SALLYANN BOWMAN

Dr. Fitzhugh Mullan,
interviewer

Mullan: I'm with Dr. Sallyann Bowman. The date is May Day, May 1, 1996. We're in her office at Health Partners. If we could start at the beginning, tell me a little bit about yourself, where you were you born and grew up, and what your life was like as a youngster.

Bowman: I was born here in Philadelphia, about a mile from here, which is inner-city Philadelphia. My father was a shipfitter; my mother was a homemaker. Dad had an eleventh-grade education; Mom, tenth grade. I'm the second of three children; older brother, much older brother, seventeen years older. He's a teacher. I have a younger sister who is three years younger, and she has cerebral palsy, so it was the three of us at home.

Mullan: They really spread that family out.

Bowman: Yeah, they did.

Mullan: Ended up with a lot of caretaking at the end, I would guess, with your sister.

Bowman: Well, my sister's really good. Her handicap is very mild. She went to school. She finished, until she was eighteen. She has a mild palsy on her left side, but she's able to dress, feed herself. She's actually taking care of my mother most of the time now.

Mullan: Good for her.

Bowman: Yes. She's my buddy.

Mullan: When were you born?

Bowman: March 18, 1950.

Mullan: So you grew up in Philadelphia?

Bowman: Yes.

Mullan: What was it like?

Bowman: I just remember my childhood as a happy childhood. The community was--growing up in Philadelphia, you grew up on a block, so that there were ten, twenty kids on the block. My closest friends were the neighbors from down the street, across the street. It was almost like another community at the other end of the block. I remember summers being long, amazing, and lots of fun, filled with stuff to do. I was one of those kids that liked school. I went to parochial school, which was a big deal in those days.

Mullan: You mean in the sense that it was atypical to go to parochial school?

Bowman: Well, it was atypical for a black kid to go to parochial school at that time. The neighborhood was primarily Irish and

Italian, and the Catholic church was built by the Irish settlers in the area. There were only two or three of us who were African-American at the time.

Mullan: Is that the neighborhood you lived in?

Bowman: Yes.

Mullan: So you lived principally in a white or an Irish neighborhood?

Bowman: No, no. On my side of Lehigh Avenue, it was predominantly black. On the other side of Lehigh Avenue, it was predominantly white. So where I lived, that was why it was atypical, because most of the black kids in the neighborhood went to the public schools. I was one of the few, and my three friends, one of the few kids that went to the Catholic school. So that was the way it started in 1955, but that was not the way it ended up when I finished there in 1964.

Mullan: How did it change?

Bowman: Oh, God, it seemed like it happened overnight, that overnight the entire area was 90 percent black. White people moved out so fast, it made your head spin.

Mullan: So both sides of Lehigh Avenue?

Bowman: Yeah. From Broad Street to the park, and 30th Street down to 15th, the neighborhood completely changed in that time.

Mullan: And the school changed as well?

Bowman: Yes.

Mullan: How did you perceive that? As you look back on it, how do you perceive it?

Bowman: It was so gradual as to not be noticeable as a kid. I don't think I noticed, I don't think I felt an effect, while I was still there. I was fourteen when I left eighth grade. So I don't really think there was a change in the level of education. I don't think there was a difference in the attitude of the Good Sisters of Saint Joseph.

Mullan: How about the other kids and their families? Was there hostility about blacks moving in to the neighborhood, and were you subject to that?

Bowman: I remember the first person who called me a nigger.

Mullan: Careful of the tape!

Bowman: I was in first grade. No, she called me black. I remember feeling stunned when she called me black, and I got into a fight with her over it. I think I hit her. I usually got into trouble when I hit somebody at school. No, I didn't hit her. I

wanted to, but I didn't. So I went home. I hit somebody in kindergarten and got in trouble. [Laughter] So I went home, and I told my mother, "This girl called me black."

And she said, "Well, you are black."

I said, "What do you mean, I'm black?"

She said, "Well, you are. You're black and you're beautiful. If she calls you a nigger, then you slap the shit out of her, but otherwise, you are black." [Laughter]

That was my first introduction into someone being not nice to me about being black. And again, it was taken for granted. You just sort of knew that this was our world and that was their world, and it didn't come together an awful lot, not in those years.

Mullan: Was your parents' sending you to the school--clearly, most of the parents didn't do that. What did they have in mind, sending you to the Catholic school?

Bowman: Well, my brother is seventeen years older, and Arthur had gone to college. He was the first in the family to go to college. I think he had gone to public schools, and he had had a negative experience with a guidance counselor in the public schools. Arthur had expressed his desire to go into college, and was dissuaded against it. He was told that, "You guys don't go to college. You're better off learning a trade," and that kind of thing. So he went into the army, initially.

I think it was partly my brother's experience and my parents' perception of what had happened to him, that they said they didn't want me to go to public schools. Black kids don't go

to college. After he got out of the army, he went to Cheney and became a teacher.

Mullan: So he would have been in college when you were starting school?

Bowman: Yes.

Mullan: What happened after eighth grade then?

Bowman: Well, in Philadelphia, we go to the regional catholic high schools, and the regional high school was Hallahan High School for Girls, so that's where I went. It drew from south Philadelphia, Center City, Manayunk, some of the more northern suburbs, north Philadelphia. So there was a mix of kids again. Again, predominantly white. When it started, it was about sixty-forty, and then when I finished, the classes coming in had a little different mix, maybe seventy-thirty, and then it was closer to sixty-forty, fifty-fifty, in the freshmen class.

Mullan: How was it at the school?

Bowman: I loved it, but I loved it because I was a musician. I played French horn. I was introduced to the orchestra in the summer before my freshmen year. I had never touched a French horn, but I heard a record, and I said, "What is that? It sounds really neat." "That's a French horn." I said, "Okay. Well, I'll play that." Little did I know, I was picking the hardest instrument to play. The nuns were amazing with us. They took

kids who had never touched an instrument, and had you doing ensemble work at the end of the year.

Mullan: This was which grade?

Bowman: This was ninth grade. Ninth grade. So by the end of ninth grade, I was good enough--well, I got into the senior orchestra as a freshman. You normally didn't get in until the sophomore year. That was the center of my life in high school.

Mullan: The orchestra was important. French horn was important. At that point in your life, what were you thinking about where you were headed, what you wanted to do?

Bowman: It's always funny trying to talk about your life in the linear fashion, when things don't happen that way. Things happen parallel, and things happen in series. There are other things that were working on me, that I can see now, but that I would not have known then.

My mom's family worked in and around hospitals, in various capacities. My grandmother worked at the University of Pennsylvania in the medical school. She had a job that doesn't exist anymore. She would help set up experiments for the med students, and she would cater lunches and things like that. She was a general, all-around kind of "gofer" lady in the Penn Med School, but she loved the job, so I heard her stories about working at the university, which is how we referred to it. Now you say HUP. You almost genuflect when you do it.

Mullan: HUP being Hospital of the University of Pennsylvania?

Bowman: Yeah. Her two sisters were at Philadelphia General Hospital in various labs, taking care of animals, watering, feeding, changing the papers, again, assisting with the basic science labs. Her brother worked at Penn. My mom worked for a time at Philadelphia General as well, as an animal caretaker. Since the animals need to be fed on the weekends, somebody needs to do that, so that was the job my mother had. I would go with her on Saturdays and Sundays, when she had weekends to do, to go in and feed the animals. And I can still remember the smell of the hallways of Philadelphia General Hospital.

So I kind of always thought that I would end up somewhere in and around a hospital, not exactly knowing in which direction, but I always thought the stories that they told were fascinating, about the hospital and the doctors and stuff like that. I certainly didn't have an ambition to go to medical school. I just knew it would be something in science.

Mullan: And were you comfortable with science, or how did you feel about science as a student?

Bowman: Oh, no, it was fine. I did well in chemistry, physics, and biology. It didn't come easy. I worked for it, but I did okay.

Mullan: Besides French horn, what were your variety of interests at that time?

Bowman: That was it. I swear it, that was it. That's all it could be at that time.

Mullan: You were really into it?

Bowman: Yeah. We were up at 6:30 and into school by quarter after seven, so that we could get an hour's worth of practice in before home room started. Then every afternoon we had orchestra practice or instrumental practice of one sort or another. I didn't have much of a social life, quite frankly. All right, there you are! I didn't have a social life in high school. [Laughter] I really didn't. I had a pity date for both proms. It was school. It was the orchestra. My best friend was a flute player in the orchestra. My most treasured memories are from playing with a 150-piece orchestra, and that point comes when you know that you're all playing beyond yourself, and it's so wonderful. It's really great.

Mullan: I've never played an instrument in an orchestra, but I've fantasized. It must be great.

Bowman: It is. I mean, here we all are. I remember we played at the Academy of Music, so we're all sitting in our gowns and our headdresses, and our instruments poised in our lap, as the curtain goes up in the Academy, and you see 2,200 people sitting there, waiting to hear you play. It's wonderful. It was wonderful.

Mullan: What was your thinking about college? Where did you go, and how did it come about?

