ORAL HISTORY PROJECT

Donna O'Hare, MD

Interviewed by
Joseph Dancis, MD

August 26, 1996
October 17, 1996
New York City
Donna O'Hare, MD
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PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events which are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

Joseph Dancis, MD

Dr. Dancis graduated from the St. Louis University School of Medicine in 1938 and then returned to New York City for housestaff training. His residency was interrupted in April 1941 by the U.S. Army. On discharge, he resumed his training at the NYU-Bellevue Medical Center. Except for five years in private practice, he has remained a member of the full-time faculty at NYU ever since.

Dr. Dancis had the great pleasure of observing the development of Dr. O'Hare from an eager medical student at New York University into an effective voice for children at the city, state and federal levels of government.
Interview of Donna O'Hare, MD

DR. DANCIS: It is August 26, 1996, 3:00 p.m., and Dr. Donna O'Hare and I, Joe Dancis, are seated in a quiet study room in Skirball Institute of New York University Medical Center in New York City. This is tape number one.

Donna, I've known you since you were a medical student at NYU [New York University], but I know little of what led you into medicine, and not enough of what you've done since you finished formal training. So let's start with some vital statistics. When were you born?

DR. O'HARE: I was born February 7th, 1933, in New York City, in Doctor's Hospital.

DR. DANCIS: In Doctor's Hospital. And you were born into a family?

DR. O'HARE: I'm an only child, born into a family of a mother and father who stayed together until I was four years old, and then my mother and I lived with my grandparents, who were European-born. Both came from Czechoslovakia.

DR. DANCIS: That's interesting.

DR. O'HARE: Neither one of them are involved in medicine; neither one of them were involved in a profession. They came to the United States to get married because they came from different parts and hierarchy in Czechoslovakia and could not get married there.

DR. DANCIS: These are the grandparents.

DR. O'HARE: Grandparents, yes.

DR. DANCIS: And your mother and father met here?

DR. O'HARE: Met here. My mother was born here; my father was born here. He was of Irish descent, and my mother was of Czechoslovakian descent. They eloped and were married and had me three years after they were married. We lived in New York City and my father worked in the hotel business.

DR. DANCIS: And your mother?

DR. O'HARE: My mother did not work until after they were separated then divorced later.
DR. DANCIS: And you went to school here in New York?

DR. O'HARE: I had all my education here in New York State. I started out at Hunter College in the elementary school, I don't know if you remember back in the early '40s, late '30s...

DR. DANCIS: For gifted children! [Laughs]

DR. O'HARE: Yes, I know. [Laughs] It was a special model school in which one did six years in five, and if you remember it was the new teaching system that we were learning. We only went to school from 9:00 in the morning to 1:00, never had homework, and it was a very unique environment. From there I went to Lenox School for two years, and then I went away to a Quaker boarding school, Poughkeepsie Friends Academy in New York. From there I then entered Sarah Lawrence College [Bronxville, New York], and stayed there for my four years pre-med. I knew I wanted to go into medicine by then.

DR. DANCIS: You knew you wanted medicine before entering Sarah Lawrence?

DR. O'HARE: Oh, I knew it way beforehand. My grandmother was an invalid, and was wheelchair bound. So I was very acutely aware of both medical care or lack of and the need for more scientific information so people would not be invalids and not stay in wheelchairs for all their lives. My grandfather died from cancer of the brain when I was approximately 11 years old. I was very involved in that, since we were a very close knit family.

I was the only child in that family, and I made up my mind that I probably would like to go into medicine at that time. When I went away to boarding school, we were offered many opportunities in community service. Since I loved to swim and that was one of my major sports, I taught swimming to children with polio, which reinforced my concern about people who were ill and what could we do for them.

DR. DANCIS: How old were you then?

DR. O'HARE: I was approximately 14. I always sort of knew that that was the direction I'd like to go in if I could. When I was in college in my second year, the New York Times Fresh Air Fund had their first handicapped combination normal camp, and I was the swimming instructor in charge of that camp for both handicapped children and normal children.
David Harris, who also went to NYU, was the Associate Director of that camp. I met him that summer. I was still determined that I would go into medicine. We had many long talks at night and really had a great deal of fun discussing the children and how they were getting along. And to me that was a very exciting environment to be in, to actually see normal children and children who had handicapping conditions interact and be able to work together in a camp setting. I found it to be very rewarding.

I knew I was going to apply to medical school. In fact, I met my husband in my freshman year, who was a good friend of the person I was going out with, and announced I wasn't getting married because I was going to medical school. He announced he wasn't getting married because he was going to medical school, and we got married the summer before we went to medical school. [Laughs]

DR. DANCIS: It fits.

DR. O'HARE: Much against both our families' wishes, I must tell you that.

DR. DANCIS: But, after all, your mother eloped also.

DR. O'HARE: That's right, but she didn't want me to elope. We applied to five medical schools in three cities. New York City at that time had five, and Chicago had three or two that we applied to together. New York was our first choice, and we were both fortunate enough that we both were accepted at institutions here in the city.

DR. DANCIS: You had a double hazard that both of you didn't get in.

DR. O'HARE: Yes, not only did we have a double hazard. I don't know if you remember that in the '50s women going into medicine were very high risk people that they wouldn't continue in their careers. We both had our second interviews at Cornell [University Medical School]. The person who interviewed me at the time, who I'll leave nameless, looked at me and said, "You don't look like our usual candidate. Don't you like men?" And I said, "Yes I like men. [Laughs] In fact, I'm engaged." And he said, "I hope it's not to one of these medical students." I, unfortunately, said it was and he said, "Well, I have a suggestion for you. Here's my telephone and why don't you discuss which one of you should stay on the list." And it was decided that Bob [Brayton], my husband would stay on the list to be [accepted], and that's what happened.

DR. DANCIS: Fascinating, this dramatic change in the '90s where we have over 50% women.
DR. O'HARE: That's correct. If you remember, there was no housing at that time when you finished medical school for married interns at Bellevue Hospital. They created some around '57, '58, when a number of us graduated that were married. There was no one married in my husband's class at Cornell at the same time.

Those were different times. There were not as many women in medicine at all, and the career choices were more limiting than they are today, where it's a broad open field.

DR. DANCIS: I'd like to come back to that, because that of course is very interesting and has a long history at NYU as you know of course. You graduated from NYU and you took your residency in pediatrics. You got to pediatrics because of your experience with children?

DR. O'HARE: I think for two reasons. First of all, there were two fields I was interested in. One was surgery, and, under Dr. [John] Mulholland here I had an externship which I thoroughly enjoyed. I would have loved to have been a surgeon if you really want to know. And my second choice, or almost my first and half choice, was pediatrics because I did enjoy working with children. I found them to be less complicated than adults. I found them to be absolutely honest, much easier to deal with. It was their parents that were more difficult to deal with, I thought, and I thought it was more of a challenge. If you could do something for children, you really changed the rest of their lives.

I think the thing that made the decision final, thinking back on it, was one night in January. My husband and I had both gone into the [matching] program and we were very concerned that we would be in the same town. [L.] Emmett Holt [Jr.] called me up, and it was about 8:30, 9:00 at night, and asked me if I would like to join pediatrics as an intern and get out of the matching program and I said, "Yes, I would." I was absolutely thrilled to pieces, and my husband had been told that he probably stood a good chance of being at Bellevue on the second division. I must tell you that's really what made my final decision without any difficulty at all, so I didn't have to wait until March. [Laughs]

If you remember, that was the beginning of the matching program. It was not as strict as it is today. There were options of going outside of it, if you recall. One didn't have to wait until March to hear a final decision. So I think that, plus the idea that we did want to have a family and I thought that pediatrics in general would be more compatible with that kind of a schedule than a surgical schedule. And, particularly at that time, there were very few
women in surgery. I did an externship at St. Vincent's [Hospital] and there were very few down there, as well as at Bellevue.

DR. DANCIS: Oh yes, women didn't sweep in for some years after that. Now they're in.

DR. O'HARE: They're in. So that was really the reason at the time.

DR. DANCIS: Well you must have stood out as a student, because Holt didn't make many such calls. You must have done well as a medical student here.

DR. O'HARE: Well, I was interested in pediatrics. It was very difficult at times to be married, and one of few people married and living all the way uptown near Cornell, and not down here. If you can remember at that time the new NYU medical school was just being built. We had just moved from the old building across the street. There was no beautiful hospital here. There were no housing facilities here. In fact, even when we became interns the room at Bellevue was in the psychiatric division for the married interns and residents, if you recall. It was difficult to go through the maze at night and through the dungeon, as we used to call it. So it was not very conducive, shall we put it that way?

DR. DANCIS: You can put it that way.

DR. O'HARE: [Laughs] That's right, it was trial by fire. But if you got through it I think you were in it for a lifetime, and I think it gave you an insight both to the world and to people that many never had going through academic training.

DR. DANCIS: It's interesting that you'd call the psychiatry building the dungeon, because I can remember walking through the basement and watching the rats scamper away.

DR. O'HARE: Yes. It was like a dungeon. I'll never forget when we opened the door of our room on the seventh floor, and my husband said, "Don't look in, I'm not letting you in here. We're going out and getting the room bombed." You couldn't see the beds for the cockroaches. He said, "We won't come back." It was a unique experience.

DR. DANCIS: Please make sure to say that it's different now.

DR. O'HARE: [Laughs] I believe it's different now. I haven't had the experience so I can't say, Joe, but I must say at Cornell they had a new dormitory that had just gone up and it's very pleasant.
DR. DANCIS: Tell me about your experience as a resident in pediatrics here.

DR. O'HARE: My experience here as a resident of pediatrics was one of the most exciting times in my life, I must tell you. We were here, as you remember, every other night. We had magnificent teachers, including yourself, Dr. [Robert] Ward, Dr. [Saul] Krugman. These were the people that I looked up to as mentors and people that I've always admired and continue to admire.

DR. DANCIS: Thank you, I won't delete that part.

DR. O'HARE: OK. And I have to tell you, there were many people that were just magnificent that came through. The opportunity we had here as residents was that we had guidance, but we also had an opportunity to think for ourselves. Sometimes our mentors didn't always agree with us, if you remember, Joe. We would make observations and people would say, "I'm not sure." I remember one time I wanted to submit an abstract and he said, "I'm not sure." Well two years later Dr. [Felix] Stein in Brooklyn did. If you remember, it was on the loss of hypersensitivity, during varicella.

I always found it exciting because it was always an opportunity for people to tell you more and to teach you more. But it didn't stop curiosity. And I loved pediatrics. I mean, I like doing things. I love clinical observation. Between Edith [M.] Lincoln and Margaret [H. D.] Smith and Rosa Lee Nemir, I had a wonderful opportunity. And Genie [Eugenie Fleri] Doyle...

DR. DANCIS: Those were all on the chest service.

DR. O'HARE: Those were all on the chest service. And Genie Doyle, they were wonderful models as women that were here at Bellevue and NYU, where I think it was unique to have women that stood out along with men in their fields.

DR. DANCIS: Why do you think there were so many gifted women at Bellevue, at NYU? We always talk about Bellevue.

DR. O'HARE: I think the women that were here went into medicine because they loved medicine. That was what they wanted to do, and they didn't really care about everything else. Private practice wasn't very important. Taking care of people was important. And I don't think it made any difference whether they were in their own office or whether they were seen in a clinical setting. And I think that's really truthfully very important. They weren't in medicine for the business of medicine, they were in medicine for medicine's sake. And I think they were all devoted to it. I mean, I
remember I had Janet [Sterling] Baldwin for a few years before she died early. These people were just wonderful medical people, scientists, and also could really inspire.

The work was hard; there was no question about that. You wondered how you could live through it. But you lived through it. It gave you an inner strength. I'll never forget midnight meals. People today would think that we were bizarre. But we would all rush down, if you remember, for that horrible food, and we'd all talk about our patients. And everybody would want to have a patient that they could tell about that was better than the other patient. And they would love to have puzzles. That was the whole idea of it, to go down to the table and exchange ideas. And be able to go and visit all the patients. It wasn't just on pediatrics, we had the four divisions here if you remember at Bellevue. And to me, losing those was a loss to medicine, because it was a wonderful spirit of sharing. There wasn't competitiveness like we have today. It was sharing our experiences and sharing our minds, and seeing who could give the best care.

DR. DANCIS: Now you'll have to explain what four divisions are, because your audience doesn't know that.

DR. O'HARE: Oh. Well there were four divisions there at that time. Columbia had a division at Bellevue, Cornell University Medical School had a division at Bellevue, and NYU had one, and at that time there was a postgraduate medical school that had a division here. Only NYU had a pediatric service.

We would share our medical experiences over midnight supper and all go and visit patients until you got a call. And this really, I thought, gave us all a wealth of information that we never would have achieved without it. And also clinical observation, of just looking at patients and seeing. Bellevue was a place to come to learn when you saw a sick patient. That was the experience; you learned that at Bellevue, to tell a sick patient from a patient who wasn't ill.

I think a great number of valuable lessons were learned through those long hours. You managed to get some sleep; you were young enough so you could do it. I don't think you could do it as you got older because you don't have the same stamina. We all, as we get older, don't quite have all the same abilities. But I think at that age it did work. Except on a few occasions when we were overburdened with too many patients, which did occur, I'm not sure that many of us really were too tired to do our best. I think there were those times, but I don't think they were everyday times.
DR. DANCIS: Did you have any kind of a social life outside of your profession?

DR. O'HARE: Yes, I would see my husband every other night. The first six months we didn't see each other every other night because we were on opposite schedules. You couldn't change the schedule once it was set in stone when you arrived here. However, we had a social life limited to our colleagues, basically, and a few old friends from college. I think those old friends from college, which are a handful, are not acquaintances but true friends, and we still have them today 35 years later. But in general they were our colleagues in medicine. That was our social life. If you had one, if you weren't too tired, if you didn't sleep, I think that basically was it. There wasn't much of a social life for the first four years, I'd say, of training.

DR. DANCIS: It's an interesting picture that you describe, and you describe it very well. It's an insulated existence, in which your friends and your colleagues, and everything was rolled into one.

DR. O'HARE: That's right. And you had little time really to see your family, your parents and other people. It was limited, there's no question.

We did make that opportunity for our parents. Both our parents paid for our education, but our apartment and everything else we paid for. So we did work and we did have jobs in medical school; both of us did. Not once we got into our internships and residency, but in medical school both of us held down jobs. Both parents were very skeptical about this culminating in degrees in medicine, but once we got into our internships and residency, at $15 a month we couldn't support ourselves so they helped us. [Laughs] They did help us, because that was limited income. My mother in particular felt it was important to have an apartment outside of the hospital on the nights you were off. And I think she was absolutely correct.

