

**Perspective of Change:  
The story of civil rights, diversity, inclusion and  
access to education at HMS and HSDM**

**Interview with Ernesto Gonzalez March 10, 2015**

JOAN ILACQUA: [00:00:00] Hello, today is March 10, 2015. This is Joan Ilacqua and I'm here with Ernesto Gonzalez Martinez at Massachusetts General Hospital in Boston, Massachusetts. We are conducting an oral history interview for the Center for the History of Medicine. Dr. Gonzalez, do I have your permission to record this interview.

ERNESTO GONZALEZ: Yes, you may.

JI: Excellent, thank you. So, if we could just begin. Could you tell me about yourself and your family and where you grew up?

EG: Yes, I was born in Aguadilla, a very small town on the west side of Puerto Rico. That was back 77 years ago now, 76 years. We were very poor. Prior to my birth, I understand from speaking to the family and my mother specifically that my mother was a homeless person. She was raised by my grandmother who had six children. My mother was the youngest of the six. Her husband had died already so they didn't have a home to sleep or to live in. And according to my mother, they used to live on their house up in the

hills in my hometown where my grandmother shared that facility which was boarded with cardboard and no facilities for water or disposal of anything. And my grandmother was living there with my mother and two other siblings of my mother of which two of them had tuberculosis. And I remind you they were living in cots with no sanitary facilities and those two siblings of my mother died shortly after. So my mother eventually lived with my grandmother until eventually she married my father and then my aunt, she was the sister of my father, gave my mother and her husband, my father gave to me, small house, rented for them to move into. And so that's how we were born with a home but my mother for several years was completely homeless. As a matter of fact, she could not go beyond second grading of school because she had nothing to wear. So eventually she had to stay home because she didn't have shoes to be able to go to school. So after second grade, she basically stayed home and that's all of her education even though she learned to read and write in her second grade. And she used to write very well and read very well. And she used to teach us early on to read the comics and things like that and she was also trying to stimulate us to read and to learn about the world which nowadays was a very narrow minded world because we were so poor the resources that we

had were very, very limited. But it was always that from the beginning that she was interested in our location. And even though she was a widow when I was five years old, she was always sitting with us, teaching us, reading to us, very interested about all of the school activities to make sure that our grades were as good as they could be. And luckily either we learned well from our mother, my brother and myself, and we became very good students. Obviously at the beginning it was forced upon us to be good students from my mother. She was a very strict person, very caring person but very strict at the same time. And we go back to the times where spanking was not a big deal. And that was the way that you disciplined your children. Now, obviously, [00:05:00] that's a no-no. But I remember getting spanked until I was probably about seven years of age, always done in a respectful way. She never hit us on the face, any other place. It was always on the buttocks with a message. So we learned from those spankings and the message that went along with it. So we were disciplined well and after seven years of age, well just her looks was enough to put us in the right pass. But she was always interested and the education was always her primary reason because she knew that that was the only way that we could get out of the slumps. Reminding, living with my mother,

her mother was living with us, and my brother and myself. My father died when I was five years old. My brother was six and a half years old. And it was amazing that at that point most of the women that were widowed usually will look for a husband to help raising the family and she decided she would never get married again. That was it. She was very loyal to my father who has an alcoholic. He died of tuberculosis and alcoholism and I don't remember too much about him because, as I said, he died when I was five years old. And it was always only remembrances that we have in our family life was with our mother. But she decided to never to marry again. And she would dedicate to us no matter what. Many people would advise to go someplace else out of the slums in my hometown, go to New York and get a welfare. And she always said, "No, I'll bring them over myself." And she used to work as a maid and she also did crocheting and things like that on her own at night. She was a very hard working woman. I mean, I could never envision ever work as hard as my mother did considering the fact that she was never remunerated, obviously as I am. So it was amazing to see her sacrifice just for two children. My grandmother died when she was 96 years of age. So she died when I finished medical school so she was able to see us through the whole process. And my mother, obviously,

