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Revolutionizing the Health Care Delivery System

During my 35-year professional career in the Bronx, New York City, I struggled to make radical changes in the community and hospital based health care delivery system, with a focus on primary care. Over the years I have returned frequently to the Philippines. During those visits I nurture my professional connections, lecture to faculty and staff in the department of pediatrics, University of the Philippines, College of Medicine, and make presentations to professional groups in other medical institutions and the Philippine Pediatric Society. During these visits to the Philippines I have noted a professional barrier between specialist and generalist pediatricians. I provide advice on public health issues when appropriate. My goal is to effect changes in the Philippine primary health care delivery system along with corresponding changes in medical education and post-graduate training. My vision for the Philippines is based on my experience with the primary health care system in the Bronx, NY. In this chapter, I reflect on why I decided to focus my medical career on primary health care, the leadership actions that were instrumental in achieving this vision, and the leadership qualities I have learned from my upbringing and experience. My medical career has shaped my leadership philosophy: "Knowing is not enough; we must apply. Willing is not enough; we must do." (Goethe) It is my belief that health care is a human right. I have disrupted and helped transform the health care status quo.

BUILDING A LEGACY

In June 1994, during one of my visits to the Philippines, I founded the Philippine Ambulatory Pediatric Association, Inc. (PAPA). PAPA is an organization of diverse pediatricians and general practitioners from different parts of the country, engaged in private practice, or in hospitals and government health facilities. The objectives of PAPA is to advocate and support the establishment of training programs that will increase the number and distribution of general pediatricians whether they are involved in clinical practice, teaching, or research. The goals are to enhance the quality of medical care provided to the general pediatric population; to improve the organization and delivery of pediatric health services in ambulatory settings; and to increase research activities relevant to ambulatory pediatrics. PAPA also promotes publications and advocates for public policies that support children's health. Since its inception, the organization has collaborated with national and international groups to develop initiatives that impact the work of pediatricians, especially initiatives that benefit families and children. The advocacy programs of PAPA on Community Based Tuberculosis Control Program in Children; Brief Advice for Smoking Cessation: Tobacco Control in Children and Adolescents; Health Supervision Guidelines for Infants, Children and Adolescents and Reach Out and Read Program, an innovative evidenced based early pediatric literacy program are nationally and internationally recognized and acknowledged. Currently, PAPA has chapters in Cebu, La Union, and Bulacan.

Developing Others to Share a Vision

I initiated the establishment of PAPA working with four pediatricians in the Philippines. Three were graduates of the International Pediatric Fellowship Program, Department of Ambulatory Medicine, Montefiore Medical Center, Albert Einstein College of Medicine, of which I was the director.

The International Pediatric Fellowship Program offered one-year fellowships to physicians from other countries opportunities for education in Primary Care in the United States. The fellows were mostly junior faculty members of teaching institutions, or departments of health. Fellows were selected for their organizational skills and potential for achievement in the academic world as primary care clinicians, teachers and researchers. Fellows were required to return to their home institutions. All 16 graduates of the International Pediatric Fellowship Program from the Philippines returned to the country and have assumed leadership positions in medical schools, teaching hospitals, the Department of Health, and non-government organizations.

Returning to the Philippines for at least two to three months a year has been personally and professionally rewarding to me. I left the Philippines in 1957 when I was 22 years old and had completed medical school at the University of the Philippines. I went to the United States for postgraduate residency training in pediatrics at Sinai Hospital Baltimore, Maryland and at Johns Hopkins and Baltimore City Hospital. Whether I was in a hospital setting or outside, adjusting to life in the United States was not easy for me. Being separated from family and being a minority in a foreign country was a learning experience that at times was depressing and stressful.

LEARNING TO BE RESILIENT

I believe that my childhood during World War II in the Philippines helped me learn to endure hardships and made me tough. I was seven years old when the Japanese invaded the Philippines. We vacated our house in Manila when the Japanese commandeered it, making it one of their official headquarters. We were forced to move in with relatives in the province of Rizal. Food was scarce, and we ate mostly coconuts and yams. Everybody in my family had to work. My job was to deliver carabao [water buffalo] milk to village houses early in the morning. When the defeat of the Japanese seemed imminent in late 1944 we returned to Manila, walking through the mountains. We prepared for the journey by putting on three layers of clothing. As the top layer became torn and dirty we took it off and threw it away. Memories of the long march, being constantly aware of dangers that I did not fully understand, dodging American bombs, and running into the forest to hide from retreating Japanese soldiers left me with nightmares that lasted long into my adult life. Despite these hardships, I learned the courage that is required when one must persevere in the face of obstacles.