DR. DANCIS: Now, during your residency, did you pick your direction as to what you would do after you finished?

DR. O'HARE: Yes, I had hoped to go into pulmonology full-time. Not only tuberculosis but pulmonology in general. And, I don't know if you recall I did get a fellowship from the American Lung Association for part time. But there wasn't any money at that time, nor was there any formal division of pulmonology. In adult medicine there was some, but it was limited. And therefore, the other half of my time, in order to make a full-time person here at NYU, I was asked to become pediatric coordinator of the Spina Bifida Clinic at the Rusk Institute. There was a salary attached there from some federal grants, if you recall, because we were one of the regional centers in the United States.
That was probably one of the most broadening experiences, although I might not have thought so at that time. I didn't realize, basically, how severely handicapped [spina bifida patients were] and how much it affected the rest of the family until I became the pediatric coordinator for Rusk in which we sat around in a multi-disciplinary team. [We worked] with social workers and therapists as well as with orthopedists, urologists, pediatricians, and the nurse, and made home visits to really see how much a handicapping condition affected the entire family and their community.

After having been there for a number of years, I was asked by the Commissioner of Health at that time to come down, if you recall, and direct the Bureau for Handicapped Children. Having had this tuberculosis experience and my spina bifida experience they felt that clinically and scientifically I would have the basic knowledge to try and change things down there, and also be able to work in that department. If you recall, I agreed to do that provided I could stay with the Chest Clinic, with my one-half day a week. They agreed to that, and so I did. I think we did make some good improvements. We did develop guidelines, which are probably the beginning of practice parameters or standards, whatever you want to call them.

We did develop some guidelines for some special Centers of Excellence at that time, and I was instrumental in doing some of that. And developing pediatric cardiac centers. We would set standards and look at the clinical experience of the numbers of patients they saw around New York. I was in charge of the city program and in each of the specialty areas -- asthma, cardiac disease, seizure disorders -- all of these disabilities were then turned into Centers of Excellence. And we would visit them, we would hire consultants, go around and see if they were meeting the standard we expected. We actually did close down a number of hospitals from doing certain procedures that did not have good outcomes, and would not reimburse them under the state reimbursement program for poor children unless they came up with a year of good experience or two years of good experience.

DR. DANCIS: You've touched on a number of very interesting things I'd like to come back to, Donna. First of all, this team approach that you experienced here was remarkably thorough and broad as you describe it. You sat and discussed patients with a half dozen sitting down?

DR. O'HARE: A half dozen or more people sitting down, including preschool teachers, play therapists, occupational therapists, speech therapists; it was a whole team approach. It was really a very exciting one and a very good one for that particular child.
DR. DANCIS: It's the sort of care that it would be impossible to purchase.

DR. O'HARE: That's right.

DR. DANCIS: And it was found here at a city hospital.

DR. O'HARE: Yes. Well, Rusk was not a city hospital.

DR. DANCIS: How did they afford it then?

DR. O'HARE: That was through a federal grant. A federal grant, which was a model that we hoped, if it was proven to be effective, would then be used in other areas throughout the country. And they have been proven to be effective. Unfortunately, as you know -- something that happens very often -- things that are proven to be effective are never fully funded, and therefore not as many of them develop as should develop. But some of them do develop, the Rusk model has remained.

As you know Aaron [R.] Rausen and his colleagues run the oncology regional center [Stephen D. Hassenfeld Children's Center for Cancer and Blood Disorders], which really came up from the Bureau for Handicapped Children. That's where these things really were born, where they were developed. And they developed in other areas. For instance we have these AIDS [acquired immunodeficiency syndrome] multi-disciplinary centers today, and they follow that same pattern.

Unfortunately, as you know, there aren't enough to go around the country. And, unfortunately, sometimes we're not willing to utilize regional centers, I think, in the most cost-effective way. Everybody cannot have a regional center unless you have the population base to support it; it doesn't make sense. I think this is something that we're going to be facing in the future, but as they've grown we've not faced it. I think that's one of the reasons that medical care in some ways has become so expensive.

DR. DANCIS: Well what you've done, and I guess this started when you were with the [Department of Health], is you defined handicapped in a very broad way, much broader than it ordinarily would be thought of. Had all of these subdivisions…

DR. O'HARE: That's correct.

DR. DANCIS: And you were able to develop each one on a consistent model. You found funds in the federal government through the state?
DR. O'HARE: Found funds for this in the federal government through the states to reimburse the institutions. We did it differently from other states. Some of these have survived, as you know through the oncology center. I think Bellevue is approved for a number of these centers. At first we couldn't get hospitals to buy into it; it was very interesting. At first the hospitals were not interested. And then they became more interested as they became more involved in taking care of people who didn't have the means to reimburse them for care.

DR. DANCIS: How did this thought get started? Did somebody in Congress, or Children's Bureau?

DR. O'HARE: It was Children's Bureau that started some of it. The cardiac piece was actually started first, I think here in New York and Boston, where people were brought together to see how we can give the best possible care. You know: where does it start, how can we develop it, so that when children go into the hospital and are diagnosed with congenital defects they go to the appropriate hospital. Because this is what we first recognized in pediatrics anyway, were congenital defects. Where should we take them; how many surgeries were necessary a year; what kind of expertise did you need to have? From that I think we then looked at all the other models. I think the other models grew from that, basically. Children that needed special care.

DR. DANCIS: Now this was accomplished in a particularly favorable period in this country, wasn't it?

DR. O'HARE: Yes. It was expanding period, when government wanted to do a lot. And this was also the period of Title V, if you remember, of the Social Security Act. This was the predecessor of the Children's Bureau, which had special programs or projects, and which came up with the idea of funding programs that were more interested in prevention. These were the programs, the Children and Youth Projects [C & Y], Maternity Infant Care Program, dental care, family planning. This was the era of those projects in which the federal government sought the areas in the United States of highest need because of uncovered patients, non-insured patients, patients in need of care who had no access to care, and offered grants to particular areas for these programs in order to develop them and to develop standards in them.

DR. DANCIS: You were there at the initiation, and you're still in it.

DR. O'HARE: Dabbling about.
DR. DANCIS: How much of it has had a lasting effect? Was it just a flare-up and then subsided?

DR. O'HARE: No, I don't think it was a flare-up and just subsided completely. I think being able to identify it clearly is more difficult. If one looks at Title V and the Children and Youth Projects and Maternity Infant Care, these were developed into state programs. But when we reid the budget in the Reconciliation Act in 1981, they were phased out and replaced by Block Grants to the states. Without a mandate, many states did not continue the programs.

DR. DANCIS: What happened to all that money?

DR. O'HARE: All that money went into other avenues. And what happened was some of those continued. For instance, I still run a Maternity Infant Care Program, as you know, in which we have gotten money from a different stream, but some of that same money. The Children and Youth Projects, if you recall there were five of them in New York City, developed into what they call Pediatric Resource Centers. That's what we did at Bellevue. The programs were translated into newer models, but basically it was a similar model.

The problem is, as you and I both know, Congress likes new programs with new titles that they can be identified with. It's a very fickle country. We need a new title on the door, we need a new title for a program so people feel it's new and people are starting all over again. What people don't realize is that you will always need to have children born and children being brought up. I hope we're not going to change that, and do it all in a test tube, but we might in years to come. But at the moment I really don't see it. So basically I think we're going to have to have some programs that do have some continuity to them. Yet we always need to look at them to change them, to make them better, because as I look back on our experiences now, I see ways in which we take better care of children than we did. We certainly do more in the developmental area than we did before. I think we're much more careful about watching children as they develop, trying to identify problems and trying to do some supportive therapy.

DR. DANCIS: Who is "we"?

DR. O'HARE: I think pediatricians in general, or people that care for children, who are involved with children. But I think mainly the pediatric community. I certainly think in the maternity area that we have improved what we can do for pregnant women, with better outcomes. We can certainly diagnose better with the new technology that we have, there's no question, and I think we make some better decisions. We can also, as you know, do
surgery if we wish to in some areas today. I don't think it's a common practice, but it can occur. So that we can have a better outcome. We can also give women the right vitamins and the right care ahead of time so perhaps they have a better baby, so we don't have handicaps to worry about. Perhaps if they all take folic acid we can do away with the spina bifida clinics. I don't think we'll do away with all of them.

DR. DANCIS: That would be a dream of yours.

DR. O'HARE: That would be a dream of mine. And the other dream of mine has been genetics. I've always been interested in genetics. I don't know where that's going to go in this new era, Joe. You know it's been something I've been very interested in, when I was in Washington. To me, metabolic defects, genetics, all fit together as new knowledge that we can apply and really help people with, and in many cases be able to prevent handicaps.

DR. DANCIS: Let me bring you back. Now, you've got so many interesting things to say but I want to try to keep it on some sort of track. We received one of the first, if not the first, C&Y grants here; that was when Saul Krugman was the Chairman. It was his first or second year as Chairman. And I can remember the impact of that on our pediatric clinics. It was a difference between crisis care, patients wandering in and out, and continuity and preventive type of care. It made an enormous difference. You've stated that over the years it's continued in one form or another with a change in title. Is it still going on?

DR. O'HARE: In our clinic at Bellevue? Yes, I think it is. I hope it will continue in this new era. I think what it had to do was to select patients because of limited funds, where at one time in our C&Y we could take anyone that came. The change was really in high-risk children. In other words, it was a category of child you could see that would need these special services. It couldn't be just any child, as we had had at the beginning in Children & Youth, when it was open to everybody. The rest of it, I think, is still multi-disciplinary. There still is a bigger approach to the child, the total child and the family, and there still is, I think, the continuity of care that exists to the point it would exist in any city.

We have physicians that are here for a long time who that child can grow up with. For instance, I'm one of the examples as is Dr. [Wanda Scala] Walsh, Dr. [Emila] Sedliss and Dr. [Benard P.] Dreyer, who's been here for a number of years. In between there have been many changes as we all recognize, but there's been a cadre that's remained, that's provided continuity. I think that exists, along with the procedures and policies that we've developed over the years on the certain types of screening that we want done on every child, on the kinds of reports we want done on all children, and the kinds of care we
want them to receive. So I think from that point of view, it's continued here at Bellevue.

Not all of them have continued, as you know. Certainly there's one hospital in New York that did not apply for a renewal for PRC. And I don't think they have continued that same model. And as the crisis is coming now with more of a crunch and the cuts are coming deeper than they have for a long time, I think it would be more and more difficult in this era of managed care for them to redevelop the multidisciplinary approach to the child. They may develop a continuity of care, having a child go to the same practitioner all the time, and I don't think we know the results of that yet. I think it's too early to tell just how meaningful managed care will be in this population that we deal with.

DR. DANCIS: I'd like to come back to that Donna. I'm sorry.

DR. O'HARE: That's all right.

DR. DANCIS: I'm very anxious to get your ideas about small government, getting government off everybody's backs, and eliminating government from their roles. I'm very anxious about your viewpoint there. But to come back, it seems to me that the United States has developed a rather unusual approach to this business of giving health care. I'd like to get you to describe some of that. You've talked about Congress initiating programs. They don't come out of the heads of Congress. How do you get Congress to initiate a program?

DR. O'HARE: That's difficult, because it changes with each era. But I think basically it's by having the people who are in the legislature understanding the scope of the problem, and being personally affected by it. I really think that much of the legislation we have ever gotten through in this country that's helpful to children has been by some leader in Congress having been affected personally or committed personally. You have the example of the Kennedys who were very affected by it, both in their own family and by the children that had difficulties. I don't think we've had a leader recently of that stature, with that kind of commitment, that's concerned enough. And concerned enough about poor children. We're in an era now, I think, in the United States where people are concerned that we're taking care of too many of the poor and don't have enough money to take care of our own, "our own" in quotes. I think that's the direction in which we're going at the present time. And unless we get a leader that comes along, I'm very concerned we will have difficulties in continuing programs for children and maintaining them.

DR. DANCIS: Well are there people in the medical profession that are actively involved in interesting Congressional leaders, or does it stop with them?
DR. O'HARE: I think there are. I think the American Academy of Pediatrics has been extremely important in the last quarter century. I think before the '70s they were not really as involved as they have been since then. I've worked with the Academy, when I was in Washington. In fact that was the reason I went to Washington, if you remember, for two and a half years. It was not my idea.

DR. DANCIS: What was your title there?

DR. O'HARE: I was in charge of the Office of Maternal and Child Health, I was the Bureau Director, which was the old Children's Bureau. During the transition we almost lost it. And I basically went to Washington, if you remember, at the bequest of John [C.] MacQueen, Don [Donald A.] Cornely, and a few other people, in order to try and maintain that office so that it would not be just thrown out. And that's what I did for two and a half years with Dr. Lou Hellman, if you remember, who came from Brooklyn and headed up the Division for Maternity Services.

DR. DANCIS: Lou Hellman, the Chairman of Obstetrics.

DR. O'HARE: He was the previous Chairman of Obstetrics at Downstate [Medical Center]. And at that time, if you remember, we had Norm [Norman] Kretchmer at NICHD [National Institute of Child Health and Human Development].

DR. DANCIS: The Chairman of Pediatrics at Stanford.

DR. O'HARE: Yes. And we also had Sidney Blumenthal, who was a cardiologist, who had worked with me in New York with the Bureau for Handicapped Children. So I think a number of us in Washington at that time, in the middle '70s, saw things in a very similar way.

DR. DANCIS: Well it's fascinating that all of the names you've mentioned are in New York City. It must be an imprint in New York City that sensitized these various people.

DR. O'HARE: My feeling has always been, Joe, that the people in New York City, at least in the years I've been in medicine, were always ahead of the game. And truthfully speaking, they were sort of resented by the rest of the country. For two reasons, I think. One is our population is so big and the number of people in need was so large that we sort of took all the money if we could. I have to tell you that we were resented, and I think the rest of the country still resents [us], and so does New York State. Whether we retain that leadership in the next decade or the next quarter century I don't know,
because certainly California is giving us a good run for our money. But I have to say that it was mainly people trained in New York that had this commitment to children, not in general to medicine, but to children, where we really felt it belonged. And I think that's an important concept for the country. I think that people talk about children, advertise and use children to raise money, but when it comes to giving out money for programs, that's not where the money goes.