died much later when she was 90 and by that time I was already married and already a physician. So that's basically the story growing poor. I remember that even when we had a house, a small house, we didn't have any water. So she used to carry water from a central public faucet of water supplied, she used to carry that on her side with of hanging to her skirt and walking, it was about a block carrying water and carrying us together at the same time. So it was just amazing that -- we had a latrine in that house until I was going to college. So it was a difficult situation at the time but what was funny was that with my mother, she was always positive about. You know, there was never complaints that we were poor, obviously aspired for us to be better, had a better life. But she never really complained even when she died. She never really complained that her love was different. And so I think we did learn from her to live a life of positive thinking and I think it's, for both me and my brother, has been the models of the way that we envision. And the other thing is the importance that we give to education, not only our children, our grandchildren now. They are well educated or on the path to be well educated. And they know that to us education is the most important part of it.

[00:10:00] Obviously, being a citizen too but usually

those things go together if you're disciplined. So, as I said, sometimes we probably even embellish our mother's effort and impact on our lives but she was an amazing woman. So, for me, all my inspiration of becoming a good citizen and becoming a productive person, being positive about life experiences, and going into medicine which is a service oriented profession, I think it's all owed to my mother and the same with my brother.

JI: That's wonderful. And that's what I was going to ask you next. Did she encourage you to study medicine? Did she help lead down this path to becoming a physician?

EG: Well during time, obviously, our knowledge of life was so limited. I remember, for example, a simple like we take for granted like buying cold cuts, ham and things like that. We never had any idea that you go to a supermarket to buy a slice of ham to eat it. So we were so naïve about life experiences. I remember that we had a doctor that we used to go and see only when we were sick and there was no prevention back then. Because our father had died of tuberculosis, we had to be checked every six months for tuberculosis in the public service hospital. So we used to go for that checkup but after that, when we became adolescents for example, you only go to see the doctor for emergency purposes. And I was the one that was frequently

sick so I used to go there. But never aspired to think, "I'm going to be like my doctor. I'm going to be this way or that way." All we aspired at that point was to finish a year by year, go from first grade to second grade to sixth grade. And then you aspired to go to intermediate school. And then you aspired to go to high school and then once we got to high school we never expected that it would go any further. There was no money to be able to go to college. And so luckily we were good students. So I was an honors student all throughout, so was my brother. And so when we got to finish high school, I had the highest grade of the admission exam to the University of Puerto Rico. So because of that, I qualified to get assistance which means that the government would pay all my expenses to go to college. Because there was two brothers at that point, the law specified that no two brothers will get public assistance. So I could only get it even though he had as good of as grades as I did. So, what he did, he went to the University of Puerto Rico and interviewed and asked to see if he could apply for this assistance. And they had changed the law that same year, the year before. And they told him, "Yes you can apply and you can receive." So both of us went to the University of Puerto Rico with all of the expenses paid because that was the only way that we could

do it. As a matter of fact when we were in high school the principal of the high school was trying to convince my brother to become an assistance teacher which was a small amount of pay with no real professional degree which would've put him there probably for many, many years with no advances professionally speaking. And he decided that he didn't want to do that. He wanted to go to the university. So to answer your question, we had no idea what a physician is until obviously I got to the University of Puerto Rico and then you start to expand your horizons and see other people. I went into the sciences field when I was at the University of Puerto Rico [00:15:00] and eventually got into premed. So obviously at that point I started to realize that at least I was in the pathway to become a physician even though I had no idea what that entailed. It was not probably until my last year at the University of Puerto Rico that I realized how many years it takes, what you have to do, that you have to go through another application process. And at the time, there was only one medical school in Puerto Rico. And it was part of the University of Puerto Rico system. And they only accepted 50 students per year which is obviously a very small amount. And so to apply and be accepted, you really have to be one of the top students in the whole system and