Family Values

I am the youngest of seven in a family that values higher education. Among my siblings, the oldest became an educator and principal of a public high school. There were two lawyers, a dentist, a pharmacist and another physician with whom I spent most of my summer vacations. My mother was the quintessential Filipina mother: always there for us, taking care of our needs and keeping us together. My father was a writer, journalist, and editor-in-chief of *Taliba* and of *Bagong Buhay*, both Tagalog newspapers. My family was central in my upbringing. They nurtured my motivation to achieve, determination to face challenges, resolve to overcome obstacles and resilience in dealing with stressful situations.

SETTING VISION

Early in my career as a medical doctor, I was determined to create a community-based primary care facility. This vision was influenced by my medical school experience at the University of the Philippines, and my experiences at the Philippine General Hospital and pediatric residency training at Sinai Hospital, Johns Hopkins, and the Baltimore City Hospital. At that time, medical education and residency training was oriented toward inpatient care and medical specialties. Most patients were seen in overcrowded emergency room and outpatient clinics. The health care delivery system was fragmented, episodic, and specialty care oriented with no single person responsible for providing comprehensive, continuous and coordinated medical care.

Finding the Courage of My Convictions

My eyes would not shut. Lying in bed that night, scenes from the emergency room (ER) killed my sleep. ERs always smell like sickness. They smell of blood and vomit, followed by gusts of alcohol and Lysol from someone cleaning up a mess before another erupts. It was the end of 1966, I was alone in bed and the house was silent. My body felt heavy and dull, but I could smell the ER. Interrupting the chaos in my head of sick and wounded patients and frantic doctors was the voice of the secretary of the Chairman of the Department of Pediatrics at Montefiore Medical Center: "The Chair of the Department of Pediatrics, Montefiore Medical Center wants to see you first thing tomorrow morning." A simple phrase, one that would have evoked excitement not long before the call from the secretary. The secretary had said that he wanted to talk to me about my future. He and I had spoken about it just a few months before, so I knew what this meeting meant: he was offering me a pathway to join him in the upper echelons of academic pediatric medicine. He would give me my own laboratory and help get grants to carry out my research on carbohydrate metabolism in the newborns of diabetic mothers. Any sensible young doctor just a few years out of residency would have jumped at such an opportunity.

That night, in those hours before the meeting with the chair of the department of pediatrics, my mind skipped between memories of patients, dysfunctional medical establishments and what on earth I wanted from being a doctor. My gut said what the chair of the department was offering was not right for me. Tossing in bed, I questioned myself, how could I be stupid to think of throwing away such sure success?

What made that night especially hard, and what made my thoughts so fierce,

was not just the imminent meeting with chair of the department, or that my identity as a physician was in crisis. I could not rest because I was alone. My three children Emmanuel, aged five; Ariel aged three and a half; and Angela, aged two years, were in their rooms sleeping, and it was just me there in that bed. Normally, I would have talked about this with my husband. We would have figured it out together. Should I forgo my ascent in academic medicine or should I stay in clinical medicine? But that night I could not do this because my husband was gone. Eight months earlier, he died of liver cancer at age 31. We had been classmates in medical school and both had done residency training in the U.S. I became a pediatrician and he became a surgeon. I could not sleep that night, thinking of my late husband, my children and the patients whom I cared for in the hospitals in Baltimore, Maryland and in South Bronx, New York. I weighed the risks and consequences as I decided on the future direction of my career.

Doing Whatever It Takes; Compassion and Commitment

It was 1958, some eight years before I faced a decision on my future in medicine. I was doing a rotation at Baltimore City Hospital during my residency training in pediatrics. Late one night, on my way out the door to go home after more than 20 hours of treating patients, I happened to glance a woman holding a small baby that appeared to be about six months old. The infant's body was stiff and puckered. I bent down. He was barely breathing. The mother had been sitting in an overcrowded ER lobby waiting for someone to call her number. I grabbed the infant and yelled for the mother to follow. We ran up the stairs to the pediatric intensive care unit where I worked. I called to the staff, "Code!" The baby was given oxygen. The intern and resident checked the vital signs. They pulled back the baby's eyelids hoping to find a response. I said, "Let's start an IV. We have a severe dehydration here!" I needed a vein to start the IV. Feeling with two fingers along one of his arms I searched for some slight throb, but dehydration shrinks the veins. I found a spot and stuck the needle in, but nothing. I kept prodding one withered arm, then the other. The resident reported the baby's vitals were not good. The oxygen started to flow, so at least he was breathing. My fingers dug into a spot on his leg and found a vein. Some blood beaded up, but the vein collapsed. I was so frustrated! Why was this baby on the threshold of death? Why did the baby not get help from someone in the ER hours earlier? None of this needed to be happening, I kept thinking. My fingers continued to probe his flesh. Finally, I hit a vein in his leg and the needle stayed put. The nurse turned on the IV and everyone breathed as if we all shared the baby's lungs. I stayed through the night with the baby and he recovered.