DR. DANCIS: This is a fascinating paradox that you're pointing out. I can insert this, New York City is resented for a number of reasons. One of them is it's pictured in the rest of the country as being excessively materialistic, and competitive. And here the picture you're describing is of those who you might say have been excessively interested in helping those who need help. Exactly the reverse, so, well, there we are. But I think both have their elements of truth. But now I'm going to bring you back to history. You're so obsessed with where we're going from here.

In the course of your presentation, you said when C&Y projects, Children and Youth Projects, first started, these were federal funded grants that were made directly to the city, and then the state got into the game with block grants. Now this is very much on everybody's minds. A lot of people want to give money to the states in a block grant and forget about it. What was your experience? Was this transition from the direct funding to the channeled funding bad?

DR. O'HARE: I don't think it was bad, because there was in that legislation a mandate to continue programs that were in place. So from that point of view, it was not [bad] at that time. Since then, that's no longer part of that mandate. Since then, we have become more involved in collecting Medicaid and other third parties. And getting people more involved in Medicaid. As we saw that occurring, if you recall, in the late '70s, early '80s, I started working with Jim [James R.] Tallon [Jr.] in the New York State Assembly, because we knew the block grants were coming. The late Solin Chao, MD, and I worked with the March of Dimes. We co-chaired the Health Professional Advisory Committee and worked at a conference with the legislators and with leading people providing care to children and pregnant women in New York City, held at the New York Academy of Medicine, and a white paper came out of that, as to what direction we should go in. We decided that we needed legislation that would first cover access to prenatal care and pregnancy for all women and children up to one year of age. We were going to start there, so that we would develop a program that would cover all children eventually. And then the next year we'd go from one to five, and then from five to ten, and then from ten to 18. It was all mapped out.
We worked on it from '79 until '84, when the legislation was written by Jim Tallon and his group. He was Chairman of the [New York State] Assembly Health Committee at that time. And in that legislation, we got the prenatal care piece. We didn't get up to age one, and we didn't get antenatal complications. We didn't get labor and delivery, because they claimed that those were covered by other programs. Jim Tallon advised many of us...

DR. DANCIS: Can you spell his second name?

DR. O'HARE: James Tallon? T-a-l-l-o-n. He is now with United Fund in New York. And Jim said, "Take this legislation; don't balk at it. I promise you we'll work and we'll get the other pieces." I don't know if you know, but in 1990 the other pieces of the legislation came along. We did get the antenatal care, we did get the labor and delivery, and we got all children covered up to one, to 185% of poverty. Now that's a fairly good point in New York State in which to cover people. It covers most people that either work for small businesses that are uninsured or else are really poor.

DR. DANCIS: Now repeat that number because it's so vital. What of poverty?

DR. O'HARE: 185% of poverty.

DR. DANCIS: That's terrific.

DR. O'HARE: But it wasn't the best in the country. There were some people that were getting 200% of poverty. But Jim said, "You get 185%, stick with it, and keep working at it." And we did. And the following year we were hoping to go with children one to five. But at that point, if you remember, the Academy came out with Child Health Plus, which was the insurance program for children. So there was really no need to because they were going to pick up that piece, and they worked on that legislation.

So there's been a group of us that have been really concerned, as Block Grants came in, to make certain that children would be covered by some kind of third party, knowing that federal funds would not always be there. We were very realistic about it, I think. However, you still don't cover everybody; there are still gaps. You still need a safety net for those people who are not covered. Or if you don't have a safety net, you're going to have a child who gets polio, measles, or a mother who doesn't get appropriate care who gives you a bad baby. And the expense to society is far more in terms of dollars, so it doesn't make very much sense if one looks at it from an economic point of view, not even a medical point of view. Joe, don't laugh. I have to tell you, that between a number of us, including Lou [Louis Z.] Cooper as you know, we've worked very hard trying to look ahead. The
thing we're not sure how to approach is how you look ahead at managed care.

DR. DANCIS: There we are back to the future.

DR. O'HARE: Back to the future. But everything leads to tomorrow. [laughs]

DR. DANCIS: [Laughs] We'll get to tomorrow.

DR. O'HARE: Am I correct? So that's really how it was approached. So that's really one of the major things that concerned me. The second thing if you remember, I was very concerned back in the '70s about genetics. And if you recall, there was a very small group in the '70s that were working in genetics. We actually got the first genetic directory, it came out of New York State through the March of Dimes and the Health Professional Advisory Committee. And then that led to the development, if you remember, of the PDL [Prenatal Diagnosis Laboratory], offering prenatal diagnostic laboratory services to poor women. And if you remember, that was funded through NYU at that time.

DR. DANCIS: Of course I remember, and I'm delighted to hear the story put together as you're putting it together.

DR. O'HARE: So that, these were the things. Now today there are genetic labs all over the world, and all over the United States, and what concerns me is will the PDL survive as we go forward with competition in the market place in a capitalistic environment, where the funding must come from patient fees, not necessarily just because it goes to a good laboratory and good work that's done? I'm back to today. [Laughs] I can't live in the future, because if I did I'd have trouble.

DR. DANCIS: Let's go back to history, when you started the end of the '50s.

DR. O'HARE: There was no Medicaid. There was no Medicare, there was no Medicare and no Medicaid.

END OF SIDE ONE

DR. DANCIS: This is the first tape with Dr. Donna O'Hare, and we are returning to the period prior to the late '50s when we didn't have Medicare and Medicaid.
DR. O'HARE: Medicare and Medicaid came in in the '60s. Prior to that time, if you recall, we had volunteer physicians, and we had, in New York City anyway, a good network of child health stations that did provide good preventive care, good parenting skills. If you remember, they were out there with first aid. They were the first people to do the hearing tests. I mean, they really did a good job and the families felt comfortable there. There was no means test at that time. Anybody could walk in; it really didn't make any difference. But they were located in areas of high risk in terms of low economic status, low income status families.

DR. DANCIS: Let me stop you there. Because you're touching on an interesting aspect of history that may not be familiar to some of your audience. You can't get volunteer doctors now to do that. What's happened?

DR. O'HARE: I think that once Medicare and Medicaid came in it changed the climate of medicine. Those volunteer physicians were excellent physicians. They provided the best care, they really did, and they were concerned about the patients when they came. They were dedicated, Joe. I mean, think of Sam [Samuel] Stone, think of some of those other people who would leave their private practice every week and come to clinics at Bellevue and take care of those patients. Probably even gave them more time than they gave their own private patients, and made certain that the interns, the residents that were working with them, and students that were with them, all learned at the same time. This takes more time than just seeing a patient on your own as you well know.

DR. DANCIS: So there was something in the atmosphere prior to the time of Medicare, Medicaid, something in the atmosphere that encouraged and invited volunteerism, people who would give of themselves without expecting financial compensation.

DR. O'HARE: I think that was true, not only here at the centers but also in their offices. I think the climate before Medicare and Medicaid was that if a patient couldn't pay, many physicians did not really push them or send them to collection agencies. That was not common. Most physicians didn't have a lot of people in their offices. They didn't fill out a lot of papers. All they needed was a receptionist and a nurse, and sometimes the nurse was the receptionist if you recall.

DR. DANCIS: I do. That was true in my office. [Laughs]

DR. O'HARE: Paperwork was minimal, am I correct? It really was, you didn't worry about paperwork. You sent a bill or they paid you when they got there and that was it. And nobody really worried about it.
Medicaid and Medicare, I think, really changed medicine to a business, which it hadn't been before. It was a profession before. And I think it changed it into a business unfortunately. I must say at the time I was not for it. I'm still not for it, truthfully speaking. I'm for a safety net, of being able to have access for people to have health care, but I'm not for the way in which it was done in this country. It either belongs to everybody or it doesn't work, and I think that's the problem with it.

It won't ever be one class of care. It isn't one class of care in England, it isn't one class of care in the Scandinavian countries, even though they talk that way. I mean, everybody has access to a certain level of care. If they have enough money, they can go outside that level of care to whatever they select. So that has always been true and I think it will continue to be true. I think it's worse here. I think there are many levels of care in the United States, and most of it is being driven by insurance. But prior to Medicare and Medicaid I think there was one kind of care, or maybe two kinds of care. You either went to a private doctor's office or a clinic. But it was the same kind of care wherever you went; it was the same person usually. It wasn't any different.

So, I sort of feel that medicine was changed greatly and I personally think we're in the next great change. But at that time it was an environment where you cared for people. And, of course, there were some people who charged excessive fees and those were doctors everybody talked about in town, and sort of said, "Oh well, be careful because if you don't have the money he won't see you." And that did occur; I'm very honest about it. But I also think the majority of physicians did see patients, and did see patients that couldn't afford it also.

DR. DANCIS: That was certainly the climate here.

DR. O'HARE: In the city, I think New York probably had more of those facilities than other areas of the country. I don't think you'd see this as much in the Midwest or in smaller towns and other areas, but certainly in this large city we did have that benefit. But I think the changes we're seeing are going to be great. Once again we're back to the future because I think that's where we're going. And we need to be sure that we're doing it in the best way possible, I think, to take care of people. But I think it did change medicine; I think it won't ever go back. Maybe I'm wrong or pessimistic. I think that physicians feel that they're not valued any longer. If you get paid for anybody you see, and you're going to be in the business, well, business people rarely volunteer in their own field; they volunteer in other fields. And physicians volunteer in other fields, not in their own field. And I think this is what we are seeing in medicine today as a result of that, truthfully.
DR. DANCIS: Well, so be it. This is history. Can't change that.

DR. O'HARE: That's history. Can't change history. All you can hope for is that we'll continue not to lose sight of the three things that count the most in medicine. And that is you don't get good patient care unless you have good research and training. And that's a lesson I think people need to keep in mind as we face the new era.

DR. DANCIS: I'd like to come back to one point that you touched on and then open up a new area. You mentioned that the Academy has gotten into the game, and you mentioned several names, people who I think are associated with the Academy, like Lou Cooper.

DR. O'HARE: That's right.

DR. DANCIS: And this aspect of what you might call organized pediatrics who are very much involved in seeking legislation that doesn't have direct advantage to the doctor, that's done for the patient. It seems rather a new thing, is that correct?

DR. O'HARE: It's not that new. It's honestly been going on since the '70s, late '70s and '80s.

DR. DANCIS: I call that new.

DR. O'HARE: Oh, OK, then that would be relatively new; yes, it would be for the Academy. I think the Academy always cared about patients. I think there was no need because legislation wasn't as important. Funding and initiation of funding and programs or direction of policy of medicine didn't come from the government. It came from medicine, medical schools, the academic environment, and the pediatricians themselves. But I think in the last decade we're seeing where government intervention, state intervention and business intervention are all going to have big impacts on medicine. And unless we're involved in it for the patient's sake, and concerned for the patient's welfare, and getting good care, I don't think medicine will survive the way we'd like it to survive. So I think that the Academy may look as though it's in a different direction, but the Academy always cared about children. I think it still cares about children, but the direction from which children's services are funded has changed so the Academy needs to be in the forefront to speak out for children.

DR. DANCIS: There's been a new development, and I can date this fairly accurately because I was involved more or less, and that's the cordial relation between academia and the Academy. That, too, is relatively new in my experience,
to the point where they have joint programs and joint offices, trying to involve the
government in the care of children. I like that.

DR. O'HARE: I do too. I have to say I think that Norm Kretchmer
and a couple other people had a good deal to do with that direction, and that
came from that same group that could see the changes coming and could see
that we're going to all have to work at it together. If we don't speak with one
tongue, our message will not be heard. I'm pleased to see it, because I think
basically we always needed to be closer together and, particularly in this new
era, I think we need to be very close. I think we need to support academics
as much as academics needs to support clinical services. It's not one or the
other, Joe, as I said earlier.

There are three things I think we need to keep medicine whole in this
country, and they are basically being concerned about good clinical services,
good teaching which comes from the academic center, and good research
which comes from the academic centers. And without those being together,
sort of in the same circle, I think we'll be lost, because business would like to
pick us apart. I think business would like very much just to pull out the
clinical services piece and say, "We really don't care about the other piece.
It's too expensive, we're not going to worry about it." We can't let that
happen. I think we all have to fight very hard to keep those things together.
And all of us need to care not just about what we're doing but care about
what the other two pieces are doing.

I think we've been successful this year in New York State. Whether that will
continue or not I don't know. You are aware with the change in legislation,
the big fighting about HMO's [health maintenance organization] and who's
going to pay for what, that we have retained the graduate medical education
piece with minimal loss. Which, if you recall, was going to be cut drastically.
So I feel that people are beginning to work together a little bit more closely.

DR. DANCIS: Spell that out a little better, Donna, you said the graduate
medical education...

DR. O'HARE: Medical education, which pays for internships and
residencies in programs in the state of New York, was going to be cut. People
said, "That's no longer necessary. We are now paying for patient services.
That should pay for all of this training and everything else." Fortunately we
were able to have the legislature see the light and make them realize that it
will not, particularly as we discount fees and as we capitulate people. The
insurance companies are not about to support the medical centers, let's be
honest about it, and give them money.
The state stepped in, not the federal government at this point. What will happen to Medicare and graduate medical education, we don't know yet. That budget isn't due until October. But we do know that in New York State, the graduate medical education line item in our budget was supposed to be drastically cut. Instead, it's been cut to a minimal degree, considering that New York has a special problem, and has for a long time, in having too many medical schools, and too many hospitals.

DR. DANCIS: There was a differential hospitalization rate for teaching hospitals. Was that retained too?

DR. O'HARE: I don't know if that's going to be retained in the same format, and that's the question we don't know. I don't believe it will. There's going be deregulation, but it's coming in stages. What the formula will be, I haven't seen yet. I don't know if you have, Joe. But I have not seen it yet, and it's not quite clear. Nor is it clear what the State of New York is going to do about welfare reform and health care reform.

We don't know whether we're going to be supporting legal immigrants and illegal immigrants, which at least at Bellevue was a significant portion of our population. And in our city is a significant portion of our population. It may even be as high as 25%. So we have all these unknowns at the moment that we are looking at.

I do think that medical schools here in the State of New York have a real problem and so do the hospitals. We have been the supplier for the United States for years. So since New York's my home and my concern, my concern is how are we going to do this in a proper atmosphere and environment. Particularly NYU, as you know, we're going to face our merger, and I don't know what that will mean to all of us.

DR. DANCIS: Let me bring you back to history.