Bowman: Oh, God, I haven't told this story in so long. I was going to go to pharmacy school. I had applied to Philadelphia College of Pharmacy and Science, and I got in. I even had a little money. At the time, there was a company in town called the McCloskey Foundation. This was a Philadelphia Irish builder who felt that it was important for him to support minority kids in their goals and aspirations for college, and so he had set up a scholarship fund for, I think, five or six full tuition and book scholarships to Catholic colleges in the area. I was sitting in my history class, and the nun said, "Sallyann, you should write an essay for this scholarship."

And I said, "But I'm going to Philadelphia College of Pharmacy and Science."

She said, "Yeah, but, you know, you ought to do it."

"I don't want to go to one of the Catholic schools."

And it's like, "Well, you ought to do it anyway." So I wrote this essay in this class. I pass it down to my girlfriend Joann and said, "Read this. Will this fly?"

She said, "Yeah, it sounds good to me."

I handed it in. I won a four-year tuition and book scholarship at Chestnut Hill College. It helped that I was eighth out of 550 girls in the class. It didn't hurt. It didn't hurt that my SATs were good. But, you know, I won a tuition and book scholarship. So I went off to Chestnut Hill, not having a clue what I was going to do.

Mullan: Was it hard to set the pharmacy notion aside?

Bowman: No, because there was no way--I was already struggling figuring out how I was going to pay for it. I didn't know how I was going to pay for it.

Mullan: So this was the easier path, in that sense.

Bowman: It was a no-brainer. There was no way that I could turn down a four-year scholarship. So I went to the Hill, had an undecided major, still the Good Sisters of Saint Joseph. [Laughter] I had an undecided major, and toward the end of the year, the academic dean called me into her office and said, "Sallyann, you need a major."

I go, "Yes, s'ter."

"What's it going to be?"

I said, "I have no idea."

"Well, let's go through some. Is it going to be the humanities, or is it going to be science?"

"Oh, I like science."

"All right, how about mathematics?"

"No, too hard."

"How about physics?"

"No, definitely too hard."

"How about biology?"

"No, not biology, because the only I can do with that is go to medical school."

"All right, that leaves chemistry, Sallyann."

I said, "Okay. Well, then it's chemistry." [Laughter]

I took a general chemistry course at Temple over the summer so I could catch up with my class, and then come sophomore year, I caught up. I did well. I got into the honors track, and I had a great time.

Mullan: Chestnut Hill is co-ed, all girls?

Bowman: No, it's a girls' school. It's a women's college.

Mullan: How big?

Bowman: Class size of about 100 to 120. I guess the entering girls' class was about 120 or so.

Mullan: Did you like it?

Bowman: Loved it. Absolutely loved it. Well, you'd have to see it to love it, too. It sits up on a hill in the furthest, most northwestern point in the city. Rolling campus, there's a creek that goes through. These old buildings; it's really a pretty, pretty campus. It was just what I needed. It was small. It was close enough to home that I didn't have to worry about getting to and from home, but it felt like it was away from home. It was like another world, but I was still in the city.

Mullan: What about the French horn?

Bowman: Gave it up. I gave it up. I tried playing in the college orchestra, and it was not the same sensation. And I

didn't have the time. You can't do French horn part time and be good at it.

Mullan: Ever pick it up again?

Bowman: No.

Mullan: It's not the kind of thing you sit around and play by yourself?

Bowman: No. I play piano, so if I want to amuse myself, I do that. But you can't dabble with French horn.

Mullan: Are you Catholic?

Bowman: Yes.

Mullan: Was your family Catholic, or was this from your experiences as you went?

Bowman: My father sure didn't go to church, but he was a Protestant, in his own way. My mother was born and raised a Baptist. Her whole family is Southern Baptist ministers. I don't why she converted to Catholicism, but she did. I know why she did. The neighbor across the street belonged to the Catholic Church, and there was a nun that they introduced her to. Mom just really admired this lady, and heard what she had to say, and thought that the church would be a good place to be. So Mom converted. I was baptized at three or four, and my sister was

baptized as a baby. My brother is not Catholic. I think he's going to a Methodist church.

Mullan: When did medicine then emerge as a possibility?

Bowman: Sister Eleanor Marie. But this oral history. I mean, she'd roll over in her grave if I didn't give her credit, because the credit is really due to her. I guess I was in my junior year, late junior year, early senior year, walking through the chemistry lab, and she goes, "Sallyann."

"Yes, S'ter?"

"There's a conference at Women's Medical this weekend. Signed you up."

I said, "Sister, but I'm not going to medical school."

She said, "But you have to go, because I signed you up."

I said, "But Sister, I really don't want to go to medical school."

"Well, you're going anyway."

"Yes, S'ter."

So I went, and it was the first time that I had really--and I got enthusiastic about it. There was a room full of high school girls, and there were about five or six female physicians that were really excited and enthusiastic about being doctors. They had families, they had lives, they had other interests. They weren't hard and crusty and "guyless," like your image of the lady doctor was, you know, giving up everything for medicine. And that was the first time that I ever thought about it as a real possibility. Once I did, I just said, "Okay, I'm going to

medical school." I had volunteered. I had done my volunteer thing in grade school and early high school, and it was okay.

Mullan: Volunteer thing in hospitals?

Bowman: In hospitals, yeah. I worked at Saint Joseph's Hospital as a Candystriper. It was okay, but I wasn't sold on medicine on the basis of that experience. But I was, after I'd gone to the conference at MCP.

Mullan: How did your thinking develop from that? That overcame some of the barriers of reasons not to be in medicine. Did you have an image at that point of what you wanted to do in medicine?

Bowman: David Wade interviewed me for [Milton S.] Hershey [Medical Center], and I remember telling him several things. One was that I liked problems. I wanted to be a diagnostician. This is how naive I was. I said to him, "I want to be a diagnostician," whatever the heck that is. And I also said that medicine would provide me with more options in my life and other career choices. That turned out to be very true.

Mullan: And as you entered, that was what you had as your guiding notions?

Bowman: Yeah. I just liked solving problems. I knew that I could make enough money in medicine to take care of myself and my sister or whoever I needed to take care of.

Mullan: And the prospect of studying medicine was, at least, passably interesting to you? Up to that time, you had said biology was no good, because all it did was get you medicine, etc. Something must have softened a little bit in your attitude towards it.

Bowman: I'm sure there had to be, but I'm really not aware of what it would have been or could have been. I can't think of a-- oh, yes, I do. Oh, yes I do. Let's back up. My mother got breast cancer in 1969.

Mullan: This was when you were in college?

Bowman: Yeah, while I was in college. I was a sophomore in college. It was the fall of my sophomore year. Mother had a mastectomy, and three months after she got out of the hospital for the mastectomy, she had a heart attack and was in the hospital for eight weeks, which tells you, you know, 1969, you stay for eight weeks. But during that time, my sister lived with me on campus, and the nuns never charged us a dime for room and board, in order to sort of get me through, so I didn't have to drop out to take care of family stuff. That's how good to me they were. Providence being what it was, it was the absolute right place for me to have been.

I remember taking care of my mom after she had had classical halstead radical, followed by cobalt radiation. If you've never seen the burns of cobalt radiation, it's awesome. Helping her to take care of her burns and wounds, I was the only one to help her do that. Just touching her, and helping, and realizing that

she--I guess in that reaction, the strong reaction that she had to what had happened to her, I'm sure that that had something to do with my decision to pursue medicine. It was never, "I want to go--" I've interviewed any number of kids going to college who say one thing or another about their life experiences, and parents, or brothers and sisters, with medical problems, or themselves with medical problems. But in 1971, I was not that conscious that this was a formative issue for me.

Mullan: As you approached medical school, how did you go about applying? How did you end up at Penn State? What was it like?

Bowman: I applied to two schools. Times have changed. Two schools: the University of Pennsylvania and Hershey. I interviewed at University of Pennsylvania and they wait-listed me. I interviewed at Hershey, and they accepted me right away. So I said, "I flip the bird to Penn, so I'm going to Hershey. You wouldn't take me right away, so I'll go to Hershey." [Laughter] Besides which, its tuition was like a third to a quarter of what it would have been at University. In retrospect, it was probably a bad idea, a little ivy on the wall never hurt. I know that now.

Mullan: Tell me more. Tell me more about what you mean.

Bowman: About a little ivy on the wall? I mean, the University of Pennsylvania certainly has a tinge of prestige that is enviable, that going to Milton S. Hershey Medical Center doesn't.

Mullan: This is in terms of the cachet. In terms of substance, how was the education? This must have been an early class.

Bowman: Yeah, we were the sixth class. But actually, it was the right decision for me, because the class size was small. There were only eighty kids. It was away, and I needed to be away from my family dynamics, but close enough that I could get back home.

I've made lifelong friends. Four of us got together at the ACP last week. I went to visit a med school friend that lives San Rafael, and a college friend who's in Davis. So I've kept in touch with a number of people and we're very close. So it's good. And the education was, I think, outstanding. Totally underrated, given that I've taught in medical school now fifteen years. They really kicked our butts, but I think we got a lot out of it.

Mullan: So in terms of the Penn State differentiation, it was not in substance so much as it was in reputation.

