DR. NEIL CALMAN

Dr. Fitzhugh Mullan,
Interviewer

Mullan: It's the 26th of June, 1996, and I'm in the office of Dr. Neil Calman. We're on 16th Street in New York City in the Institute for Urban Family Health. We'll hear more about that. I wanted to ask Neil to start by telling me a little bit about where he grew up and what his youth was like. There's a big question.

Calman: There's a big question. I was born in New York City, the oldest of three and then later of five kids, meaning that my parents had two more children after I was out of the house, already at college.

My family moved to New Jersey when I was about four years old.

Mullan: When were you born?

Calman: 1949. About a year after we moved to New Jersey (1953), my father was drafted into the Army. So I spent two years in Virginia on an Army base when I was six and seven years old. And then moved back to New Jersey where I eventually graduated from high school.

Mullan: In New York, where did you live?

Calman: In Washington Heights.

Mullan: And in New Jersey?

Calman: In New Jersey, about fifteen minutes across the George Washington Bridge in Glen Rock.

Mullan: What did your folks do?

Calman: My dad's an oral surgeon and took over his dad's practice who was also an oral surgeon in Washington Heights. My dad just retired last year. But he worked there through the whole transition of that community from mostly a Jewish immigrant community to now mostly a minority immigrant community, and stayed in that community the whole time, in the same office.

Mullan: What about college?

Calman: I went to college, I went to the University of Chicago for four years and really loved being in Chicago. I wanted to stay there, but couldn't because I was involved in too many political things in college. They didn't want me there.

Mullan: Had you been political before college? What kind of expectations did your parents give you?

Calman: I guess all of my political stuff came from my grandfather, whose plaque is over there. My grandpa Maurice Samuel Calman was a socialist alderman in the city of New York. Basically, he was an incredibly political person. He grew up as a socialist with all of those ideals and everything. He was an attorney. He was an alderman, which people have told me is sort of the equivalent of what New York's City Council now is. In those days, it used to be called the Board of Aldermen. My grandfather was also a dentist and a lawyer. He had a degree in agriculture, and he was a three-letter athlete in college. He was just one of these all-around incredible human beings and probably the most influential person in terms of what inspired me through the years. He led a very decent life but was always involved in, inquiries about the bigger picture of what was going on about everything. He had a philosophy about everything in the world that went on. Nothing just existed as an event. It always existed in some context of me having to understand what kind of world it was that we lived in that allowed this thing to happen. So,

Mullan: You knew him?

Calman: Oh, yes, I knew him very well. In fact, he died when I was in my second year of college. It was a very, very difficult time for me. It was really the only major psychological crisis I had in my life. It took me a long time to sort out what it was about, but after he died, it was like there was this huge anchor

that just got lifted. It was very, very difficult for me because I really hadn't realized what a big influence he was on my life. He was just somebody who lived out his ideals. His notebook was filled with stories. Interestingly, he was arrested a number of times during the time he was an alderman. One of his arrests was for a fake coal crisis that he lived through? In the twenties there were huge stock piles of coal and stuff all in outlying parts of New York City that were being stockpiled by the companies to drive up prices. As a result, they were going through a brutal winter where people in tenements, couldn't get coal. He went around and photographed all of these stockpiles of coal and led this huge protest march in New York. I mean, that's just the kind of guy he was.

Mullan: Did he or your dad or anyone else in your family push you into dentistry or medicine?

Calman: Not that I really recall. My dad seduced me into it, but he didn't push me into it. My dad was associated with a small hospital, which has now been torn down, called Jewish Memorial Hospital, which was in Washington Heights. It was a hospital that took care of all poor people by the time I knew it. But there was a docctor there named Harry Wallerstein, who was an oncologist-hematologist. He ran a small research laboratory with funds that were donated from somebody whose daughter had died of leukemia that he had taken care of. It was called the Marsha Slater Research Laboratory.

I don't think that it produced any major, significant work, but it was responsible for more leadership people going into medicine than anything else. Because he ran this program where any of the staff of the hospital could recommend their children to come and work in the research laboratory for the summer. He literally closed the lab in the summer to run his student program which he funded completely out of the research monies that he used to get. There were always seven, eight, or nine daughters and sons of people that worked in the hospital that he would run this research program for in the summer. It was completely done on his own inspiration and good will.

I started going when I was fourteen. My dad hooked me up with this program. I was always interested in science, but my dad hooked me up with this program when I was fourteen years old. So I went there and basically washed beakers and glassware for the first summer. The second summer, I got to handle the mice and inject mice with stuff and do things. By the time I was eighteen, which was my senior year, I was the second-in-command of the student programs. I was teaching all the younger kids that were coming up what to do.

But I'm still in contact with some of the people who were there. One of the people is the head of cardiology in a big Philadelphia hospital. Another one is the head of OB/GYN in another place. I think they were kids who were ambitious as kids, but also had this opportunity to connect with something that was very real. I mean, he would set up a set of experiments, and we'd spend the first week having to learn

about--I was probably the only fourteen-year-old in the country that knew the entire Krebs cycle and every aspect of purine and pyrinidne metabolism. I couldn't even tell you about it now, but I knew every transchemical transformation and everything that went on, because we had to learn it. He would force us to learn the basic science behind the research that we were doing. We'd sit in lectures, sometime for hours and hours.

Mullan: Were religious values part of your upbringing?

Calman: My mother's father was a cantor, but they were more cultural Jewish values than they were religious Jewish values. You know, my grandfather was of the, again, sort of the socialist Jewish tradition where the most important thing was whether somebody was Jewish or not. He knew everybody that was either half Jewish, quarter Jewish, or an eighth Jewish. You know, every entertainer, every everybody. That was just part of his values. But I didn't grow up in a religious Jewish family.

Mullan: By the time you got to college, you were politically engaged. Tell me a bit about that. Where did that come from?

Calman: The thing that made me want to go to the University of Chicago, which was my first choice of schools, was a *Life* magazine article that ran probably in 1965 or '66, that basically was about all of the political activity that was going on in the University of Chicago, about politics, about the school and the

student body forcing the school to deal with issues in the community. It was Black Panther time and everything was going on in Chicago, Chicago, Chicago. I said, "Wow, that's the place I want to be." So there was obviously some attraction to this level of political involvement. That's my first recollection of having any kind of real political thought or interest. It was probably my junior year of high school.

One of my babysitters down the block was in graduate school at the University of Chicago and kept coming home talking about how exploding it was of a mental experience to go out to this place and be part of all these things that were going on. It just sounded to me like I had to be there. So there wasn't any question at all about where I was going to go to school or what I wanted to do.

Mullan: In terms of the University of Chicago, you arrived there in what year?

Calman: 1967.

Mullan: Tell me about it.

Calman: Well, the other major thing about the University of Chicago is that it's very big on liberal arts. Robert Maynard Hutchings was the founder of liberal arts education. He was the first person that really espoused the idea that people shouldn't go to school to learn what they were going to do in their trade,

but to go to get a broad education as a human being. That was perfect for my eclectic interests. I took literature and poetry and music and everything. I just figured this was perfect. I was doing plenty of science in my summer work and everything else. This was just like a perfect opportunity for me to kind of go to a school that was the way I was.

So I took courses in archeology and did all kinds of great things. You could take courses in any division of the school no matter where you went, no matter what you were doing as a "major." You weren't even allowed to have a major until halfway through your third year. So it was just a great a great educational environment.

But somewhere along, I guess it was along the lines of the first year I went to school, I got a part-time job working in a research institute at school. There was also a group of students that were beginning to get together there over student issues, a lot of which had to do with how the school was responding to political issues that were going around in Chicago at the time.

I just got very interested in the social issues that were being talked about in a variety of different places around campus and everything, and how the school was responding, and what role students had. There were lots of incidences of violence on the campus, a lot of rapes that were going on the campus and things like that. It was like a white island on the South Side of Chicago. According to the school, it was kind of like a white island which was being invaded by the people around it. There was no integration of the school at all into the community, the

school played no role in the community, and the community, I think, was responding. It was like it was a foreign body; it was walling it off and invading it. And I think a lot of people felt like there was different vision of the school that was needed. People started talking about it, and although I didn't know anything about it, but I became very interested in it.

There were actions by students to design courses that were more socially responsible. Some of the teachers who were talking about involving students more in the design of course work and curriculum were being systematically persecuted by the school and not given tenure. That was what was going on all over the country at the time. Then the Vietnam War, of course, started bringing other protests to the campus.

I guess the major issue, around my second year of college, in the middle of my second year of college, there was a sit-in in the Administration Building. The issue was around the firing of one of the teachers who'd been a really outspoken political figure on campus, a woman teacher, and the issues around students wanting a voice in the curriculum committees, various places around the school. There was no voice at all of students anywhere in education. I guess there probably wasn't in any other place in the country at the time either.

So I was involved in the sit-in in the Administration Building, and I got suspended. The sentences that people got ranged from being expelled from school to being suspended for anywhere up to two years. The sentence depended upon what

happened in the hearings that the school set up after the sit-in was over.

Mullan: This is all administratively within the school?

Calman: Yes, all within the school. So at the hearing, I basically discussed how people needed to be true to the their values, and that when there are things going on that you believed in, that you were forced to act. Because I showed up for the hearing and went through their process, which a lot of people just refused to do, I ended up with being suspended for two quarters. One of them was the summer and one of them was the spring. So I ended up out of school for about six months.

Mullan: The cops weren't involved?

Calman: The school dealt with this without the police. They held hearings for students at the law school. There were about thirty students who decided not to show up at all for their hearings, and they were all expelled from school, and a number of them joined the Weather Underground. A number of leaders of the Weather Underground came from that group of people who were expelled from the school. It was a hot time in Chicago.

Mullan: And through the summer of '68, I guess, you weren't there then? During the convention?

Calman: I was home. Thank goodness.

Mullan: But the environment, nonetheless, was highly charged?

Calman: Very highly charged. So I went back to school, but during the time that I was out, I went home to New York. I was trying to figure out how to salvage this six months so that I wouldn't get totally off track. What I did was, go back to the research lab, and I talked to Harry Wallerstein. I said, "I need a job for six months."

So he said, "Fine," you know, after he gave me a little lecture about how stupid I'd been, he gave me a job. It was very interesting, because somebody in their lab had left, one of the full-time research people. I went home, and I designed an experiment I wanted to do based upon the research I had done in the prior years. I came in with a proposal for an experiment that was related to what the lab was doing, but something that I was very interested in, independently, and he approved it. He spent about $10,000 for special equipment and supplies that they needed to do my experiment because Dr. Wallenstein really believed in it.

I designed it to run over the period of time that I was going to be out of school. We published four papers off of it--all of us. It really turned out to be the only reason I believe that I got into medical school, because I applied to sixteen schools, and on my transcript was all this stuff about my

political activity in college, and nobody wanted to touch it. I only got two interviews out of sixteen applications.

I really consider that I got into medical school on a complete quirk. The person that interviewed me was somebody who had actually read one of the research papers that I had published, and he was doing research in an area that was very similar to mine.

Mullan: What was the area? What was the paper?

Calman: I was studying how cancer cells became resistant to chemotherapeutic agents over time, and the changes that were going on in them. People were just beginning to look at things related to the immunology of cancer. What I showed is that if you immunized mice against cancer cells that you injected into them, you could actually immunize them so they wouldn't get the cancer. Which was no big deal; people knew they could do that. But what I did was I took the cancer cells after they had become resistant to one of the chemotherapeutic agents and showed that even though the immunized mice were totally immune to the basic leukemia virus that we were giving them, that they had no immune recognition at all of the same virus after it had become drug-resistant. So that while you were killing the cells with chemotherapy, the cancer cells, those that were growing up had a different antigenic structure, and they were no longer recognized as being "foreign" so you were hurting the mice's own immune

response to its cancer while you were helping them by reducing the tumor load with chemotherapy.