Understanding the Context

In the spring of 1966, within months of my husband's death, I had to start moonlighting because I did not earn enough at my job as an attending pediatrician at a hospital and a faculty position at Albert Einstein College of Medicine. After my regular weekday shifts as a specialist in neonatology, I worked weekends at a public hospital in the South Bronx, the borough's poorest section. The Bronx sprawls north and east just across the East River from Manhattan. It has middle class enclaves and working class areas but most notoriously, it has poverty. The South Bronx in 1966 had buildings that had been gutted by fire. There were garbage-strewn lots instead of parks. The streets were desolate and weeds grew from buckled sidewalks. Crime was rampant. Hard drug use was endemic. Sideswiped by unemployment and municipal disinvestment, residents lacked basic services and the resources to move away. At the time the South Bronx had one of the country's highest rates of drug addiction and crime. Its children suffered from high levels of infant mortality, lead poisoning, and malnutrition. It felt like a developing country.

I remember one time I called the cops when I saw a man breaking into an apartment. "What are you doing in the South Bronx, doc," the policeman on the phone said. "Get the hell outta there!"

On the contrary, the more time I spent as a doctor in the Bronx, the more I wanted to stay. I know it seems crazy, so let me explain. Moonlighting for the hospital in the South Bronx entailed making weekend home-visits to premature babies and their mothers. We would usually see two newborns on Saturday and two on Sunday. The driver would take my nurse and I through the South Bronx streets looking for the address the mother had given. That was when I truly began to see the poverty. The burned out apartment buildings had giant black sockets where the windows used to be. Sometimes people lived on the lower floors of rotting buildings. Weeds grew through holes in the roofs. Front steps were crumbling. At that time, a quarter of all New York City's structural fires flared in the Bronx. No one hung out on stoops, the streets were too dangerous for anyone but the gangs. I would walk into an apartment building and up the stairs; pitch black, littered with garbage and shit; animal or human, I could not tell. A fetid smell would fill my nostrils and stay for days. I always wore my white coat, like a flag of surrender that could be seen, however faintly, in the bleak surroundings.

On one visit, we knocked but no one came. I turned the knob and the door creaked open. The nurse and I stepped in, softly calling, "It is your doctor from the hospital." The mother answered from a doorway across the small living room. There were no windows and no lights were on. It was morning but we could barely see our way to the bedroom. She was under the covers with the baby, who was

faintly grunting. I pulled back the sheet to look at him. My job was to make sure the preemies were clean and fed and healthy. But my eyes having adjusted, as I looked at the baby lying there, I saw dark spots on the bed: cockroaches. They scattered, running under the sheets and onto the floor.

The nurse and I washed the baby in the cramped kitchen sink. There was a window, the only one in the place that provided a tiny respite from the gloom. We fed the baby. I talked to the mother about how to keep him clean. We turned the lights on and swept the floors; we told the mother that a brighter apartment would make everyone feel better. She just looked at me and said, "Who is going to pay the electric bill?"

It was this experience that planted the seed, and on that sleepless night alone in my bed, the seed began to sprout into a vision. If I could understand my patient's life circumstances, what happens outside the hospital, then I could provide them with health care that mattered. If I simply give them treatments and prescriptions, they might take care of themselves, but they might not, even if they wanted to. It might be that they are so depressed, they cannot get out of bed to clean the apartment, or they cannot get a job to pay the electric bill. It could be that no one has ever treated them with the kindness and respect they need in order to know how to delicately and lovingly wash a baby. Believe it or not, this is what gave me hope during that torturous night alone.

As part of my duties moonlighting at the hospital in the Bronx, I worked nights in the Emergency Room. At the end of one of my shifts, as I crossed the street toward my car, I spotted the silhouettes of four young men, teenagers sitting on the hood of my car. The car was low on the ground, all four tires slashed. The boys were waiting, not for me in particular but to see the shock and fear on the face of whomever owned the car. It made me angry but I was not afraid. I headed back inside the hospital knowing I would have to stay the night. I could not go home, no tow truck would come to the neighborhood so late at night and it was not safe to ride in a taxi alone. I could have called the police but I did not. Even though I was still new to the South Bronx, I knew that if I, the doctor, called the cops, then these kids would not trust me. Even though I did not know the boys, they would know the doctor got them in trouble. Their friends would hear and all this would do was sow even greater distrust. I called home to tell my babysitter I would not be back home that night. I found a stretcher in the emergency room and wheeled it into an empty examination room and slept.