Bowman: It was style. I think I would have gotten lost at Penn. I think it was style again, because George Harrell had the view of family medicine around which the medical center was built, and the philosophy of the medical center was built.

Mullan: This was Hershey?

Bowman: Yes. And the students were recruited, so that family medicine was their push. We had early patient contact in the first weeks of med school. I got attached to a family my first

week there, and had a preceptor my first week, and was in his office within the first month. So it was really neat. It was really cool to file with family, go with Dr. Bower. It sort of kept you aware of why you were there, kept you in touch with why you're putting up with all the crap. So I loved it. I loved it at Hershey. And I think that we got an outstanding education.

Mullan: How was it to be away from home and familiar haunts?

Bowman: It was fine. It was fine being away from home. I don't think I could have lived at home and have done as well with just the demands of being home.

Mullan: And as you progressed through medical school, what was your thinking about what you wanted to do?

Bowman: I know exactly the minute I decided. I had taken medicine; I liked it. I had taken surgery; I liked it. I did OB; I hated it. I did peds, and I couldn't stand sticking kids. It just took everything out of me to hurt a baby, so it's not going to be peds. I hated psych. I was on a neurology rotation, and there was a gentleman there who was quadriplegic. He had like a C-3,4 fracture. Everybody else was going off about the neurologic lesion, and how the neurologic lesion did this and that, and what he couldn't do. And I wanted to know why he fell. Like, "Oh, he fell and broke his neck." Well, why did he fall? It turned out, nobody had asked the question, "Why did he fall?" He fell because he had had a TIA, a drop attack. So I was going through the differential. Well, was it his diabetes, was it

this, was it that? It's like well, okay, now I'm satisfied. I know why he fell. Now I can get excited about his neurologic lesion. [Laughter] And I said, "Okay, that's it." I was struggling between medicine and surgery, and I said, "Forget it. I'm going into internal medicine." Never thought twice about it.

Mullan: Was family medicine on the scene then?

Bowman: Yeah.

Mullan: How was that at Hershey? Was that ever an issue for you?

Bowman: The family medicine guys were weird. They were just strange. The people that we looked up to were the internists. Graham Jeffries is my idol. He was the chairman of medicine at the time, and he's a gastroenterologist. I got to meet him the first week of med school, and saw the guy in his shorts--in Bermuda shorts, excuse me--because my big sister knew him. We went over to his house, and he took us out to his greenhouse and showed us his plants and stuff, and he gave me a fuschia plant. I kept that plant the whole time I was in med school. I wanted to be like Dr. Graham. I mean, he was so cool. He could go to the bedside and teach on anything, anytime, and make it seem so interesting. And I just wanted to be like him.

Mullan: So what were you thinking then, post-medical school?

Bowman: Internal medicine. Not a university program, because I was sick of the medical center, the intensity of the medical center. I wanted to come back to the city. There weren't a whole bunch of people like me in Hershey.

Mullan: Was that a problem?

Bowman: It wasn't a problem. It just was, you know, people always know who you are. It was hard to be anonymous as an African-American in Hershey at that time. I mean, just going to the grocery store, people would say, "Oh, you must be from the medical school." It's like, "Uh, yeah." [Laughter] You go to the movies, it's like, "Oh, you from the medical center?" "Uh, yeah." So I wanted to be anonymous. I wanted to come back to Philly and I wanted to blend in. I had done a rotation. (SNMA was giving fellowships at that time.)

Mullan: That's the Student National Medical Association program?

Bowman: Yes. I had done two rotations with their fellowship, and went out to Martin Luther King Hospital in Los Angeles. It was wonderful. I mean, it was the first time that the only thing that distinguished me was how well I did what I did, and not because I was different because the color of my skin, which is usually how you stand out, but it was the first time among all minority physicians, or predominantly minority physicians. I was flabbergasted for the first couple weeks I was there. I had a great time.

Mullan: So you did your residency, though, back--

Bowman: Yeah. Here at Einstein Northern Division here in Philly.

Mullan: Was that good?

Bowman: Oh, God. Is any internship or residency good? I mean, you know, they put you through the internship so the rest of your life pales in comparison in terms of the stress and sleep deprivation. It was okay. It was all right. Nothing special. I got through it.

Mullan: What were your perceptions of the specialty versus non-specialty tensions within that program, and what, as you reached the end of it, was occurring in terms of your--

Bowman: The teachers were the specialists. It's hard to look back on that, because people who did general internal medicine weren't in the hospital, they were in their offices. and those are the dreaded LMDs that drop in and interfere on what you and your teaching attendant are trying to do. So I didn't have much of a relationship with community doctors at the hospital. There was only one guy, Sidney Greenstein, who was a generalist, a general internist, I would say. Sidney was one of the brightest guys I've ever met in my life, funny as hell, and just so bright that everybody just sort of had to stop and listen to him when he made rounds. So Sidney was really the only star among the general internists that I recall.

But I toyed with GI, because endoscopy was just being introduced. I went to the library, and I could not get excited about reading about the electrolyte composition of stool. I said, "This isn't it. I can't read the literature. I can't do the fellowship."

Cardiology, that was the second choice. Then I did rheumatology. I did a rheumatology rotation, and I liked it. It was fun. It sort of let me do a little bit of everything. I still had to do endrocine, I still had to do renal, I still had to immunology, hematology. I could do a little bit of everything. So I applied for the fellowship and got it.

Mullan: That was at Einstein?

Bowman: Yes.

Mullan: You did two years there?

Bowman: Yes.

Mullan: And then what? We're up now to 19--

Bowman: 1981. George Erlich was the program director, and he moved. After he left, I was miserable. So he called me up, New Year's Eve, and said, "I have a spot for you at Hahnemann." I said, "Okay, cool. I'll be there." So I quit my fellowship, invoking the wrath of Warren Katz forever. I quit that day and then resumed my fellowship the following day down at Hahnemann. There weren't any jobs in rheumatology, and I was bored with

outpatient rheumatology. I hated outpatient rheumatology. I enjoyed the multisystem disease.

Mullan: Was it mostly arthritides of various sorts?

Bowman: Oh, yeah. It's like the same achey knees three or four times. The same little old lady comes in with a knee fusion to get an injection the day before she goes off to Atlantic City to walk the boardwalk. You get the point. And I was also frustrated because you encounter a lot of systemic disease in the context of rheumatology that has to be addressed. As a consultant, if you want to keep business flowing your way, you send the patient back to their primary care doc, and let them manage those things. And I was frustrated not being able to treat the uncontrolled hypertension, and diagnosing a hypothyroid in a young man with Down's Syndrome who presented with carpal tunnel syndrome. It's like, "Oh yeah, he's hypothyroid and I can't do a darn thing about his hand until you treat his hypothyroidism." I was frustrated not being able--I couldn't find a delicate way to relate back to a primary care physician. I wanted a more holistic or global approach to care. I wanted to be able to take care of people. So I kind of knew I wasn't going to stay in rheumatology, but it was a good place to hide out for two years.

Mullan: So you finished that out, and then?

Bowman: And then the job that was open was in general internal medicine at Hahnemann.

Mullan: And had you wanted to be a teacher?

Bowman: Nope. Total surprise. Sounds like I've lived my life just running from one thing to another.

Mullan: You're not what you might call a strategic planner, but it seems to work.

Bowman: No, I'm not a strategic planner.

Mullan: So how did that come about? What was it like?

Bowman: It was a job open. It was in town; I wanted to stay in town. I applied for it; I got it. And then I started getting excited about medical education. It was a whole new field, and I found out I loved teaching.

Mullan: And what was the job? Who were you teaching?

Bowman: It was a staff position in general internal medicine. I was junior course director for seven years.

Mullan: So it was junior medicine at Hahnemann?

Bowman: Junior medicine rotation. I knew I didn't know anything about it, so I got introduced to the AAMC and LCME, and was on the admissions committee for a long time. It was just a whole new world of stuff. I enjoy it. I still enjoy it. I'm one of those people that used to love getting dressed for graduation and

sitting on the stage and watching the students go by as doctors. You've got a story for each and every one, as junior course director. They all came through your office, one way or the other. So I'm very happy with that experience. I'm really glad I had it.

Mullan: Did you practice during that time, as well?

Bowman: Oh, yeah. It's a very active, clinically active, division. We had four or five patient sessions a week, and made rounds twice a week. Hahnemann is not one of those institutions that traditionally has had the month of service, month off. We were in the hospital fifty weeks out of the year.

Mullan: Was there an ambulatory component, or was that mostly inpatient?

Bowman: We did both. We did inpatient rounds. I did inpatient rounds twice a week, and I saw patients two half-days in the clinic and three half-days in the faculty private practice.

Mullan: Was there a publishing imperative for that?

Bowman: That's why I'm not there. If I have any regrets about my career, it's that, that the whole idea was given to us that, no, we didn't really need to do that, but then the rules changed and AHERF (Allegheny Health Education and Research Foundation) swallowed up Hahnemann, so the rules of the game now are traditional rules for academia. You've got to have a portfolio.

So I knew about five years ago I was going to have to start looking elsewhere.