It was a very interesting thing, and many years later, they began to understand that you could actually map the antigen on the cell surface, and that people began to map the cell changes that went on as cells became drug-resistant. So that you could actually prove that the antigen structure changed.

So it was really fascinating to me, and I was deeply into this. I mean, I was putting sixty, seventy hours a week into the research lab. I was coming in on Saturdays and Sundays and I was totally engrossed in this project.

So it turned out that I got into Rutgers--one of sixteen medical schools to which I applied--for three reasons. One was that there were two professors at Rutgers at the time who were really furious that the student body was looking very homogeneous, and that they were systematically eliminating people who were interested in political issues related to health care. The admissions committee allowed them to make recommendations for a few slots. I was one of the people they picked for that. Secondly, I got lucky, because I was assigned a doctor who interviewed me who knew about the research that I was doing and was interested in it. Thirdly, it also turned out that the same interviewer became very interested looking at my college transcript about courses that I had taken in archeology. One of the courses that I had taken was the archeology of the Dead Sea Scrolls, which one of the few things you could take without knowing another language, either Egyptian or something else, in

archeology. It turned out that his father was on the team of people that discovered and translated the Dead Sea Scrolls. So it was just one of those lucky things. His father had written one of the books that I had read in this course, and we talked about that for half the time and my research for the other half of the time. So I was lucky, because that was the only school I was admitted to.

Mullan: What did you major in Chicago?

Calman: Well, a few things, but I ended up in microbiology because I got credit for all of the research that I had done.

Mullan: And did you graduate on time again?

Calman: Yes, I doubled up my courses in a couple of my quarters and graduated with the rest of my class--even graduated with "Special Honors" because of my research .

Mullan: But the transcript actually had on it some evidence that you been suspended?

Calman: Yes. I tried but was never able to get the school to edit it off. It's probably still there.

Mullan: What did it say?

Calman: It said--

Mullan: "Scarlet letter."

Calman: I can't remember, but it was clear enough that it said I was suspended for disciplinary action or something like that, for two quarters. They never took it off the transcript. They decided that they were going to have people carry that with them for life.

Mullan: Was the war an important factor in your mind?

Calman: It was very important. It created the entire atmosphere around college campuses at that time. As you know, it was the major element of real personal insecurity that people like me, who grew up in white, middle-class life had ever experienced. As I perceive it now and look back on it, it was the only real threat that I had experienced in my life. I mean, we had never been under attack as a country or anything like that. But it was like the only real threat, the threat that you're going to end up going and fighting in this war that was totally ludicrous and that nobody believed in or anything. It was just something we just lived with.

I was eligible during the years of the draft lottery, you know. My number was 219. So I watched it each month the draft data came out, to see what number they were going to get up to and where things were at. But I was clear I wasn't going. I

never really had to face what I was going to do, but it was clear to me that there was no way I was going into the Army or going to war.

Mullan: So, you went on to Rutgers?

Calman: So, I went on to Rutgers.

Mullan: The year being 1971?

Calman: Yes, I finished my work at University of Chicago. I worked in the research lab there at LaRabda (phonetic) Institute all the way through college until right before I graduated. Then I went to Rutgers.

As I viewed medicine at the time, I still thought that I was probably going to go into medical research. I wasn't sure. I mean, I really went to medical school to become a researcher. That's what I was into. I totally believed that people with scientific minds had a responsibility to try to solve these big medical problems that people faced. This thought helped me to connect my sense of social responsibility with the fact that I was spending all this time in a lab. I knew I had been successful in research and was being told by people that were mentoring me that I had a real skill for this and that it was something I should cherish. I was told I had "golden hands. I had been offered a fellowship at the University of Chicago in research, because that didn't have to go through the same

admission process as for medical school but my research mentor told me I should become an M.D. to maximize my options to do both laboratory and clinical research.

When I landed in medical school, I quickly connected with about half a dozen people who were very socially aware, much more socially aware of issues in medicine than I had been. At the time my politics wasn't well connected to my medicine. I was involved in University of Chicago and political activities, but it wasn't at all connected to medicine. I guess what happened is that clinical practice allowed me to integrate two parts of my life which had been totally disconnected. Spending hours and hours in a research laboratory and my political interests helping people and society and other things like that were very much there.

There was a group, (I can't even remember the name of it), but it got formed when I was at Rutgers--of about six or seven medical students. We used to meet every week or two to discuss political issues around medicine.

Mullan: People in your class?

Calman: Yes, this was in my class. My recollection is that people were very critical of my research interests. That it was viewed like being a radiologist. That if you were political and you were in medicine that you needed to be taking care of people out in the community not doing research.

There was a pediatric faculty member that ran a community clinic, a free clinic, called NABE.

Mullan: The guy?

Calman: No, the clinic. I don't even remember what it stood for--the Neighborhood Health Clinic or something like that. It was run by him and students.

Mullan: How do you spell NABE?

Calman: N-A-B-E, I think. I don't remember. He was a physician, and he brought students from the medical school there in the evenings to learn how to take blood pressures and to do other things like that. So, I went there. All my friends, the people who were in this group, all went there and so I went there. That was my first real clinical experience.

Mullan: First year.

Calman: Yes, my first year of medical school.

Mullan: Did you like it?

Calman: I liked it after my first day. My first day I was incredibly frustrated because I spent a whole night there being totally unable to take a blood pressure. It seemed I I could

just not learn how to take a blood pressure. It was just impossible. I couldn't hear it. I thought there was something wrong with me. Finally, at the end of the night one of my colleagues figured out that I had one of those reversible stethoscopes and nobody had bothered to teach me that it clicked on and that I was listening to the wrong side of it.

Mullan: Did you start a research program or were you involved with any researchers at Rutgers?

Calman: No, not at all. My research ended at that point. I really didn't do anything with laboratory research from that point on. During my first year of medical school, I worked in this neighborhood clinic for a while, and then I started to get interested in what health care was about and became part of this study group that was learning about the health care system and health care issues and political issues around health care.

At the time, I was really a follower. There were a lot of people there who were a lot more sophisticated about this stuff than I was. I knew that I was interested and hung on and read the study readings and showed up at the meetings and found that I was really interested in it. But I was not a leader. I had all I could do to hang on to the academics of medical school during my first two years.

Mullan: Was it tough?

Calman: Oh, it was very tough. For me, it was very tough. I mean, I've never been somebody who was incredibly good at memorization. Everything to me always had to be connected to logic or something that I could understand. And there's just no logic to the majority of things that you learn in the first few years of medical school. Memorizing the names of bones and veins and nerves was absolute torture for me.

Mullan: Was it better once you got into the clinics?

Calman: Oh, yes, it was fabulous. I was flying high. But my first two years of medical school were at Rutgers. I was dying in Piscataway, New Jersey. [chuckles] Having come from Chicago, I felt I was in a wasteland. Rutgers was just beginning to establish itself as a four year school, and they were taking only a third of the class on, I believe, into the four year program. So, most of us were being encouraged to look for places outside if we didn't want to stay in New Jersey, and I was just dying to get out. So, a recruiter, who's now actually the president and chief executive of Rush Medical College, came to Rutgers to interview a bunch of students that were interested. I was wanted to go back to Chicago. So--

Mullan: Who was this?

Calman: Leo Hennikoff, and I'll never forget his interview. I took on a passion for going to Rush his interview. Dr. Hennikoff

is a pediatric cardiologist. He sat down, and he took two or three clinical problems that were clearly beyond what a second year medical student should know anything about and reasoned them through with me for a couple of hours. That's what I remember about the interview.

I remember one of them was about a person with aortic insufficiency. He was talking about what happens to the blood pressure. What would happen to the blood pressure with the blood running out the aorta in two directions instead of one. We discussed the EKG, the part of the EKG representing the atrium, and what one would expect the EKG change to be over time as the person's heart enlarged. He went through this clinical problem with this incredibly logical way of thinking that totally clicked into the way my own mind thinks. I was so enamored by that way of thinking. I was sure I wanted to go to that school.

And Rush turned out to be exactly like that was an absolutely phenomenal two year clinical experience. I've never experienced anything like that afterwards. Just incredible clinical training for two years; brilliant, thoughtful educators and clinicians.

Mullan: Did you find a group of politically simpatico people?

Calman: Oh, yes, and I almost got thrown out of Rush, too. It is one of my claims to fame. I've been thrown out of everywhere I've been. My closest friend from Rutgers and I went to Rush together. His name is Bobby Cohen. You know Bob?

Mullan: I did his oral history.

Calman: Did you really?

Mullan: This story sounded familiar. Yeah. Keep going.

Calman: That's interesting. So, Bob and I were roommates in medical school. We were in this group called Concerned Medical Students at Rush which started a year before we were at Rush by a group of people who I hear are still in Chicago, mostly at Cook County and other places. We were involved in many activities. Again, I was mostly a follower there.

Mullan: Talk about Rush and your experience there. There was a simpatico group who was politically active. This was Co-Student Health Organization. That was no longer on the scene?

Calman: The group I was in was called Concerned Rush Medical Students.

Mullan: The SAMA/AMSA didn't appeal to you?

Calman: I don't remember any contact with them. All I remember is this group, and what we did. Marge Cohen, who's Bob's sister, was also very active in that group. There were a few other people. Gordon "Gordy" Schiff, Marge's boyfriend (later husband) from Chicago and a few other people who were there and

from whom I learned a lot. They were more widely read than I was in terms of political issues related to medicine. But I was very much in tune with the things that were going on there. I was very interested in their work. They did this fabulous paper on the pharmaceutical industry that people were circulating ten years after it was out of date. They just did great work. But I had a harder job with the academics than they did.

Then I got really involved in the politics there because it was at a time when Rush had James Campbell as president then. Campbell had a plan which divided up the whole city into districts all of which figured into a master plan for health care in Chicago. My recollection is that it was a plan that showed great disfavor to poor inner-city communities and which segmented the population so everybody who couldn't afford to pay was going to end up at Cook County Hospital rather than Rush. It was a great for Rush but many thought not for Chicago. Rush would take over all the private care that was going to be given in a hundred mile radius. We got very involved in opposing that politically. Commenting on it and understanding it. There were some people at Chicago at the time who were very savvy about all of the health systems issues in Chicago. We were learning from them about what those issues were.

This was a major turning point for me at Rush though. I found myself in the middle of this huge dispute which eventually ended up causing me some problems in school. I was on my OB-Gyn rotation. Rush then had segregated OB-Gyn services. There was floor at Rush which was largely for paying insured patients, and

a floor for the poor patients from the community. They were staffed differently. They had different nursing models and different staffing levels. All the same types of things that just last year they were blasting Mount Sinai in New York for was going on twenty years ago at Rush.

There was a Doctor there who was doing experiments on black women who were getting caesarian sections where they would anesthetize the woman and then start taking arterial blood samples, measuring oxygen content from various sites after they were under anesthesia--drawing blood from the radial artery, the uterine artery and the umbilical cord--the way I remember it. This was all done before the baby was delivered..

We had learned that the idea when you do a C-section is to put the mother under anesthesia, and deliver the baby as quickly as possible so the baby doesn't come out sedated. But for these poor mothers who were being experimented on they open the abdominal incision, and then they wouldn't deliver the baby. They would just start drawing arterial bloods from the uterine artery and from the radial artery and from all different places. That would go for minutes and minutes and minutes.

So it occurred to me that this is probably dangerous because we had learned that the idea was to deliver the baby as quickly as possible. I became concerned, and I asked the chairman of OB what was going on and then discovered by asking one of the women that was involved in this that nobody had ever gotten her consent or done anything to advise her that she would be participating in these experiments.

