SUSANA MORALES

Dr. Fitzhugh Mullan,
interviewer

Mullan: The date is June 26, 1996. I'm in the office of Dr. Susana Morales at Columbia Presbyterian Hospital, in the Vanderbilt Clinic. A word about Vanderbilt Clinic versus Presbyterian Hospital versus Columbia University. Where are we, actually?

Morales: Columbia Presbyterian Medical Center consists of a number of buildings, including the Presbyterian Hospital, the Millstein Hospital Building, Babies Hospital, Sloane Hospital for Women, Vanderbilt Clinic, which has been a traditional ambulatory care site for years, the Black Building, the Physicians and Surgeons Building, the Hammer Health Science Center, etc., etc. So it's a huge complex.

Vanderbilt Clinic was a traditional ambulatory care site, although now there is a network of ambulatory sites in the community.

Mullan: Why don't we start at the beginning. Tell me a little bit about you, where you were born, grew up, and sort of the precursors to medicine.

Morales: I was born in Manhattan, at Flower Fifth Avenue Hospital. I grew up in the Soundview area of the Bronx. I'm from a Puerto Rican family. My mother's a nurse. My father was

a community activist, community organizer, social worker and became a hospital administrator.

Both of my parents have worked most of their lives in Latino communities, either in East Harlem or the South Bronx. My dad worked at Boriken Health Center in East Harlem as the executive director when it first started. Boriken is a federally funded community health center in East Harlem. My mom worked at one of the first federally funded community health centers, Martin Luther King Health Center in the South Bronx, for many years. My dad still works in the South Bronx now. He worked at Lincoln Hospital for many years and now works at Union Hospital, which is an affiliate of Saint Barnabas. My mom is now working in the Health and Hospital Corporation as the director of women's health.

Mullan: For HHC?

Morales: For HHC. She trained as a nurse practitioner at Martin Luther King. They both had a lot of involvement in the community health center movement and in community health politics, and certainly influenced me a great deal in terms of my career choice, both in terms of my interest in health, obviously, but also my desire to serve a low-income community and provide primary care services. That has been the bent in my family for years, even before it became chic.

Mullan: Tell me a bit more about them. Were they each born in Puerto Rico?

Morales: They were born here, but all my grandparents were born in Puerto Rico. I'm whatever that makes me, second generation, although Spanish is my first language. They taught us how to speak Spanish first, and were very interested in maintaining our Latino/Puerto Rican identity.

Mullan: So their parents would have come to New York back when?

Morales: Their parents came to New York in the twenties, right before the Depression. They actually married here and raised their families in East Harlem and South Bronx.

Mullan: The Puerto Rican community must have been much smaller in those days, I would think, in New York.

Morales: It was. There have been Puerto Ricans in New York probably at least since the late 1800s, but there was a migration around that time.

Mullan: It was the Spanish-American War, if my history serves me, which made Puerto Rico a U.S. protectorate. Before that, I think it had been Spanish?

Morales: Right. It became a colony of the U.S. in 1898, but it's had different names. Now it's called a commonwealth. That happened in the forties, and it's still a commonwealth. But clearly in the twenties, there were a lot of upheavals. Certain things happened, including the devaluation of the currency in Puerto Rico. Right before then, Puerto Rican citizenship was

imposed or given to everyone universally right before World War I. Then the American sugar companies took over a lot of Puerto Rican agriculture, so there was a lot of displacement of Puerto Ricans at that time, which continued over the next two decades. But their migration preceded the big, huge migration that happened during World War II that was actually encouraged by the U.S. government and by the Puerto Rican government as a way to solve the "overpopulation" problem and also to provide labor for the munitions plants.

Mullan: Was that largely to New York?

Morales: New York and other urban centers. The big migrations were in New York and Chicago. Now, of course, people are all over the place, but mainly in the Northeast.

Mullan: So your parents came before that.

Morales: My grandparents came before that, and they had their families already. Actually, my father's father had wanted to come here to study, but there was no money. So he just went to work, and he eventually ended up working for the Armour Meat Packing Company and was a meat packer.

Mullan: In the Bronx?

Morales: I think it was in New Jersey. He had to travel from the Bronx to Jersey. My mother's father did electrical work, did a lot of different things, but that's what he ended up doing.

Both of them were big union men. And my grandmothers were both homemakers, for the most part, and they raised their kids.

Mullan: The focus on health and medically-related careers in both your parents, and then, of course, yourself, was it happenstance, chance, or somebody's idea or ideal?

Morales: No. My mother entered nursing against the protests of her family, because at that time it was viewed, certainly in Puerto Rican culture, as a dirty profession that nice young ladies didn't go into. That was definitely a bias that they had.

Mullan: That's been different between nursing and medicine. And that was not carried over to medicine at all?

Morales: It wasn't even a concept for my mother that a woman would be able to go to medical school at that time. She didn't go to college. She entered a diploma nursing school, in which she was the first Puerto Rican woman.

Mullan: But nursing was definitely seen as a menial and unclean profession?

Morales: Right.

Mullan: Because of the manual nature of it, or because of the potentially sexual nature of it?

Morales: I think both things. You know, you were going to see men and all that stuff. I think hospitals historically were not nice places. They were places that you would go to die. Maybe that was true in the United States, but it certainly was true in the Caribbean. That was like the last straw, that you would go to the hospital. Nursing was certainly underpaid, and it just was not something that nice women did.

My dad did a lot of things. He actually had wanted to be a teacher, despite the fact that he was born and raised in New York and, if anything, he just has a Bronx accent. He was rejected by the Board of Education because they said he had an accent and they didn't want him to teach.

Mullan: Rejected from school?

Morales: He was not allowed to become a teacher after he finished college. He had a lot of different career interests, but he did do social work and a lot of community organizing. The changeover to health happened in the seventies. He decided to get a master's degree in health administration.

Mullan: So it was a bit happenstance?

Morales: Yeah. In him, I think so.

Mullan: Did your mother influence him in terms of her commitment to health?