DR. O'HARE: [Laughs]

DR. DANCIS: A lot of things you can't solve. Looking over your CV [curriculum vita], it's bewildering the array of involvements that you have had, all focusing on the child. One constant theme is the concern for the inner city child, that comes up again and again. I'd like to explore both your experience and thinking about that a bit. By the inner city child, I mean the child in poverty, family in poverty, with all of the problems attendant on that. Now you've been involved in it really for a long time. Two questions I'd like to pursue with you, in any way you'd like to. What are the fundamental problems, the basic problems, the biggest problems in these children? Can they be defined? And has there been success in handling this over the years?
DR. O'HARE: That's a difficult question and really can't be answered quickly. I think if I look back to the '50s and '60s, I would say equal access to services. Preventive services were there in New York City. We're talking about New York City and the inner city child here. For specialty care services in general, they were here. Access to education was here. And what they needed, I think, was a great deal of support.

DR. DANCIS: Financial.

DR. O'HARE: Financial support, and support in general. And I think many of them could overcome it. I can give you examples from the chest clinic. I can give you my favorite example of my Bellevue patient, Andrew Woods, who you know had a very complicated illness, or little Tommy Jasinski, who if you remember I presented with Dr. Sherwood Lawrence as an immune disorder before immune disorders were known at the [New York Academy] of Medicine one night, when I was a fellow. It was a very great point in my career, I must tell you. They had unique illnesses, and fortunately they could receive all the care because we had a system, such as Department of Hospitals, now known as the Health and Hospitals Corporation, that took anybody no matter what it cost. And I think it was possible to cure those children and to be concerned about those children, and to have them live a healthier life basically. The concern was making sure they got into care and the parents weren't afraid to ask for it.

At that time, in the '50s and '60s, people didn't feel as though the country owed it to them. Medicaid and Medicare changed that too. They were owed it. Health care was a right, and that then changed what their expectations were and what they wanted to receive.

At the same time, in the '70s and '80s, our culture changed greatly with substance abuse, far more than I think we'd ever seen. And also, I think, with more and more destruction of the family value. I think that the social background to all of this has led us to have more problems in our current era than we had before. I think there was a goal in the '50s and '60s for our immigrants that they wanted to better themselves. They were still concerned with bettering their children's lives. I don't think we saw that as much in the '60s and '70s, from this same population. And we haven't seen it as much today as being concerned with myself, with what's happening to me, rather than what's happening to my child. That's just an impression; I may be very wrong, Joe, but I think that's a very real look at how I see each of the 20 year segments that I have experienced in the last 34 years.

That, in essence, has led to the fact that children are left alone more. Our society has changed where more women work, not just the poorest women
who are on welfare. We have many more independent, latchkey children who get into many more accidents, whose lives are not supervised as they might have been at one time. But we also have schools, maybe you can explain to me, why we have schools with bars on the windows and a policeman at the door. This was not what we had in the '50s. This is a changed society, with changing rules, and a changing way of playing the game. Which bothers me, as I look toward the future.

Again we're back to the future, because to me that's what yesterday led to, what today leads to. But it concerns me, as to how we turn this around. I have one, I guess, gleam of hope. I don't know if you remember, but I was very involved with the "No Smoking" American Lung [Association] campaign in the '60s. And I came to the conclusion, as did a number of people, it was going to take two generations to change the attitude. Nobody believed it. I will never forget wearing a button, that said, "Make Love, Don't Smoke." And I have to tell you it created a lot of uproar. But I also have to tell you, it took me many years to have my husband stop smoking. But I must tell you, there is a change in society's attitude toward that, which gives me hope that we can change society by educating it, by starting with our youngest children as to what we mean by a family, what we mean by individual responsibility, and what we mean by good health. But I don't think it's going to happen right away, and if it's ever going to happen, it has to be a dedication for at least two generations, or three, and it has to be people that are committed to this goal. Because that's what really happened with smoking. If you remember it started off with people laughing at us, "You're never going to change that." You would walk into a room and didn't everybody smoke?

DR. DANCIS: Oh yes.

DR. O'HARE: I didn't. I never did. I hated it, so I mean it was natural for me. But I must say I lived with a man who smoked since he was 15. He doesn't smoke today and hasn't smoked for the last 15 years.

DR. DANCIS: Our socials in college were called smokers.

DR. O'HARE: That's right, OK? So I really see, and maybe I'm wrong, but I look hopefully to the future that we'll become as committed to having children brought up in the right environment, and that not only means medical care and homes; it means school, because that's where they spend most of their time. It means having people start out from the beginning, and it's going to take awhile, and we can't expect instant magic. It's not like finding an antibiotic to cure an infectious disease. It's a different process. And I think that process is more difficult for America than maybe anybody else, and I don't think it happens overnight.
So I'd have to say those are changes I think I've seen, and those are concerns I have. I hope it can change. I hope that having a child will become more valuable to people as I think it was at one time, and that people will become more concerned about what the future will bring. If nothing else, our economy will do that to them, because there aren't as many jobs and that entire scene is changing. I don't know what the future technology will bring, I don't know, and once again I'm back to the future, because I try to look to the future. How can you direct your life, Joe, if you don't look to the future?

[Laughs]

DR. DANCIS: I was holding you off, I didn't want to... [Laughs]

DR. O'HARE: I set my path. I was going into medicine and I was going to be in private practice and everything was going to be very simple. The first thing I learned when I covered Edith Lincoln's practice, when she used to go down to Puerto Rico for four months a year, was I couldn't charge people. So I'd be an absolute failure at practice, and that's why I knew it was never for me. I have to tell you that. So my feeling has always been I'm not sure today where I'll be ten years from now or 20 years from now, but I can think of the direction I'd like to be in, and the goals I'd like to achieve, basically. And hopefully I'll get there. They're not all successes, but you try to make some of them a success.

DR. DANCIS: All right, let's open the door to the future, Donna, I can see you've been banging at it.

DR. O'HARE: [Laughs]

DR. DANCIS: We are facing an enormous revolution after a build-up. You're describing a build-up, a change of attitudes, both in society, and among doctors, who are part of society. That's the commercialization of medicine, calling accounts as to what things cost instead of what results are.

DR. O'HARE: Right.

DR. DANCIS: So it's an entirely different emphasis. Where do you think the major roles are now? You described a series of players. There's the federal government; there's the State; there's good old New York City; there are these various agencies that you've been involved in; there's the Academy; there's the private practitioners. Do they have an important role in facing this new era, can they modify it, or is everybody helpless while waiting for things to happen?

DR. O'HARE: I think right now the picture's probably more confused than it's ever been. A lot is going to depend on what kind of legislation and
safeguards we put in place, as to who the players will be. I may be wrong; however, if you recall, when New York State had a penalty of 9% on managed care companies that did not have at least 10% of the Medicaid population, many of them hurried to gather these people in so they wouldn't have to pay the money. The new legislation passed in New York State omits that tax on managed care companies. As of one week from when it was passed and signed, there are two managed care companies who have already opted out of New York City.

I don't know what that will tell us about the rest of them, truthfully speaking, because I don't think they really know how much it will cost. I don't think there are any good numbers, even in commercial insurance, on care for the indigent. And care for people who emigrate. I don't think even Kaiser [Permanente] or any of the old companies have any really good numbers as to what it will cost if you give good care. I mean, the GAO [General Accounting Office] looked at it and said they didn't see any difference in the cost given by the managed care companies and fee for service. That's the only study that I'm aware of at the moment that's out there. So I think it's very difficult to tell.

I think the Academy and private practitioners have to work together. I think particularly the private practitioner worries me. This is a difficult environment for them to survive alone, Joe. They're going to have to, during the interim anyway, belong to some managed care companies, particularly if they're in an area where you have a high percentage of Medicaid people. There are certain parts of this country where they don't have 33% of their children on Medicaid. The parts of the country where you have 33% or almost 40% of your children on Medicaid, unless you take some Medicaid patients, I think there are going to be some problems in maintaining your practice. I think a few people will survive, but I think the general pediatrician won't. They're going to have to work with the system as it evolves.

The only way you know about a system is to work in it and with it, truthfully speaking. I think the rest of us are going to have to work very hard to look at the inefficiencies in the system that interrupt or interfere with patient care, and there are many. For the primary gatekeeper, and somebody who has a chronic illness, it's ridiculous. Well, we're already seeing some companies that are doing away with that, and that was something we recognized three or four years ago. We also have it with maternity care. You don't have to wait for the primary gatekeeper, it may take you two months to get an appointment with him, and then it would take you two months to get an appointment with an obstetrician. We've done away with that. In our legislation in New York State, we've also been careful on family planning, to
make equal access. You don't have to go through a primary gatekeeper. So I think new rules will be developed as we work within the current system.

What worries me in the United States is once big business gets involved, big business rules. All right? Big business even got the government to help them out, like Chrysler, when they were broke. So I'm not sure you're ever free of government involvement. I think, as pediatricians, we need to take the initiative for kids and get there before the businesses get there and make them realize their problems.

I think we have a good example: early discharge. They were sending them out seven hours after delivery. All of a sudden people said, "Hey, wait a minute, we're getting kids back in with kernicterus. Let's do a study, let's stop it." And we got the patients also to help us. The thing that concerns me the most in the era we're in right now and the future direction is that AARP [American Association of Retired Persons] really the most powerful political group in health care in this country, hasn't said a word about managed care. They've almost gone to bed with them. I don't understand that one. I have to say it has been some of the women in this country with their physicians who were the ones that turned around early discharge, and a legislator whose wife got out too early. So you have that example once again, and that's all you need.

I think basically what we have to do is carefully look at what's happening, and if we see problems with it, get together and identify it as a group and all of us approach it, not just one piece. Not just the academicians, not just the clinicians, not just the Academy, and not patients. Unfortunately, because I'm an older generation person maybe, I have difficulty getting patients involved. I don't want to send handicapped children to Albany on a bus, and I won't. And I don't want to send pregnant women on a bus, and I won't. Because I think that's wrong. If intelligent people who understand the problem can't change it, I think it's wrong for us to be doing that kind of thing. But that is the direction we have gone in to a great extent.

I do think we have an opportunity, I don't think we have to give up; I don't think we should give up. But I also think we have to be more critical as we look at ourselves, I really do. There are too many beds currently in this city, too many medical schools in this city. Can the deans of the medical schools come together and do something in a rational, intelligent manner? I'm asking a question; I don't know. It's a difficult one because they're not independent souls. They all have boards, they all have hospitals behind them, so it's really more complex, I think, than the general public understands. There are a lot of players, and it's not simple. But unless we do it ourselves once again, we're going to be at the mercy of these people rather than the leaders, and that's the concern I have. Because I think we need to
be in the forefront, we need to see the problems, and we need to be able to say, "OK, this is what we need. We don't need this. This is what we have to do and we need to do it." And that's not easy; it's very difficult and it's very complex.

I mean, why should a physician have to fill out 25 credentialing forms, all of which ask for the same information to be included in a managed care organization because they can't get their act together and just do one form? Why can't it come with your license? I mean, the silly things like this that shouldn't waste money that we should be spending on patient care. Or being willing to do another kid's brain surgery, to take care of another child for three more days in the hospital, rather than on paperwork. But we've got to speak out, Joe, and not enough of us are there to speak out.

I think my greatest concern as I look to the future, I'm looking behind me to see who's there. I don't see a big line. And I know people thought I was crazy when I went into the field I went into, and when I went and did the things I did, but I really did it because I thought it would improve children's care.

DR. DANCIS: Well, you've both succeeded and enjoyed it, Donna; that's why I'm sitting here talking to you. I take it that you think this is something that other physicians should get deeply involved in.

DR. O'HARE: Yes I do.

DR. DANCIS: You would recommend it, think it's a good way to spend your professional life.

DR. O'HARE: As long as you always keep your clinical life with it. I will tell you, I would never want to do this 100% of the time because, first of all, I don't feel you remain in the forefront. You don't understand the changes that are going on, and you make decisions without knowing how it affects people on the front line. I don't think there should be anybody making policy, in the bureaucracy or in big business, that has not been a clinician and involved in clinical care. I don't think we should accept it. I think that's something that we should look at very carefully, simply because I don't think they understand what goes on between a patient and a physician, and what's necessary to do good medical care. You can't see six, seven patients in every hour; it doesn't work. I mean, this is the reality of life, it just doesn't; you know that, Joe. It doesn't work that way. Yet they make policy in this direction rather than the direction of what care is needed. So I really think that's important.

DR. DANCIS: Is the legislature listening?
DR. O'HARE: I don't know. I think certainly early discharge was turned around. I think we've gotten a number of items for children's care turned around. Whether it will continue or not, I don't know, as big business gets bigger into health care. It's very possible the future may show that big business is going to get out of it because they don't make money in it. That's very possible, and we're going to be left high and dry with no system. And that's a bigger concern that I have. That if it's not successful, and the investors don't continue to make money, what will the future hold? Will we continue to be organized enough to still have in place a system that's been called a non-system? But it's been a system where people from all over the world come to the United States for care, whether it's to Minnesota, Texas or New York. This is still where they come for care.

DR. DANCIS: Do you have optimism about the future?

DR. O'HARE: You have to have optimism about the future, Joe. [Laughs] I think if we work hard at it, perhaps we will develop a system that meets the needs of this country; but not if we don't stick together. And not if we're not critical of where we have too much, and we really should pare down a little bit.

DR. DANCIS: Well Dr. O'Hare, for one thing I've seen the energy that keeps you driving, you're still as fresh as when I started, but I'm not.

DR. O'HARE: [Laughs]

DR. DANCIS: Let's stop here, either as a pause or just stop. I want to ask your advice as to what we should do from here on. But it's now...

DR. O'HARE: Time flies when you're having fun.

DR. DANCIS: Yes, it's been a long time. I'm glad you've enjoyed it. I have.

PAUSE

DR. DANCIS: This is an addendum that came up in conversation after I thought we had finished. But I do think that it's worth adding. Dr. O'Hare brought up the qualifications of an individual that is in public health. And I'd like her to tell you in her own words what she thinks is important.

DR. O'HARE: I still feel that clinical acumen has to be a big part of anybody who is in public health, and I'd like to give you one example. The example I recall is out of the early '80s, when we first identified HIV [human
immunodeficiency virus] and when it was decided that it was a homosexual disease, and obviously in women and heterosexuality it didn't occur. I did the first anonymous screening in pregnant women in my centers that I run throughout the city of New York, and of course we identified HIV at that time, and we presented that at the first HIV conference in Sweden, an international conference. So, I think it's important that we not just accept what ideas are given to us, but look at them very carefully. I think one needs a clinical background in order to do this, and make the right policy decisions.

DR. DANCIS: You mentioned another aspect that's important, and again I can't remember whether we have it on tape. And that is that in laying down policy and directives, unless you have firsthand experience, you cannot provide intelligent direction.