The Department of OB refused to do anything about it. I and one of the other students went and Xeroxed a whole bunch of their medical records and showed there were no consents in the medical records and showed that the delivery times after induction of anesthesia were eight and ten and twelve minutes where they should have been two or three minutes. And then went back to the OB director and said, "Look, this is ridiculous. People aren't even being asked if they want this done or anything, and there were no consents in the chart or anything." And they refused to change this stuff. So, we took it to the newspapers which was probably not the smartest thing to do when you're a third year medical student.

There was a black newspaper in Chicago that really picked up on the story and put it on the front page. The other Chicago newspapers picked it up and ran articles about Rush University's illegal experiments on black women, and that they were done without consent.

Mullan: What happened to you?

Calman: I don't remember exactly, but I know I was in deep trouble for quite a while in Chicago. Eventually, they set up their first human experimentation committee at the school in response to this. We were asked to participate in the committee.

Mullan: The students?

Calman: Yes, specifically, this one other student and myself who were involved in bringing this issue to light.

Mullan: Did you get thrown out all the way or suspended?

Calman: I don't think I was suspended, actually. I don't really even remember the details of what went on. But I remember being up to my ears in hot water for quite a while in relationship to the deans and the other people that were there. You know, of course, it was very difficult for them to do anything to us, because it was a real public issue where they were totally in the wrong. They were smart in not wanting to complicate that by throwing out the very students that exposed it. But inside the school, it was clear that we had crossed the line in terms of what people should do in such circumstances. But we had documented every meeting we had had with the people that we had gone to first to try to do things inside the school, and nobody paid any attention to us. So we were pretty much on the side of right.

Then at the same time, Bob and Marge and the other groups were really going full-scale on a lot of other issues. There was wide spread dumping of patients to Cook County across the street, This group, the Concerned Students group, was working on lots of different issues simultaneously within the school.

Mullan: We're at mid-seventies now?

Calman: This was '73, '74, '75.

Mullan: What was your thinking about what you wanted to do? Did the notion of generalism become an issue?

Calman: I've been plagued by being kind of a dabbler my whole life. I played seven different musical instruments, none of them terrifically well, and still do. You know, liberal arts education, I mean, that's been kind of my style. My style has always been not to spend huge amount of time in one focused area, but to keep a very broad vision of things.

I did fabulously well in my third year. Every rotation I was in, the faculty would try to recruit me to that specialty. The chairman of pediatrics took me out to dinner and said, "You'd make a fabulous pediatrician." The chairman of psychiatry offered me a job which I kept for a while working in the Psych Department, taking care of patients. The chairman of surgery said I had golden hands.

Mullan: OB probably--

Calman: No, OB wasn't one of my strong suits. I loved everything that I did. I really couldn't figure out what I would do as a specialty. My recollection of this is a little foggy, but the events aren't. Somewhere around the end of my third year, when I had to start thinking about residencies, I found out about

family practice. It was definitely not through the school. There was not a single family physician at Rush at the time.

I wanted to find out about this specialty and I had heard about Jorge Prieto, who was over at Cook County doing something in family practice, and I went over and talked to him. He was telling me about this new specialty. This was probably '73. And family practice only started as a specialty a few years before that. I mean, it was really a new specialty.

[Begin Tape 1, Side B]

Mullan: This is side two of tape one, Neil Calman, the 26th of June.

Calman: So there really were not any family physicians to get attached to. I went to the dean, and I said, "I want to learn about this new specialty called family practice."

He said, "Well, you're going to have to find something, somewhere to do it, because we don't have it. I don't even know anything about it."

I think it was at a point where people weren't even discouraging about it because it didn't really exist. Nobody was a GP anymore. The Dean hooked me up with a narcoleptic psychiatrist who was my psych preceptor, who had done six or seven years of general practice down-state Illinois before coming back and doing a psych residency, and they made him my advisor, unofficially. He said, "You know, this is great. General

practice is where it's at, you know. It's fabulous." He said, "After seven years of this, I could retire." He said, "I burned myself to the bone, and I can retire."

He was seeing sixty, seventy people a day in his office. He was the only doctor for miles around. He had literally made enough money in seven or eight years to almost retire, but he was working seven days a week, twelve hours a day. He semi-retired and became a psychiatrist, which was not exactly a profession befitting somebody who was narcoleptic, because he constantly fell asleep in the middle of his therapy sessions. It really was one of my funniest experiences in medicine. He kept insisting that he wasn't asleep, but the medical students would run the whole session, because he would be totally asleep, snoring in the chair. In the end we'd go, "Doctor!"

And he'd say, "Yes, I'm paying attention to you. You did a fabulous job. Didn't he?" And he would turn to the patient. It was very weird. [Laughter] But, anyway, this was the guy who helped me understand what general practice was all about.

Then one day, in the back of the *New England Journal*, there was an advertisement that had been placed by the United Farm Workers Health Clinics by a family doctor there who was interested in getting another doctor to come and do a *locum tenens*. He had been working there for years and years without a break; in Delano, California. I said, "Ooh, this sounds interesting."

So I called him up and I said, "I'm interested in coming out there. Is there any opportunity for me to come and to work there as a student?"

He said, "Well, it's run by the United Farm Workers, and you have to go through their headquarters before you could come here."

And I said, "What do you mean?"

"Well, you have to go and meet with Caesar Chavez, and you have to be indoctrinated into the Union first. Then after that, you can come and work in the center. We'd love to have you. It would be a great help to me, I mean, even though you are only a medical student, it's better than nothing. And I have no help out here."

So I went to the dean, and I said, "Look, I want to take a few months off, and I want to do this." I guess it was the spring of my third year.

He said, "Well, if this is really what you want to do,it's fine."

So I took off two months. Got in my car, drove out to California, went to a place called La Paz, which is where the headquarters for the United Farm Workers Union was, and got my union indoctrination. Then went out to Delano, California, where I lived in the emergency room, on the emergency room cot for two months in this clinic.

That, I think, was actually the single most important thing that ever happened to me in my career in medicine because there were so many things I learned there, not things about medicine so

much, but the medical world has this view which, I think, we all have become victim to, and even me, over time more and more, that you can't do anything unless you're a specialist in it.

We were taking care of people who had no access to the general health care system. None of them had health insurance. You either went to the health clinic and got whatever you could get done, or you got nothing. I mean, it was that or home care or zero. If you were brought in by ambulance to Bakersfield, which was thirty-five miles away, you could be seen as an emergency patient, but were unlikely to be admitted. If there were any questions about your immigration status, forget it. Everybody knew that going to Bakersfield to the public hospital was a direct route to possible deportation.

Mullan: How did that experience play itself out?

Calman: The doctor that I was working with had been there for a while and he had a large number of books in a small room and he did everything by the books. He had learned over the years.

Mullan: Did he count himself a family physician?

Calman: Yes, but I don't recall what his training was. I know he wasn't boarded because there was no such thing at the time we had trained. He was a general practitioner, but he was a young guy.

Mullan: Do you remember his name?

Calman: No, but I have it at home in my journal. We did everything. We did all our own lab work. Really nobody could pay for a laboratory. I mean, we did CBCs in the office, and we did urine analysis. We did vaginal smears, and we did all our own lab work. We did all our own X-rays. At the time, every hypertensive patient had to have an IVP. That was the standard. We did IVPs in the office. I mean, I learned to do IVPs. I was a great X-ray technician. I did probably did five, six, seven, eight X-rays a day. Probably did at least two, three IVPs a week. We did complex suturing. I'm talking about farm wounds, things that were just brutal. You know, he would suture in layers and do everything. We set fractures and did casting. We delivered probably twenty babies during the time that I was there, including a molar pregnancy which I'd never seen before or since.

He had this whole group of liberal-minded, caring, specialty people who made themselves available to him free of charge all the time by telephone. So we did a lot of telephone consultations with people all over the state and, in some cases, outside the state who just were sympathetic to the farm workers' cause and who would talk about cases with us over the phone.

So the take-home lessons from that place were, number one, I developed this enormous sense of confidence that people could do more than what you saw people in sub-specialty areas doing in medicine. The other thing was that the people in the union there

that ran the clinic were enormously political. The clinic closed for half a day every day. We all went out marching. The whole clinic staff had to go out on a weekly march. There was a weekly march through some town or through some grape fields where everybody was required to go. The clinic was closed except for somebody who sat in the emergency room, one of the nurses.

But we went out, and I've got pictures of myself carrying the United Farm Workers' flags and banners from the clinic, and all the little farm towns around where people would cheer the clinic staff on. It was very much an understanding that the health care we were rendering existed within this political context. I mean, they were one and the same.

In fact, in my journal, which I read a couple of years ago, and which covers the time that I was out there, is impressive in its description of how much I believed at the time that you couldn't separate the way people felt about their work and their jobs and their family from their health care. It was just like they were one and the same. The clinic was right there. The people lived in the community.

Mullan: This was 1974?

Calman: Yes.

Mullan: And this was towards the end of your junior year?

Calman: Yes. So then I headed back to Chicago knowing "This is what I want to do. I want to be a family doctor."

On my way, I had one more week left, and I left the clinic a week early. I made a bunch of phone calls right from Delano to arrange to visit some of the California family practice residencies on my way out. I took a swoop through Northern California, and I went to the family practice residency in Sacramento and in San Francisco.

That's where I ran into Bob Massad for the first time. It was in San Francisco and we ran through just what family practice was about. I looked at the San Francisco program, and I looked at Jorge's program. Then I went to Montefiore, and I fell in love with Frankie Seigel, who was one of the people I told you about. She was a woman family physician with forty years of experience in family practice in the Bronx, a person who had gone back to be the residency director at Montefiore. I really got inspired politically by a couple of the faculty people there--Margie Gold, who is still there as a faculty member at Montefiore, and people who really tuned in to where I was at in terms of the connection between my politics and what I wanted to do in primary care.

So I went to Montefiore really because I wanted to be trained under this incredible woman who had been doing family practice for years in the Bronx.

So although I knew I wanted to be in family practice, I knew I couldn't live in the farm lands. So the only three programs I applied to were San Francisco General, Montefiore, and Cook County. Monte became my first choice because I wanted to come

back to New York and because Margie Gold, who was a faculty person there, and Frankie Seigel were just people I connected with instantly.

Mullan: And the Montefiore social medicine program, family practice residency was relatively new then?

Calman: Yes, I think I was either in the third year of the program.

Mullan: How many incoming interns were there?

Calman: It could have been six or eight.

Mullan: Tell me about the Montefiore experience. What was it like?

Calman: Well, it was strange, actually. I think that the few critical things that happened to my at Montefiore were, number one, my exposure to Jo Boufford, who I learned much from and from whom I got my first real taste of administration. It was amazing watching her struggle to stay on top of this program of crazy-minded radical doctors, all of whom were moving in lots of different directions at the same time. She was going through a transition at the time which I've used as a model in my own mind about leadership stuff, which was being in a program where there were a lot of very independent-minded people and being able to

allow those people enough flexibility to allow the program to grow, because that's really what the richness of the program was all these people, but still being very clear that she was in charge of the program, and that there needed to be certain established values and limits set to where things go. She really struggled with that through the whole time I was there through lots of public meetings and many one-on-one discussions.

Mullan: Her role, at that point, was what?

Calman: She was director of the social medicine program. At one very seminal point, which I refer to a lot now as a leader of an organization, she got up in front of the group and said, "You know what?" She said, "This is a program where we share a lot of responsibility and decision-making, but the world out there holds me accountable for every single thing that goes on in this program. So when I have the authority out there to a curriculum committee and when there are other committees, they report to m. Nobody cares outside this program that there's a curriculum committee and that you screwed up and the family practice curriculum doesn't meet the R.R.C. requirements. They hold me accountable for that. The hospital holds me accountable for the fact that everybody shows up at their rotations on time."