Morales: It's possible.

Mullan: I'm sorry to spend so much time on your parents. We're here to talk about you.

Morales: They definitely influenced me. There really was, I think, a movement at that time, and then I got my own health care in the community health centers as a result. So this was something that I was very familiar with, the whole idea of a community-based primary care and team approach. The fact that my mother's a nurse, working with nurses and social workers and other people to provide family care was something is that I was introduced to young.

Mullan: Can I ask your date of birth?

Morales: 4/25/60. I don't think I really decided to become a doctor, though, until I was in high school. That was the year that we moved to the suburbs, and I was introduced to this whole new world of science that I had not had much exposure to hitherto. I attended public schools, but it just wasn't something that I had really been exposed to in school. We had a wonderful science program in the school that I attended.

Mullan: What school was that?

Morales: Pelham in Westchester County. I wanted to combine my interest in science and helping people. At that point I was undecided, and in my applications to college I wrote that I wanted to be a primary care doctor and serve the poor.

Mullan: Was the notion of serving the poor part of what was inculcated into you by your parents, part of what you intuited yourself? As you're aware, I'm sure, in many circles the argument that we should have more minorities in health because, among other things, it means there will be more minority positions to serve minority populations, is countered by some people who say there should be no expectation that somebody coming from a community needs to go back and serve it. It makes a difficult argument that tends to go around, and I'm just curious about where your own world view, your own self-perception, came from in this regard.

Morales: Certainly, growing up in the sixties obviously had something to do with it. As a child, we were very aware of the civil rights movement and movements for social justice, and we would go on civil rights marches and anti-Vietnam marches and protests. My mother was also very involved in the community control movement of the schools. Even though we were little kids, it was ever present, the idea that we should serve was inculcated in all of us. Personally I think people need to do what they like to do, but, certainly, statistically it's been shown that minority physicians do preferentially serve minority populations and poor populations. I'm sure a lot of it came from my folks, no question, that this was a value on which a lot of emphasis was placed. It was something that was right and good, and that those who were more fortunate should serve those who are less fortunate.

Mullan: So high school, Pelham, good science, an interest in a potential career in medicine. What proceeded from there?

Morales: So then I applied to college and went to Harvard College and did my pre-medical work there, and also became very involved in campus politics. A lot of what we did at that time, there was the divestiture movement in which we were very involved.

Mullan: This is now late seventies, early eighties?

Morales: Yes. We were trying to get Harvard to divest from South Africa, which they never ended up doing, but which we were very involved in, as well as in Latino politics on campus, specifically working on recruitment and retention of Latino and minority students to the school. I did a lot of work on that.

What really helped me in terms of refocusing again on proceeding to medical school is that I started to work in a community health center in Jamaica Plain in Boston. I trained to be a family health worker, which is, in essence, a lay person that does some initial screening and history-taking and vital signs and some simple things. I also would do Pap smear callbacks, and I did a study to try to decrease the no-show rate. I would do home visits and did a nutrition study.

Mullan: This was done in your free time?

Morales: Well, I ended up getting credit from my school for a couple of courses that I took. I took a course called Black

Urban Communities. The first half of the year was theory and the second half of the year was practice. So we learned a lot about community organization and sociologic theories of bureaucracies, but then we had to go and actually do something in a community.

I also took something called the Community Health Improvement Program, a cross-registered course at the School of Public Health, so they could also give you credit for doing a project.

I ended up working there in the summer, and worked there for about two years. So that it was crucially important in terms of focusing me, because I think I had felt somewhat isolated in terms of my health interests in the ivy tower, and it was really important to be able to go into the community and work with patients. That was my first time that I worked with patients, and I worked with patients of all ages, but mainly adults.

They also had a preceptor there who was a Puerto Rican physician, who gave me a physical examination textbook and started to teach me how to do a physical exams and let me observe him, and was really a wonderful person and is still a friend.

Mullan: Who's that?

Morales: His name is Juan Albino. He was really a mentor in terms of my continuing on the community health route.

Mullan: What did you major in?

Morales: Biology.

Mullan: Did you like that?

Morales: In retrospect, I probably should have done something else, only because I realize now that it was going to be science, science, science, science. There were a lot of other things that I was interested in, including political science and literature and so forth and so on, but it got me where I needed to go. I did take a lot of other courses.

There I s a Department of Afro-American Studies that I took a lot of courses in because they were relevant to my interest in minority communities. That was at a time when the department was not as--how shall I say this--strongly supported as it is now. Now it's basically the powerhouse of African-American studies in the country. It had some wonderful professors, including this one Dr. James Jennings. He was really crucial to us because he was a professor, and he was really cool and very supportive of the students. The wonderful thing about Harvard is its size, its diversity, and it has always had for many years a strong commitment, at least since I went there, to diversity, a lot of different interests, but because of its size, obviously, it can be isolating, certainly for minority students. Sometimes I felt that way. And so to have somebody that was--he was from New York City and he was politically progressive. For a lot of us, it was very important to have a person like him on the faculty.

Mullan: The identity that you felt with black studies or African-American focus is, I presume to some degree, because perhaps there was less well-developed Latino focus?

Morales: There was no Latino studies department. There were no Latino studies. There was one Latino studies course in the whole time I was there. So it was frequently through the African-American Studies Department that we could act. For example, we developed a Puerto Rican history course as an elective in the Afro-American Department with the support of a Trinidadian professor. James Jennings is half Puerto Rican, so he talked about things from a black and Latino focus. Especially in New York, of course, blacks and Latinos have lived side by side, and a lot of the issues are common, although certainly there are issues that are not.

I think also a legacy of the sixties, there was clearly this concept of similar social goals in terms of racial justice and social justice that people were interested in. Certainly on campus, the minority students, the black, Latino, and Asian students, all united to try to address issues of equity and representation.

Mullan: Was there a Latino community in the sense of folks that socialized together?