DR. O'HARE: We did bring that in, in our other conversation, and I feel that's terribly important. You really cannot. And that's why I think it's so important that one remains in clinical medicine even part time. So that one realizes what the impact of any direction that you set is, and also can interpret other policies I think much more broadly, by having that capability.

DR. DANCIS: So you think somebody who's in Washington, sitting down with the bigwigs, should take time off and work with children.

DR. O'HARE: Yes, I do, I really do. If they don't work with children, work with adults, whatever their field or specialty field was at the time. If they liked doing surgery, certainly Dr. [C Everett] Koop I think is another example of somebody who brought to Washington the ability of understanding what policy meant at the individual patient level, and I think that's key.

DR. DANCIS: That's a good point at which to stop. I think that's an excellent point. Thank you very much Donna.

DR. O'HARE: Thank you.

END OF SIDE OF TAPE

DR. DANCIS: This is tape two, my second meeting with Dr. Donna O'Hare. This is Joe Dancis again. We're at NYU Medical Center, this time in the Plans Room, and we will continue with the discussion that we had previously. First, Donna, you've been involved in public policy making and implementation for many years, and we got glimpses of that in our last discussion. I wonder if you could give me a more historical perspective, how it was when you first entered, and how it evolved, and where are we.
DR. O'HARE: I believe that it's been cyclical to a certain extent. I think in the late '50s and early '60s, health policy and health direction in general was made by the federal government. There wasn't very much involvement of the academic world or the practicing world. I think this evolved with some input from voluntary foundations: the American Lung Association, the American Heart Association, and the March of Dimes, just for a few. And I think these were the people that were more involved.

I think we then come to the late '60s and '70s, it becomes more important at the local level. If you remember, in the late '60s there was legislation funding money for the uninsured and other programs that we spoke about on the first tape, which gave some input to local involvement and advocacy in shaping policy.

DR. DANCIS: What is local?

DR. O'HARE: Local is by county or by city, by urban, by rural, which is where the specific initiatives were placed. I think we then would go on to say we then reverted back to local block grants first started in the '80s. This is not something new in the '90s, even though it has become a broader topic. Under the Maternal and Child Health, Social Security Act, monies of Title V were put into a block grant in the early '80s under the new budget act that was developed in Washington. This gave more impetus and impact at the state level. So I think that what we've seen is that it's been a federal advocacy level from voluntary organizations to where it was then involving local organizations or local health entities, and then we see block grants actually be made to states in order to have more of an impact.

We then go from this time to the later '80s and '90s, where we not only have more block grants being discussed on a broader topic of health care reform, Medicaid and others, but now we have the interest of the practicing physician and the academic centers, as capitalism and insurers have come into the picture. And in the '90s, I really think the major influence at this point in time, which we are going to have to become more involved in, is that of the insurance industry. This is a very powerful lobby, and unless physicians at all levels--academic centers, practicing, and associations--really begin to work on priorities in health care and what's important in health care, I think we stand to lose a great deal of our medical care system and any achievements we've had over the past ten to fifteen years, particularly in the area of prevention, particularly in the area of public health.

DR. DANCIS: Tell me how the block grant functioned, who got the money and who made the decisions.
DR. O'HARE: The block grant functioned with some regulations tied to it in 1981, '82, to the states. It was to reduce the administrative costs, to bring together the genetics program, sudden infant death program, the pulmonary regional center program under maternal and child health, the research programs, and also the money that went to states. It went directly to the states, and they were to determine their priorities, because states have different needs, as you know. There are very different needs in New York versus Kansas versus other areas. And these plans would be submitted on a yearly basis to the federal government for approval, and then they would fund programs. Therefore, the direction did not come from Washington, but in essence would be approved by Washington and cooperatively worked out at the state level. However, Washington still continued to maintain some accountability. In other words, they did want reports annually, they did want to know how many people had been served and what was being done and accomplished by these moneys that were being placed at the state level.

DR. DANCIS: This is very interesting, because I don't think this is generally known. Do you think it worked well?

DR. O'HARE: I think there were some problems. It's not all the money in health care because there's far more money in health care in the Medicaid program for the uninsured, and in private dollars, and the insurance programs that take care of people. So therefore, it represented just a portion of what was going on. In the '80s and '90s, each state began to look at what it was accomplishing or not accomplishing, and in New York State I think we had a very proactive program, trying to do things that would improve care under Medicaid. Medicaid, at that time, was paying $7 per visit to a practitioner. Well, you can't even cover walking in the door with that, basically. And what we did was build standards into a Medicaid reimbursement fee, so that we would assure that we would have better care, quality care under that program, and it would be paid for in a more adequate manner.

DR. DANCIS: Who's "we"?

DR. O'HARE: I think a number of people; nothing ever gets done by an individual. Numbers of people did. I think this is what I was talking about, of more people becoming involved. I think it was a combination of the medical societies, including the American Academy of Pediatrics, certainly, and the American College of Obstetricians and Gynecologists. I think even people that worked in academic medical centers, began to understand some of the importance of what was going on and how you were going to be able to improve health care across the board.
This effort continued and is continuing now, but I think that what's happened since legislation was introduced with mandatory Medicaid waivers replacing some of these programs and replacing some of this Medicaid expansion with built-in standards of care, is going to have to be watched very carefully. Because at the moment, for instance in New York State, there are very few requirements of the managed care organizations who are going to be serving the underserved and the poor for quality care. I think that has many of us very concerned.

DR. DANCIS: Money here is now given to the state.

DR. O'HARE: Correct.

DR. DANCIS: Who in the state?

DR. O'HARE: It's given to the state health department. It used to be given to the State Department of Social Services under Medicaid, if you recall. Now Medicaid has been incorporated into the Department of Health in New York State. This has just occurred recently, so the responsibility for Medicaid will be in the Department of Health. Before only federal moneys were in the Department of Health, the other moneys were in the Department of Social Services.

DR. DANCIS: Who is the Department of Health? Are these political appointees?

DR. O'HARE: Yes. Dr. [Barbara A.] DeBuono and her staff, under our new governor, [George E.] Pataki.

DR. DANCIS: Well the first big decision, I would assume, is where does the money go? It's a big state. Does it go to Troy; does it go to Syracuse; does it go to New York City? Is there a formula?

DR. O'HARE: There are formulas for this money. The formulas for the money are based somewhat upon need and priorities.

DR. DANCIS: By whom?

DR. O'HARE: By the state. By the state councils, advisory councils, and many other groups. For instance, with the Maternal and Child Health block grant monies and Title V, there is an advisory council, which I have been on since the inception of this, in the '80s. We look over the priorities as they're determined. They are not equally distributed throughout the state. In fact, there's some concern that many of us have that New York City is certainly not getting its fair share based on the needs assessment, and that's a
concern that we have and something that we have to see if we can correct. There is a projected cut for New York City in many of the areas, and New York City has the bulk of the problems if one looks at the state of health care and trying to prevent further disease. So I think many of us are very concerned that in this new era we have to be very alert to the fact that we have to have the governor and the people on these advisory committees understand what the problems are in the city.

DR. DANCIS: When you say "we" again, you're talking advisory groups. Do you have power, or do you just talk?

DR. O'HARE: We have advisory powers. The advisory powers are interesting, because many of the committees that are set up at the state level are representatives from the Assembly, from the Senate, and from the Governor. So there are three places where these people are appointed from in general. We have to know who's on those committees, and if we have concerns, try and work with the individuals. Since these committees are advisory, obviously, and the information is made available, certainly the legislature can have some input as well as the Governor's office.

DR. DANCIS: Well it's the old conflict between upstate and downstate, and I assume that it invades this area as well.

DR. O'HARE: The upstate/downstate issue I think is a more acute issue in this current administration than it has been in the past. And I don't know how we're going to resolve it at this point in time. I think that you've seen the conflict between the Mayor [Rudolph W.] Giuliani and Governor Pataki. I think we don't have an answer yet; I think both of us thought we would, on how welfare reform might be coming out in New York State. As you know, New York State is losing over a million dollars a day at this point, for not having put a plan in. Supposedly one is coming out in today's paper, I don't know if it has or not because I haven't seen it yet, but that will be a very interesting plan to look at. And that will give us some idea of how New York City will fare in that plan.

DR. DANCIS: Now you've mentioned the legislature and the governor on these committees, representatives on these committees. Where is the medical input?

DR. O'HARE: The medical input has been interesting. That also has had some historical perspective. I think if you go back to the '50s and '60s, there was very little organized medical input into it. I think in the '80s we had more, in the '90s we have even more. I think there is representation, or we have attempted to have some representation from the medical societies across the board. Not only the state medical society, but certainly the
[American] Academy of Pediatrics, and ACOG [American College of Obstetricians and Gynecologists], and all the other groups. I think they have tried to have some impact on assuring that appropriate care will be given, and being concerned about the quality of care that's being given.

So I think that this has also changed and evolved as we go across the board. I think there has been too little medical input in some instances and in decisions being made. And that is a concern that I have.

At one time, I think medicine in New York State tended to be apolitical. We had an excellent Department of Health, as you know, that led the country in many areas. If you look historically I'd say that we've gone from sort of medicine being apolitical to medicine being a political [football], and I think this has been a big change that is going to affect what happens to the future of medicine. I think in New York State, as I believe we stated on the first tape, we have an overabundance of training programs, medical schools and hospitals.

DR. DANCIS: Overabundance.

DR. O'HARE: Overabundance. And, I can't make this point strong enough, I would love to see the leadership come from the academic centers regarding how we should approach this. Don't wait for the Governor to say you must do it, don't wait for the federal government to say you must do it, but just take the leadership. How can we organize in this state the most effective kind of health care training programs, clinical programs and research programs? I think it's a very important issue. At the moment we're sort of playing around. Should I put it that way? That's my interpretation.

DR. DANCIS: Now you've been involved with the Academy for many, many years as well. I think you were President of one of the districts as I remember. Is the Academy involved in this?

DR. O'HARE: The Academy of Pediatrics?

DR. DANCIS: Yes.

DR. O'HARE: I think the Academy of Pediatrics has taken, tried to take a very strong stand at the state level. The Academy itself has just announced, as you may or may not know, that they hope to have more technical assistance available to state chapters and try and give them more support. The Academy has also evolved from the '60s to now, as I spoke about earlier, where it wasn't involved at all in the process and then became involved in the process. And so I think the Academy is trying to provide more support and more guidance, and give us examples and help us
understand what's happened in other states that's been successful or has not been successful. I think the Academy is a player, a very strong player in this particular administration. I think this has been very helpful. Dr. Cooper obviously is our chapter representative for New York State, and I think this has really had an impact on what we've been able to do for children. As you know, we've maintained our children's program even though the bill has been changed radically. How long this will last I don't know. But I certainly think we've been able to at least keep it there, so that we can maintain and not lose any ground in that area.

DR. DANCIS: Academia?

DR. O'HARE: It's been my perception that academia has not taken a strong leadership role in the state. And I hesitate to say that because Dr. [Saul] Farber, as you know, has been very influential in many areas. But I really feel that they have not taken as strong a stand as they should. I really think that academia needs to take the lead in this, and help show people the way. But I also think academia has a responsibility, and that is that in many instances, as I said, we're involved in research and training. Clinical care is not our responsibility, and, as I stated in my first tape, I think they're all interrelated. I think they all go together, and I think that a stronger responsibility needs to be taken in this area.

Now that there's some money in this area, some of the academic institutions have gone out into clinical practice and into satellites and have expanded. But there still is not the same recognition, or it's not held in the same esteem, if you are a researcher versus a clinician. Or you are just a teacher versus a clinician. I think we need to level that playing field a little bit in recognition from the academic centers. They need to be involved, because that's where the results of their research will go. I think if they want to maintain funding, particularly in the future, it's going to be very important.

As you know, I don't think the HMOs are going to pay for research. I don't think they're going to pay for training. And training in this state has been strongly supported both by the federal Medicare graduate medical education money, and the state graduate medical education money. So I think we have to think very carefully about it, and really see if we can't persuade them in many areas to take a stronger view.

It's interesting to me, you had asked me earlier about the Stan James award that I had received. Stan [L. Stanley] James and I, and Dr. Chao, Solin Chao, worked very hard for many years in New York State to develop some legislation. And then in the 1980s, late 1980s, I think the three of us felt that it would be helpful to have an advocacy group, not only of physicians, nurses, social workers, but also of consumers.
DR. DANCIS: Let me explain for the benefit of those who don't know. Stan James was one of our outstanding neonatologists, who has contributed extensively to our knowledge and clearly would be classed among the academicians.

DR. O'HARE: That's correct. Stan realized that it was really important to develop some advocacy in this area. And Stan was the first person I think really to come out of academia in this way, to take an active role. Many of his peers did not even realize that he was so active in this and was very, I think, important in helping maintain the importance of this advocacy role as we developed our legislation for prenatal care, and for regionalization of perinatal care. I think that this just points out how very important the academician is, to work with other people.

DR. DANCIS: Let me get a better feel of this, Donna. You and Stan...

DR. O'HARE: And Solin Chao, who was an obstetrician, and recently died. He was Chairman of St. Luke's- Roosevelt [Hospital Center].

DR. DANCIS: I see. The three of you had got together and said, "There's work to be done."

DR. O'HARE: "How do we do it?"

DR. DANCIS: Exactly.

DR. O'HARE: Yes. Actually, it was Solin Chao and I who, in 1978 with the March of Dimes, said, "There is work to be done. Pregnant women aren't being cared for. Outcomes of pregnancy are bad in New York State. How do we improve it?" And with that we then went to the legislature, as I said earlier, and involved Senator Tallon -- not Senator, Mr. Tallon at that time -- who was then involved with the Health Committee at the Assembly of New York State. And he helped us formulate, along with other legislators including Dr. [Alexander B.] Pete Grannis, how to proceed and develop some legislation. And he said it would take a group not only of physicians, but of consumers and of other people, to really get this through. And that's how it really started.

DR. DANCIS: You made up a group?

DR. O'HARE: We made up a group, and we worked on it. Every year we got a little bit further until in 1984 some legislation was drafted and then passed. After it was passed, as I said earlier, it was not passed totally as we desired it. We only got the outpatient care; we felt we needed the inpatient
care and labor and delivery and special care for neonatal intensive care units. We did get that later in 1990. That was after we had formed New York State Perinatal Association.

DR. DANCIS: Who are consumers? Babies aren't.

DR. O'HARE: Babies aren't, their mothers are.

DR. DANCIS: Any mother?