this was not only students that were applying from the University of Puerto Rico but all the colleges also in Puerto Rico. So you were competing with at least four different universities that were providing students that were well qualified. And out of those 50 were only accepted. The rest usually had to go to Mexico or Spain to train in medicine because they couldn't do it in Puerto Rico. So I was one of the lucky ones that was accepted to go into medical school at the University of Puerto Rico. As a matter of fact, at the end of my four years of medical school, only 35 of us graduated, so 15 did not graduate. Either they couldn't do it or they decided medicine was not for them and quit early on in their educational career. So 35 of us eventually finished the medical school in Puerto Rico. Now, they have four different medical schools in Puerto Rico, the University of Puerto Rico Medical School accepts 200 students now. And the other wants accept similar numbers so it's much easier now obviously to get into medical school even though also the population has increased significantly. So it's more people applying but back then it was very, very difficult to get into. So that was when I finally got to realize that medicine was a choice for me. Back then when I was at the University of Puerto Rico if you wanted to be a professional, you would

think about engineering. They used to have a good engineering school in Puerto Rico and a lot of people gravitated towards engineer, law school, and medical school. That was it. You couldn't think of anything else. Again, that was our narrow knowledge of what things you could do. And I knew that I was not going to be a lawyer. I was not that kind of person. And I didn't think that I had the skills to be an engineer, again narrow minded thinking that you have to be a good mathematician and things of that which is not necessarily true. But those limited knowledge just limited me to think, "Well, if you want to go beyond a college degree then medicine might be a choice." But, understanding also that I was poor and I didn't have the financial resources, I also wanted to start working and help my mother as soon as I could finish college education. So medical school was there but it was a distant plan for me and it was probably a second choice if I had the choice of going to work -- which is what I did for two years. I finished college and I decided to go to work for two years and then I went into medical school two years after I finished college. So that's basically the way that we envisioned. When we went to the University of Puerto Rico, I went into the science fields and eventually premed. My brother went into business education. And

eventually he finished his four years of college and he got married early so he had to go to work as soon as he finished. So he went to be a [00:20:00] teacher at the University of Puerto Rico Mayaguez compound. So he became a teacher there. Eventually then he continued his studies, post graduate studies, and he eventually became a professor of economics at the University of Puerto Rico at Mayaguez compound. So eventually both of us were able to obtain the maximum education that we could. Again all with the serendipity and the lucky strike that all of the education was paid by the government. We could not afford to do that.

JJ: That's wonderful. Thank you. So, I'm curious, eventually you come move to Boston as part of your dermatology training but before that, had you served in Vietnam? I wasn't sure about the timeline.

EG: Yes, I did. So I went to medical school. And at the time there was draft -- you will be drafted as soon as you reach, I think it was, 17 years of age or 18. So I was drafted then but what they do at that point was that they postpone the service as long as you're a student. So because I went to college education and eventually to medical school, all my service was postponed. But as soon as I finished my medical school education, when I went

into my internship, then I received a letter from the draft board that I was going to serve as soon as I finished my internship. This was in 1967. And when you're drafted, what you do is you go through -- when they ask for the service, you have to give to the armed forces of the United States. You have no idea where you're going to be assigned. All that you know is that you're going to be trained as a physician doctor in the army and then you don't know where you're going to be assigned to work. And I was assigned to go to Vietnam. So I went to San Francisco during my training, Texas first and then San Francisco during my training, and then from there was shipped to Vietnam. In the process my mother did not know that I was going there. As a matter of fact she had been living with us sick for two years when I was finishing my medical school and doing my internship. She had multiple medical problems and she was living with us because she had to be taken care of and be close to a facility where she needed to be hospitalized in San Juan. So she was living with us, my wife, and my first daughter. And then when I was drafted to serve, then my mother had to go back to my hometown to live alone. And my wife had to go to New York with my daughter so that I could go into the armed forces. You should be aware that Puerto Ricans are born citizens of