Morales: We had a Puerto Rican organization, a Mexican-American organization, and the Puerto Rican organization was pretty active in politics and in a lot of the recruitment and retention activities. So I was involved in that as well, on the steering committee.

Mullan: So your focus remained, however, on medicine and getting into medical school?

Morales: Eventually it kind of returned to that. I think I was a little distracted by all these other interesting and fascinating things. In retrospect, it was all related, because I think that campus politics are a microcosm of politics in the world. Certainly organizational skills are things that are transferable. In the end, I think it all added up to be meaningful and focused even though at the time it may not have felt that way.

Mullan: As you approached medical school, what were your thoughts in terms of what you were about and where you would go? How did you decide?

Morales: Tell me what you mean by that. What do you mean what I was about?

Mullan: I don't want to lead into the generalist/specialist paradigm prematurely, but your notion about becoming a physician who could, and would, come back and serve in New York in your community or ones like it stayed with you?

Morales: Yes. One other thing that I pursued later in college was studying literature courses. That's when I realized that I'd always loved literature and that I probably should have been an English major or something because to me that was fun. When I realized that you could just read all the books that I liked to read, for fun, and get credit, I didn't know why I never put it together before. So the other humanities focus became more prevalent in some of the things that I was doing, course work and

whatever. I think that's relevant later because I have found that the humanities are important in terms of understanding patients and people in terms of my medical practice.

Anyway, in terms of applying to medical school, I wanted to come back home to New York. I did want to go to medical school in a community that was a poor community, but I wanted to be at a good school. So I decided to come to Columbia.

Mullan: Sounds like it was made for those particular set of tastes.

Morales: It's in Washington Heights, a low-income community, Latino community.

Mullan: And a good medical school.

Morales: And a good medical school, so it was perfect. It was a hard transition in the beginning. Medical school is different from a liberal arts education in terms of sitting there and memorizing five million arteries, but eventually I got into the swing. I did remain active in extracurricular activities, specifically the black and Latino student organizations. I also counseled adolescents in the Young Adults Clinic and do other extracurricular stuff. The first two years, which were at that time totally in the classroom, felt very removed from a patient focus. The Young Adults Clinic was very helpful; at least I could see a patient. It certainly wasn't what I expected medical school to be like. I don't think I really had any idea of what

medical school would be like. But when I entered the clinical years, that's when I really was thrilled.

Mullan: Was it good coming home?

Morales: Yeah. It was good to come home.

Mullan: Was it complicating? I've often heard of students in general coming back to a community they know well and family pressures and expectations to make life more complicated.

Morales: In my case, I think it was helpful, although I had to deal with my grandmother's worsening dementia, which started to happen, I guess maybe right when I came back. She died in my senior year of medical school. I don't know what would have been worse, to be far away and not be able to see her or to be right there and dealing with it. I didn't live with my family, but I did see them often. I think, overall, it was very helpful to be near a supportive environment and to be able to go home and be pampered.

Mullan: And was your family supportive of the idea of medical school?

Morales: Oh, extremely. Yes, very. They were thrilled that I was going to go to medical school, although there were times when I was really miserable as a pre-med, my father would be like, "Well, why not law school?" [Laughter] They were very

encouraging, but they didn't care what I did. They never told me to go to medical school. They just supported me.

Mullan: How about the prospect of debts or issues of financing, both for college and medical school?

Morales: Well, they helped me to do that, although clearly I worked both through college and medical school. I certainly have a huge loan debt I'm still repaying, but certainly my parents helped contribute. My graduation day from medical school, my father was introducing me as, "This is my hemorrhage." [Laughter] My brother and I were both in school at the same time, so the college fees were certainly a hardship.

Mullan: So you have one brother?

Morales: I have two brothers, two younger brothers.

Mullan: Is either in medicine?

Morales: One of them is finishing his doctoral work in molecular biology, and the other one is working in a social service agency for disabled kids, but neither of them went to medical school. Probably having seen me go to medical school, they opted out, but neither of them were interested in medicine.

Mullan: So the second two years made more sense to you, or resonated better with you?

Morales: Definitely. That was when I think I blossomed in medical school, because in the beginning it was really a struggle. Although theoretically there was relevance to the biochemical pathways, it really felt remote from patient problems. That whole idea that you're learning a new language, the language of medicine, all that stuff can seem very, very far away, I think, to medical students. But going in there and actually seeing patients and examining patients and helping them was really wonderful. I think I had a special advantage in being Spanish-speaking, because frequently I was the only one on the team that could really talk directly to the patient. I worked at translating a lot, which can be a hardship sometimes, but actually it means that you hear and see a lot. That was wonderful. People really even more saw me as their provider of care, even though I was only a third-year medical student. I still remember a lot of those situations.

Of course, also you see very sad things. You see your first person die, and you lose your first patient, but you also see people get miraculously better. It feels miraculous. You deliver your first baby. You do all that stuff. It was wonderful.

Mullan: What was the culture of Columbia like? It had the reputation of being a fairly stuffy school.

Morales: I was pretty nervous. I wondered if I was going to have to conform to this behavior. Medical students, you feel like you're assuming this role, one foot as a lay person, one foot in the professional arena. That can be pretty difficult to

know, where is my role really? Am I the advocate? Am I a lay person, or am I on the other side? I think that's a lot of the discomfort. It's healthy, actually, and it's good that there is that discomfort, because I think some of the shock has worn off for a lot of us in terms of gallows humor and stuff like that that doctors have. It's good that students don't have that yet, and I think students keep other doctors honest. That's one of the nice things about teaching hospitals.

Certainly there were experiences. How can I say this without maligning my school?

Mullan: You'll have an opportunity to edit this.