FINDING MY SENSE OF PURPOSE

You might think that since I had recently and suddenly become a widow and

single mother that I would want comfort and not this intense, insecure career alternative. Yes, indeed. Security is what the chair of the department could give me. But it became more apparent that that was not what I wanted.

Yes, I was unsure, but I embraced the challenges of being a physician in the South Bronx. After only a few months, I had already begun to feel a sense of purpose I did not have before. I could not say no to the community I had begun to discover and turn away from my promising ideas about a better kind of health care. Maybe I did not need a prestigious career. Other doctors may have wanted to retreat from the South Bronx, but I could see a role for myself as I never had before. The challenges of giving health care in the poorest neighborhood in the biggest city in the United States excited me. The people called me.

The 1960s and early '70s were the time of the war on poverty. President Lyndon B. Johnson's program created Medicare and Medicaid and allotted new funding support for community based health care centers. Money began to flow into neighborhoods like the South Bronx. At that time, I was an attending physician, and a neonatologist, conducting research on carbohydrate metabolism on newborns. Administrators at Montefiore Medical Center and the Albert Einstein College of Medicine collaborated on a proposal to open two community health centers in the Bronx, one affiliated with Albert Einstein College of Medicine and other with the Montefiore Medical Center. As my research funding on carbohydrate metabolism was running out, I took a job as an attending physician at the newly opened Montefiore Morrisania Comprehensive Child Care Center serving the South Bronx. Initially what attracted me to the job was the salary. It paid more than my attending physician salary at both hospitals where I was working. I was surprised by how much I loved the new job. I had not expected that my role as the primary care pediatrician of their children would mean so much to them and to me. Providing care on the front lines in this ravaged community, in contrast to the rarefied wards of a traditional hospital brought medicine to life. But I knew that the chair of the department would not like this. He wanted me to leave the Montefiore Morrisania Comprehensive Child Care Center for an academic position in the department of pediatrics at the medical center. However, when I thought of the mother of the baby in that apartment I had visited, I realized that as I was teaching her to care for her baby, she was teaching me how to be a better doctor, one who integrates the bigger picture of her patient's lives. Primary health care means having a specific primary care physician, who can provide comprehensive, preventive, acute episodic care; and coordinate all medical services on a longitudinal basis. It also means paying attention to the neighborhood and the resources it can provide. It means valuing the customs and cultural beliefs that at first may seem ignorant. Primary health care prevents unnecessary visits to the ER and hospitalization.

Primary health care shows patients who do not think they can do it how to take care of themselves. It nurtures within them self-confidence.

When I kept my appointment with the chair of the department, I informed him, "I want to stay at the Comprehensive Child Care Center in the South Bronx. I am happy there. I am a people person." Surprised by my decision, he said, "You know that if you stay there, you will have less chances of moving up, of being promoted to full professor." He reminded me how important it was for my future to become an academic physician and how the institution would benefit from my research and teaching. I had made up my mind. I chose to follow my heart.

Leading Innovation

In March, 1967, I was appointed director of Morrisania Montefiore Comprehensive Child Care Center, six months after I had joined it as an attending physician. I organized the medical services as a non-profit HMO (Health Maintenance Organization) with an emphasis on primary care. Most people, especially the poor, go to the doctor only when they are sick. In the South Bronx there were almost no private doctors so all the residents had access to were hospital emergency rooms and walk-in clinics. In medicine this is referred to as episodic care. This is when someone waits until they feel so bad that they have no choice but to get outpatient treatment at a hospital. Thus there is no continuity. No specific identified primary care physician to track their medical status over time and help manage their illness with an accumulated knowledge of their health. In addition, there is fragmented care, when patients are seen by different doctors each time they visit the ER and/or the outpatient clinic. It was obvious to me that this health care delivery system needed to be changed along with corresponding changes in medical education curriculum and postgraduate residency training.