the United States and one of our responsibilities is to serve the armed forces even though we don't vote for the president of the United States. So that's why I was drafted and recruited and eventually went to Vietnam. And so I was assigned to a place called Pleiku which is in the kind of mid-, South Vietnam they called the highlands. And I was assigned there as a physician in charge of the battalion, what they called in the medical course a battalion surgeon. Even though you are not a surgeon you're just a physician coming out of training. And so I had about 300 soldiers assigned to me that I would take of sick calls, all the emergency vaccinations, and everything else. I was responsible to provide that to that battalion. And as well I would go and assist in surgical operations in, what we used to call, a unit where they had surgeons and other physicians. We go there [00:25:00] to help as well. But most of my responsibility was to the soldiers that were in my battalion. And so I had to travel to visit them in the front. So I used to spend a lot of time in the war zone, living in bunkers, in tents to go and give vaccinations and attend all the medical needs that they have. So I spent a year in Vietnam doing that and I saw a lot of, obviously, what you expect to see in a war or battle where people die, being attacked the enemy. So a

matter of fact, I was there during the Tet Offensive which was the biggest offensive of that war because the enemy decided to join forces and attack us one more time and see if they could defeat us. They didn't but they killed a lot of our people during that. And it was really the most intense battle of Vietnam in all the years that the war lasted. So I was there during that time. That was the beginning of 1968. So I was there from '67 to '68. And it was an interesting experience aside from the fact that you were in the war zone and you're afraid of being killed, you've never been exposed to that kind of persistent and consistent involvement of war activities. But also the human relations were interesting because obviously the army soldiers are kind of the low echelon of society. Most of them are people who are recruited with no education that just finished high school and they're going to the armed forces. So many of them are not too well educated. There were good ones too, they're good people in spite of the fact that they did not have a good education. But at the same time you see the biases, people from the south for example who didn't believe that a Puerto Rican could be a doctor for example or they don't want to be treated by a physician that was from Puerto Rico. Comments that I hear from one that became a very good friend, he was a captain,

and he told, we were watching TV and we were watching on TV Sammy Davis Jr. who is a tremendous performer but he's black. And this guy was sitting in the officer's club with me and, again we became very good friends, he was very helpful to me, but when he started to see that picture of a black performer on TV he says, "That negro guy, you know, he shouldn't be there. He should be eliminated." He was just making all kinds of crazy comments. All that I could think was he's probably thinking that he's sitting back in wherever he came from. I think he was Oklahoma, that he was probably thinking like his parents have probably trained him to think that black people are not good people. And then I look at him and I start laughing. I said, "You know what you're saying. You're sitting next to somebody who is even less than an African American, I'm from Puerto Rico." And so we started laughing and then suddenly he realized that he was making a mistake and that he was bringing all the biases from home into this incident. But he was like that, the African American soldiers, he would treat them completely different. So I saw all that not only with the other soldiers but even with me as a physician. Luckily because I was the physician, they all depended on me. I would give them vaccines. I would treat them when they were sick. I was also in charge of

sanitation so I had to check the mess hall to make sure that the food that they were eating was appropriate for them. I was also involved in the entertainment part of it. So I would be the one that distributed [00:30:00] beer and drinks, movies, and things of that sort. They obviously saw me as a person that they needed to be close to. So I became very good friends with a lot of these people but understanding of the biases that I never saw in Puerto Rico because there's no real minorities in Puerto Rico even though Puerto Rico there's still a lot of bigotry mostly because of the status, financial status of the poor and the rich. There's a big divide. And I was on that side of the poor people living in Puerto Rico, so I saw that kind of, but in terms of color or ethnicity, there was nothing like that in Puerto Rico. So that was my first experience to these kinds of biases. And it was an interesting phenomenon. So while I was seeing them suffering the battles of the real war, I was also involved in this behavior pattern that I saw in Vietnam. And the worst thing was when I came back from Vietnam because that was the time where everybody was opposed to the war and they included the soldiers as part of the equation. So they felt that we should not have gone to the war, that we should've gone to Canada or someplace else or deny to go to