Morales: On the urology rotation they gave me honors, but they told me, "We don't need any more women in urology." Right? Stuff like that. I don't think it's just Columbia. One experiences hearing patients disparaged. That was very upsetting to me and my fellow students, for example, having patients called names like "gome" and "dirt balls" and other stuff. I think, in retrospect, some of that comes from the incredible workload that residents have. It mainly comes from residents, and their own feelings of anger, frustration, and fatigue. I think people sometimes want to separate from the emotional stuff of what they're seeing. Some people get very angry certainly at certain types of patients, including people that use drugs, or alcoholics. The "gome" word is against old people who can't talk, because it's so frustrating to take care of people that can't talk. So there are reasons for it, but it was very distressing to see the way that sometimes trainees will depersonalize

patients. Now, of course, as a faculty member, I have perspective. At the time I felt like "Oh, these people are so nasty." Not everybody was like that, but there were some.

There were some people, on the other hand, that were incredible humanists. When I was an intern, my first resident, we went and sang happy birthday to the patient. There were things that were sweet. In the attendings, obviously there were a lot of wonderful teachers. There's a whole phenomenon of the Socratic method and how it can be used, the way that you ask medical students questions, and that's how you teach them. Clearly, that's a tried and true and very old method of education which I use, too. On the other hand, there are ways to do it that are more humiliating than others. I didn't encounter that many humiliating people, although certainly there were people who taught us the meaning of obnoxious, that would scream at the students or scream at the house staff. There were people who were infamous for throwing things at people. Certainly that kind of behavior happened.

The other thing that was happening when I was a third-year medical student was the AIDS epidemic was really starting. It was 1984, and in the beginning, we did not know how AIDS was transmitted. We didn't really know what to do about blood. It was certainly on our minds when we were students, but even more when we were residents, because we took care of a lot of people with AIDS, and it was very frightening. People that would be in the hospital, --the support staff would gown and glove just to go in the room of the patient who just had AIDS, because there was so much fear.

Mullan: Tell me about your class. What were the men and women ratios?

Morales: There were a lot more men than women. There were 150 people, and I think there were only 25 women. Gender issues were prominent in the culture of my class. We had an AMWA chapter, American Medical Women's Association, so some of the gentlemen made the AMBA chapter, American Medical Boys Association as kind of a counterweight.

There was a lot of racial tension, actually, in my class, because people were very resentful of the black and Latin student organization. Minorities used to study together sometimes. There's a long history behind that, there was a time when minority students did not do as well in medical school, so there was a whole system set up by the students to provide academic support for each other. The upperclassmen would help the lowerclassmen so that people would get through. That was resented by some of my classmates, but not by the faculty.

Mullan: What was it centered on, Hispanics, Puerto Ricans?

Morales: I think there were like ten Latinos, eight or ten Latinos, and eight or ten blacks. We had a Black-Latin Student Organization, which is not the case in every school. A lot of schools would have an SNMA and a Latino group, but we had a joint group. We also had a very supportive minority affairs director named Margaret Haynes, who is a wonderful woman. I miss her a lot. But certainly that was very unpleasant and unexpected.

Mullan: And different than your undergraduate experience?

Morales: Really different from my undergraduate experience. As medical students, we were all stuck in the room together and had to live together, so it's very intense. It wasn't everyone in my class. I had many friends in my class who weren't like that. Given the pressure-cooker nature and then this whole issue of the minority students having an organization, it became a big controversial thing, and it was really difficult.

Mullan: How much do you think the difference in your experience between the two institutions and the levels of schooling was institution-dependant and how much was level-dependant?

Morales: Grad school versus undergraduate?

Mullan: Yes, and how much was Harvard versus Columbia?

Morales: I don't know.

Mullan: Hearsay is admissible.

Morales: All I know is based on hearsay. I don't think that that many of my friends that went to other medical schools had as bad a problem, and I don't think the problem is that bad now. One of the things that happened is that Columbia has instituted a lot of the support mechanisms that we used to do. We would have review classes that we would give or the upperclassmen gave to us. The white students that were having academic trouble, we

would invite them to that, because we kind of knew through the grapevine who was having trouble, and we wanted to help people.

Mullan: Was that accepted?

Morales: Totally. They came.

Mullan: Great.

Morales: And some of the people that did the reviews were white students. Anyway, the whole thing has been instituted for the whole school, that you should be able to have tutoring. There was very little academic support. It was really sink or swim. People just had this ad hoc way of doing it. Now there's a tutoring system. There are review courses. There's this whole emphasis on academic support that came modeled on what BALSO did. That has been one of the ways that the institution responded to this, because clearly there was a need. It wasn't just minority students who historically had difficulty there. There have always been students with difficulty, but people may have had alternate mechanisms for dealing with it, and certainly not all minority students had difficulty. A lot of my classmates were the stars of the class. But because of some issues of feeling alienated or whatever, the multiple factors that may influence people's performance which has nothing to do with their academic capability, there have been these alternate study aids invented by students.

Mullan: Was there at all a similar degree of collectivity or helpmateship among women students as there was among minority students?

Morales: It was different. It wasn't as intense, but the definitely the AMWA chapter was active and people did stuff, and it was good.

Mullan: What about the generalist/specialist culture as it existed and as it was experienced by or applied to your class and you as an individual? What was taking place in the mid-eighties at Columbia or prior to that?

Morales: It was definitely very sub-specialty oriented. A lot of surgery. It's a big surgery school. If you are going into medicine, most people are going into medical sub-specialties. So I was an anomaly in saying that I wanted to do primary care. I was still saying I wanted to do primary care when I applied to residency.

Mullan: Was that disparaged at all?

Morales: Sort of. For example, the family practice department only just started recently. There never was one. They're just starting a family practice residency now.

Mullan: On site, I gather.

Morales: Well, community-based and in the community hospital, which is part of our hospital. There was no primary care course until about two years ago. Internal medicine was purely an in-patient rotation in terms of the required clinical courses. You were not exposed to mentors encouraging you to do primary care, except through courses that emphasized psychosocial aspects of medicine which happened to be taught by generalists. That's how I met the generalists here. They are some of the people that encouraged me to continue my interest in general medicine, like Rita Charon and Rafael Lanngua, who work with me in my practice now. Rafael and Rita were my teachers, as well as several others.

Mullan: So they actually arrived in your curriculum not as generalist role models per se, but teaching something else such as psycho-social issues?

