess about the future of the IMG migration?

Lifshitz: I believe very strongly that, because of financial constraints and the changes with Medicare reimbursement for residency physicians, and the changes in terms of specialty and primary care and everything else, that the number of IMGs who come to this country is going to decrease dramatically. I think it's happening already. I believe that some of the IMGs who come to this country might end up being exploited, because they're going to be cheap labor, but are not really going to get a good quality education.

Mullan: Different than now? That doesn't go on now?

Lifshitz: I think it's going to get worse. I believe that a lot of doctors--in general, with the changes in health care--but in particular IMGs, are going to be singled out in terms of being employed by large HMOs and in places where you end up with two or three large HMOs dominating a market. A lot of IMGs who have serviced a community very well are going to end up not being part of the system because they might be older and they might not know the HMO way of practice. And, because OF the xenophobia that we see wit PROP 187 in California as an example, and other things happening in the country, the perception that IMGs are second-class doctors is going to be perpetuated and accentuated. So that it's going to be tougher. There are still going to be some IMGs who are going to do very well. But as a group, the battle is going to be uphill.

Mullan: Let's go to a cheerier topic to conclude. How about yourself? Where do you see your practice going?

Lifshitz: I know that I love practicing, and if was independently wealthy, I would not be in private practice. I would donate my services. If I got to the point where I could actually have enough income from other things related to health that I love--education, communications--I would love to just donate my services to underserved populations. That's what I would love to do. Will I be able to do that? I'm not sure. If I'm not able to do that, I see myself probably joining a group. I hope that I can find a group that believes in what I believe

in, in terms of patient care, and that allows me the flexibility to be able to do the other things that I like to do.

Mullan: Are you going to stay in Los Angeles?

Lifshitz: I don't have any plans to move anywhere else. I'm married, and my husband has a business here, which makes it more likely that I will stay here. I'm not saying that if an opportunity came up that was just fantastic, that I would say, "No, I have to stay in Los Angeles." Do I believe that Los Angeles is the place where you have the best quality of life? No. [Laughter] It's been very good to me, but it's not a very safe city. In some ways, it's a bit more materialistic than I would like it to be, so that I'm not sure. I'm really open.

I hope to get a chance to continue to work with underserved groups. I believe that, in terms of my role in the Hispanic community, because of my background it's easier for me to help that group, but it doesn't mean that that's the group I'm necessarily interested in exclusively. Well, I can tell you, it is not. I'm interested in everybody, but I believe that I have a little more knowledge and expertise to help that group, so it just happens that the opportunities have been there, but we'll see.

Even though I gave you a lot of the negative things, I don't in any way want to imply that I see everything as terrible. I think that change is necessary--and I believe that there's still a lot of work to be done to find what that change really needs to

be--but that zeroing in on one area alone will not take care of the problem. Just like managed care is not the best nor the worst. It has some good things, it has some bad things, and eventually, hopefully, we'll get the best out of it, and will continue to evolve.

Mullan: Good. Well, you've been very generous, and thank you.

Lifshitz: Thank you.

[End of Interview]