It's been a very helpful model for me because I refer back to that frequently as a model of distributive decision-making without ever abdicating your responsibility for being in charge. I remember that one community meeting where that happened. It

was like a "buck stops here" kind of meeting where she finally came to grips, in tears, with the fact that she had to run the program, and that she couldn't any longer allow certain things to go on because the world was holding her accountable.

I've used that a lot of times because I think that all of us who have leadership positions in organizations are faced with wanting to bring in super creative, independently-minded people because that's the only way that organizations can grow and flourish, but still being able to keep enough ties to them to make sure that things don't go off in directions that aren't consistent with the mission or that actually even invade what the mission of the organization really is or should be.

Mullan: Say a quick word about the residency program, just for the record. How is it special?

Calman: I think it was special in the cohort of people it attracted in its self-perpetuating nature of bringing people who were very independent-minded, socially committed people in medicine, and allowing them enough opportunities within their residency to pursue some of that. So that when they came out after three years, instead of going into a traditional system where that gets beat out of you, and where you come out like processed cheese, you actually have an opportunity to explore that part of your being and allow it to grow and develop. So I came out my third year, I was ready, me and three other people there, my partner Marna Sternbach and Pat H. G. Bloom, who became

good friends of mine. We started a health center as third-year residents. Our social medicine project was to start a health center. We never, ever worked there, but it started. It got built up and it was growing. It's up in the northeast Bronx, and it's still thriving.

Mullan: What is it called?

Calman: Ronald Frazier Health Center. It was an interesting project, and it was my first real community health center experience.

So I think that's what the residency was. The bad part is that Montefiore Hospital is just the absolute worst environment for the program. To this day, the program exists as a fourth-class citizen within that institution. The family practice attendings still don't have admitting privileges to the hospital except for the family practice floor, you know. You can't admit to another bed in that hospital if you're a family physician. And that problem has always existed. It was something that drove me crazy while I was there. I just hated the feeling of being second-class, perceived of that way within a larger institution. I think that influenced a lot of what I did afterwards, too. But the camaraderie of the people that were there and the people that I met there, I mean, there's probably not another group like that anywhere in the country.

Mullan: As you proceeded through that and looked to the future, what did you think about doing and then what did you do?

Calman: Well, I discovered a few things about myself at the time. One was I discovered I had a great administrative mind. I was the chief resident there, and I loved organizing things. I have always been an organizer. I loved organizing things. I shared the chief residency there with two other people in the year. I became aware of the fact that I had some administrative skills, that I liked setting agendas for meetings and taking minutes and writing policies and procedures. I kind of had a head for that stuff.

But I was thrown out of residency, too, for about two weeks. [Laughter] By Dave Kindig, who was the president for a brief period of time in his history, he served as president of Montefiore. I don't know how brief it was. It was probably only a year or two, maybe even less. I don't know, but in between Martin Cherkasky and Spike Foreman, there was a very short Dave Kindig era.

Mullan: Cherkasky was still there. Dave was the president or director and Cherkasky was the--

Calman: CEO? Is that what happened?

Mullan: He wasn't called CEO then, but it was, anyway, Dave was there.

Calman: Yeah. There was a big 1199 strike, and within the Residency Program in Social Medicine a group of people who were not on critical rotations organized to support the 1199 strike. Most of us were on dermatology and other kinds of rotations that were not essential. It was one of the first real struggles that 1199 had. It was a very bitter strike. It was in 1976, July of '76. I think July 7th through 17th. It was a ten-day strike.

Those of us who didn't have to go into the hospital went out on the picket line in support of 1199 and refused to go to our elected rotations and everything. The hospital basically said, "You don't show up, you're out." And some of our faculty members did, too.

That event dominated my life for about a year afterwards, because we were all fired. Then the CIR [unclear] came in and got us our jobs back. The National Labor Relations Board came in and supported the faculty people that were fired. Then there was a sympathy strike of other residents in the hospital, about thirty or forty of them, who went out on strike to support our being fired. We and our firing became "the cause" instead of just people supporting the 1199 cause. That was kind of weird.

Mullan: How many were fired?

Calman: About a dozen, I believe. Eventually, the Hospital was forced, to take us back as residents. I can't even remember what the details were. The National Labor Relations Board, like a year or more afterwards, forced them to reinstate all of the

faculty people with back-pay and public postings that the Hospital had done wrong. It turned out that there were laws protecting people that supported other people who were on strike which the hospital conveniently ignored, but ended up paying for afterwards.

Mullan: How long were you out, and did it affect the length of your residency?

Calman: It didn't affect the length of my residency, and I can't remember why. I think I skipped a vacation month or something like that to make up for the time that I was out. I don't remember much else about it. I guess we were out about a month overall.

Mullan: Which year of your residency was this?

Calman: End of my first.

Mullan: So as things developed beyond politics, what were you thinking about?

Calman: Do you mean in terms of career stuff?

Mullan: Yes.

Calman: Well, I don't know. I was very much torn when I graduated residency. I really didn't know what I was going to do. I knew I wanted a combined administrative and clinical job. I started feeling these development parts of me, having had this experience, even though it was a disastrous experience, setting up this community health center.

The four of us, as I mentioned before, got together. Some community folks in the Northeast Bronx had been trying to get federal funding for Ronald Frazier Health Center for a long time. In fact, I think I even met with you. My recollection was during that time, we came down and met with you. This would have been, I think, in '78.

Mullan: You were at the National Health Service Corps?

Calman: Yes, and we were trying to get money from the Corps, and we were trying to get money from the Bureau of Community Health Services. We met with you and somebody else who I can't remember in Washington and got a very sympathetic ear, because we were planning on going into a transitional community. We were in a community which was not listed on the number one worst, needy communities--it wasn't the South Bronx. It was the North Bronx, but it was a community that's now almost 100 percent minority, but was in transition at the time and had no services, no health services, no primary care services. Nobody was doing outreach or any kind of public programming.

But it was my first experience working with a community-based organization, a real community-based organization, not one that was coming out of the hospital or some outreach program. We were working with people from the community that were building up this health center. We outran them. We were incredibly self-assured and incredibly aggressive. The only thing was we forgot to include them in everything that we were doing. So we were running around. We got them federal funding when they had been trying for years. And got them National Health Service Corps positions when they had been trying for years. We were very, very successful. We just forgot to include them in this whole thing. We had all the plans. We rewrote their grant. We did everything.

It was just one of these real lessons that you kind of never forget in your life that sort of no matter how smart you are and how fast you run, when you're in a collaboration, the collaboration moves at the pace of the slowest partner in the collaboration, not the fastest partner.

In fact, there were a lot of things that we were planning that ended up in struggles with the community. What happened at the end was the community leader said, "Thank you very much. You've done a great job, but I don't think we want this program the way you've designed it."

We had designed it. We knew that the only way to keep doctors in the community was if they were involved in faculty positions. So we had arranged for all of us to be part-time preceptors back at Montefiore while we were going out to work in

this community site. We were right but the community didn't want resident doctors. They wanted real doctors out at this site. They didn't want medical students out at these sites, you know. They wanted a real practice in the community, and we just we weren't smart enough to figure out how to really sell it. So it was a really blown out, horrible experience. They threw us out. They basically said, "Look, you either do it our way or leave."

We said, "You know, but we're the ones who got you all the funding and did everything."

And they said, "And we're deeply appreciative for all that help that you have given us, but you've got to understand, we started this project. And even though we readily admit that it wouldn't have gotten where it is without you guys and what you've done, that still doesn't mean that we've given up our control over the project."

So we left. We all just said "No way. We're not going to be part of this."

And the woman there that ran the program made a lot of mistakes. She brought in some guy who was a real well-known bad guy in medicine to be the medical director and to sit over us, and that was sort of the way they got rid of us. They brought in this guy who had had his license sanctioned and everything else. He was going to be the medical director, but he was an OB/GYN who had delivered her kids. She figured that was all the credentials he needed to be the medical director. Anyway, it was a long, bitter struggle. At the end we left.

Mullan: What did you do?

Calman: I went and worked with New York Medical College for two and half years running a center in East Harlem. It was actually on the border of Yorkville and East Harlem. We had Yorkville patients and East Harlem patients. It was a really, really interesting practice. We had people were poor and uninsured, and we had people who had million-dollar-plus incomes all coming to care in the same place. I inherited this practice.

Administratively it was a disaster, but it was such a small, little laboratory that you could practically do anything and it would be fine. I mean, we saw, total, each of the providers saw six patients or seven patients a day, spent like an hour on them. The guy that was the head of the place was a behavioral science person who believed that the more time you spent with people, the better they would get. So there was just no pressure on productivity at all. It was being supported by the medical school where their finances were not a major issue. It was called the Center for Comprehensive Health Practice. After a few months the medical director there left. I was picked to be the medical director, which I was happy to do. I was just three months out of residency, and I was the medical director of this place. But I had learned about teams at the Social Medicine Residency Program.

I used to run back to speak to Jo Boufford every couple of months and say, "Okay, here's my list of questions, you know." How do you get so and so to work with so and so? And this

person's doing a great job, but they don't come to work on time. I mean, from the most mundane to everything, and she was wonderful even though I had been a pain in the neck to her while a resident.

Mullan: What sense did you have about family medicine in the city? Did you have a sense of being a pioneer?

Calman: Definitely. My admitting privileges were at Metropolitan Hospital. I got privileges in medicine, peds and OB/GYN, and did deliveries at Metropolitan Hospital. I was the only family physician that ever got privileges there. I worked through every one of the departments and got privileges. In fact, at one point, I just remembered a couple of weeks ago, that I actually wrote a residency application to get a family practice residency started at Metropolitan Hospital. It never got off the ground, but it was just because I didn't stay there long enough to do it.

At the same time I was there, there was a residency program starting up that was affiliated with New York Medical College at Kingston Hospital two hours north on the thruway, up in central New York. I asked if I could get involved in that because I was the only family doctor in the whole center, and I was feeling a little isolated socially from what family medicine was about. They needed preceptors up there. So I made arrangements, and every Friday, I drove two hours up to Kingston for two years.

Every Friday I drove up there, and I got involved in the start-up of the residency training program in Kingston.

But the most important part of that activity for me was working so closely with the head of the Kingston program, David Mesches, a very entrepreneurial family doc who had merged his private practice with those of a few other family docs and set up this family practice network up in Kingston in the mid-Hudson area, started a department and started a residency program. He was bringing medical students up from New York Medical College two hours away to do a rotation up there. He'd set up this organization called the Mid-Hudson Consortium for the Development of Family Practice.

I was totally enthralled by the idea that he had set up this separate corporation. He had gone from being an employee of a hospital to having this independent consortium of family practice people. Then he was going back and negotiating relationships with the hospitals as an independent entity. I thought, "Wow, this is so cool, you know. This is a great idea."

It was in my head that there was something that at some point seemed right for New York City an independent group of family practice people should somehow get together and really take leadership around family practice in New York City. I think the most incredible thing about it was that being more independent, he could do all this family practice development and hospitals were dying to attach themselves to him because of what he was doing, even though the hospitals themselves would never

want to do anything in family practice. I thought, "Wow, this is just perfect for New York City."

So I left the Center for Comprehensive Health, and I went to become the founding medical director of Soundview Health Center, which was in the southeast Bronx.

Mullan: What year are we at now?

Calman: 1981. I became the medical director of Soundview Health Center.

Mullan: What sort of health center was it?