Morales: Right. But I knew that they were primary care people. Since I knew I had this predilection for primary care, I gravitated, and they encouraged me. On my ward rotation in medicine, two of my attendings were generalists, general medicine people, Ken Fine and Connie Park. They were really wonderful. Some of it was happenstance, but I did have these supportive people involved with me in my medical education, who encouraged me to stay here for training, despite the fact the training program was even less primary-care oriented at that time than the medical school.

Mullan: What about among classmates? We'll go on to talk about residency. Were there others in any significant number who had some sort of primary care model in mind, and did they talk about it?

Morales: There were a few people in my class going into general medicine or primary care, but very few. There are more now.

Mullan: So the cultures that existed, as well as the intentions of the students as they came through the system, was largely sub-specialty oriented?

Morales: Right.

Mullan: Was it discouraging, or was it just a fact of life? How problematic was that environment for someone of your predilection?

Morales: I think since I walked in the door wanting to do it, just because people weren't encouraging, didn't mean I was going to do it, but a lot of people do not walk in the door knowing what they want to do.

Mullan: This is Susana Morales, tape one, side two, continued.

Morales: If the thing that you see that's really cool and really dramatic is brain surgery, then you're going to want to do brain surgery. It's totally neat and cool and interesting and whatever, but it certainly isn't primary care. I think there

certainly was a special interest in the miraculous, fascinating things, surgical things. You get immediate results. It's really dramatic. It's really cool. And it is, of course it is, but there are other rewards that can result from developing relationships with patients, figuring out diagnostic dilemmas, management problems, psycho-social issues that are some of the pleasures of being a primary care doctor. It wasn't like it was the first time that I was doing something against the grain, so for me it wasn't a big deal. It became more of an issue in residency when I was really discouraged.

Mullan: You were persuaded to stay here?

Morales: Yes.

Mullan: Why? First you made a decision, I gather, on medicine?

Morales: Yes. Why medicine? Well, I didn't make this decision until right into the fall of my fourth year, and it was between obstetrics, medicine, and psychiatry. I really loved OB/GYN. I loved delivering babies. I realized what I really liked about OB most was medical complications of pregnancy. I really liked psychiatry also because I love, of course, to talk to patients. Then I realized that I would still be able to talk to patients as an internist. Now as a practicing internist, I realize how much of my practice is psychiatry. So it all ended up well. I also liked OB because I like taking care of women. That certainly is an interest. A lot of my patients are female. What I didn't like about OB was the hours. The surgery wasn't as much fun for

me. It just didn't turn me on as much. The lifestyle was an issue for me, especially imagining, you know, the future and seeing all these older doctors in the labor room at 4:00 a.m. with me. I thought that was terrible. [Laughter]

Mullan: So how were you persuaded to stay here?

Morales: I applied to a lot of different programs, including primary care programs. This program was the opposite of primary care. It was extremely tertiary-care oriented, although this hospital had in the meantime become a community hospital as well and it was doing secondary care.

Mullan: Can you say a word about that?

Morales: Well, it used to be that you could be admitted at Columbia if you had an interesting disease and were referred from another hospital or if you had money. There were several community hospitals in Washington Heights that all closed. This hospital became the major hospital of northern Manhattan and suddenly it had to provide primary, secondary, tertiary care to all of northern Manhattan as well as continuing to be a referral center. That was a painful role change initially, because there were town/gown conflicts about the responsibility to care for the community. There was a lot of community pressure on the institutions to be more responsive, to provide more community health services, primary care services, etc. However it all evolved, it was providing a lot of those services.

But in terms of staying here, I had friends in the program. They wondered "Why do you want to come here if you're into primary care?" They wanted to do primary care, and they regretted coming here because they felt that it was not primary-care oriented. At the time I felt it was the best program in the city, and I knew it was one of the best in the country, and if I could get in, I wanted to get in.

It was a very homogeneous program at the time. There were very few minority house staff. I felt that perhaps if anyone was going to be able to get in, it would be maybe a Columbia student. That might be helpful. I loved taking care of patients in this community, and loved my experience as a student. I knew that I would be able to provide a service that other people just would not be able to provide just because of my language ability and cultural knowledge. I had mentors within the institution that were really encouraging me to stay, primary care doctors working at Columbia. So I felt that you could be primary care oriented and survive.

Mullan: So you were accepted and proceeded on into the program?

Morales: Right.

Mullan: Tell me about that. How was it?

Morales: Well, a couple of weeks before I started, my grandfather was diagnosed here with stomach cancer, so that definitely colored my internship year, because he had advanced stomach cancer and died in January of my internship year, and was

cared for by, Dr. Lanngua, who had been my teacher and is now one of my partners, who was very wonderful to my family. That certainly was horrible. I don't think the Bell Commission had happened yet, so there wasn't this idea of limiting hours. We had just started having somebody do admissions at night for some rotations. You still had to carry a beeper all night and stay up all night when you were on call, and there was still every other night in ICU, and there were no IV teams. There was one blood draw in the morning, and you did the rest. The ancillary help just didn't exist. It was incredibly hard just in terms of the amount of scut work.

Mullan: What year are we at now?

Morales: 1986. I just remember it as one long IV. The AIDS issue was even more of an issue now because of our fear, because we were constantly drawing blood and some of us were stuck. I had a needle stick once. There was a lot of anxiety about personal risk besides all the aspects of internship, being paged constantly, being constantly exhausted, dealing with death and dying and the tragedy that you sometimes would see.

Luckily, I had very supportive fellow interns who are still very good friends. It's almost like a "combat buddy" mentality. You're all in the trenches together and live together every single minute. A couple of people married a couple of other people, and I baptized somebody's kids. It was really special in that way, and it was different from the way friends described their residencies. Some of my friends would say, "When I leave,

I don't want to see those people," but for us, it was the opposite.

Mullan: How large an intern class?

Morales: I think there were about twenty of us.