DR. O'HARE: Any mother. Actually some of our consumer people are people that we knew who had delivered babies who had difficulty, or who had delivered healthy babies but were concerned that everything was not covered. You know, it's taken us a long time to get coverage for the infant. Most insurance companies many years ago did not cover the infant. Eventually, I think through advocacy, they did. And I think that many neonatal intensive care units, all of that was not paid for through insurance. And I think through advocacy we've been able to overcome that.

DR. DANCIS: All right. Now, I can easily play the ignorant one because I am. Here you have a group together, and you sit down as a group. Ten of you?

DR. O'HARE: Mm-hm.

DR. DANCIS: And you say we need x and you work it out together. And you actually prepare a document?

DR. O'HARE: Yes. We prepare a document with the help of the aides of the legislators. In other words, we did sit down and talk with them, they would know what our goals were, that we'd like to have all women under 185% of poverty level covered. We'd like to have them covered for regional perinatal care. And that we would like to see that they were covered up to the first year of life. And then they would sit down and draft the appropriate legislation and how this would be funded.

DR. DANCIS: This is our New York State legislature; they are accessible. You call them up?

DR. O'HARE: They are accessible. Oh yes, you call them up. First of all, you're one of their constituents. You are, I am, we all are. We all have the opportunity to go in and express our concerns to them. And particularly if we have some constructive suggestions. If you're just going to go and complain, it doesn't work. You're going to say you don't like this. However, if you can work it out with them, find out what their attitudes are, you can certainly work with them in a most constructive manner. This is what we've
been able to find. This is not only true at New York State; this is also true at the federal level. So I think this is the manner in which one has to approach the problem.

DR. DANCIS: Sounds suspiciously like a democracy.

DR. O'HARE: It might be. [Laughs] It doesn't always work the way you want it to, Joe. You don't always get everything you want. But you get some of what you want. So I think it was very pointedly seen when we changed the early discharge of mothers. That was really a physician/consumer advocacy group that determined that what the insurance companies were doing was inappropriate.

That's an easy issue, that's a mother and apple pie issue. That's not difficult. Other issues are far more difficult. How do you get the public in general to feel that we have to be responsible for all the babies that are born? That we have to be concerned that we give them the best opportunity to have the most productive lives and the best quality of life. That's a far more difficult area politically for everybody to accept. Particularly right now when I think the public is concerned about costs, their taxation, and the concern that we have too many people utilizing the system that shouldn't be.

DR. DANCIS: Now physicians' groups, not particularly the Academy, maybe less the Academy, are often accused of being motivated by the dollar bill. How were you received?

DR. O'HARE: In general as pediatricians, once again -- obstetricians not as much -- but as pediatricians, we were well received. As you know, the legislators and political people are not as afraid of the Academy looking out for their pocketbook as they are other groups. I think we have a reputation for having stood up for children rather than for what's happening in our own profession, what's happening in our own practices to a great extent. And therefore I think the Academy has had entree much more readily into these offices, and still does, than other groups have. So I think that that's been part of the effectiveness, to be very honest with you.

DR. DANCIS: A couple of questions. I find this very interesting, and important. You are now associated with what organization?

DR. O'HARE: In my work?

DR. DANCIS: Yes.

DR. O'HARE: The Medical and Health Research Association of New York City, Inc., which is a not-for-profit organization that receives funds
from many different sources. They run the Ryan White programs throughout the city of New York [New York City HIV CARE (Comprehensive AIDS Resources Emergency) Services]; they run the I-CHAP [Infant-Child Health Assessment Program] program which is following up on children born at-risk. They run the EI [Early Intervention Service Coordination] program, the SIDS program [New York City Information and Counseling Program for Sudden Infant Death], many programs that in the past probably would have been funneled through the New York City Department of Health. Because the New York City Department of Health became more of a political organization, it was more difficult to keep the moneys separate, and to utilize them within a budget year. This organization has been utilized more and more for many programs that are funded for the city, but have a time-limited amount. In other words, it is not an entitlement program, it's a grant program, on an annual basis that needs to be renewed. If you have this kind of a funded setup, you can't go through city council, you can't go through the whole civil service system. So therefore, it was far simpler for this to be developed.

As you know, I run the Maternity, Infant Care - Family Planning Projects [MIC] in New York, which serve approximately 10-12,000 pregnant women a year; and approximately 20,000 family planning patients a year, all poor women, high-risk, in the low economic areas. We have ten centers. This program helps you to start them. Originally when legislation was passed in the late '60s, this was funded directly to the New York City Department of Health. Legislation was passed, it was felt these programs were effective, the C&Y and the MIC [Maternity, Infant Care – Family Planning Projects]. And then the 516 Amendment of Title V was placed. Actually Mr. [Ed] Koch was very influential in this when he was at the federal government level. This then became something that was in every state plan. Every state plan for maternal and child health had to have an M&I [Maternity and Infant] and C&Y and all the rest of it. This then developed into the fact that the city found it difficult to manage these funds on an annual basis, and they wanted to put it into the city coffers, and therefore it was determined this was not appropriate for a grant program. So they looked for a not-for-profit corporation in which to put it. And the Medical and Health Research Association [MHRA] was available at that time, and that's where it was put.

DR. DANCIS: It's fascinating because I worked for years with MHRA and I had no idea it was not a state organization.

DR. O'HARE: There is a state organization that's very similar, that was formed after MHRA. MHRA was originally formed in the '50s to be utilized for special grants, usually for research. In fact, my first research grant was through MHRA when I was at the Bureau for Handicapped Children. There was a comparable state organization that was started later.
There was a big discussion in the '70s, 1974 or 1975, as to whether the funding for the block grants and the 516 money at that time, special programs, should go to the state not-for-profit or city not-for-profit. At that point it was felt that the state not-for-profit had not developed to the same extent that the city one had, and since these were city programs, they probably should go to the city. So there is a comparable organization at the state which is utilized also for purposes of grants. It's difficult for grants to go through a large budget. They get lost, as you know. When there's a freeze and someone leaves, you can't utilize that money or fill that position. That's not an effective way of using money if it's time limited.

DR. DANCIS: This is fascinating, Donna, because unbeknownst even to me, and I'm so close to it, what you have here is a relation between federal, state and private going on, and doing a job, is that correct?

DR. O'HAIRE: That's correct. Private not-for-profit. They do an effective job because they don't have the total bureaucracy that they must go through. It also helps keep it apolitical, and as I said there has been a big change in health care, where health care has become very political. And it's more difficult to carry out some of the programs if it's involved with the political process.

DR. DANCIS: As I remember it, it was quite a bit of power exerted by this not for profit private organization deciding, setting standards and distributing funds. Is that so now?

DR. O'HAIRE: Yes, I think it's continued actually. Not setting standards as much as being able to distribute funds to appropriate institutions or appropriate grantees. And certainly the Ryan White moneys which come to a considerable amount of money in New York State, almost 100 million dollars, is distributed to grantees. And there is less political input here. It is done on a more objective basis. Even though there are ex officio members on the board that are representing the City Department of Health, Health and Hospitals Corporation, Department of Mental Health, and Department of Social Services, they're ex officio. The board has not consisted of these members. Actually they can distribute it in a very efficient manner. The decisions are not made as to who will get the money. The decisions are made at the funders level. The granting agency still makes those decisions, so those decisions are not in the power of Medical and Health [Research] Association. To see that they are carrying out what they said they would do, and reporting back to the federal government or to the state, or to foundations, is the responsibility of the organization.
DR. DANCIS: You stated that academia is not involved. Of course some of the people that you've already mentioned are really academic in their orientations, but you mean a more formal association. And you also stated I think, that this is changing. Is that correct?

DR. O'HARE: I see it changing, perhaps not as rapidly as I would like, but I see it changing as we become impacted more and more by managed care. And I see it changing as funds that are crucial to academic training centers are being impacted upon. But I haven't seen leadership at the level I would like to see coming forth from academia.

DR. DANCIS: An anecdote. When I was Chairman, I would meet periodically with the other chairmen in the city, and we arranged to meet with the health care honcho, one who had an intracranial hemorrhage at a later date.

DR. O'HARE: The Health Commissioner. Yes.

DR. DANCIS: The Health Commissioner. Who received us, I've forgotten his name.

DR. O'HARE: Dr. [David] Axelrod.

DR. DANCIS: It was Axelrod, that's right. Received us very politely, and we talked, we were offering our services, what could we do to get involved in this. And I could tell, polite as he was, that we would never hear from him again, and that was the case. It sounds to me like we were just naïve, that that was not the route. The route was through an organization like this?

DR. O'HARE: No, the Medical and Health Research Association is not the route. The route basically is you shouldn't have given up. Excuse me for saying that, but I do want to tell you that. You shouldn't have given up. Because that was Dr. Axelrod in a lot of areas; I worked with him. You had to be persistent, you had to put a constructive suggestion on board, of things you thought needed to be improved, and how you needed to be involved. And you also had to go to the legislature and the health committees with specific problems or concerns, and have them understand it. Because then there would be interest and that was the approach that needed to be taken, I think. The other thing is, I think I remember your committee, in fact I think it used to meet at New York Academy of Medicine or something. Am I right?

DR. DANCIS: Periodically, yes.

DR. O'HARE: Periodically. I recall that being in place anyway. I had heard about it. So I think you had some impact. You were there. But I
think it really needs academic centers, the deans. And I know that Dean Farber, is involved with a committee I've heard about, but I don't think it has really, from what I understand, approached very specific problems. They've been general problems.

DR. DANCIS: But he's not child-oriented.

DR. O'HARE: No. [Laughs] You said it, Joe, I didn't.

DR. DANCIS: He's an internist and a dean, and we're interested in children.

DR. O'HARE: In children. Yes.

DR. DANCIS: And what you've been telling me for these past couple of hours is that people that are interested in children have to do things.

DR. O'HARE: Mm-hm.

DR. DANCIS: So what?

DR. O'HARE: I think you can work through the department chairman, but I don't think you give up. I think you have to be far more persistent. I also think that you have to be constructive about how you do things more effectively, more efficiently, and what you'll accomplish by it. And I think if that goal were in mind, I think you could be very, very influential, in New York City in particular, where I think we do have more problems probably than upstate, and we probably have more medical facilities than we need. And I think we have to come to grips with that, understand it, and try and work it out equitably. And in a way that's meaningful.

I am concerned, as I look toward the marriages and divorces as I call them of hospitals and university affiliations, and what actually is going on. It's a concern I have that we have so-called networks, and yet the networks are hopping, skipping and jumping over into other networks. I don't want to be more specific; but there's not really any true coalition of what's really going on. I know that's maybe beyond the pediatric departments because they're only a small piece of the medical pie. However, I think we're an important piece of the medical pie, and we could show the way to other people as we have in other areas.

As I mentioned earlier on my other tape, we certainly did show the way in pediatric cardiac surgery. That was started, not from adult cardiac surgery evaluating how many cases were done and what the outcomes were. That was done in pediatric surgery. So I think we can show the way as we have in
many other areas. So I really look forward to that happening in the next five years. I think that's a dream I would like to see come true.

DR. DANCIS: Let's come back for a moment to the role of the Academy. Does it exert its influence as the Academy, or is it the members of the Academy that individually exert their influence?

DR. O'HARE: I think its influence is more as the Academy, but without their members taking the active part, it would not have the same influence. The Academy has accomplished what it's done through the active participation of its members, who have been very, I think, influential. Not only in the areas of health, they certainly have worked across the board with the USDA [United States Department of Agriculture], food programs, school lunch programs, in developing day care standards. I think that it's been its members that have made the Academy; so I can't separate the two. Without that strong membership capability, the Academy couldn't be as influential as it has been, Joe, in accomplishing what it's accomplished.

DR. DANCIS: When Lou Cooper goes up to Albany, does he go up as a representative of the Academy?

DR. O'HARE: Yes, yes he does. He goes up as a representative of the Academy.

DR. DANCIS: Is he responsible to the Academy, or just to his own district?

DR. O'HARE: To his district, and the Academy. There certainly are policies the Academy has, you know, our position papers, so therefore if he goes up and is representing the Academy and not St. Luke's-Roosevelt, he certainly must not deviate except as an individual from the position papers. I think that's the purpose of the Academy. In areas where the Academy doesn't have a policy because it's a state concern, I think he then represents the district, and what we all talk about at the Academy council meetings as to what the important issues are and what we feel will need to be done in certain areas, whether it's pediatric emergency care, whether it's something concerning child abuse, or whether it's domestic violence, any of those things. What we feel as a group are our key issues and our key concerns, and things that could be done constructively.

DR. DANCIS: The Academy council being the national organization.

DR. O'HARE: No, there, as you know, at each district, there are district councils, and then there are chapter councils. All that input then
goes up, and then Dr. Cooper is on, of course, the council for the Academy, and would bring that to the council and national concern.

DR. DANCIS: You were directly involved with the Academy in District 2, was it?

DR. O'HARE: Yes.

DR. DANCIS: Where was the emphasis of your involvement? What were you doing?

DR. O'HARE: That was a long time ago. That, basically, was before I went to Washington. And I think our concerns at that time, because we certainly had a lot of private practice, was to make certain that the practitioners understood what was going on. I'm trying to remember, Joe; I can't recall. I think we were concerned at that time in particular about covering premature infants. I think that was one of our major issues, of getting them covered under insurance. And also immunization programs. I think those were the two major issues that I recall as being key things that we were very concerned about. At that point in the '70s we were not, I think, as broadly represented in as many other areas, for instance as concerned about food stamps. We were interested in day care guidelines; that was another large initiative. Because in New York, if you remember, there were a lot of non-licensed home-based day care areas. And we were concerned that there be some kind of standards built in, in New York City. So as I recall, and it's a long time ago now, 20 years ago, those were our main issues at that time.

DR. DANCIS: So it was really a political, medical-political involvement.

DR. O'HARE: Yes, again, advocacy.

DR. DANCIS: Advocacy, yes, I guess that's a better term, at working through politics, which you have to do in this country.

Let's go on to another subject. I noticed in your CV that you lecture regularly, first at Harvard and now at Columbia to the public health group. What is the message that you're trying to give them, what are you trying to accomplish?

DR. O'HARE: First let me address it historically. My lecturing at Harvard was when I left the federal government. I lectured on what was happening in the federal government, how I perceived it, and how I perceived we could be effective. And my concern was that we involve more people in the process, whether they be nurses, social workers or physicians. This continued and I had been involved in Columbia at two levels. One, at developing maternal and child health curriculum for the public health school,
which was developed by an advisory committee. Columbia University was funded by the federal government and Title V for many years, for a program in maternal and child health. So my role there was to advise in the curriculum committee, as well as to address the class on an annual basis. It was to inform them of the different avenues of funding for maternal and child health, to have them understand how care was paid for for those who could not pay for it and the uninsured, and have them understand the importance of standard setting and the role it could play.