Calman: It was a 330 funded community health center. An Urban Health Initiative Project, I think it was called. It was a great place. The man who was the director there, Pedro Espada, was a community resident who was a social worker and is now a state senator in New York, was a very brilliant guy, again, very entrepreneurial and had a lot of ideas about what he wanted to do in the community about different kinds of community services and other things that he wanted to put together as a vision. He did a great job. He really put together a lot of stuff.

Because he had larger personal political aspirations, he gave me sort of carte blanche to set up the health center to deal with the medical and administrative systems and everything. That was my first foray into being almost like a CEO. I mean, I could still turn to him. He was a very good decision-maker, and I

could still turn to him when I felt like I was over my head in terms of making decisions. But I put together the finance department. I put together the billing department. I wrote computer programs for billing and for other things and set up the clinical models and did the charting systems and did everything.

Mullan: How big an operation was it?

Calman: Well, when I left there, there were eight family physicians and two family nurse practitioners.

Mullan: All family physicians?

Calman: Yes, it was interesting. At the Center for Comprehensive Health, I was the only family physician. There was a pediatrician and an internist and a nurse practitioner. I felt that I was a great model having a family doc at the helm because they have the broadest vision and then having people in different primary care specialties. That's sort of what Montefiore was like, too, RPSM . So I figured this is great model.

So I got to Soundview, and I was, of course, the first family doc. I met another family doc who was coming there through the Corps, and then there were two of us. It came time to hire the third person. So I said, "Now let's get an internist and a pediatrician."

There was a third family doctor I brought in, Joe Halbach who is now the residency director at Yonkers family practice

residency. He said, "You know what? Why do we need an internist and pediatrician? Why don't we just keep hiring family docs?"

And I said, "I don't know, Joe. You know, I just always assumed I was going to do this like the other place."

He said, "Well, I know somebody who is really interested in coming here as another family doc, you know. Why don't we bring her on, and then there will be four of us. Then we can decide after that whether we want to hire an internist or pediatrician."

So to make a long story short, we never did hire an internist or pediatrician. It just kept growing, and we kept bringing in more and more family docs. Interestingly, there weren't that many places in New York at the time where family docs could go and work and get full admitting privileges, including privileges to do OB.

We had developed a relationship with Bronx Lebanon Hospital Center because there was a vice president of clinical affairs there at the time who was a visionary, as was the president of the hospital, Fred Silverman. They decided at the time that they needed to reach out to community-based health care centers and start to bring them in to become parts of the hospital, really to gain some loyalty and to gain some admissions and specialty referrals.

So he brought us in, and he said, "You want to start a Department of Family Practice? Fine."

So I went up there as the medical director of Soundview and started a Department of Family Practice at Bronx Lebanon. It was

the only department that had a voluntary director because I wasn't paid at all through the hospital. I was the director, but I was on full-time payroll at Soundview Health Center.

But it started a division, and we negotiated OB privileges and pediatric privileges and internal medicine privileges. I shouldn't say negotiated. The president of the hospital and Ira Lubell, who was the V.P., put these people together and said, "You will grant these people privileges. This is exactly the kind of health care that we need to be doing, and they're doing a great job."

And every place I went, they said, "Oh, yeah, yeah, family practice. It's terrific." Years later, I found out how much strong-arming had been done in the background of this relationship.

So we're right at the end of the pre-natal period for the Institute, which came out of a combination of my work at Soundview, where I had this large family practice group together, and where we were all talking about what we wanted to do. One of the things we all talked about was how we needed to get into training because we thought we were sitting in this fabulous health center that was just a great place to bring students and residents. We were looking for some long-term way of maintaining the interest of the docs that were coming into this practice. The first three or four of us were pretty committed, but we were now hitting number six, seven, and eight. "You know what? We don't want to keep recruiting docs. We want people who are going

to be here for a really long time. To do that, we need to get into developing training programs."

So from our group of doctors, who were the only family physicians on the staff at Bronx Lebanon, we were rotating and doing service in the hospital as family physicians and had a very big service that we were running. From that we wrote a residency application to start a residency program. The inpatient training was going to be at Bronx Lebanon, and the outpatient training was going to be at the Soundview Health Center. That was going to be the family practice center.

We did a construction plan to do some minor renovations to the health center and to do everything else. We needed to start the residency. This was my number two experience in outrunning the community. The application got funded. We received federal funds for a faculty development program in family practice to teach us all to be faculty people. We hired a faculty development director who's still working with us to this day, Jim Deary, who had his doctorate in education and in organizational development.

I had brought a family nurse practitioner, Yvonne Eisner, with me, who worked with me at New York Medical College. She then came to Soundview Health Center to work with us as well.

Mullan: What about the Soundview Community ethnically, economically, and geographically? It is in the South Bronx, you said?

Calman: Southeast Bronx, yes. It was an all Spanish and black community, but probably one cut above what things were like in the Deep South Bronx. It had basically been a landfill area, so most of the housing was newer. There were still a few private homes down in the peninsula. It's kind of a peninsula in the Bronx.

So we wrote the residency applications and got funding. It's very interesting, but we got a residency training grant and a faculty development grant from the feds. We got accredited for this residency program which was supposed to start in July of 1986. The community board and Pedro Espada, who was the executive director, again felt that we had gotten too far off track, that this sort of very excited leadership group of docs who are really committed to what they wanted to do and everything had just gotten way off track. In fact, when they looked at the vision of their community health center being turned into a training center and whatever, all they could see was that this wasn't what they had all had in mind when they started it.

So we found ourselves staring down the throat of a brand-new residency program that we were recruiting residents for already that had no family practice center site because Soundview refused to do the kind of work that needed to be done to have this happen. So the hospital became the recipient of this gift, a new department and residency, completely grant funded. Fortunately they were absolutely enthralled about this. Bronx Lebanon heard about this and said, "You know what? We're there."

I said, "What do you mean?"

They said, "Here. Take this floor." They handed over a floor. They cleaned out a floor, their ambulatory care center that was like 8,000 square feet, practically overnight. They just moved everybody off the floor. They said, "Here, Neil, you're the chairman of the department. Run this floor, and you can run your residency right here."

So we took the hundred-and-something thousand dollars that Soundview was going to get to renovate, and we put it into this floor, wrote up the grant revisions and had them approved. We had just had a major change of plans. This was a freestanding ambulatory care center that the hospital had, and we renovated that instead. It was an the old Department of Health building. And we ran the residency program there for four years. Almost the entire staff of family docs that were at Soundview came and became the core staff of the new residency training program on site.

Mullan: What happened to Soundview?

Calman: They restaffed. We left as they filled the jobs, we left one by one. First, I think only two of us left and then a year later, two more people left. It kind of lost its spirit because the heart had been cut out. You know, this is why we all went here. This is what we were all there for. It was an incredible group of people.

Four of us, Yvonne Eisner, who's a family nurse practitioner, Eric Walsh, who's a family doctor, myself and James Deary founded the Institute.

Mullan: What was the idea behind that?

Calman: Well, again, sort of looking back at it, I think it was really modeled after the Mid-Hudson Consortium concept. The idea was to set up an independent corporation. We did it just about the time we made the transition over to Bronx Lebanon so that we would not be employees of Bronx Lebanon Hospital. So none of us ever worked for Bronx Lebanon. To this day, there's never been a family physician employee of Bronx Lebanon. All of us worked for this separate corporation and we said to the hospital, "If you want the residency, that's fine. But we want the residency to be run by the Institute, and the hospital can contract with the Institute around running the residency and hiring the faculty."

Again sometimes there's real visionary people who help things happen. The visionary people in this equation were two or three of the leadership people at Bronx.

Mullan: This is tape two, side A, continuing with Neil Calman.

Calman: So Fred Silverman, who was the president, Miguel Fuentes, who was then the vice president, who now is the president of Bronx Lebanon, and Ira Lubell, the Vice President for Educational Affairs, saw that this was an opportunity to get

hooked up with a group of entrepreneurial family docs who were going to do good things and the hospital was not at all into controlling this piece. They said, "If you folks have gotten this far as you've gotten so far, we support that. Do it. We'll give you the space."

I said, "Look, I'm going to make a proposal, a no-lose proposal for the Hospital." This is what eventually sold them. We've used the same format a few other times since. We said, "Tell us what budget you used to operate this ambulatory care center before we came. Give us your last year's budget and pay that to the Institute in twelve monthly installments. We will come in, put in a primary care model, create your first model for continuity of care between outpatient and inpatient by hospitalizing and caring for our own patients." These were all things that were very new concepts ten years ago--for people in a community health practice to be doing inpatient work and taking care of people in the ICU.

We said, "We'll do that. We'll run your residency program, get it accredited, and increase the productivity of the center by 20 percent. If we fail to meet any of those criteria, you can cancel the contract in one year."

So they gave us a contract. It was $872,000, divided into twelve installments. We created a budget to pay for the staff and pay for the family docs and the nurse practitioners and the support people and staff the whole place up. That was the Institute's first real major contract.

Mullan: Tell me a little more about what went in to Institute thinking. Surely, you could have gone into Bronx Lebanon and simply joined the staff and built a Bronx Lebanon-focused activity. But, presumably, you had a bigger concept cooking there and the Institute was a vehicle for it. Was that so?

Calman: There was a combination of a personal issue and a professional philosophy. The personal issue was that Soundview had been my third attempt at working for somebody else, and I think at that point I realized that I need too much independence personally and professionally. I work very, very fast and move too fast for the majority of people that I could ever work for. I really saw at that point that I had two choices in my life. One was to continue to be frustrated working for people who didn't move as fast as I did. The other was to start my own company. This was really what was going on in my head.

Mullan: So, this was, in essence, your own company?

Calman: Yes, definitely. The four of us became the board but it was always clear that I would be the boss..

Mullan: This was a not-for-profit?

Calman: Right. I think that if it weren't for my social commitment I would have gone out and started a group practice that probably would have twelve branches right now be in suburban

communities. That's just me--a developer. I'm a developer and that's what I love to do. But because of the way things were, I said, "You know what? You could do this." So what I really did on the professional side, I described this as a hybrid between a community health center and a private group practice. For years, I've described it that way when people said, "What the hell is this stupid thing?" I said, "It's a hybrid, extracting the best from both." And the way I would explain it is that from the community health center model I took a sense of real mission and purpose that we were there to take care of people who hadn't gotten care before, but I was absolutely sure that the way community health centers employed physicians was wrong and didn't work. It was years later that the National Health Service Corps and everybody else started to develop a consciousness about the fact that doctors had a real role in health centers and elevated medical directors to report to the boards and lots of other important things.

In the 70's and 80's in community health centers, doctors were just employees. They were treated just like clerks in the health center movement, you know. I was just absolutely sure that was a bankrupt idea, and there was clearly no way I was going to have anything more to do with this after my three experiences. And yet it seemed to me that what I was saying by saying that at that point in time was that you had to give up your political commitment to taking care of uninsured people or taking care of poor people because there was no way you could open a private group practice and make it work financially. So I

was convinced that we were going to create an organization that was going to sit right on that line and capture the best of both worlds. That was the original vision and purpose of what we did, to bring in a professionally run organization that could build on the entrepreneurial spirit of smart people that wanted to come in and develop programs and give them lots of freedom and flexibility to do that, and not have to be accountable to some outside group of people that were saying, "No, don't do this. That's not the way we want it."

So a lot of this just had to do with me saying, "Nobody's tying me down anymore. I'm not going to do this again." First Ronald Frasier Health Center, then the Center for Comprehensive Health, and finally Soundview Health Center. Three job experiences and I was at the end of my rope.

Mullan: Tell me about Bronx Lebanon. How did it develop? Where did it go?