Mullan: As you progressed through residency, how did you experience the generalist versus sub-specialist teaching attitudes or environments?

Morales: Very sub-specialty oriented, extremely sub-specialty oriented. There was definitely a milieu of "of course everybody's going to sub-specialize." It was weird if you weren't going to. Indeed, of all of my classmates, only me and one other guy in residency became generalists, although a couple of the people who trained in sub-specialties are practicing general medicine. It wasn't that my colleagues would say it was bad, but there was an idea that there was no other way. Some things that contributed to that attitude, especially for trainees include the fascination with exactitude and knowing all the answers immediately, right away, going to somebody that is an expert and getting the answer. And the idea that the breadth of stuff that you need to know as a generalist is too intimidating and, conversely, "There's no way I'm going to be smart enough to do that, but on the other hand, people who do general medicine aren't as smart." It was that atmosphere, although certainly a couple of the favorite teachers here have been generalists.

Mullan: How about your actual learning? How much was it affected by what I take as an absence of role models and environment that was generalist-focused? Was that an impediment or not?

Morales: We did have our primary care clinic, and we did have general medicine attendings.

Mullan: Everybody had that?

Morales: Yes, so that was very important in sustaining my interest. In fact, it's one of the reasons I wanted to stay here, so I could keep my clinic patients. Certainly some of my generalist teachers in that setting were very important. It was very nice to be able to see walking, talking people as opposed to shattered, horizontal, hospitalized people. It was fascinating to see people that had been near death, and then they would walk into your office with their little hats on. It was cool. Then discovering the joy of getting to know patients, and patients bringing you presents, like cooking you pastoles. I had a lady that crocheted me booties.

Since a lot of the patients were Latino and they were able to communicate with me in Spanish, it was really important for them. A lot of patients were older, it kind of felt like I had a hundred grandmothers. That was very pleasing, especially during internship when you wondered, "This is what I was trying to do? This is what I paid all this money to do? Why did I do this?" It was very pleasing to me, even though you were always tired when you went to clinic, and people were having seizures on the

floor and you're in the clinic. It was very emotionally rewarding to see people get better because of what I did.

Mullan: The argument is made that in internal medicine, the structured, traditional part of departments is something of a holding company. There's a Department of Medicine that is, in fact, a series of fiefdoms of specialists.

Morales: Correct.

Mullan: And that the mind-set that is brought therefore to teaching is fragmented and irregular and that departments of medicine need to be restructured to provide optimum generalist training. Would you agree with that surmise or that description, and, if so, how much of a problem is it? How much potential improvement in training could be achieved by reorganizing along generalist principles?

Morales: I think that certainly the fractured nature, "Okay, I'm in the CCU, so I'm only going to think about cardiology," and very in-patient orientation which does not reflect what most doctors do with their days, which is take care of patients in the office. There is a skill set that you need in terms of being able to focus on the medical history. In fact, one can get most of your diagnostic material from the medical history, but after medical school no one ever actually taught you how to take a medical history.

We identify other things as important in the skill set: knowledge of some of the psycho-social aspects of medicine;

issues of compliance, judicious test ordering, things like that. In the in-patient setting the focus has to be a shotgun approach just because you don't want to miss anything, and this person's acutely ill, and you have to find the answer quickly.

I'm not certain how to restructure a department to accomplish some of those things. Certainly training can be refocused. We have changed the training program through expanded attention to the outpatient and ambulatory issues. We instituted an ambulatory care block rotation so that rather than this conflict of staff between simultaneous in-patient responsibilities and outpatient responsibilities, they have a specific block of time where they focus on issues in ambulatory medicine and feel more of the pleasures of actually sitting and talking to patients.

Mullan: This is now part of the residency program?

Morales: Yes. This was definitely influenced by the New York State emphasis on "upweighting" residency programs. We applied for and were upweighted, which meant that 20 percent of training time is spent in the ambulatory setting. Part of this time is in block rotations, part of that time in continuity clinic, with the goal of exposing people to the longitudinal care of ambulatory patients with special emphasis on generalist skills. That's been very successful. It's one of the residents' favorite rotations. The employment market has changed, but many more of our residents are entering general medicine than in the past. It's no longer weird to enter general medicine.

Mullan: Well, let's take the story forward, because I realize we jumped ahead. Bringing this towards the present, you did three years' here as a residency?

Morales: Right.

Mullan: Then you were at another decision point. What happened then?

Morales: I did consider sub-specialty training because of the nature of my program. Then I realized that I was looking for a sub-specialty in which I could practice general medicine, and I realized that that was stupid. So I decided to do general medicine. I am not sure I even knew at the time that there were general medicine fellowships. I don't recall really in any way thinking about a general medicine fellowship or anything in terms of further training.

I decided to do was I wanted to just go into practice and see if I liked it once and for all. My chairman was somewhat discouraging about my interest in general medicine, and certainly most of my cohorts were going off to fellowships. I was one of the one or two that weren't going to do that. I guess I just wanted to answer the question, "Is this what I really like?" It was what I'd been saying I liked. I decided to just go on to work. I was asked to stay here as faculty so I stayed at Columbia.

Mullan: This is now 1990?

Morales: '89. It was house staff-faculty practice then, although it's much more unified now than it was.

Mullan: Unified in the sense--

Morales: Well, it was separate, like house staff were on this side and attendings were on the other, and there wasn't much intermingling.

Morales: The house staff was the house staff faculty clinic?

Morales: Right. Now we practice side by side with the residents, see each other's walk-ins, and it's a better run practice.

Mullan: That was a conscious decision?

Morales: Yes.

Mullan: Was that driven at all by the Medicare teaching guidelines requirements for a supervision sign-off?

Morales: No, because there had always been supervision, but we felt we wanted to present generalist role models, they had to be there with you, and they shouldn't be off someplace else. We wanted a teacher next door so we could grab somebody and say, "Look at this rash for me." A lot of it was the role-model issue, wanting to demonstrate that, "This is a career option, and here are people who are doing it."