the war. So when I came back, if you wore your uniform in a civilian place, people will scream at you, throw things at you. They keep on saying, "Why don't you go to Canada. Go someplace." And now, I remind you, I'm a Puerto Rican listening to all of these things. And I said, "I came to help. I have no say in the political issues that happened when the war started or continued and I'm just here to serve my country." And to be treated that way and for many, many years until probably recently, at least I didn't want to think about Vietnam. That was such a bad experience, not so much what happened in Vietnam proper, but what happened in the United States, to be unaccepted by your own peers. It was very, very painful. So I never wore uniform in public places. I would only go where the uniform when I go to the base of where I was stationed. And I never thought about staying any longer than two years because I was involved in this kind of attitude of everybody and that was the time where the hippies were very strong. There was a lot of unrest in the United States. And so I lived through all that. And I'm glad that now people think differently about the veterans from the more recent wars but I remember comparing myself as a veteran from the Second World War, which were considered heroes and a very important part of the community. And the government

provided a lot of things to them to develop after the war. Nothing like that happened in Vietnam. Now there's a lot of concern about post-traumatic syndrome. The thinking process back then even by the government was that we were crazy. Coming back we were all crazy and we were not good people and there was nothing really available to make you better as a citizen coming back, as a veteran. Luckily, obviously, I was a physician already so I didn't really suffer too much of that. I just went on with my professional life but I could see the people who had no education coming back who really had nothing to aspire to because either the government or the citizens, everybody was against the soldiers. So it was a bad experience. Yeah, so I was a captain there because as a physician you go to lieutenant and immediately made captain. I won a bronze medal. I don't know why, probably for [00:35:00] being in the war zone but it's supposed to be one of those awards that you receive in the armed forces. So that was the experience. And again, it prepared me for what was coming on later on in my life as a professional dealing with diversity and dealing with minority issues because I was part of it. I saw it.

JJ: Before you enlisted and you said your wife and daughter ended up in New York City and you were in San Francisco and

then Vietnam, had you left Puerto Rico before? Had you traveled outside of Puerto Rico?

EG: Yes, I had to finish my study about my location in Puerto Rico when I finished college, University of Puerto Rico, I didn't aspired to become a physician because there's no money. I didn't think I could afford to go to medical school with no funding. And because my mother had been getting old and I saw her working all my life, I figured that it was time for me to go to work. So when I finished my college degree, I had a major in chemistry. I decided to go and work. So I worked with a paper company in Puerto Rico, International Paper Company. At that time the origin of Puerto Rico was providing tax incentives for American companies to move to Puerto Rico so that they can provide jobs for the community there because up to that point Puerto Rico was very poor and primarily dependent on agriculture, cane sugar. That was it. So the governor of Puerto Rico at that time decided to provide tax incentives bringing a lot of companies to Puerto Rico. And one of them was the company called International Paper Company which is a big company in the United States. And I went to work as a chemist when I finished my college degree. And I worked there for a year and a half. Again realizing that Puerto Ricans with the same degree, I was a chemist,

compared to the Americans that were brought in from the United States to work in Puerto Rico, I was making a quarter of the salary that they were making just because they were Americans and I was a Puerto Rican. And the government obviously allowed that because that was the only way that the companies would move to Puerto Rico. So after a year and a half of making a quarter of the salary that a person with the same experience and the same education was making I said, "This is discrimination. I cannot." Then that's when I think I really started to think about medicine. "I need to be independent. I cannot depend on these vagaries of how people are going to deal with me being a Puerto Rican or being minority or whatever." So after a year and a half I went to visit my wife now at that time. We had met in my hometown. And we started a relationship and she asked me to come visit her parents in New York. My wife is what we call New Rican. She was born and raised in New York but from Puerto Rican parents who had moved from my hometown to the United States in the '30s. So I went to New York for two weeks or one week I think just to visit. That was my first trip to outside of Puerto Rico. And then I met her parents. And then a friend of mine, again another lucky strike, who I saw in New York during that visit, he was working in New York as a