DR. DANCIS: Let me get this to the other side of the tape…

END OF SIDE OF TAPE

DR. DANCIS: This is side two of the tape with Dr. O'Hare, and we're in the midst of discussing her activities with the public health schools. Could you continue?

DR. O'HARE: OK. At Columbia, it was amazing to me that I never knew anything about public health when I went to medical school. Nobody ever mentioned how anything was paid for, you just didn't worry about it. There certainly has been a change over time in this area, and people are still not well informed about different kinds of money and where they come from. Whether they're federal, whether they're state, whether local, how we match and how we maximize the dollars. The other thing that I do get concerned about and we talk about is how standards are developed, how they're monitored, what the outcomes are, and how you implement a program like that. These are things that most physicians know very little about, nor are they very concerned about.

People who go to public health school are there because at some time they probably will go into the public health arena in some way, shape or form. So it's important for them to understand it. It's been amazing to me that many of our academic pediatricians, practicing pediatricians, know very little about the political process, know very little about how medical care is paid for until it becomes a problem. They all know now about insurance companies and managed care. But many years ago, they cared very little and knew very little about it. So I think that this has been my major concern, the major thing that we work on in the class. We also have them try to identify needs that they have seen and don't understand how they're addressed. I think this is how most of the lecturing evolves. That's been my major role, to discuss maternal and child health, avenues of funding, how medical care has been arranged, how standards have been met or not met, and what I perceive the needs are in the future. And that changes from year to year. Certainly it's changed this year dramatically.
DR. DANCIS: Yes. Who do you talk to? Who's in the class?

DR. O'HARE: The class is made up of physicians, nurses, social workers, and students who have graduated and would like to have a career in public health, public health administration, public health running hospitals. It will include people that will come from the school of administration and school of business, so it's a cross-section in those classes. Many of these people do become involved in policy later on. Certainly Allan Rosenfield, who's now Dean of the School of Public Health at Columbia [University], has had a great impact on what's happened in public policy, in family planning and population control in the United States as well as internationally, and has really had a great deal to do with RU486 and some other products that have come on the market, and that should be on the market in the United States. So I think this group is a wonderfully interesting group because it's so broad-based.

It's been interesting that more and more physicians have become interested and actually have been interested enough to go on and try and get their MPH [Master of Public Health], which I didn't ever get, by going part-time. The schools finally, after many years, have learned that they can run the course on weekends or one week every three months, which makes it possible for someone who's in practice, someone who is in academia even, to get their degree and understand more about the process by doing this, not on a daily basis for a year and half and leaving whatever they're doing, but doing it intermittently. We talked a great deal about this back in the '70s when I was in Washington, because some of the money from Title V went into schools of public health and their curriculum. So this has become something that's a reality, which I thought was very important.

DR. DANCIS: Are there many such schools?

DR. O'HARE: There are a number of schools around the country that do this, and will do it on an interim basis. There's still the traditional course in public health, but there are schools that offer this part-time type of curriculum in which you accomplish the same thing but can continue to work in whatever field you're working in. It also gives a background in epidemiology and statistics, which are very important to understand, particularly if you're going to work with population-based health care. So I find it's really quite useful for many people as they [look forward] and address different problems.

DR. DANCIS: Very good. And you're finding a new interest in this from physicians as well as others?
DR. O'HARE: Yes. I think we are. I think we're finding more physicians that are interested in it, as they see the whole political process around them evolving very quickly and they do not understand quite what's happening.

DR. DANCIS: They're interested in this country or international problems?

DR. O'HARE: I think most of it has been in this country. There are some that will go on to become more interested in international problems. But I think we have as many third world problems, Joe, in this city, as we do in the third world, only we're not willing to acknowledge it. I wish we could give the same esteem and acknowledgment to the people that work in this area as we do to the people who go abroad and do things in the third world. I think that's something that we have not adjusted to yet, because I think there are great needs throughout this country, not only in New York but in other areas where I think we have health problems that need to be addressed.

DR. DANCIS: I know at Bellevue there are really programs to try and reach the homeless children and to help them. This is the sort of thing you're talking about.

DR. O'HARE: That's right. I think that Bellevue's been a step ahead. I guess I'm biased, coming from Bellevue, but Bellevue, to me, has been a step ahead. As we discussed in the first tape, it's been amazing that many of the people that have worked in the public action field have had a home in New York, and many of them had a home at Bellevue. Stan James did come from Bellevue. And had his training here. So did Sidney Blumenthal who was involved, so I have to tell you I think that much has stemmed from the fertile ground of Bellevue. [laughs]

DR. DANCIS: I don't mind hearing that. Another of your major interests has been in the treatment of the child with pulmonary disease, particularly TB [tuberculosis], and I know that you attend the clinic at Bellevue religiously every Thursday afternoon. What can you tell us about the history there?

DR. O'HARE: Well, you know that Bellevue has been a leader in pediatric tuberculosis in children, through both Dr. Edith Lincoln and Dr. Nemir who followed her. As you know there was a great deal of tuberculosis in New York City in the '50s and '60s and '70s. Bellevue Pediatric Services led in the treatment of children in doing bronchoscopes, bronchial lavages, looking at whether prednisone helped or did not help bronchial TB, which we don't see as much of any longer since we do do more prevention. I think it's of interest and it's concerned me that we almost closed the pediatric TB clinic here at Bellevue in the '80s, because the amount of disease that we were
seeing had diminished. It was certainly great, and the immigrant influence had not quite affected us yet.

As you know, in the late '80s there was a resurgence of tuberculosis because we were no longer doing the preventive and the outreach and the contact tracing that we had done at one time. We were one of the few clinics left along with the clinic at Kings County that really continued to have an emphasis on this. This was discussed with me as I was the co-director or director with Dr. Nemir as to whether this clinic should be continued or not. For a few years it was continued simply because Dr. Nemir was around. When Dr. Nemir was no longer around, for a year I tried to persuade them to continue it, because I had a feeling that tuberculosis was going to increase. Well, I was right, it did. We did have a resurgence of tuberculosis, and we were there and ready to take care of the patients.

I think it's important that we not let our guard down in a disease that's not completely cured, that's not completely gone away. We must maintain our vigilance and maintain our public health efforts, and we tend in this country, once things are not a great problem, to say we don't need to fund that anymore. I think that's a concern that I do have in tuberculosis. Certainly with the multi-drug resistance to tuberculosis, which we didn't have at that time, this is a grave problem for us now. So I'm sort of pleased that I was partially responsible for maintaining that hold here at Bellevue, and having us looked at as one of the regional centers.

As you know, I've participated in the New York City Department of Health effort on the development of where we should go with standards, what kinds of things we needed, and perhaps having developed some regional centers. And I think Bellevue stands a good chance of maintaining that, even if we do get a decrease in tuberculosis. We have people that are knowledgeable about the disease in children, which is different than it is in adults, and they are aware of all the newest developments, in PCR [polymerase chain reaction], the newest developments in treatment or anything else that should go on. I'd love to see us do more bench research in that area in children. As you know, we have Dr. [William N.] Rom here now, who is well known in the field of adult tuberculosis. I don't think his interest in children is as great as it should be, but there isn't as much disease in children so it's much more difficult. I think it's an important aspect as we look at cost efficiency, what we're going to change, what we're going to make more efficient, that we not lose sight of certain things that need to be maintained, just as immunizations need to be maintained. I think it's very important that we not let down in these efforts.

DR. DANCIS: Your interest in this started way back.
DR. O'HARE: Yes.

DR. DANCIS: As I remember it, when you first got started, the problem offered by these children was immediate treatment, case finding and treatment of contacts. How has that evolved over the years; how has that changed?

DR. O'HARE: It certainly has changed drastically, Joe. If you remember we would have children on F4 for six months to a year for treatment. We certainly have evolved with how we treat people today. The thing that's interesting is that we did not need to hospitalize, once we had effective anti-tuberculous medications. The thing that is interesting was that their compliance was not as good, and this took us a long time to realize. Now we have developed a mode of treatment which is called "Directly Observed Therapy," DOT. With cases of active disease, we ascertain that they do need to have observed therapy two to three times a week, and not daily therapy. It's as effective from the information we have and the medical follow-up that we have.

Most of our data in tuberculosis has been empiric; it can't be scientific, we don't have the tools yet. And as you know, we always felt we had to keep children in the hospital for a certain period of time. We had to treat them for a certain period of time. There's been some experience in Europe over the years that says maybe it's not a year; maybe you can treat them for just six months if they have infection, not disease. I don't think we have a long enough follow-up. You have to remember at Bellevue we had a follow-up that goes back to the '30s and '40s, so we would then see these people through adulthood. I think that gave us the ability to make some of these decisions. It takes a long time, as you know, to see what the effective treatment is and whether or not there's reactivation. I think this will come in time. Maybe new tools will come in time and will change how we approach this problem.

DR. DANCIS: Has HIV changed your problems?

DR. O'HARE: I can't say to the greatest extent. It certainly has made it more difficult in adults more than in children. I think that the impact in adult tuberculosis has been much more than in children. But it certainly has affected us to a minimal degree. As you know, I felt very keenly that Bellevue should be involved in HIV in children from the beginning. We do have a center here, and I think that's very important.

DR. DANCIS: Well, Dr. O'Hare, I feel we've covered the most significant points that I was anxious to hear from you, and I thank you for your cooperation.

END OF TAPE
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CURRICULUM VITAE
Donna O'Hare, MD

BIRTH PLACE: New York City

CURRENT POSITIONS:
Clinical Professor of Pediatrics
Associate Director
New York University School of Medicine
Children's Chest Clinic, Bellevue Hospital

EDUCATION:
1958
MD, New York University, New York City
1954
BA, Sarah Lawrence College, New York

POST DOCTORAL EDUCATION:
1960-64
American Thoracic Society Fellow,
Bellevue Hospital, New York City
1960-61
Senior Resident, Bellevue Hospital, New York City
1959-60
Assistant Resident, Bellevue Hospital, New York City
1958-59
Pediatric Internship, Bellevue Hospital,
New York City

LICENSURE AND CERTIFICATION:
1958-present
New York State License
1964
Diplomate, American Board of Pediatrics
1971
Fellow, American College of Chest Physicians

ACADEMIC POSITIONS:
1978-present
Clinical Professor, Pediatrics, New York University, School of Medicine
1970-96
Lecturer, Public Health Medicine,
Columbia University, School of Public Health
1978-81
Visiting Lecturer, Harvard School of Public Health
1975-78  Associate Professor, Clinical Pediatrics, New York University, School of Medicine
1965-75  Assistant Professor, Clinical Pediatrics, New York University, School of Medicine
1960-65  Instructor, New York University, School of Medicine

PROFESSIONAL APPOINTMENTS:

1977-98  Project Director, Maternity, Infant Care-Family Planning Projects, Medical & Health Research Association (MHRA) of New York City, Inc.
1994-98  Medical Director, Medical & Health Research Association (MHRA) of New York City, Inc.
1975-77  Assoc. Bureau Director, Office of Maternal and Child Health Services, Department of Health, Education and Welfare (Title V)
1971-74  Assistant Commissioner, Maternal and Child Health Services, New York City Department of Health
1967-71  Director, Bureau for Handicapped Children, New York City Department of Health
1967-80  Consultant Physician, Roosevelt Hospital
1965-present  Assoc. Attending Physician, New York University, School of Medicine
1965-present  Assoc. Attending Physician, Bellevue Hospital
1964-67  Pediatrician, Spina Bifida Project, Institute of Rehabilitation Medicine, New York University School of Medicine

AWARDS AND HONORS:

1998  American Medical Association Jacobi Award
1996  New York State Perinatal Association Dr. L. Stanley James Award
1996  National Perinatal Association Individual Contribution to Maternal and Child Health
1995  March of Dimes Elaine Whitelaw Award for Volunteer Service
1995
National Association of WIC Directors
1992
March of Dimes Leo Jaffe Service Award
1987
New York Chapter March of Dimes Service Award
1984
Alpha Omega Alpha (AOA), New York University, Alumni Award
New York University Service Citation
1983
Public Health Association of New York, Award of Merit
1977
Association of State & Territorial Maternal & Child Health Directors, Certificate of Appreciation
1977
U.S. Department of Agriculture, Certificate of Appreciation
1974
National March of Dimes Service Award
1973
The City of New York, Certificate of Appreciation

PROFESSIONAL SOCIETIES:

1990-91
President, New York State Perinatal Association
1991-96
Delegate, American Medical Association
1989-91, 96-98
Alternate Delegate, American Medical Association
1989-90
President, New York County Medical Society
1987-present
Board of Directors, New York State Perinatal Association
1981-present
Delegate, House of Delegates of the Medical Society of the State of New York
1980-present
Member, Children's Aid Society
1977-present
Member, American Pediatric Society
1977-present
Member, American Public Health Association
1974-present
Member, New York County Medical Society
1973-75
Consultant, Department of Health, Education and Welfare
1971-75
Trustee, New York Tuberculosis and Health Association
1971-74
Trudeau Fellow, American Lung Association, American Thoracic Society
1971-present
Member, American Lung Association, American Thoracic Society
1971-present  Fellow, American College of Chest Physicians
1969-75  Member, Professional Advisory Committee for Easter Seal Society
1964-present  Fellow, American Academy of Pediatrics

SPECIAL APPOINTMENTS:

AMERICAN ACADEMY OF PEDIATRICS:

1995-present  Member, AAP Breast Feeding Task Force
1993-present  AAP Liaison, National Breast Feeding Consortium
1991-present  WIC Liaison, American Academy of Pediatrics
1987-93  Consultant, AAP Committee on Community Health Services
1988-91  Member, Advisory Committee on the Homeless, Chapter III
1981-84  Alternate Chapter Chairperson, New York Chapter III
1981-83  Member, Committee on Early Childhood, Adoption, Dependent Care
1973-76  Executive Secretary, New York Chapter III

NEW YORK COUNTY MEDICAL SOCIETY:

1990-present  Chairperson, Committee on Maternal/Child Welfare
1989-91  Member, Committee on Women Physicians
1989-present  Member, Special Committee on History and Archives
1988-present  Co-Chair, AIDS Task Force
1987-present  Member, Peer Review Task Force
1980-present  Chairperson, Public Health Committee
1976-80  Member, Regionalization for Perinatal Care