Mullan: How large a faculty group is there in the generalist practice?

Morales: In our practice there's about twenty-five.

Mullan: Twenty-five faculty?

Morales: Yes. Not all of them are full-time. There are several researchers, and there are some people that do other activities.

Mullan: That spend part-time as general internists?

Morales: And spend time teaching.

Mullan: And the patients are drawn from patients who are hospitalized here and this is follow-up, or are these people for whom this is their source of primary care?

Morales: Both. Most of the patients in our practice are people from the community, and most of them are poor.

Mullan: And this is the practice you've been in from '89 to the present?

Morales: Right.

Mullan: What if you stepped back from that practice and looked at its role in the institution as a whole? I know a little bit

about your patients. Is this something that the institution needs in order to serve the community?

Morales: Yes.

Mullan: Or is it something the institution tolerates because it needs to do a certain amount of generalist care? What is the role of the general internal medicine practice?

Morales: Well, how did it start in the first place? It may have been in part a result of community pressure. I'm not sure. Certainly it provides a huge service to the community, and we do at least 50,000 visits a year, and that number has gone up. I think there was a time where it was "tolerated." It was just not a mainstream thing. This was very much a sub-specialty-oriented department. Previous departmental leadership was not always as supportive of general medicine. As time has gone on and national and institutional events have occurred, that attitude has changed. We've got a new chairman who is much more supportive of general medicine.

Mullan: And who is that?

Morales: Mike Weisfeldt. There's much more of a recognition of the importance of generalism in our Department. In terms of medical training, the emphasis on general medicine has become more and more a national mandate. We are providing a lot of the teaching for that aspect of training. It's importance has been much more acknowledged. The community has demanded access to

primary care services all along, and this is one of the places that it occurs.

Mullan: As you participated in all that for six or seven years, I gather it's grown in size?

Morales: Yes.

Mullan: As you look at its trajectory, both for you personally and for it as an entity, how do you see it? Is it sort of fixed now, or is it evolving ways of service or education that are different?

Morales: It's growing. It's still growing because our institution must become a Medicaid managed care provider, for its survival and to provide care for the community, as a lot of our patients have Medicaid. We're not yet a formal Medicaid managed care provider by the state of New York. Columbia Presbyterian has the highest Medicaid population of any voluntary hospital in the city. Ambulatory care capacity must expand to meet Medicaid managed care requirements.

Primary care providers must be more accessible to ensure continuity. The training program has accommodated that requirement, and residents will spend at least two sessions a week in the clinic, and patients will have increased access. Space constraints and supervision constraints make implementation a challenge, but in terms of education, it is positive. Residents will know what it's like to manage practice.

Residents used to have rotations where they would not have clinic for weeks, so patients would have no access. Patients would come to different bridging follow-up mechanisms. It will be better to have enhanced continuity.

Mullan: Is that tied to the Department of Medicine?

Morales: Well, sort of. The ambulatory care network corporation resulted in part from the pressure of community groups for the institution to provide better primary care. As far as I know, part of the deal to build the new hospital included community practices. This was before the real recognition that primary care was the way to go. Different sites have opened up which are really nice, and the internists within the sites are part of our division.

As part of another New York State grant, we've placed categorical house staff in one of those sites to provide community-based training. They have loved it. We hope to expand that to another site. There is a national movement to provide community-based training and to introduce people to real practice sites with obviously the special model of urban community-based care. It is similar to the Martin Luther King Health Center, which was the teaching site for the Montefiore social medicine program. That began in the seventies, so now it's at Columbia.

Mullan: As you look now into the future for both yourself and for the enterprise here, where do you see things headed? Are you optimistic, pessimistic about the developments in medicine?

Morales: Should I talk about me personally or medicine first?

Mullan: Why don't you do medicine first.

Morales: I think that there are certain challenges facing medicine now that are unique. Obviously the growth of managed care is the main one, both for academic medicine and clinicians. The irony, of course, is that managed care started as a nonprofit enterprise serving working people. It's evolved into this profit-making giant, for the most part. Doctors have always wanted to make money, and it's not like medicine has been free of pecuniary interest, but clearly now the corporatization of medicine has major implications for the humanistic aspects of medicine. There is great fear that medicine will be bureaucratized and corrupted by a lot of those financial pressures.

Clearly the waste and inefficiency of medicine has contributed to this, that care can be done more cheaply in a managed setting. The profession has not policed costs. I'm especially concerned about what managed care will mean for the poor, especially Medicaid patients, immigrants, non-English speaking patients, and certain patients that are especially at risk. In managed care you probably have to be able to fight a little to get what you need. It's not that you're going to necessarily get bad care, but there may be times when you need to be able to advocate for yourself. I just think that it's going to be harder to advocate for yourself. It will be harder for the poor to advocate for themselves. Our present medical system is imperfect in terms of care for the poor. However, the safety

net, which has a lot of holes in it but still exists, may be even more threatened when there is a profit motive in health care.

Certainly there are ways that health care rationing happens now. The people most at risk are the poor, minority people, and the women and children are most represented in the Medicaid program. Anti-welfare sentiment bleeding to Medicaid cutbacks and people getting thrown off public assistance. These policy changes will differentially impact on women and kids.

Obviously the issue is not just managed care; it is the interplay between managed care and the social movements of '96.

It's a frightening time in terms of the population I'm very concerned about and work with, minority poor people.

The other concerns in managed care involve the ethical issues that have been raised, for example the gag rules that exist in certain managed care contracts for physicians. Some say rules state that physicians cannot complain about the managed care organization, cannot tell patients about financial relationship with the managed care organization, including financial liability for over-ordering tests. This is viewed as an incentive to cut costs, but it can also be viewed as a corrupting influence. A lot of ethical issues are raised by some of the structures of for-profit companies.

Mullan: Do you feel that those strictures or guidelines or those factors as they play on your practice in this setting are still within the bounds of responsibility?