chemist. And he said, "Why don't you come and work in New York and I can help you getting a job here." And so I thought about it and I said, "Well, you know, that would be good. I can be with my girlfriend closer." So that's what I did primarily based on that discrimination that I saw in Puerto Rico. So I went to New York about three months after I had done that visit with a job to work in the urology department as a technician basically. So I worked there for about eight months and the friend of mine and myself applied to the medical school from New York and we were both accepted. So [00:40:00] after eight months in New York, again, seeing more discrimination in New York, he and I went back to Puerto Rico. Then I got married before I left New York with my wife. We went to Puerto Rico to study medicine. And then because I didn't have any income, my wife had to work to support me. And she was working as a secretary while I was in medical school. So they were paying all of my expenses in the medical school but I had no personal income to provide myself so my wife was supporting me for four years in medical school. And we had no car. We had to take public transportation. We do a lot of things that poor people, a lot of sacrifices, but we had fun. We loved it. And we always loved music. I think I did not mention that. I think one of the sublime things of

our lives being poor, my mother, my brother, and myself was we loved music. We used to sing together. We used to listen to music together. So music was kind of the thing that made us forget the environment that we were. And so it continues to be the case. As a matter of fact, I was a musician when I was 14 years old. So music has been always in our -- even now. When my mother was still alive I used to call her to sing over the phone so that she could listen to me sing. And I used to play saxophone over the phone for her. And now with my brother, who is the only one left of the family, we used to call each other and sing to each other. I played music for him and he sings to me. We talk about music. And this is popular music. We were not trained to listen to classical music. There was none of that kind. But the old music from the big band era, we loved that as well as the music from Latin America as well. So we enjoyed music as kind of the thing that joins us together. And so when I was married with my wife in the medical school, we had a lot of limitations financially but we were very happy with music. My wife and I were excellent dancers so we used to dance whenever we could for free. We couldn't afford to go to hotels. But we used to spend an excellent time. So then when I got to Vietnam, my wife had to go to New York City and she lived with her

parents there with my first daughter. When I finished my career in Vietnam, we were assigned to med unit with the army and then my second son was born when I was still in Vietnam. So I didn't see him for the first five months of his life. The third son was born when I was assigned in Maryland, in a hospital there, as part of the armed forces. And that's when, finally, we finished it, three children. And then we finished the armed forces. We went back to Puerto Rico to study dermatology.

JI: Was there a reason why you picked dermatology? Did it interest you?

EG: That's an interesting question because when I'm trying to look back and I think it's probably true, when I was in medical school, I had excellent teachers in dermatology. But also I think I developed the visual acuity to identify things of the skin. Dermatology has the advantage of being able to be it's an organ that you can see. So it was an interest of mine but I was also thinking about internal medicine, etymology, those are the things that I was interested in. When I went to Vietnam, there's no specialists in Vietnam. We are all kind of broad medical physicians or surgeons. So they asked me when they started to distribute the physicians all over Vietnam, they asked me, "What do you want to be called or do? Or what do you

want to concentrate on doing?" I said, "I would love to see [00:45:00] dermatology cases." "OK, you're going to be the dermatologist." So as part of the battalion I would see a lot of things because it's a very hard, inhuman environment so you see a lot of infections, primarily fungal infections, bacterial infections. So with a book I read and learned and treat and eventually, I finally got good enough that then other battalions used to send patients, soldiers to me to see. And at that point dermatology was very primitive. There as not that many medications though it was easy to identify medication to treat one thing. Now it's much more complicated. So I kind of gravitated to dermatology when I was in Vietnam. And I became a pseudo dermatologist in Vietnam. When I came back to finish my last year in a hospital in Maryland, then I kept on doing the same thing. People used to call and show me cases by that time. In Maryland, obviously, they had dermatologists and everybody was specialized but they used to always call me to show me interest in dermatology cases. And I think that between the experience as a medical student in Puerto Rico and the experience that I had in Vietnam, then I think that made my decision to go into derm. And then so I went back to Puerto Rico with the University of Puerto Rico medical school. At the



university hospital I did my first two years of training in dermatology.