Mullan: In terms of your teaching, during the mid- to late-eighties when the generalist flag was perhaps at lowest mast, people were, at least in terms of general statistics, not using primary care in legion numbers. Was that something you were aware of? Was that an issue about where kids were headed, and what their perspectives were?

Bowman: It was an issue, but--my life at Hahnemann is broken up into fourths now. In the first five years, I was there full time. Things got really crazy at Hahnemann--changes in leadership, blah, blah, blah, and I was miserable. So I went to work at Health America, which was a staff model HMO.

Mullan: This was when?

Bowman: This was in 1985.

Mullan: This was part-time?

Bowman: The deal that I had was that Health America paid me full time, and Hahnemann bought back half of my time to do the same job that I had been doing as course director. So I worked half time in the staff model HMO. I had five patient sessions at Health America. I took call with the staff. I did Saturday office hours, two hospitals kind of stuff. Four half-days I worked at Hahnemann, doing the course administration. That was

when I developed my interest in managed care, obviously. So I walked in the door, and I said, "I don't have a clue."

Mullan: You walked in the door at Health America?

Bowman: Right. And this is after five years of practicing in a university faculty practicing clinic. I still didn't have a clue. I had to put pregnancy back in my differential diagnosis of abdominal pain, because that's just not kind of the patient that you see, at that time, in a university faculty practice. You know, Bell's palsy. A guy walks in from work and says, "My face doesn't move." It's like, "Oh, wow." That was all fresh stuff. Concurrent utilization. We were doing peer review of our consults. On Friday afternoons, we would all meet and say, "Why do you really need this bone scan?" And if you defended well to your peers, you got it. If you didn't, then you'd have to come up with another strategy, because we all sat at the table together and went through the referrals.

Mullan: This was in staff model HMO?

Bowman: Yes.

Mullan: A good one, well run?

Bowman: I thought it was good and well run, but it got bought out by Maxicare, and Maxicare went bankrupt.

Mullan: And what sort of patient population?

Bowman: Urban. It was right down the street from Hahnemann, so we had a mixed bag of folks, people who lived in north Philadelphia, people who worked in Center City, so we had a real cross-section.

[Begin Tape 1, Side 2]

Mullan: This is Sallyann Bowman, Side B, continued.

Did you have any sense, either as you approached it or as you got in to Health America, that managed care was something that you liked, or was a new direction for you, or was it just happenstance?

Bowman: It was structured; it wasn't happenstance. I really didn't want to leave my student activities. I looked for a way to still keep close to that, and this group had been a part of the hospital. The group was on the medical staff of the hospital. It was two blocks away. The structure of the HMO, in terms of the compensation, was attractive. I knew one or two of the people who worked in the group, and they were good. They weren't castaways. They were good docs. Board certification was one of the requirements to be eligible for the position. I liked that. It was a multi-specialty group. You had pediatricians and obstetricians in the office, and I liked that. It wasn't one that I fell into.

Mullan: You said there were four stages, and this is stage two?

Bowman: That was stage two. While I was there, once I got over my own culture shock personally, I said, "This is cool stuff, and we're not teaching it. We need to teach it." So that's when I started my education about managed care. What is it? How do you do it? And then being so that I could teach it.

This was '86 or '87 that we developed a module of managed care for sophomore students, and workshop, and presented that one at the AAMC. I had a lot of fun with it, I really did. We developed patient problems, mostly around choosing health insurance, for second- and third-year students. They weren't clinical problems at that time. I took the same materials that we give employees to make their choices about health insurance. It included commercial Blue Cross and one or two HMOs. One was a staff model, one was an IPA. There were two different families. We'd say, "Here's family A, here's family B. You've got thirty minutes to choose a health insurance plan."

It was always amazing how students made their choices. They had their consumer hats on, of course, because that's all they have at that point. It was very interesting that the relationship with the doctor was at the bottom of the list of the things that medical students use to make decisions about insurance coverage. The first was affordability. One family was a hospital executive, and the other family was a hospital janitor with a sick wife. So they chose the HMO for the hospital janitor, and they chose commercial Blue Cross for the hospital executive.

We changed the cases around a lot. I changed the cases around to sort of tweak them a little bit to see which way they would go. But it generally went down to finances first.

Accessibility, second. Where was the office? How easy was the office to get to when I gave the hospital executive a kid with asthma. About half of the class started to choose one of the HMOs when the kid developed asthma, because there was an enhanced pharmacy benefit. But the relationship with the doc was the last thing.

So that's when I started learning about managed care, and there wasn't a whole bunch. There are books here and there, and it's mostly about Kaiser. David Nash's book came along, and we incorporated that into the workload just for the structure of HMOs. And then I started realizing, "Wait a minute. This is much bigger than a staff group model, IPA, and stuff."

Around that time, the penetration of IPA model HMOs was starting to increase in Philadelphia. U.S. Healthcare came to town in the middle eighties, and everybody ignored them at first. ha. Little did we know the juggernaut that had started. But U.S. Healthcare had just arrived. Penetration was about 10 percent. It was no big deal. You could ignore it and get around it. The Blues didn't even have an HMO initially.

So a lot of what I'd learned, I'd learned through the newspaper, through the *Wall Street Journal*, through the *New York Times*, in terms of what was happening around the country, in terms of health care delivery; what was happening in Congress, when compared to health care delivery; what employers were saying about the cost of health care. That's where the debate was. The debate still isn't in the medical literature. The driving forces are coming from society, as a whole, for what it's going to look like, and it was then.

So in 1989, Allen Adler had applied for a HRSA training grant for primary care internal medicine, and he asked me if I wanted to come back full time, to develop that and put it together. I said, "Absolutely," because it was the first time that my experience, both clinically, academically, and pedagogically, came together. I had actually done it. I had done the primary care thing, was doing the primary care thing, taking these damn calls at two o'clock in the morning. Back pain for the last two weeks. Rounding in two hospitals, Saturday office hours, the whole bit, and had enhanced my skills, had a sense of what skills are needed in order to put a program together. So I went back full-time at Hahnemann in order to do that, and I loved it, absolutely loved it. You can send the word back to HRSA for me that the year that they decided to take a bye on training program funding was the death knell for the program, and it was not enough time.

Mullan: To build something else to support it?

Bowman: That's right. It's a sea change to change mentality from traditional training to a generalist focus. The first year, I spent more time talking to specialists and trying to explain that just giving me the syllabus that you give to every other student who comes through your rotation in dermatology doesn't mean that this is going to be appropriate in a primary care setting. And to allergists, similarly, "No, I don't really want them to know about every bizarre immunodeficiency in the world, but could you please spend some time on making rational choices among antihistamines?"

The first two years were really spent doing the legwork with the specialist faculty to tailor a primary care curriculum for the residents. There's not enough time in a four-year granting period. It takes six to make a real change, six steps. People leave, they come and go, the residents come and go, and you need to build a culture, and that takes longer time.

Mullan: This was a faculty development grant?

Bowman: No, this was a HRSA training grant.

Mullan: So this was stage three?

Bowman: Yes.

Mullan: And this was '89 to--

Bowman: '89 to '94. I had a great time, I really did. I loved the residents. I still keep in touch with a couple of them. We had a lot of fun together developing new projects. I got them involved in development, and they would come up and they would say, "Oh, that's not a primary care focus." I'd say, "Okay, journal club. I'll let you pick it. All right, let's talk about warfarin dosing. How are we doing that? Let's talk about this, let's talk about that."

"Oh, Dr. Bowman, you know what we really ought to be doing?"

So I'd say, "All right, fine. We'll do it." So I had a great time.

I ran into one of the first residents at the ACP meeting. This woman walked by, and I looked up at her, and it's like "Oh, God, she looks familiar."

She said, "Oh, Dr. Bowman, Janice Ryden." And she stayed in general internal medicine. She's at the old Frances Scott Key. I think it's Bayview now. That was one of the most gratifying experiences.

Mullan: That was developing a general internal medicine residency, which had not existed as such before?

Bowman: Yep. Right. Defining it.

Mullan: And when the grant ended?

Bowman: When the grant ended, it killed it, yes.

Mullan: So there is no generalist residency program?

Bowman: No, there's a remnant. There's a remnant of it, and the focus has been to shift to more office-based experience; but that's not what it's about. Generalists in primary care are not synonymous with ambulatory. To make sure that the psychosocial issues were included, to make sure that the curricular content included generalist-focus topics, it took a specific effort to do that. To fight the tide of the specialist bent, you've got to have somebody that is constantly looking to bring generalist relevance to the curriculum that's presented, to go out and to

find quality training experiences, and not just a place to stick a student or a resident.

Mullan: The lesion within the school was what? With four years of external funding, with the purpose of developing a generalist, or recultivating the generalist base within a medicine department, and yet when external funding goes away, the department continues on its merry balkanized specialist way. What is the problem there?

Bowman: Leadership.

Mullan: Which was non-belief in the leadership? It was not committed?

Bowman: Leadership was not committed to a generalist focus. The leadership in the department was not committed to a generalist focus.

Mullan: Was the notion of a kind of holding company department with all the specialties within that company, that was a comfortable vision and remained so for the leadership in the department?