Calman: Well, what happened was that Jim Deary, Yvonne Eisner, Eric Walsh, and myself became the four founding members of the Institute. We got some good legal counsel and said, "You know what? Not only are we going to be the four members, but we're going to be the board of directors."

We had no qualms about not being a community-based or community-controlled organization. We made no qualms about not having a community board. We were the board of directors of the non-profit and the first four employees of the non-profit, which

is perfectly legal as long as you don't use it for your own purposes and make a sham out of the fact that it's a non-profit.

So we set our salaries according to what to what people were making in similar positions in the community that we investigated and had a lot of really good, sound legal advice from very smart people in New York who said, "There's no reason you can't start out like this. Just do this and make it what you want to make it."

So we had a non-profit. It was tax exempt. It had charitable purpose. We were the board. We were the directors. We were making the contracts with everybody. About, I guess, two months after the Bronx Lebanon program was born, the board of the Sidney Hillman Health Center was going bankrupt. There was a big employee trust fund that had been used for health care purposes for years and it had almost been depleted.

The Amalgamated Clothing and Textile Workers Union ran a 40,000 square foot health center on 16th Street in Manchester, exclusively to service its numbers. It was supported by a trust fund which was losing a million dollars a year funding the center. There was three and half million left in a trust fund that had fifteen million in it just six years before. The reason they were losing all this money is that they had thirty specialty physicians there and no primary care. The specialists would come in. The union members could come there for free. The specialists would come in and they would say, "Ah, you need a vein stripping." They would then refer them out to their private office. All the patients had was catastrophic coverage which

paid for surgery. So practically every person that walked in the door here ended up in some surgical room somewhere or getting some procedures that were unnecessary. Not only did the specialists do that, but they charged the Trust Fund $100 an hour to come here on site and do this stuff.

When we came in and looked at the charts, we were so appalled. It was just the most atrocious health care system that anybody could have ever imagined. What happened was we called an independent auditor in and found 78 percent of all of the services that had been done in the prior year were medically unnecessary. We were asked to come in to bid on this. We bid against St. Vincent's Hospital, Beth Israel, St. Luke's, Roosevelt, two private doctors' groups, and some big employee health outfit that was in here.

I came in, and I brought three family docs down with me and we said, "Look, we looked at your records." We did a patient origin study and we printed it up on maps and stuff for them and said and we figured out this whole thing. I said, "What you need here is to get rid of thirty-two specialties, to close your specialty centers." We gave them a budget for the operation, and we gave them the exactly the same proposal we'd given the Bronx-Lebanon Hospital six months before. We said, "For one year, give us what you lost, just the amount of money that was lost as an operating budget. Then after that, you don't have to pay us another nickel. We can make this place completely financially solvent." And we had a proposal to do that.

We actually broke even two months earlier than we expected. We closed down four of the six floors of the building. We fired all the specialty people. We set up a panel of outside specialists we could trust. We brought four family docs in to run the center. There were only 30,000 visits a year going on in the whole building. We brought in four family docs. We took something like two hundred people off of weekly allergy shots, some of whom had been getting them for twenty years. I mean, it was the most--nobody complained. The patients were so relieved. We thought there was going to be an uproar with the patients. The patients said, "You mean I don't need these shots anymore? Oh, God, doctor, I can't thank you enough!" It was an amazing transition.

We brought in this group of family docs, and we closed down most of the building. We met all of our financial projections. I think we lost only $600,000 the first year we were in operation and then broke even in year two. All they did was pay us a very small fee for service for the patients they did, and we opened up to the community and started doing work with Medicaid. We developed HMO contracts and a lot of other stuff. The building filled up in five years, refilled with community patients of all kinds. We now have probably fifteen different programs that run out of the building that have all been developed for HIV patients, for the homeless, and for many other kinds of patients. We are continuously writing grants and developing other programs here, student programs and all kinds of training programs as well.

Mullan: How did the union feel about that?

Calman: Well, the union's almost gone. They were on their way out back then, and the leadership knew that. Most the clothing is imported now. The men's apparel industry is almost dead in Lower Manhattan. When we came in, there were more than 15,000 members and 100 shops. Two years ago, there were 6 shops and 4,000 members. Now I think there's only two shops left.

We still supply care to whatever the union members are that are left, and to union retirees and people who had been laid off from the union. We provide them all care. I mean it's our roots. So we still take very special care of the clients that come in from the union.

Mullan: What happened to the fund?

Calman: The fund is still there somewhere in a bank account. We guaranteed them that after the first year, they'd never have to touch the trust fund again. And they never did. We actually entered into a sort of illegal managed care contract with them. We told them that no matter what volume of services we provided, that we would never charge them more than what the interest was on the trust fund. It was good, because those were the years when the interest rates were high, and they were making a lot of money. So we got three, four hundred thousand dollars a year from the trust fund. By the time the interest rates had fallen

and there was only a hundred thousand dollars coming in off the trust fund interest, the membership had dropped in the union.

So, again, we benefitted from a number of speculations I made, but they were speculations based upon good data. I mean, I had graphed the membership of the union going back ten years, and it was headed on a straight linear decline, and they knew it, and we knew it. We had set up a financial arrangement where the same dollars were going to buy less and less over the years, but we had anticipated the membership was going to drop, and it did.

So, when Sidney Hillman and Bronx Lebanon, we ended up with two huge projects almost instantly when the Institute started. Actually, three. We had a faculty development program for which we had gotten a grant from the federal government.

What happened with the faculty development program was we put together this fabulous program bringing in consultants from all over the country to teach our core group of faculty, all of whom were good community-oriented family docs, but none of whom had done any teaching or really knew how to teach. We set up this great group of consultants, we put together this proposal, and the feds funded it. As we were negotiating with them, because we never just write grants, you know. We've always gone down and talked to people and tried to figure out how and what we wanted to do and matched this with the grant program. As we were down there talking to somebody, I have no recollection of who was, they said, "You know, if you're going to do this in New York, it's really a waste just to do this for your own ten faculty people. Why don't you offer it to the other family

practice residency programs while you're bringing in all these national consultants."

I said, "How are we going to be the faculty development program center for New York City? We don't even have our residency yet."

They said, "Look, you can administer it.

I said, "Yeah, but we're going to be the only faculty development program in the country that's never actually run a residency, and we're going to be the ones teaching everybody how to be faculty?"

So Jim Deary, who had this background in organizational development and in education, said, "Hey, I'll run it." He said, "You know, that's right up my alley."

So he ran it, and it got funded consistently for twelve years until they eliminated the family practice funding last year for faculty development. We were continuously funded for twelve years.

Mullan: How many people have you trained?

Calman: I think he's tracked about 140 people that have come through our year-long training program since the beginning of it. We train about ten to twelve a year.

Mullan: It's a year long?

Calman: It's a year long.

Mullan: You do it part-time?

Calman: You do it part-time while you're on your job. You attend ten workshops, ten full-day workshops which you have to be given release time for by your employer. You do videotaping and videotape reviews of your precepting abilities. You do an administrative project and a research project with some staff people that we have. You prepare some seminars that you have to give at a few different residency training sites, to perfect some talks that you give and learn how to use aids to best advantage. It's really been oriented more towards junior faculty. Now we have a track. The last funding cycle we did a track called the Continuing Education Track, which was for people who'd been in our program before, who were still in the New York area and are now more senior faculty and administrative folks. We have now started to do advanced faculty development stuff around organizational development, some advanced organizational development concepts and budgeting and some topics on managed care and things like that.

Mullan: So what happened next?

Calman: Jim Deary. Big, big issue related to having that guy on because he was the organizational development training professional with us. He's just this very incredible, stable person who you looked to and you say, "Wow, he could teach me." You know? He's great.

Yvonne Eisner, who was on, basically kept beating us up about nurse practitioner training and why were we doing all this stuff with physicians. She was on the board. We developed our whole collaborative practice model around her image of how physicians and nurse practitioners should work together, which was very different than what was popular in the educational culture at the time that we started in the eighties, you know. She was really a maverick and has been a half-time clinician and half-time promoting nurse practice in our Institute, but that's what really got us into collaborative practice. I think then we became known for being a very good and friendly place for NPs to come both to learn and to practice.

Two other key people have been pivotal. Bruce Soloway, who became the medical director of the Family Practice Center up in the Bronx and Red Shiller, who became the director of this campus and is now the Beth Israel Chairman but who works for the Institute.

Mullan: Chairman of the Family Practice at Beth Israel?

Calman: Right, but he works in the Institute. The year after we came to 16th Street, we made a proposal to Beth Israel to do exactly the same thing that we had done at Bronx Lebanon, to set up a residency at our 16th Street and start another community-based residency. We offered to do the whole thing, but they said, "Thanks, but no thanks."

Then two years later, we sent them another letter, and I went over there and actually met with some senior people, including the president of the hospital. They said, "You know what? There's no way family practice would be accepted."

Then when the Medicaid managed care thing started to hit, I said, "You know what? This is really the hook for B.I. We've got to go back there and say, 'We will be the Medicaid managed care people for you. You can do Medicaid managed care, and we'll do the risk-sharing stuff. We'll do the risk stuff out in the community in our site. This will be an opportunity for you to get involved in opening this site.'"

They said, "Wow, we've got to talk to those people."

Next thing we knew, they had awoke to discover all this stuff that we'd been talking about for years. Departments and correspondence and plans and everything. We had rooms full of vice presidents, finance, everything. Everybody wanted to do family practice instantly. They wanted to be the first family practice residency in Manhattan, which they were. You know, they were like feeding us money and resources to make this development happen fast. It was like an instant transformation.

Mullan: What year?

Calman: I guess '91, '92. So that became our second big hospital contract, a hospital contract with Beth Israel to run their family practice department and residency and to supply the director for their department.

Mullan: How many residents in your program?

Calman: Bronx Lebanon has 30, and Beth Israel has 24. A total of 54.

Mullan: That was '92.

Calman: Yeah. Then the next big breakthrough for the Institute was hiring Maxine Golub. Maxine is an MPH, and she was the head of the Bronx Committee for the Community's Health, which was a consortium of all the Bronx community health centers. We were doing some training for them about telephone medicine, and hooked into Maxine, who had a long and varied history in public health and health services development. She'd worked on lead screening. It was like an instant connection between Jim Deary and myself and her. We were doing this training. It was like the day we both left there, he and I looked at each other and said, "Some day we are all going to work together."

I guess about a year later, the Bronx Committee folded, and she came to work for the Institute. She really had this vision of how community organizations could link up with health providers and form these health centers in the community that were not really community health centers. I mean, they weren't run and developed by community boards. It was like an instant match with this plan that I had originally thought of in '86, which was how we were going to combine these two pieces. She said, "Look, they don't want to run it. Health care's too

complicated right now. No lay community leaders or social workers are going to come up and figure out, learn the managed care contracting business, learn all the issues related to labor relations and all these other issues that were hot, hot issues in health care, and write a new 330 application to get federal money to start a health center." I mean, it was a dead model from everybody's view.

So we said, "Well, we have a potentially perfect answer. Let's just collaborate with committees and committee agencies that need health service." We'd had these great successes and collaborations with the hospitals and said, "Let's just agree that these are going to be collaborations, that we're going to take two agencies and bring them together on an almost equal status and see if they can't collaborate to do a health project."

But our first attempt got blown out. We were in a community working with a community organization, had done the architectural planning, the community board there decided that it was potentially that the Institution, mostly led by Jewish people was going to be connected to this organization that was led by a group of Catholic priests who were very concerned that if we counseled anybody about birth control or abortion or anything like that, that their principles would be violated. The next thing we knew, the project went to a Catholic organization to run. This was a total violation of process. We had answered an RFP. We had the highest ratings on the RFP. We knew this from certain people we knew on the inside who were very unhappy with the decision.