It was at this time that a larger segment of society had begun to view health care as a human right. I did not consider myself a political activist, but I understood what I did as political. For me, the federal funding for the community based comprehensive primary care centers in poor neighborhoods and the awareness of inequity created fertile ground for new ideas and unorthodox actions. As required by the funding agency, I created a community board composed of parents of children registered at the center. The community board met with the administrative staff at least once a month to discuss issues regarding medical services provided at the center and how the center could address the health issues in their community, such as lead poisoning, teenage pregnancy, HIV. The core of the delivery system was the primary care practice teams composed of the pediatrician or internist, nurses, nurse's aide, and clerk.

Children were assigned to a specific team with one physician responsible for the provision of comprehensive and coordinated medical services on a continuing basis. Patients were seen by appointment, and by the same physician at each visit. A complete range of services were available, including speech and hearing, eye testing, dental, laboratory and x-ray. Psychological consultations were made available for both parents and children.

The Morrisania Montefiore Comprehensive Care Center departed from the fragmented service pattern of the past and found ways to provide health care geared to the needs of children as whole human beings. On December 2, 1969, I testified before the Senate Appropriation Sub-Committee on Labor, Health, Education and Welfare, chaired by Senator Warren Magnuson, on the need for continued funding of community health centers throughout the country. Funding was granted.

Directing a Neighborhood Family Care Center (1973 - 1976)

Morrisania Neighborhood Family Care Center (NFCC) was designed to operate as the outpatient facility of Morrisania Hospital, a municipal hospital. In 1973, when the NFCC opened, I was appointed as director and given responsible for program planning, implementation and coordination of all services provided at NFCC, including pediatric and internal medicine primary care and the subspecialty services surgery, obstetrics and gynecology, ophthalmology, otolaryngology dentistry, as well as the hospital emergency room services, home care, and employees health services. As director, I was responsible for the recruitment, appointment, hiring and firing of medical care providers. The functional independence of NFCC facilitated the establishment of priorities for the different components of medical services provided to the patients of NFCC.

Expanding the Concept: North Central Bronx Hospital (1976 - 1997)

When Morrisania Hospital closed in August 1976, I was asked to open the new North Central Bronx hospital and to serve as the director of the Department of Ambulatory Care Medicine, also known as the outpatient department. The Department of Ambulatory Care Medicine was an autonomous department with its own budget, occupying the first four floors of the hospital, including the emergency medical services (ER), all the specialty and subspecialty services and primary care teams.

Comprehensive primary care services were provided by teams. Each team had a pediatrician or internist, nurse practitioners, nurses, nurse's aides, and clerks. In addition, there were the social workers, psychologist, speech and hearing therapist, early childhood educators, nutritionists and laboratory technicians. Subspecialty consultation was provided within the primary care teams by the subspecialist to minimize unnecessary referral to the subspecialty clinics.

Community Outreach Programs were established, including the adolescent pregnancy clinic with two years follow-up after delivery for both adolescent mother and baby; breast feeding promotion; HIV/AIDS; a program to provide Graduate Education Diploma (GEDs) in collaboration with the Department of Education; after hours telephone services; child abuse services, and linkages with schools for health care promotion.

Transferring Lessons Learned: Montefiore Medical Center (1997-2002)

In 1997, I moved the entire Department of Ambulatory Medicine, including the medical staff, nurse practitioners and some nurses and program structure to the Montefiore Medical Center. The move to Montefiore Medical Center gave me the opportunity to establish the Department of Primary Care Medicine at a non-profit voluntary hospital. The lessons learned from North Central Bronx Hospital were put to good use, including the administrative arrangement of having an autonomous department with its own budget, responsible for program planning and implementation; the structure of the primary care practice teams; and the Community Outreach Programs.

The success of the Department of Primary Care Medicine demonstrated that it was possible to establish the primary care model in a hospital-based outpatient setting in both private and public hospitals. The idea was replicable and scalable.

Ensuring Sustainability: Medical Education and Postgraduate Residency Training

Both the North Central Bronx Hospital Department of Ambulatory Medicine and the Montefiore Medical Center Department of Primary Care Medicine became the site for education and training of medical students from medical schools in the U.S. and from abroad. Albert Einstein College of Medicine residents in training and other health-care professionals, from the U.S. and from international organizations.

MY LEGACY: GIVING BACK

My medical career in the Bronx set the stage for my sustained involvement and leadership over 35 years. I was able to develop a successful alternative primary health care model for the poor. I was successful in changing power structures. Planning and implementing a new health care delivery model included sharing the vision and subsequent collaboration with various internal and external teams, as well as working with diverse stakeholders. My leadership demonstrates that changes can bring about results in a health care model that provides comprehensive patient-centered, family-oriented care that benefit the poorest of the poor. What I learned about leadership in the Bronx is now being tested with the Philippine Ambulatory Pediatric Association.