Bowman: Well, there's new leadership. Jeffrey Glassroth was the new chairman, and I think he has--

Mullan: There have been a lot of changes, too. Is that what it is?

Bowman: Yes, yes.

Mullan: So from at least that point, it didn't come to rest, or didn't invade the basic thinking of the department sufficiently to carry itself on.

Bowman: No. But let me be fair, that I think a change occurred. There was a change in the culture. More residents are choosing general internal medicine out of the program. It's not just because they didn't get fellowships. They're declaring their intent for primary care in internal medicine in their second year, and sticking with it. The RRC has demanded that ambulatory time be increased, so that has encouraged people to take more ambulatory-like experiences in doing their sub-specialties. And simultaneous with this, I think the announcement of the generalist grant came around 1990, '91, somewhere in there, '91, '92. So in there, that also helped to keep the fire burning.

Mullan: This is the Robert Wood Johnson grant.

Bowman: Yes. The Robert Wood Johnson announcement came out during that time. So there was a movement to keep the word out there that this is important, and it gave credibility to generalism, and the idea and practice of generalism. But I don't think it's enough to change habits.

Mullan: This was phase three for you?

Bowman: Yep. That was phase three. As the grant died, Hahnemann was going through cataclysmic change. Allen Adler, who was the program director, and the division director, my boss, left, and I was left with Allen B. Schwartz, a nephrologist who likes to call himself a generalist.

Mullan: There was a Division of General Internal Medicine?

Bowman: Oh, there is. There still is. And Allen B., the nephrologist, was named acting chair and division director of general internal medicine, and he was the liaison to the generalist initiative for the department. Also I realized that the lack of publishing was catching up to me, and that I was going to need to make a professional career change, because I would not have viability as a chair, or as a division director, or section chief, just because my CV was too light. So I knew that I would probably be looking at a managed care company, or hospital administration, or group medical directorship, as my next step.

I haven't talked too much about the practice of medicine. I've talked about the other stuff. There still isn't anything I'd rather do with my clothes on than make a good diagnosis. I love it. I love all aspects of it. I've enjoyed every minute of being a general internist. I love being able to dabble in a little of this and a little of that, read a good cardiogram better than the cardiologist, or suggest a diagnosis and actually see it through. Just like the other day in the office, the intern was presenting a case to me. He said, "This guy was seen here the other day by one of the other faculty or the resident,

and he's got a node behind his ear, and they were thinking that it's toxoplasmosis."

And I said, "What? Did you look in his ear?"

He goes, "No."

I said, "Go look in his ear."

And he came back with the biggest grin on his face. He said, "He's got the biggest wax impaction you've ever seen!"

And I said, "Great. You want to lavage him? Go ahead." He took a plug out like this, and it looks like he's got an abscess in the post-auricular area.

But I mean, that's fine. The downside of it is that the university practice is less and less satisfying in large doses, and it's less and less satisfying because people are so sick. Oh, God. People at university hospital, at least Hahnemann, are so sick. They are desperately ill, in so many ways--physically, spiritually, economically. By the time anybody lands in the hospital, they're desperate. And it's very taxing and demanding. The way I do it, I don't hold back when I'm there, and, I guess, also being a woman, people want to talk to you, so I end up spending an awful lot of time listening to people and letting them express their concerns or tell me their stories, or try to answer their questions. I enjoy that, but it's taxing physically. I've kind of consciously put some distance between myself and all-out clinical practice just because I would burn out.

Mullan: It sounds like that had to do with the next transition, the transition to here. Before we do that--and I'm anxious to get to that--let's drop back. As you said, we haven't touched on

the personal side at all. Tell me a little bit about you. I mean, beyond the French horn. We got that one, but after that, we haven't focused at all in terms of your life, connections, family.

Bowman: Well, I'm gay, and my partner and I have been together for twelve and a half years. Those guys up there. Brett is nineteen. He's a sophomore at East Stroudsburg. Kyle is--

Mullan: This is who?

Bowman: Brett's the one on the left. No, no. See the little picture of the two guys? Okay. That's Donna and I.

Mullan: Gotcha.

Bowman: And the picture above, Brett's on the left, Kyle's on the right. Same in the other picture. That's them. Kyle's the bald one.

Mullan: They are her natural kids?

Bowman: Yes. They're her children from her marriage. So we've been together for twelve and a half years. I don't know what I would do without her.

Mullan: So have the kids grown up with you?

Bowman: Yes.

Mullan: And how old are they?

Bowman: Seventeen and nineteen. Actually, eighteen yesterday, and nineteen and a half. Brett will be twenty in September. So life for the last twelve years had been kids every other weekend, kids two weeks in the summer. Basic ADLs. For awhile we had two Great Danes. Right now, we have one.

Mullan: The rest of the time they spend with their father?

Bowman: Yes. He lives about fifteen minutes away.

Mullan: Decent relationship?

It was an amicable divorce. Donna was still with her husband when we got together, unfortunately, and they divorced shortly thereafter, and we've been together ever since.

Mullan: And what does she do?

Bowman: She's a pediatric OR nurse.

Mullan: In the area?

Bowman: Yes. At Saint Christopher's Hospital.

Mullan: So you do a bit of parenting.

Bowman: Yes, yes, a bit.

Mullan: Are the boys launched, at least the older one?

Bowman: No, no. They're not launched. Are you kidding? I mean, they're coming home how. Brett's going to probably live with us for the summer while he works in between school years. Kyle is not sure what he's going to do for the summer. They don't have a real good relationship with their stepmom. We have a huge house, because we anticipated that when and if we ever needed the space, we'd have the space. It's perfectly fine if they come back to stay. They just have to get jobs and contribute. You have to contribute.

They're good kids. They're funny. I think they're exceptionally nice men, even if I say so myself. I think they're caring, sensitive people. I think they have balanced values about the world. They could have done a whole lot better academically than they've done, but then again, you can't have it. They're jocks. Kyle wants a baseball career, and Brett plays volleyball. I'm working on Brett. I think he's going to go to medical school. He's not declared that yet. He just talks about going to PT school, but he keeps asking me questions about medicine, and I answer them. I don't pump him.

I've never taken either one of them to the hospital or to the office with me. They've never asked to go, either. I've never put on a white coat, and "Let's go play doctor" kind of stuff. But I think they see enough of the good things and the bad things about being a doctor at home. You're always late for dinner, and you're usually tired. Phone rings all night. But on the other hand, you get a kick out of when you make a good diagnosis, you're really pumped up, and you like what you do. I

think it's hard for doctors' kids to naturally gravitate to medicine.

Mullan: Being a gay woman in this time when both gayness and feminism have become more visible--I was going to say, "more acceptable," but I suppose that's arguable--how has that been for you?

Bowman: Well, I came out late in life. I was 31.

Mullan: Had you been active before?

Bowman: No. I had strictly heterosexual relationships throughout my twenties. I enjoyed heterosexual relationships. I was in between boyfriends, and I kind of said, "I'm not turning down a date." I'd been celibate for over a year, and I just said, "I don't care." [Laughter] It's not like that--again, funny things happen to me. It was a little more deliberate than that. And being 31, I was already in my career at that point. I didn't have the threats of exposure that younger gays and lesbians think about in medical school and in college and high school. I didn't have to go through that.

And then, as I said, I got radical when my best friend was diagnosed with HIV. John is as close to a soulmate as I've ever had. I was just so angry, and I'm still angry, at whatever it was that made him feel bad about himself, and not proud of himself. It's homophobia. I don't know another word to describe it.

Mullan: He felt bad about himself to begin with, or when he was diagnosed?

Bowman: Because he was a gay man.

Mullan: Just in general.

Bowman: John felt bad about himself as a gay man. And I think because he felt bad about himself, he took risks that he shouldn't have taken. I mean, John was the most monogamous man in his heart and mind. That was his desire, but he would never have thought to have brought a male partner home to his family. That would have crushed them. He wouldn't have been the one to do that. Even if he said, "I love this person with all my heart and soul," he was so afraid of his family's rejection. It's not that I'm blaming anybody for chances that John took in and for himself. Those are just chances that he took. There was an epidemic that he happened to come in contact him. But I was so angry at that. His disease politicized me as a lesbian.

Mullan: When was this?

Bowman: This was '87, '88.

Mullan: And he died?

Bowman: Yes.

Mullan: That's not Jose Alvarez?

Bowman: No, no. That's a patient. John died in 1991. Yeah, same year as my grandmother. I think we knew that he was positive for a long time, but he didn't really get tested until 1989 or so. Knowing that he was probably positive, and I'm now out, that made me say, "I'm never going to be ashamed of who I am. I'm never going to be ashamed of who I love." That was one thing that politicized me.

The other thing that happened was in 1988. Donna and I had been together three years, four years at that time. I had a retroperitoneal bleed. I had an angioma in my right kidney.

Mullan: Boy, oh boy, oh boy.

Bowman: Yeah. It ruptured acutely and I never knew I had it. I went into shock, got rushed to the hospital. Five units of blood and a nephrectomy later, I'm doing fine, by the way. But that night, that experience, and the look in Donna's eyes as I got wheeled into the operating room, I mean, if she could've yanked me back from hell, she would have. After that, it was, "I don't care. This is my family. This is the woman I love, and I don't care what other people think." Who was there to take care of me? It's her. And so that politicized me, too.