I was very discouraged. This is just another example of how you can just get sidetracked. I was really ready to quit. She said, "You know what? Let's not quit so soon. Let's just be a little bit more sure about who our partners are when we go into this and make sure that everything's on the table."

So our next experiences were successful. We were able to open a whole bunch of centers in fairly quick succession over a couple of years. Maxine brought together a lot of funding from Robert Wood Johnson Foundation and many other foundations. We also were fortunate to find Al and Gail Engleberg and Carol Who both gave us and Beth-Israel one million dollars cash to support the development of family practice.

Mullan: This is to establish?

Calman: To establish the department of family practice. One gave a million dollars to Beth Israel and the Institute. He gave $450,000 more to build one of our health centers. He just gave us another half a million dollar loan, interest-free loan, to start our managed care company. So he's been right behind us, sort of boosting us along.

Mullan: Let me just get an inventory of where the Institute's at in terms of beyond Beth Israel, Bronx Lebanon, and the Hillman site. Your other operations, just kind of a summary.

Calman: Okay. The whole project, two academic training sites for residents, the Phillips Family Practice and the Bronx Lebanon Family Practice Center. We have three large five- to six-practitioner practices: Parkchester Family Practice, the Mount Hope Family Practice, and the Sidney Hillman Family Practice. We have four small two- to three-provider practices: Times Square Family Practice, Crotona Park Family Practice, and M.D.B. Family Practice, the East 13th Street Family Practice. Then we have eight part-time sites which cater to the needs of the homeless population only, that are run in soup kitchens and churches and shelters. Our total staff is sixty-five family practice people: family physicians, family nurse practitioners, and three mid-wives, 57 family practice residents and 200 administrative, nursing and support staff.

Mullan: What you've done starting in '86 or thereabout it seems to me is you have, as you described, created an intermediate form between the publicly funded health center and the privately funded private group practice. You have explored and implemented various permutations of that hybrid form, using family practice as the principal agent of service delivery, by family physicians and family nurse practitioners. Have you reached the limits of what that can do in an urban area, or have you just begun to make things work? And at what point do you cease to become an idealistic intermediate form and became instead, a business operation whose ethos begins to shift toward the more standard commercial activity?

Calman: Well, I think it comes down to different things. I think we are a business. I don't think you can have a $17 million-a-year operation with three hundred-plus employees and not be a business. In fact, what people expect of you is to be incredibly efficient in relationship to the business part of what you do, almost to the point of having the administrative part of the organization be invisible. What a doctor in a practice wants is the most efficient purchasing operation in existence. They want to be able to pick up a phone or have their nurse pick up a phone, figure out what they need, order it, and have it delivered. They don't want to know anything about what goes on in between, who you bid it to, how long it took you to pay the bills or anything else. So my philosophy about the business end of the administration is that it should be completely invisible to the people on the front end. We're never totally successful at that, but that's the goal. The administrative piece should be completely invisible.

I think we've been very good at it. I don't think that we have the same level of bureaucracy that people complain about when they work in other kind of environments. That's really critical.

The second difference between what we do and what others do is who our clientele is. I think to the extent that at some point all people will be insured, which I think will happen in the future, the real difference in organization is going to be how people define health and what the work is.

And also how true you stay to your commitment of who are you really out there to take care of. We have had a number of opportunities brought to us by commercial HMOs to operate networks and primary care sites that cater totally to a commercially insured population. We had one deal where a huge group operated by one of the HMOs was going out of business, and we could have taken the practice over lock, stock, and barrel--a program with six or seven thousand insured people that was making a considerable profit. We turned it down because it wasn't consistent with our mission.

We've turned down a number of other things. We've turned down collaborations with organizations that we didn't feel were serious about their mission in terms of wanting us to work with them. We've turned down a lot of opportunities because they just didn't seem right or didn't seem like the right organizational personality match.

We try to do what keeps us true to our purpose. We have a lot of liberal-minded people who came to work in the organization because of the mission. As much as I've become entrepreneurial in trying to develop and do new things, they don't let me stray very far from why they came here. You know, they say, "Hey, listen. I didn't come here to become part of the biggest HMO in New York, you know. I came here because I wanted to take care of this particular group of people."

In one of our practices, I was worried about the finances, and we allowed a commercial HMO to start marketing to bring in a mix of patients into the practice. It soon became the dominate

payor in the practice. The medical director said, "Look, we're not here to take care of these kind of patients. You know, this isn't why we came here."

I went, "Whoops. Yeah, you're right. That's not what we're supposed to be doing." And we shut off the stream to commercial HMOs, and we started to do some outreach to some community organizations. We shifted the payor mix back to where people wanted to see it.

Mullan: Speaking of underserved, you've got insured underserved, as in Medicaid, and you have uninsured underserved, as in non-Medicaid. You have uninsured uninsurable as in undocumented, etc. How do you define your mission, and what happens when uninsured people get insurance? Is that still part of your mission?

Calman: We don't define our mission around insurance. We define it around people who have difficulty negotiating or accessing the current health care system in New York City. Some of the people are well insured, but that just still doesn't give them access to decent health care. So we've had special programs for HIV, not because there's nowhere for people to go, but there are very few places in New York City where you can go if you have AIDS or HIV, where you become part of a delivery system that doesn't have AIDS written on the door or HIV written on the door. So we have a totally integrated delivery systems for the care of HIV. We have hundreds and hundreds of people with HIV at our sites, but

they're sitting with everybody else being taken care of by the same providers, with a very complicated network of backups. We have two or three people who are real AIDS experts that work with the Institute, one who's published a lot, and one who works half-time in the state setting policy for AIDS care for the state. Both work for the Institute. These folks are in the background of all of us who take care of people with HIV/AIDS, but all of those patients are cared for in our general settings. So that's a different kind of availability than people have in a lot of other places in New York right now.

And our homeless network. A lot of those people are on Medicaid, or we can collect some reimbursement from the federal government for their care, but they don't have anywhere to go expect emergency rooms. I mean, if it weren't for our network, there's not a care system out there for those folks. So it's not really dependent on insurance.

We also do all of the care for the home-bound with the Visiting Nurse Service in New York. We have a group of people that go out to take care of people who are truly home-bound, which means they live in places where they cannot get in and out, even with assistance, even with ambulance transportation, they cannot get in and out of their apartments. There's about forty such people each in the Bronx and Manhattan that the Visiting Nurse Service cares for, and we deliver primary care to them at their homes. A small population, but that's the kind of special work that we've been able to attach ourselves to and the kind of special programs that we do.

So I think our mission is defined by our being "ghostbusters" of a sort. If you need primary care and you have a population that's tough to serve, that's the kind of folks that we like to try to figure out health care delivery models for.

We have an ex-offenders program in the Bronx, where this group of folks came to us and said, "You know what? We have all these people that are coming out of prison. They have positive PPDs. Many have been recently diagnosed as HIV-positive. They have all kinds of other kinds of medical problems and nobody wants to take care of them because nobody wants them in their settings." So we worked out this collaboration with a group of folks who do a lot of social service support for ex-offenders when they're released from prison, to get their medical records transferred over.

Mullan: Let me explore the other axis. One axis which you've done eloquently, you've done superbly with and eloquently in defining, having to do with your "ghostbusters" mission, the other is the application of family medicine to those problems in an environment where family medicine heretofore didn't exist or at least didn't flourish, realizing it's over a period where the paradigm is changing. Tell me about that and what you think the potential is.

Calman: I have been accused of being a flag-waving family physician, which is something I accept. I'll bet we have the largest primary care organization in the country that's

exclusively family practice. I mean, we have not a single internist or pediatrician that works for us, and it is based upon a singular philosophy that if somebody were to start from scratch and wipe out the home health care delivery system in the United States, what they would create is a front line that looks a lot like family practice and a back line comprised of sub-specialists, and that the role for the primary care internist or pediatrician would not exist.

The evidence for that is that with the exception of some developmental issues in pediatrics, family physicians do not generally refer to general internists or general pediatricians. They refer to internist sub-specialists and pediatric sub-specialists.

I think the front line training for family physicians is absolutely superb in the way that it is done in terms of the breadth of training. People do all this work in GYN and dermatology and ENT and the other issues which comprise the top one hundred reasons why people need to get health care. It's a philosophy that's oriented around doing as much as you can with people and keeping them out of the hospital. I think, philosophically, it's really oriented around the fact that people are basically healthy and that these things that are happening to folks are things that need to be worked through.

It's really much more of a health-oriented training model. It's very hard to explain to folks who have gone through training in other kinds of settings, how different philosophically it is. I think pediatricians understand it a lot more because I think

the philosophy looks a lot more like pediatrics, but internal medicine is as different from family practice as night is from day in terms of just the paradigm of how doctors view people as people instead of patients. I think in terms of the transition to managed care, there's just no question that family practice is going to be much more closely a model for how things are going to need to be continued than other primary care models.

Mullan: Is the receptivity to that sort of transition, which, to be sure, is higher throughout the system than was it was some time ago, is it in the urban setting, New York setting, growing? How do you characterize the environment, the receptivity to family medicine as a movement in urban areas in general, New York in particular?

Calman: Well, I think that the medical establishment deludes itself by thinking they control this. Patient demand controls it. We've said all along that the evidence that this would predominate as a model is the fact that when you open one of these family practice centers, that in fourteen months it's filled to capacity, and we don't have a single brochure published advertising any of our clinical sites. By the time we get around to publishing our brochure and figuring out who the providers are, it's already filled to capacity. I just was laughing because today I got a memo from somebody saying, "I'm helping to write a brochure for the Mount Hope Family Practice." Two days ago I was looking at their statistics, and they're operating at

75 percent of capacity, and I'm thinking, okay, it's going to take them a month to write it, a month to edit it, a month to print it, and by the time they are done, there's not going to be anybody they can give it out to because they're already filled.

So I think that patients basically are responding. The HMOs put the booklets out. They list the family docs, the internists, the pediatricians. I don't know how the internists or pediatricians are doing, but the family docs are closing their panels. They just don't have capacity anymore. And I don't think the major draw of family practice is that the whole family gets to see the same doctor. In my own personal experience, that's the advertised piece, but I don't think that's the major draw. I think the major draw of family practice is that people can get a lot more of the things that are wrong with them taken care of in one place than they can when they got to an internist's office. Second, there's just a general philosophy that people are healthy, that people are in a general state of good health--and sometimes get sick. Family physicians are trained to be advocates for them and be with them through their illness. That is part of family practice education in a way that I think goes beyond what exists in internal medicine.

So I don't think internal medicine is going to disappear, but when you keep hearing about everybody talk about developing the "generic primary care specialty" and you look at what they're talking about and it looks exactly like family practice, you realize that we're on the right track. I've never been worried about recognition issues, because we can get hospital privileges

almost anywhere nowadays because the hospitals have floors that are half empty. When we applied to Beth Israel Hospital in the late eighties, they said, "Look, you can have privileges in pediatrics and in OB/GYN, but not in internal medicine." And we couldn't figure out what was going on. It took us months to figure this out. Well, it turned out all the medicine floors were full, and the pediatric and OB/GYN floors weren't. So that determined how they viewed family practice and our credentials. We were saying, "You don't understand. We do two years in medicine and only a year in Peds and OB combined. Why would you offer us privileges?"

"Well, that's just what the chairpeople want to do."

But it turned out it had all to do with hospital beds. So now that everybody's got hospital beds empty everywhere, they're family physicians' best friends, you know. I don't think that there's any question that economics drive people's judgments about quality and all the rest of this stuff more than anything else does.

Mullan: What about the relationship and the futures, respective futures, of the nurse practitioner and the family physician?