MEDICAL SOCIETY OF THE STATE OF NEW YORK:

1989-present  Member, Committee on Preventive Medicine
1989-present  Member, AIDS Task Force
1989-present
Member, Committee on Maternal and Child Health

1989-94
Member, Committee on Publications, Library and Archives

**FEDERAL GOVERNMENT:**

1989-96
Member, OSAP (Office of Substance Abuse Prevention) Special Review Committee: Pregnant and Postpartum Women & Infants

1978-81
Member, (NHLBI) National Health Lung Blood Institute, (NIH) National Institutes of Health Advisory Committee

1977
Member, National WIC Committee, NIH

1976-78
Member, Hypertension in the Young Task Force, NHLBI, NIH

1975-76
Member, National Advisory Council on Child Health & Development

**NEW YORK STATE:**

1990-94
Member, Governors Health Care Advisory Board

1983-present
Member, NYS Maternal & Child Health Block Grant Advisory Council

1982-present
Member, Board for Professional Medical Conduct, NYSDOH

1982-present
Member, Sickle Cell Management Committee

1978-present
Member, Statewide Genetics Advisory Committee

**NEW YORK CITY:**

1995-present
Chairperson, Preventive Medicine Committee, New York Academy of Medicine

1995-present
Member, Pediatric TB Advisory Council, NYC Department of Health

1991-92
Elected Delegate, HSA NYC AIDS Task Force

1990-94
Member, Mayoral Advisory Council on Child Health (CHAMP)
1990-94  Member, [AIDS] Partner Notification Work Group
1988-96  Member, HSA NYC Primary Health Care Task Force
1988-94  Member, Commission on Child Health
1987-91  Alternate Delegate, HSA NYC AIDS Task Force
1978-90  Chairperson, Advisory Committee to Multiply Handicapped NYC Board of Education
1973-75  Member, Mayor's Task Force on Child Abuse & Neglect
1971-80  Member, OB-GYN Advisory Committee, NYC Department of Health
1969-75  Chairperson, Advisory Committee, Federally Funded Programs, Title I, III, V, Multi Handicapped Centers
1968     Member, Mayor's Task Force on the Handicapped
1967-75  Member, Coordinating Council of NYC Department of Health & NYC Board of Education

COLUMBIA UNIVERSITY:

1982-present Member, Steering Committee, Maternal & Child Health Curriculum Committee, School of Public Health
1977-85   Member, Advisory Board, Western & Upper Manhattan Perinatal Network

MARCH OF DIMES BIRTH DEFECTS FOUNDATION:

1985-present Member, Grant Review Committee, Greater New York (NY) Chapter
1985-present Member, National Communications Council
1980-present Co-Chair, Health Professional Advisory Board, Greater NY Chapter
1982-present Member, Executive Committee, Board of Directors, Greater NY Chapter
1980-present Member, Medical Education Committee, Greater NYC Chapter
1980-present  Member, Board of Directors, Greater NY Chapter
1976-86    Member, MOD Medical Services National Advisory Committee

CHEST-RELATED:

1980-91    Member, Heart Health in the Young Committee, American Heart Association
1978-86    Member, Credentials Committee, American College of Chest Physicians
1975-86    Member, Steering Committee, Pediatric Cardiac Pulmonary Diseases of the American College of Chest Physicians
1974-76    Assoc. Chair, Pediatric Cardiopulmonary Committee, American College of Chest Physicians
1967-70    Member, Task Force on Chest Disorders and Renal Diseases, New York Metropolitan Regional Medical Program

SPECIAL EDUCATION:

1989-91    President, New York League for Early Learning
1979-89    Vice President, New York League for Early Learning
1974-present    Vice President, Board of Managers, NY Institute for Special Education

OTHER ORGANIZATIONS:

1982-present    Member, Medical Board, Children's Aid Society
1976    Alternate Delegate for United States to UNICEF
1968-70    Advisor, Rubella Birth Defect Evaluation Project, New York University
1967-97    Member, Advisory Committee for United Cerebral Palsy
PUBLICATIONS:


1991  "Tuberculosis in children 10 year of age and younger: Three decades of experience during the chemotherapeutic era." Nemir, R.L., O'Hare, D. Pediatrics, 88:236-41


1977  "Priorities in the delivery of maternal and child health services." O'Hare, D. Semin Perinat, 1:213-5.


**PRESENTATIONS:**

1997  **Cost Effectiveness of a Lead Screening Program in an Urban Maternity Population**
      O'Hare, D., Benedicto, M.
1995  **Norrplant Systems Insertion and Removal Rates in Relation to Negative Media Coverage among a Low Income, Inner-City Population**
      O'Hare, D., Benedicto, M., Baker, M., Nicholas, N.
1994  **Incidence of Low Birthweight among US-Born and Foreign-Born Latino Women**
      O'Hare, D., Benedicto, M., Nicholas, N., Zheng, J. Presented at the Annual Meeting of the American Public Health Association, Washington, DC
1994  **Lessons Learned from an Integrated Prenatal Alcohol and Other Drug Treatment Intervention Demonstration**
      O'Hare, D., Benedicto, M., Littlejohn, M., Birnbaum, S., Nicholas, N., Creamer, S., Stamatis, K. Presented at the Annual Meeting of the American Public Health Association, Washington, DC
1994  **Effectiveness of Outreach Services in an Integrated Prenatal Alcohol and Other Drug Treatment Intervention Program**
      O'Hare, D., Benedicto, M., Littlejohn, M., Birnbaum, S., Nicholas, N., Creamer, S., Stamatis, K. Presented at the Annual Meeting of the American Public Health Association, Washington, DC
1993  **Unmet Health Care Needs of Inner City Postpartum Women**
      O'Hare, D., Benedicto, M., Baker, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, San Francisco, CA
1993  **Results of a Preterm Birth Prevention Program Reconsidered**
      O'Hare, D., Benedicto, M., Baker, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, San Francisco, CA
1993 Achievement of Maximum Medicaid Reimbursement for an Inner-City Maternity Population
O'Hare, D., Benedicto, M., Madonia, L., Marshall, J. Presented at the Annual Meeting of the American Public Health Association, San Francisco, CA

1992 Prevalence Rates of Alcohol and Drug Use among an Inner City Maternity Population over a Five-Year Period
O'Hare, D., Benedicto, M., Madonia, L., Marshall, J. Presented at the Annual Meeting of the American Public Health Association, Washington, DC

1992 Needs Assessment for Dental Care among an Inner City Maternity Population
O'Hare, D., Benedicto, M.T., Benedicto, E., Lee, I. Presented at the Annual Meeting of the American Public Health Association, Washington, DC

1991 Providing Maternity Education in a High-Volume Inner City Prenatal Clinic System
O'Hare, D., Benedicto, M., Tyler, J., Fennel, J. Presented at the Annual Meeting of the American Public Health Association, Atlanta, GA

1991 An Analysis of the Cost Effectiveness of Repeating HBSSAG Testing in the Third Trimester of Pregnancy among a Specific Clinic Population
O'Hare, D. Presented at the Annual Meeting of the American Public Health Association, Atlanta, GA

1990 Pregnant and HIV Positive
O'Hare, D., Benedicto, M., Baker, M., Wolinski, S. Presented at the Annual Meeting of the American Public Health Association, New York City

1990 Needs Assessment for Prenatal Genetic Counseling: Studies of Hemoglobinopathies among an Inner City Maternity Population
O'Hare, D., Benedicto, M.A., Baker, M. Presented at the Annual Meeting of the American Public Health Association, New York City

1990 Implementation of a Trimester Oriented Dental Care Protocol in an Urban Public Health Maternity Setting
O'Hare, D., Rosenthal, M., Benedicto, M., Angello, M. Presented at the Annual Meeting of the American Public Health Association, New York City

1990 Cocaine: Where Do We Stand?
O'Hare, D. Keynote speech at Suffolk County Bureau of Youth/Office for Children Services Conference, "Reducing Infant Mortality by Preventing Substance Abuse during Pregnancy," Smithtown, New York

1990 Reproductive Health & Maternity Care
O'Hare, D. Presented at national conference, "Forging a Better Way: Protecting Maternal and Child Health under National Health Programs," Kansas City, MO

1990 Education and Outreach
O'Hare, D. Workshop panel moderator at New York Academy of Medicine's conference, "Pregnancy and Substance Abuse: Perspectives and Directions," New York City
1989 Final Outcomes in an Infant Tracking Study to Identify Factors Related to Infant Health Care Utilization among a Cohort of Urban, Low Income Mothers
O'Hare, D., Benedicto, M.A., Baker, M., Smalls, M., Nicholas, N., Robinson, P. Presented at the Annual Meeting of the American Public Health Association, Chicago, IL

1989 Who's in Charge: Grandmother or Teenage Mother - Starting a Grandmothers' Group
O'Hare, D., Benedicto, M.A., Madonia, L., Littlejohn, M., Mazor, C. Presented at the Annual Meeting of the American Public Health Association, Chicago, IL

1988 The Seroprevalence of HIV-1 Infection among an Inner City Maternity Population over a Two-Year Period
O'Hare, D., Benedicto, M., Weisfuse, I., Punsalang, A. Presented at the Annual Meeting of the American Public Health Association, Boston, MA

1988 Substance Abuse Prevalence and Demographic Characteristics of Substance Abusers among an Inner City Maternity Population
O'Hare, D., Benedicto, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, Boston, MA

1988 Comparison of Risk Factors and Outcomes among Selected Patients Attending an Urban MIC Prenatal Clinic with a Voluntary Preterm Birth Prevention Component
O'Hare, D., Benedicto, M., Baker, M.J., Wolinski, S., Ennin, P. Presented at the Annual Meeting of the Public Health Association, Boston, MA

1988 Preliminary Study on the Relationship of Prenatal Weight Gain to Birthweight
O'Hare, D., Benedicto, M., Hanouda, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, Boston, MA

1988 Preliminary Outcomes in an Infant Tracking Study to Identify Factors Related to Infant Health Care Utilization among a Cohort of Urban Low Income Mothers
O'Hare, D., Benedicto, M.A., Baker, M., Smalls, N., Nicholas, N., Robinson, P. Presented at the Annual Meeting of the American Public Health Association, Boston, MA

1986 The Young Teenage Mothers: Five Years Later
O'Hare, D., Benedicto, M., Baker, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, Las Vegas, NV

1986 Comparison of Utilization Patterns of Genetic Services among Inner City Prenatal Patients between 1978-1979 and 1984
O'Hare, D., Benedicto, M., Baker, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, Las Vegas, NV

1985 Maternity Infant Care, Family Planning Projects' Smoke-Free Pregnancy Campaign: Assisting Behavioral Change in a High Risk Population
O'Hare, Benedicto, M., Baker, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, Las Vegas, NV
1985  The Role and Needs of the Male Partner in Reproductive Health Care: A Survey of Low Income, Inner City Males
O'Hare, D., Benedicto, M., Baker, M., Nicholas, N. Presented at the Annual Meeting of the American Public Health Association, Washington, DC

1985  New Findings: The Impact of Family and Partner Involvement on Family Planning Attitudes and Practices of Young Female Adolescents
O'Hare, D., Benedicto, M., Baker, M., Nicholas, N., Nathan, B., Auerbach, S. Presented at the Annual Meeting of the American Public Health Association, Washington, DC

1985  Preliminary Outcomes of a Preterm Birth Prevention Program among Low Income Minority Women in New York City

1985  Incidence of Low Birthweight among Various Minority Population Groups
O'Hare, D., Nicholas, N., Benedicto, M., Madonia-Tese, L. Presented at the Annual Meeting of the American Public Health Association, Washington, DC

1985  Decline in Rubella Susceptibility Rate among Inner City Prenatal Patients: Effect of Rubella Prevention Programs
O'Hare, D., Nicholas, N., Benedicto, M., Baker, M. Presented at the Annual Meeting of the American Public Health Association, Washington, DC

1984  Young Teenage Mothers: The Ethnic Factor
O'Hare, D., Benedicto, M., Nathan, B., Auerbach, S. Presented at the Annual Meeting of the American Public Health Association, Anaheim, CA

1984  Community Based Pregnancy Testing, Referral and Health Counselling as an Intervention into the Problem of Late or No Prenatal Care
O'Hare, D., Benedicto, M., Baker, M., Wolinski, S. Presented at the Annual Meeting of the American Public Health Association, Anaheim, CA

1984  The Decision to Breastfeed: A Study of Low Income MIC Patients in New York
O'Hare, D., Benedicto, M., Blumenthal, B. Presented at the Annual Meeting of the American Public Health Association, Anaheim, CA

1984  The Askable Parent Program
O'Hare, D., Tyler, J., et al. Presented at the Annual Meeting of the American Public Health Association, Anaheim, CA

1983  Children, Youth and Families in the Northeast, Testimony
O'Hare, D. Hearing before the Select Committee on Children, Youth and Families, House of Representatives, Ninety-eighth Congress, First Session, New York City

1982  Parents as Sex Educators: New York Neighborhoods Realize Cleveland Results
O'Hare, D., et al. Presented at the American Association of Sex Educators, Counselors and Therapists, New York City

1981  Teen Reach, Reaching Teens: An Interagency Initiative
O'Hare, D., Tyler, J., Genodman, E. Presented at the Annual Meeting, National Family Planning and Reproductive Health Association, Washington, DC

1979  Conference on Antenatal Diagnosis, Testimony
O'Hare, D., National Institute of Child Health and Human Development

1978
**Teenage Pregnancy**
O'Hare, D. Presented at New York City Public Health Association, New York City

1974
**High Volume Evaluation of Care Quality: The Care Component Score System**
O'Hare, D. Presented at the Annual Meeting of the American Public Health Association, New Orleans, LA

1973
**EPSDT - New Letters but Really a New Program**
O'Hare, D. Presented at the Annual Meeting of the American Public Health Association, San Francisco, CA

1971
**Legal Abortion 1970-1971: The New York City Experience**
Harris, D., O'Hare, D., Pakter, J., Nelson, F. Presented at the Annual Meeting of the American Public Health Association, Minneapolis, MN

1970
**The Care Component Score: A New System for Evaluating Quality of In-Patient Care**
O'Hare, D. Presented at the Annual Meeting of the American Public Health Association, Houston, TX

1969
**The Impact of Medicaid on Handicapped Children: The New York City Experience**
O'Hare, D. and Harris, D. Presented at the Annual Meeting of the American Public Health Association, Philadelphia, PA