It was also kind of--it threw me. I was never really closeted--I think Rita Mae Brown had a term, "The closet door is open for anyone who wants to see." I was never really closeted, never denied it at work, but that event made it clear to the chairman, it made it clear to everyone that I worked with, that Donna was conducting business for me. She was my support person. She was my significant other. And I had only positive

experiences around that. So that was really heartening, that people came forward to help her and to help me that I never expected would have done so.

Then I got really political because of my affiliation with the lesbian doctors' group. A friend of mine from med school kind of got that started about fourteen years ago.

Mullan: Physicians for Human Rights?

Bowman: American Association of Physicians for Human Rights. It sponsors a lesbian doctors' meeting every year. So this year was the thirteenth. So I've been to all but four, and I ran the '93 the year that we were in Washington. That threw me out a little bit more, too, because the *ACP Observer* interviewed me. So every internist in town, homophobe or no, read it. So it's like, "Oh, yeah, hi. I'm the same gal you've always known and loved. There's no problem. What's different about me now?" [Laughter]

Mullan: How was your family about the relationship?

Bowman: My dad wasn't real thrilled. We had a little tiff over that, but we healed it before he passed away. My mom wasn't real thrilled initially. I think she was more afraid of me adopting a stereotypical diesel dyke, bike-riding, nipple-piercing individual. I've assured her that I'm a paragon of domesticity, that she's okay now. She keeps saying, "How long have you guys been together?" It's like, "Twelve years." "Has it been that long?" "Yes, Mother. It's been that long." "Oh, Donna is such a nice girl." It's like, "Okay. Thank you."

My 91-year-old grandmother--Grandma was 91 when she died--but Grandma never asked questions. My grandmother was not an unsophisticated woman. She was rather worldly. She loved Donna. She loved the boys. We did Christmas, Thanksgiving dinners, and traded off with my brother's family. It was very comfortable. Grandma would come up, have a martini, and play pinochle on a Sunday afternoon. "How long have you been together now?" "Ten years, Grandma."

My brother wasn't real thrilled. My brother's a traditional black man, and he's also a racist. So Donna he has some problems with. We got to talk about that last year. He was mad with me because he heard about my being gay from other people before he heard it from me. I understand where that comes from. That's straight from my mother's mouth, that she always wanted us to make sure that we informed her, and wanted us to be open and honest with her, because she didn't want to hear it from outside. "No matter how bad it is, you can always tell me. I may not always like it, but you can tell me." I think that's why my brother was upset with me.

Mullan: How about professionally? Has it thrown any--

Bowman: Monkey wrenches?

Mullan: Yeah. Or any slings or arrows at you?

Bowman: None that you could ever identify and cash in on in a discrimination suit.

Mullan: But you think it happens?

Bowman: Yes.

Mullan: In what way?

Bowman: I'm very controversial.

Mullan: Is that in terms of employment opportunities or honorific opportunities? Is it materially? I know it's hard in anyone's life to figure out why chips fall one way or another, but do you have any sense that you've actually lost out on opportunities because of it?

Bowman: Well, I certainly know of opportunities where other women have won out. I know of other opportunities where other black women I've competed against, and I certainly know that my CV, in many areas, is stronger than some of the candidates that I've competed with.

There was only one person who was blatant enough to tell me to my face that he would never--I was looking into a practice opportunity. This was a black guy. I said, "By the way, you need to know that I'm gay, and my lover's white." Just because he's in a private practice. I was looking to join his private practice. He pushed back from the table, and he said, as far as he was concerned, I had died, and that he didn't want people to know that he would be affiliated with me, and that ended the discussion. So to say, "Do I think?" Yeah.

Mullan: I very much appreciate your sharing this with me, and whatever you're comfortable with, we'll leave in, and whatever you want, we can take out.

Time is short. Let's jump back to Health Partners, which I gather is phase four, and current one, and in some ways, the pith of what I want to get at in terms of managed care, primary care, and the role in this community. Why don't you take me quickly into that phase four.

Bowman: Health Partners. I came to Health Partners in November 1994. I'm medical director for quality improvement. I do QI, I do credentialing. Those are my major jobs, but I do pretty much whatever Richard needs me to do.

Mullan: Richard being medical director?

Bowman: Yeah. He's the senior vice president for medical affairs.

Mullan: Step back. Tell me a little bit about Health Partners. What sort of organization is it?

Bowman: It's a not-for-profit IPA. The seven owners are seven teaching hospitals: University of Pennsylvania, Albert Einstein Medical Center, Temple, MCP, Episcopal, etc., etc. We have seventeen or so other affiliated institutions with various degrees of risk. We have 87,000 members at this point.

Mullan: Which makes you in the--

Bowman: About number four. Three or four. U.S. Healthcare, Keystone, Mercy, then us. We are under contract with the Department of Welfare to do managed care for medical assistance recipients.

Mullan: Were you with [unclear] an early player in Medicaid managed care?

Bowman: Health Pass was an HIO. It was a mandatory program in southwest Philadelphia. Health Partners was the second medical systems managed care plan in town that was voluntary. It was an effort on the part of Temple, MCP, Einstein, and Episcopal to maintain market share in north Philadelphia. So it got started with a grant from RWJ [Robert Wood Johnson].

Mullan: Health Partners did?

Bowman: Yes.

Mullan: And that was ten years ago?

Bowman: Yes. Well, eleven years ago. Eleven years ago, because the company is now eleven years old.

Mullan: The focus then being to do Medicaid/Medicare?

Bowman: Medicaid.

Mullan: And as it has developed, is it exclusively Medicaid?

Bowman: Well, now that we're independently licensed, it can't be. We have to have 25 percent of our business--there's a 75-25 rule. If you have 75 percent government programs, we have to have 25 percent that's not government-funded. So we have a small commercial product right now. It's unclear how much development we're going to add to that. It doesn't look like that we intend to market against the big players. More than likely, we will pick up the CHIPS program, that's more consistent with--

Mullan: CHIPS?

Bowman: That's the Children's Health Insurance Program in Pennsylvania, for underinsured kids. They don't quite qualify for medical assistance, but they still are underinsured, so the state supplements. I think it's from lottery funds or something.

Mullan: And so currently about 75 percent of your covered lives are under the managed medical assistance program?

Bowman: Well, it's more like 80 to 90. We're building to 25.

Mullan: Tell me a little more about why the seven teaching hospitals got into the business, and why they've stayed in the business.

Bowman: They got into the business because Health Pass had come in as the Medicaid Demonstration Project in west Philadelphia. And I think they started getting nervous about losing patients, when it became clear that--

Mullan: Because they were heavily involved with Medicaid? Medicaid was an important portion of their patient population?

Bowman: Right. Right. So they thought that the handwriting was on the wall for mandatory managed care, seeing what happened, that if you qualified for MA in that geographic area, you had to be in Health Pass. And if they didn't do something, they were afraid that they wouldn't have any business.

Mullan: And that, with a little assist from Robert Wood Johnson, got them in the business? And how has it been as a business?

Bowman: Richard's byline is, "No margin, no mission." So we're staying afloat financially, and we haven't sustained losses. We've had some cutbacks since being independent, but we're still hanging in there. We're actually doing well. We came in under the Keystone, under the HMO license, the Blue Cross HMOs, and went independent, bought an HMO license in 1985, in April, and then got NCQA-accredited the same year, which was a stretch.

Mullan: Tell me about your network. What's the physician component like?

Bowman: We have 87,077, and how many primary care sites? Three hundred primary care sites.

Mullan: So 87,077 is number of patients?

Bowman: That's the number of patients. We have about 2,700 providers in the provider database. Of that 2,700, you well imagine that the greatest bulk is specialist of one variety or another. We have 370 or so primary care sites, and about 670 to 700 primary care physicians that are credentialed with us.

Mullan: All of those, both generalists and specialists, are not dedicated in the sense that they are a full-time equivalent?

Bowman: No, no. These are all private offices. These are all private offices, privately owned or hospital-based practices.

Mullan: These are physicians affiliated with you, who may see a full day's worth of your patients, or no patients, from week to week? (Asie: Health Partners may be just a fraction of the total patient load for any given office. Most offices have three or more managed care affiliations, FFS, Medicare, etc.)

Bowman: Yeah. For each site, we have various numbers of patients enrolled at a primary care practice site.

Mullan: So all of your patients have a primary care site they're attached to, and that's where they get their principal care?

Bowman: Yes. And the patients choose their primary care physician, and they choose the hospital at which they want to receive their care.

Mullan: And that would be the seven hospitals that are in the med schools?

Bowman: Yes.

Mullan: And the primary care providers, how do they break between internists, pediatricians, family docs?

Bowman: Since every one of the university hospitals is in our system, you might well imagine that 50 percent of our primary care docs are internists. Philadelphia is not a big family practice town. We have board-certified and family medicine-trained family practitioners. They're probably about 25 percent to 30 percent of the PCP pool. The remainder break out to be physicians who have done various mixes of training. They did a year of residency in anesthesia twenty years ago, and now hung up a shingle, and they're a general practitioner.