Morales: We've partly started to do managed care. These are some of the things I worry about. Of course, most doctors feel

like, "Well, I'm never going to be influenced by this. I'm going to be pure," but there are so many things that can influence a decision. To have personal financial liability be a concern, I think is potentially corrupting, even if you try to convince yourself that it's not. There are many situations when you'll be trying to make a decision, "Well, should I really get this test or not?" You can argue the thing purely on the basis of the merits, and there may be other things that go into it like you're tired and other influences like fatigue and other things that are not greed or fear of "What is this going to do to me? Are they going to kick me out of the managed care program because I'm spending too much money?" But one tries to convince oneself, "Okay. I'm not going to do that. I'm not going to make decisions based on that." I think there are unconscious, subconscious things that influence us, and I worry about them. Legislation has been passed that doctors shouldn't be able to make profit from their radiology and labs because of conflict of interest, and this is a different kind of conflict of interest.

Mullan: How about for yourself as you look forward at the system or the future?

Morales: Of practicing within it, you mean?

Mullan: What do you envision doing?

Morales: In managed care?

Mullan: In practice in general.

Morales: I still want to continue to take care of patients. There is some potential promise in managed care. There is a primary care focus in managed care, finally, and that's good. There's some evidence of improvement in outcomes in certain managed care settings because of decreased hospitalization. Asthmatics may get better preventive care. Certainly a lot of the not-for-profit managed care organizations have produced savings, lower administrative costs, and so forth. So it's not like it's all negative. There are other challenges in clinical practice, including the five million phone calls you need to make to get something approved, and the need for an administrative infrastructure to deal with paper work.

Mullan: What do you see yourself doing to bridge that? How do you divide your time right now? How much is clinical, how much is service, how much is teaching, how much is administrative?

Morales: I spend about 40 percent of my time clinical, and around 30 percent teaching, and the rest administrative. Most of my teaching is teaching residents, although I also teach medical students. I help to coordinate educational programs for the house staff. I help to coordinate the psycho-social curriculum. I work with a psychiatrist who works with us half time on that. I precept residents in the practice, teach ambulatory morning report, and other things. We try to have a case-based approach to ambulatory teaching. I also administer our community-based teaching grant.

My outside activities over the last few years have been along the lines of advocacy, mainly around HIV issues, especially

minorities and Latinos with HIV. I used to view this extracurricular, and now I realize that's not really true although you don't get paid to do it. Part of the reason I do this is because I am a doctor, and part of the reason they want me to do it is because I'm a doctor. I serve on the Board of Directors of Body Positive.

Mullan: Which is?

Morales: An AIDS service organization, educational forums and support groups. Then during the Clinton Health Care Reform Act development, I was involved in a Latino initiative to try to implement and effect a plan addressing Latino issues. I attended a lot of meetings in Washington around that.

Mullan: I take it there were a lot of meetings.

Morales: There certainly were a lot of meetings. The plan's failure was a big disappointment for all of us, although clearly the plan had flaws. It was based on managed care, which is one of the ironies. The idea of having universal health care is so important to me, and the frustration at our present system of fractured care is terrible. Certainly I was very disappointed because I felt like, "Okay, maybe this can happen." It almost felt like a fantasy come true.

Mullan: If you look at what you might be doing, having parceled out or described for me what you do today, what do you see yourself doing ten years from now, twenty years from now? What

stake in the overall enterprise do you see yourself having? What battles will you be fighting then?

Morales: That's a big question. I want to pursue my interest in health policy, I'd like to do an MPH to get more technical knowledge. I have a lot of the experiential knowledge in terms of patient care. This is the question I've been asking myself, because I've been doing this now for a long time, and I wonder "what's next?" I love medical education, and I love to teach, and I've done a lot of things within my division, within my department. You know, we've changed the face of our residency program, which used to be very homogeneous and had hardly any minority house staff. Now we have many minority house staff, and we have more women on our faculty. We're trying to improve the diversity of the institution. I think there's been progress.

Honestly, I'm not certain. I see myself at some point going into the policy arena. The dilemma for me is that the idea of leaving patient care is terrible, because I still love and value patient care, and it still gives me intellectual--always intellectual interest. And I love to teach. So how can I put everything together and really do it all well? I don't know. I don't know if you can do that. Or does something have to go? That's what I've been struggling with.

Mullan: Do you think the Pelham High freshman who decided science was okay and maybe she wanted to go into medicine would be pleased with where you are today? Do you feel like you've connected those two?

Morales: The wanting to help people, the altruistic things are certainly fulfilled. The intellectual interest is still always there. I don't think I ever imagined the time constraints of a physician. As a child you have endless time. There's no way that you can understand the impact that you can have on people's lives, not only that you can save somebody's life, but that you can drastically improve somebody's life, and accompany them on their road. The emotional rewards of what we do are profound. There's no way I could have known that. I just imagined what it might be like.

Mullan: How has your work life affected your personal life? Obviously, the hours are enormous. Is family and children an issue for you at all, or is that something which has intertwined itself with decisions about what you do next?

Morales: Well, that is an issue. I'm single, but I do want to have a family. The hours are difficult, and I can't imagine working this hard once I have a family. I know I would have to change something that I do. All my peers are struggling with that now, because many of my peers are having babies. How you do the balancing act is the big question, especially for women. I'm learning with them what that's like. There's no question we all feel it's a sacrifice.

On the other hand, the trade-off is also good. I have friends who didn't finish school or didn't go on to school, and have their families. The grass is always greener. They tell me "But you finished your career, you're on the road, and you did it

the right way." Then I look at them, and I say, "Oh, but you have kids." Who knows what the right answer is?

Certainly for me, I was totally driven to do it this way, and I couldn't even really imagine getting married in the past, because I was just so focused on my career. I think now there's more balance. I always had friends, and I always had fun, but only recently have I said, "Okay. I've had a lot of fun." [Laughter] Now it's time for a different focus in terms of family.

Mullan: And you've been generous with your time and with your story. Is there anything else you'd like to comment on? If not, why don't we end it there. Thank you very much.

[End of interview]