Calman: Well, I think that nurse practitioners and PAs and midwives are going to have an enormous new role in a managed care-dominant health system. People are talking about being concerned that the physician glut has eliminated the need for these "physician extenders," but I think that folks who say this

are ignoring two important issues. Number one, the majority of people in medicine don't like doing what midwives and nurse practitioners, in particular, love to do, which is taking care of healthy people, doing a lot of preventive care and education. I think that in the transition to managed care where primary care providers are now at risk for bad health outcomes, that we will all be moving in a direction of depending a lot more on people doing really solid self-care education and health education. I know we're moving that way in our own organization.

I think that PAs and nurse practitioners are going to look a lot less like mini-doctors, which is what happened in the eighties where they did almost the same thing that doctors did, except maybe didn't go quite so far. I think that people are going to start, especially in nurse practice and midwifery, to rely on them a lot to do a lot of preventive and educational interventions that physicians are horrible at, aren't trained for, don't like to do, and no matter how many of them get thrown onto the market, are still not going to do.

Mullan: And the competition between them, you think will be relaxed?

Calman: I think they're going to find that there's a niche, that there's a real niche now for these providers. It was hard to define the niche when they were "physician extenders", when you look at health manpower statistics and the fact that you couldn't produce enough doctors, so you were going to create all these

other kinds of health professionals. I think that that's just not going to be the drive. The drive is going to be that people are recognizing the fact that doctors are just horrible at doing asthma education. Nurse practitioners are much better at sitting down with people and teaching them how to use metered dose inhalers and teaching them how to monitor their peak flows and how to adjust their medications and to use the nebulizers. I mean, doctors just don't sit with people for forty-five minutes and do that kind of stuff. But that's going to make the critical difference as to whether or not somebody goes into an emergency room or gets hospitalized.

Now that the financial incentives are shifting, I think the places that you see the most sophisticated use of nurse practitioners and midwives are in the really sophisticated managed care delivery systems where people realize that doctors just aren't going to do that, and yet that's what the critical prevention-driven outcomes are going to improve. I think a whole new model of team practice is going to develop around these issues that we've been paying a lot of lip service to over time, but is now going to become a very significant part of our managed care system. And we're doing that within the Institute in a number of important care areas.

Mullan: What is your view of managed care?

Calman: I think it's like nuclear energy. It can be a most constructive or a most destructive force, and it always remains a

little bit dangerous. That's the analogy I use frequently in talking to people about it. On the constructive side, it's the first time we've ever had a financing mechanism that truly supports prevention, that recognizes that keeping people healthy is actually in an organization's financial interest as well in their philosophical interest. The entire financing system before was designed around illness and sickness. The sicker and iller and the more you did to people, the more money people made. I think that redesigning a system with the totally opposite incentives has more good attached to it than bad, more potential payoff than problem.

Having said that, I think that we totally redesigned a system that the American public doesn't understand. That's where the real danger in managed care lies. Another analogy I use is it's as if you all of a sudden had some pre-paid insurance for your car and you now drove into the garage and the garage mechanic, instead of saying, "Gee, you need a new fan belt," or a new muffler or whatever, said, "Oh, don't worry about the noise. Don't worry about the clanking. I know your tires look a little bald, but they'll last another couple of hundred miles, and just come back and see me in a couple of months." And the clanking gets worse and the noise gets worse or whatever, but there's really no incentive in place for them to change anything or do it, because the fan belt price and the tires price and everything comes out of their pocket. There's nothing else that I'm familiar with in American civilization that functions with that kind of reverse financial incentive.

In America we are all familiar with being sold something that we don't need, and that's the way the old health care system was. When the doctor said, "You need an MRI. It's going to cost you $300."

"Wait a second. What do you mean?" People were into that already because it's the same way everything else is being sold in America, which is they try to sell you a product and you pay money to buy it. Now we have the only example in American culture for where the entire system is turned on its head. I don't think that 99 percent of the people in America have a clue what kind of a financing system supports managed care, and that, in fact, the "garage" they now go to has a financial incentive not to provide the care. I think it's dangerous until people really understand this, as the safety in all these things is always the consumer. So I think the big danger in managed care is we still have a totally uneducated population of people who don't understand what the financial incentives are about managed care.

So even though I'm a big supporter of managed care, I'm glad that the newspapers keep running all this horrible stuff, because that's the only thing that's informing people about what the potential dangers are. And even though the transition is going to take place and everything's going to happen, what you're going to end up with on the other side is a public that's skeptical about it in a healthy way and says, "Wait a second. What do you mean I don't need a dermatologist? I read in the paper that you guys get paid more if you don't send me to the specialist."

So I think that public education that's going on through the media is going to create some protective mechanism which will be helpful in terms of helping the public be protected about some of the managed care things that are going on. But ultimately, I think it's a much better financing system. If you look at the top ten things that managed care companies think you should do for people in order to save money, and the top ten things that family doctors think you should do to people to be humanistic, they'd be the same list of things: keep them out of the hospital; keep them in the hospital for a short of period of time as you want; use tried and true, less expensive medications instead of new designer drugs. These are all the things that I believe in from the point of view of philosophically the way I practice and its the same values that managed care supports.

Mullan: Where is the Institute headed?

Calman: I don't know. We have a new committee that I just started called Institute 2000. We are doing long-range strategic planning, like looking out ten years to try to look at this question. I can tell you what my own very personal vision is, with the understanding that that's not what's going to end up being the vision, because the vision is going to have to be created by a large number of leadership people who are all very independent-minded and have a lot of ideas of their own, and somewhere we'll end up with some sort of a vision about this.

But I believe that there are certain things that are part of our future, and the more quickly we can get there, the happier we're all going to be. One of them is a completely computerized information system, including computerized medical records. I think that is absolutely in our future. Having said that a couple a months ago, it's almost daily that something comes up that we all go, "Wow, all right. We need that." Last week we were talking about the fact that our different centers are opening on different evenings. It was something like, "This is ridiculous. A patient calls up at eight o'clock at night. We have seven centers in the Bronx. If the one that they go to isn't open on Tuesday night, why can't we see them in another one of our centers? Whoops. No medical record."

We want to start a big education and recall program around a particular drug. A new finding comes out that there's a problem with a particular medication interaction. We bring together our twelve medical directors and say, "What are we going to do to find out who's on this drug?" Whoops. There's no way we can possibly do that. We have no data system that knows how many patients in our practice are on this drug.

Or we want to make sure everybody that's got a particular condition, everybody with diabetes and renal failure, is on a particular medication. We're going through this stuff, and we're realizing there's just no way without a computerized medical record system. That's number one.

Number two is, I think we're going to have our own managed care company. We have it already for Medicaid. I think we're

going to try to figure out how all these special-needs populations, HIV people, homeless people and others fit into managed care. The same way the last ten years we've been trying to figure out how they fit into primary care. Our next goal, the next place where we're going to have a big role is figuring out how they fit into managed care. Because they're all going to end up in managed care somewhere, and they are the most vulnerable potential people in a managed care transition.

I would like us to have a citywide network of sites. I would like to have somewhere between six and ten sites in each of the boroughs, supported by the most sophisticated MIS system, and in the communities right now that are the absolute neediest. I think that a lot of the people that are doing community health care out there right now are not going to survive, because there's just no way that people are going to be able to survive with the lack of sophistication that a lot of the community health providers have. They're going to be either eaten alive or they're just going to disintegrate due to the effects of managed care and capitation issues.

Mullan: What about private practitioners?

Calman: Some will fall victim to the transition to managed care. Some private practitioners, some community health centers, you know. Unless there's just a huge increase in subsidies that are going to go to them to support them through this period, I think that you're going to find that as Medicaid gets transitioned to

managed care, you already see the commercials and a lot of other people really clamoring for Medicaid patients. They're going to have choice. What that's going to leave is a very small population of uninsured people, small in comparison to the rest of the state. It's still not going to be insignificant. But who's going to survive taking care of only uninsured people? So there's going to be a new model that's going to need to develop.

My prediction is that the [President Bill] Clinton plan fell apart because it meant that people would have to go into the old health care system. Once you gave them their red, white and blue health security card, they were going to be in the old expensive health care system. But now we have a Medicaid managed care delivery system where you can buy care for $1,300 per life per year. So you now have a system into which you can try to transition larger and larger numbers of uninsured people. And as the subsidies start to fall apart for the public hospitals and community health centers, I think that you're going to see an insurance mechanism come to support the people who are uninsured, because it's going to ultimately be at a price that's no greater, and probably less, than what we are currently supporting to preserve the so-called "safety-net" institutions. So I believe we are successful at what we're doing, we have great sites, we have great providers. I think that we should be continuing to grow our network so that this scenario can play out.

In my vision of how I would know my life was successful would be to know that in New York City, that in a large number of very, very poor communities where people would have been dropped

off the medical scene with the demise of other parts of the health care system, that we will have centers for people to go that are going to take care of everybody, and they'll get the kind of care there that's probably as good if not better than what people get on Fifth Avenue. They'll have sophisticated MIS systems, they'll have recall systems, they'll have prevention. They'll be able to be called back if a medication that they're on turns out to have newly discovered side effects. It's not going to be the same models of care that people know now as the old community health care network or "safety-net."

While I support this transition, I also think that it's moving too slowly towards its ultimate goal. What I believe is that if we do this right, at least in certain model places, we're going to end up with a truly first-class system of care with all the technological and staffing and other advances, serving the people who need it the most. I believe that the financing is going to be there to do that, and that we'll be prepared to be able to say, "Hey, we can do that, take care of those uninsured folks for this price if you attach some insurance to them and put them into this kind of delivery system."

Mullan: Is there anything that you'd like add in the way of comments? You've covered an enormous amount of ground, personally and professional as well. What makes you happiest about your work in both your work today and what you've done over the years?

Calman: I really enjoy being somebody who can do good and do well at the same time, and to watch other doctors and to watch other administrative people come in and really do the same thing. It really thrills me that Bruce Soloway came to us straight of residency in '86 and never left, and he's been working his way up through the system as medical director, associate department director, and now runs the residency, too. Many people, really talented, bright people, have given their professional careers to the Institute and see it as a place that they want to stay for a long time. The longevity of employment of people in our organization is incredible. It thrills me that they have opportunities to explore and do the things that they want to do with their own professional careers. This organization and me personally, get credit for a lot of stuff done by smart, motivated staff. If not for Maxine Gollub, we wouldn't have the kind of community collaborations that I get a lot of credit for but that come from her vision that she brought to the organization. I think that's the way it's been for everything. All of the programs that we have come out of ideas that get grown from other people. I think what we've got to do is we got to get the entrepreneurial folks out there to start to connect more with public service kinds of things.

For some reason, and I don't really understand what it is yet, I have a feeling that I'm going to understand it more in a year or two, there still seems to be this schism in the world between the people who are the public health types for whom

growing and developing and being entrepreneurial is a horrible thing that you have to feel guilty about all of the time.

Even in New York, there are half a dozen of us now, people like me who are out there building and growing and doing stuff, not for a huge sense of personal financial gain. I think there's twenty jobs that I could take right now where I would get paid a lot more that I get paid now. The entrepreneurial part of it is the personal satisfaction, the development piece, and that's why I'm encouraging the people in Boston. The greatest thing we could do is give these people freedom and say, "Go out there and do it. Don't lose sight of that stuff, but just go out there and build primary care in the nearest areas. I guess that's what I think is going to connect us eventually with work in other parts of the community..

It's one of the things that the current administration, I think, is forcing people to do more, too, saying, "We're not going to just keep subsidizing things the old way. You really need to go out and do this stuff in a new way." So I see that as an encouraging part of the future as long as enough people pop up to do this kind of work. So, that's it.

Mullan: Thank you, Neil.

Calman: Thank you.

[End of interview]

Index