The committee fought bitterly over the CT surgeon who now insisted that he could practice primary care, but because he was employed by one of the owner hospitals, we made an arrangement to oversee his retraining. So it's about 25, 30 percent family practitioners, and the rest are general practitioners.

Mullan: The two tracks here that crisscross--that is, generalism and managed care--and particularly in an IPA, where physicians are poaching in this kind of hybrid fashion, pursuing the managed care side of things for a moment, not only about your generalists, but about your specialists as well, as you see the marketplace and the practice world evolving, with managed care

being a growingly important player, what's happening out there? What is happening with physicians, in terms of how they respond?

Bowman: They're scared. They're scared, they're confused, and they're undertrained. Remember, ten years ago, people were outrightly resistant to managed care. They were angry and indifferent. Now they're very resigned to managed care, and it's like, "Just tell me what you want me to do." They're not ready for the demands of managed care. They don't have the skills. But then again, I'm dealing with a Medicaid population, and there are totally different issues.

Mullan: In what sense?

Bowman: I'll use access as an example; access and availability of appointments. A lot of the practices are in desperate communities. They've been walk-in practices forever. We come in and we say, "Patients need to have appointments."

[Begin Tape 2, Side 1]

Mullan: Bowman, tape three.

You come in and say, "Patients need appointments."

Bowman: Yeah. We come in and say it's one of our standards that patients have to have the availability of appointments. If we think that preventive care is important, and getting people to pay attention to preventive care issues and appropriate ongoing care of chronic conditions, then you have to tell them, "I'll see

you back in a month, and let's talk about your mammogram, and this, that, and the other at the next visit." Well, if people just walk in for episodic care, you can never establish that kind of rapport and relationship.

Mullan: So the kind of fragmented care typical of poor populations and Medicaid mills doesn't mix with ethos and business requirements--clinical, but certainly business requirements--of managed care?

Bowman: But it's a business requirement because it's a care requirement, because it's good care. Family charts. Some people have spoken about, "Family charts are important in family practice." That's true, but when you have fractured families that the kid is living with Grandma this month and is living with whoever next year, we need to have an individual chart, an individual patient record, that can go with that patient wherever they are. Just trying to reinforce to docs that it's not acceptable to do it on three-by-five cards anymore. You would think you shouldn't have to do that in 1996, but it's almost a different--it's not quite Third World, but it's Two-and-a-Half world in some of the practices that we go into. It really is. The medicine that's practiced in the communities we serve, one thing I'm convinced of about this organization is that we are truly an advocate for the patient, and for the member. I know that we're giving them a voice that they would not have. People would walk away from their offices on weekends, or at night, and put an answering machine on, and of course people can't do anything but go to the emergency room when they have a problem.

Or they have no answering machine. We come in and say, "That's not acceptable. If you have an answering machine, it's got to be picked up. No, you can't just shut the door and go home to the suburbs over the weekend. That's not what we want."

Mullan: Are you able to modify that behavior?

Bowman: We either modify it or we don't take them, or we don't have them for long.

Mullan: So that the kind of managed care, Medicaid managed care, I would gather from what you're telling me that the presence of a managed care operation brings some discipline and some accountability to the panel of physicians that wasn't there before.

Bowman: Yes.

Mullan: Characterize that a little more. I mean, you must have people who fall by the wayside, who don't heel, who don't respond.

Bowman: Well, we're committed to a quality improvement model, which means that you try to fix it. I've spent my morning this morning visiting with a doctor who has had some problems, and we've been working with him. Luckily, he's shown improvement, and that's the whole goal.

The goal is not to kick people out. The goal is to make sure that the care that the members get is what they deserve to

have. We're not trying to kick people out. But we have kicked people out. One doctor refused to do lead testing in a north Philadelphia practice. After working with the doctor two years, he still is adamantly refusing. He was not doing well in other measured parameters, either, and that was just one other thing. He was terminated.

We have one doc that just recently resigned in the face of being terminated, who has some funky prescribing patterns, and when we looked at his charts, the care was kind of all over the place. We have a third person who is currently appealing her termination. Her handwriting is absolutely illegible. We can't read it. The state auditors came in directly, "Can't read it." We've told her for three years, "Type your notes so we can read it. How can I tell if you're doing the right thing?" And then when we were able to read some of it, there were medical mistakes, and so we started getting--when that flag goes off that you've got concerns about the quality of care, you kind of have an obligation to do something about it. But those are three examples in the ten years of the company's existence, and those are the only three people who were terminated.

Mullan: With apologies for not knowing the business at all and coming in with a kind of off-the-cuff thing, that doesn't sound like much.

Bowman: No, it's not.

Mullan: Is that because the brand of medicine practiced in the community is acceptable, or because you haven't had the wherewithal yet to really make the kind of changes you need?

Bowman: No. I think we have very strict standards coming in, and a lot of people don't make the cut coming in. If they don't have the facility, if they don't have a chart audit that even looks like it's close to meeting our standards, then it's easier not to let someone in than it is to try to kick them out. And also to be fair to the provider, there are no recording requirements to the National Practitioner Databank, if you don't take someone on, but there are clearly reporting requirements if someone is thrown out.

Mullan: In regard to the training, or the attitude, or the wherewithal that primary care managed care providers have, if you listen to the leaders from such places as the Harvard Community Health Plan, they'll talk about the need to retrain even recently well-trained folks, because they don't have the mind-set and the wherewithal to practice good managed care. That strikes me as a somewhat ivory-tower approach to the real world of a community where docs of all ages and all training are part of your complement of physicians. How do you square the very articulate, well-argued rationale that you need special training to be a sharp managed care provider, to working with folks whose, sometimes, handwriting you can't even read?

Bowman: God bless Harvard because they've got the resources that they have, and that they can set the standard and lead the edge

on the outcomes research that needs to be done in an ambulatory care center. We're light-years away from being able to do that in the community.

I don't believe that managed care is a separate discipline. I believe that managed care is a layer of clinical practice that you do simultaneously with your care of the patient. It's an environment in which you care for the patient. To practice good managed care, it's good medical care. It's not too much and it's not too little. Hopefully, in the right managed care environment, you're doing it with more information at your fingertips than you ever had before, about your performance. You have information on the prescribing patterns that you never had before; you have information on your financial utilization that you've never had before; on your hospital bed days and those kinds of things, that you never had before; on the quality of care that you practice, compared to your peers; how many immunizations--age-appropriate and disease-appropriate immunizations--in your practice versus someone in a practice just like yours, so that you can't say, "Well, that doesn't apply to me." I think that that enhances your ability to practice good medicine.

I guess what Harvard is trying to say, though, is that the skills of dealing with concurrent and prospective utilization, you've got to get used to that, you've got to learn it somewhere. Acquiring and knowing how to apply quality assurance and quality improvement techniques to clinical practice is a skill that you have to learn somewhere. But does everybody have to learn how to do it, or do we need people who can practice in that environment? The administrators, the medical directors need to know how to do

it. Physician leaders and managers need to know how to do it. I don't think every practitioner needs to know how to do it. They need to know what it is.

Mullan: If you listen on another level, community health center apologists, or leaders, will say that the full boat of offerings at a well-funded community health center, including culturally-appropriate care, transportation, nutrition, etc., that ought to be offered to low-income populations who have got an extraordinary set of problems, is not going to be fulfilled by Medicaid, or low-income patients being seen in private practitioners' offices, gotten there through [unclear] managed care. Isn't that true?

Bowman: Yeah. But the good part about managed care is that you have a whole battery of people that are available behind the company. That private practitioner can call in to our Provider Hotline, and we have a case management department that's here. They have people here that can help them access resources. We have expanded benefits that are not available under routine, or fee-for-service medical assistance, that even the community health centers don't have access to.

Mullan: And those are available?

Bowman: We make them available. That's the margin. That becomes the mission that the margin funds for us. The guy at the community health center saw a baby with flea bites. They had already taken the cat out of the house, but the kid's been in

three times with flea bites. He calls us up and says, "I need the place fumigated." No, medical assistance doesn't have a fee schedule for an exterminator. Of course they don't. But it made common sense for us to pay the bill for the exterminator. And that's the kind of thing that I think an MA managed care plan can do.

Mullan: Is that an anecdote or is that modus operandi?

Bowman: No. That's daily working operations around here.

Mullan: Going to back to the primary care scheme, as you've seen the concept of primary care evolve over the last fifteen years, with the much greater prominence it has now, and as it is now married with the new form of paying for care called managed care, what do you see as the importance and trajectory of primary care?

Bowman: We'll talk about this in the car. We may have to continue this in the car. Trajectory. I don't know if I can answer that question. I think that what managed care has done for primary care--and I define primary care as first-level, coordinated, comprehensive medical services. I accept that definition, so it doesn't matter to me if it's an FP or internist or pediatrician. It's placed a value on primary care. It needs to place a higher value on primary care, and it needs to financially devalue specialist services more than it already has. Managed care speaks with forked tongue when it says, "Primary care is important," and then pays shit for capitation.

Mullan: And continues to reward specialists.

Bowman: And continues to reward specialists. Managed care, done well, does not deny access. Managed care, done well, appropriately utilizes resources. And I think that's a good thing. I think you should be looking over your shoulder about certain elective procedures. We should have been looking at second opinions for hysterectomies and things like that a long time ago. I know that a lot of the changes that have happened in the practice of medicine have happened purely because the managed care companies changed how they pay for care. Same-day caths as a prime example. Pre-admit the night before, stay the night you have the procedure, go home day three, was the cardiologists' standard for doing a cardiac cath. Well, guess what? Medicare and managed care said, "We're not going to pay for that." So, glory be, it's safe to bring them in the same day. [Laughter]

For primary care, though, it expands the range of skills that you have to have. And I don't think this is managed care. I think this is the influence of financing of health care on health delivery and our lack of readiness for it. Do I know what I need to know to get that cath patient ready to go in that same day? Do I know what I need to know in case the patient comes to me, if they develop fever bleeding, or pain at the site the day after, when they send them home early? Because your name's on the card, you're going to be the first one that they call. If no other thing happens, that card gives them the access to you, and I don't think that we're always ready with the problem-solving skills, not always answers, but with the skills to find the answers when the problems happen at the fringes of medical care.

If someone is on a routine insurance and they call the cardiologist directly, that's great. But in managed care, we say, "You call your primary care physician if you have a problem." And I don't know that we're always ready to get through to the specialists, to know which specialists to get to. How do you access an ambulance at two o'clock in the morning when somebody needs something? Communicating information to the appropriate specialist is a totally different skill than it used to be. Those are all new roles that managed care has introduced. It's all good, though. These are things we should have been doing.

Mullan: You're enthusiastic about it as a reform for the system?

Bowman: Yeah. I mean, we should have been following our patients as they access specialists, and communicating information to the cardiologist and the gastroenterologist and the nephrologist, as they go in and out of the health care system. Of course we should have been there, but, you know, we dropped out somehow.

Mullan: The fee-for-service system did not reinforce that?

Bowman: No, it doesn't reinforce it. It's almost like it can happen--it's not patient-focused. At least managed care puts the patient back in the middle of the equation, and it makes you, the PCP, follow them.

Mullan: How would you characterize the culture of Health Partners?

Bowman: It's corporate, but it's really an advocacy culture. Everybody really understands the mission of the company, that we're about delivering quality health care for people who have limited choices otherwise. If you walk through the departments, the working departments, and you said, "Who's your customer?" I would bet good money that everyone would say, "Oh, of course, the member." I mean, they're here for the members. The board of directors has a different view, but the people who do the work are here working for the members.

Mullan: What would the board of directors say?

Bowman: Oh, it's their bottom line.

Mullan: It's a not-for-profit, so that--

Bowman: It's a not-for-profit, but the way the finances are structured is that the hospitals benefit, obviously; instead of the money going into a 20 percent admin overhead, the money goes back to the hospitals as operating revenue. So they're obviously getting cut short in other areas, so they're looking to us to help conserve resources so that they can off-set losses in minimum ways.

Mullan: If Health Partners or a Health Partners-type managed care operation were available to all low-income people, or let's

just say all Medicaid people throughout the country, would that represent a step ahead?

Bowman: Yes, because I basically think that care for poor people sucks. And I basically think that, I'm sorry, some of the medical brethren and sistren think that poor people deserve crappy medical care. I think managed care is better.

Mullan: Would you argue it's a better use of the dollar?

Bowman: Yes, because people can't free-float through the health care system in managed care, like they do in medical, in a fee-for-service environment.

Mullan: Wasting resources as they go.

Bowman: Wasting resources as they go. Absolutely. We all know about the Medicare patient who goes after second, third, fourth opinion time after time after time. I mean, come on. Somebody's got to put a stop to it somewhere. Managed care won't let you do that. Similarly, the medical assistance patient who runs from one hospital to the next, to the next, because basically they're homeless. I mean, of course I think it's better.

Mullan: What about the argument on the other side, that choice is limited, that quality is tacky, and that this is a bureaucrat's dream?

Bowman: Medical community talk out of both sides of their faces, because, believe me, they're all signing up. The same people who are delivering care in the fee-for-service environment are the same people delivering care to medical assistance patients. Every office you go into has five or six stickers on their window that happily announce, "We belong to..."

Mullan: How about the patient articulation, the same complaint, that managed care has taken away their choice, that it's denied them services, and that it's lousy quality?

Bowman: People who have those complaints--they never interview happy people. They never interview members who are satisfied with managed care. They always get the ones who "didn't get." I think, overall, at least I remember satisfaction surveys indicate that members are satisfied with their care, to a high degree. Of course, there are always going to be people who are going to say, "But they didn't give me the referral when I asked for it." But who the heck ever said that you were entitled to medical care on demand? Just because you want it doesn't mean you get it.

Mullan: That's the sort of popular press slugfest that's taking place now.

Bowman: I know, I know. And the other slugfest is, the denial of--both sides like this, the specialists and the members like this--the experimental therapies, bone marrow transplants for breast cancer. Oh, that's a biggie. And there are always going to be extraordinary circumstances at the edge, where this is

where the physician as advocate really needs to kick in. Okay. It's a matter of who's going to pay for it. Okay. It's not paid for. Now, does that mean that you're not going to do it? Does that mean that you're not going to find somebody to help to underwrite the cost of the procedure? I mean, you're in a much better position to go to the managed care company and say, "Look, we did this. We saved this lady's life. We've done ten of these. We've saved all of these lives. We've made the quality of this life better. This is a procedure that needs to be funded." I mean, that's the way to change the system.

Mullan: Back to our primary care theme. We were talking about trajectory. What do you see as you look down the road for the generalist in particular?

Bowman: It's ugly. What I see coming down the road, unless the country gets honest about health care delivery and making health care a right, it's going to be a debacle. I can see it already. HIV is awful. It truly is an epidemic. The geriatric wave; we're totally unprepared to care for our older people. The paucity of services is astounding. We haven't dealt with that as a societal issue. We wrap up elder care in a medical mantle so Medicare will pay for it. We're really talking about activities of daily living and things just to help people get through the day. Unless we address those issues, the whole system's in crisis. It's going to collapse. So I don't think it really much matters what happens to primary care, because there isn't going to be enough money to take care of anybody. Salaries obviously

are on a dip, and nobody's going to make out. Nobody's going to do well.

Mullan: In that constellation, is the generalist in a better position to aid the system than the specialist?

Bowman: Yes.

Mullan: I don't mean to ask leading questions.

Bowman: No, I think the generalist is in a better position to survive it, because you have a different battery and an armamentarium of skills that will help you to pull a rabbit out of a hat when it comes to taking care of a patient. The person who is able to multitask, I think is going to do better than people who have more focused skills.

Mullan: In terms of your work and your career, what do you see yourself doing now? How do you feel about it at this juncture?

Bowman: I like my work. I like what I do. I like all of what I do. I don't know how long I'm going to do it. I don't know how long I'm going to do it. I'm not sure what I'm going to do.

Mullan: It sounds like there's an element of it that grates on you.

Bowman: I don't know what I'm going to do. I'm not sure. It's not like I'm waiting for the next wave to hit me before I figure out what I'm going to do.

Mullan: Stage five?

Bowman: Yeah, stage five. I miss teaching. I miss the students and residents. This is as much corporate, as much "execu-drag"--excuse the term--it's probably all I can handle. So I don't think staying in, or moving to another managed care company would be pleasurable for me. So I would like to continue on what really has been a pretty--if you take the big view, I've been learning managed care to teach managed care. Learning managed care to teach managed care. And so I kind of feel that my next step is to take what I've learned the last two years and to wrap that in a teaching package. That's what I would like to do. I think I know as much or more about managed care practice, practice in the managed care environment, and I enjoy watching other people get it. So that's probably where I'm going to head.

Mullan: So the business side of it appeals to you less than the pedagogue that lurks within you still?

Bowman: The pedagogue is always there. I interviewed with a headhunter about three years ago, before I took this job. He was trying to sort of get to know me, and he said, "What are you most proud of professionally?"

I said, "Carl Milner."

He said, "Explain."

I said, "Carl was a medical student that I interviewed and advocated for. I mean, he was on the weak side, but he had something about him that I thought was worth taking a chance." It took me six years to get that boy through medical school, including telephone calls at one o'clock in the morning when he's having a panic attack before a test. Dinners Sunday night at my house. But I got him through, and he went out to the Wadsworth VA to do his medicine internship, and he was Intern of the Year for his year. And I'm also proud of--I had tears in my eyes at graduation when we hooded him, when I hooded him. I raced to the Dean, to insist that I put this hood on. But I did, and the secretaries were all clapping and crying because they had put up with him as well. And I'm most proud of Carl, professionally, because he's a good doctor. He's a compassionate young man. It took him time to get it, but when he got it, he did it good. So I'm most proud of him.

Mullan: Great. It's a good place to end. Thank you.

Bowman: You're welcome.

[End of interview]

Index