JI: And while you were there, you met someone from Harvard Medical School you had worked with and I don't recall that name?

EG: Yeah, that's a big serendipity of my life because that really made my professional life and career. When I was in my second year, Thomas Fitzpatrick who is probably the most prominent dermatology of the last century. He wrote the most important textbook in dermatology. I don't have it. But he wrote the most important textbook in dermatology. This is his picture with me there just before he died.

JI: Oh, up on your shelf.

EG: There's pictures of him there smiling with the faculty. So he went to Puerto Rico to study the effect of sunlight on skin. You need to realize that that was in '69. There was no sunscreens back then. Nobody knew exactly what the sunlight, as a matter of fact, there was a time when parents used to tell children, "Go out and expose to sunlight. That's healthy." So he went to study that. And the study was to bring medication that was a researched medication cream to treat people who develop dark color of the face from early induced by sunlight called melasma. So he wanted to try this cream in a population of patients

where sunlight is prevalent and a lot of people suffer the consequences of sun exposure. And Puerto Rico was obviously the best place because it's easy to travel to Puerto Rico. So when he got there, he had the chief of the department at the time, Dr. [Torres?] who was my chief if somebody was interested in helping primarily just to do interpreting because the subjects that were going to participant in this study were all Spanish speaking. Most of them didn't know any English and Fitzpatrick and the crew that he brought from Harvard didn't know any Spanish. So I became more or less an interpreter. And the study lasted about a year but then I got involved more deeply into the actual study besides just being an interpreter. As a matter of fact, they used to travel every three months and in that interim I would take care of all these patients while they were back in Boston. So for some reason at the end of that year Fitzpatrick and [John Porish?] became the second chief [00:50:00] after Fitzpatrick died. He asked me if I wanted to come and finish my training at Harvard. And that was in May. The training would be starting in July the 1. I didn't know what to say because I knew that I was competing with people that I thought that were way, way above what I could compete with. Obviously, I would have to leave my family, my mother, back in Puerto Rico. I

would have to bring my wife with children, all of them were small. But I saw it as a challenge. I think I mentioned to you before, to me I also looked to be a pioneer. I accept challenges. So I told him, "Yes." I discuss it with my brother who's much brighter than I am in making decisions. He has an analytic mind much better than mine. And I called him. I said, "This is an offer that he just shocked me." And he says, "Well, you should think about it but it's a great opportunity." And then I call one of my teachers in Puerto Rico. He says, "Don't think about it. Just go. Just go. This is a great opportunity." So I told him, "Yes." So I was, in May, to start in July. So I did not apply. I didn't come to Boston for interviews. So I was just accepted just by the word that Fitzpatrick brought to the rest of the faculty of the admission committee. Nobody knew who I was. Many faculty assumed that I was very rich in Puerto Rico and I was paying my way through into Harvard which obviously of course is not true. So anyway, I came in July the 1 with no application papers, nothing. I just came here and became a resident in my last year of training. And then I finished here. I think I did a good job because four years after then they recruited me as a faculty member back again. So then I came back in '76 as a faculty member. So it was a lucky strike. And one of

the things that I keep preaching for why I defend minorities and diversity is because you should not depend on lucky strike. You should be accepted for the skills that you have and the quality of the service that you provide. If you depend on lucky strikes, in my case for example, obviously I would not have been here. Not that I diminish my contribution, but at that point for somebody like Fitzpatrick who was the biggest dermatologist of the last century to pay attention to me, bring me with basically taking a risk in me against the rest of the faculty who didn't know who I was and why I was coming here is a lucky strike that is very difficult to comprehend. And I used to talk to Fitzpatrick always after I came back, "Why do you select me?" He said, "Well, Ernesto, you're not a minority. You're not a Puerto Rican. You're not this. You're just somebody that I respect and I admire what you have done in your life." And I said -- it's funny because Fitzpatrick was a bigot. He didn't like African Americans. He didn't like Jews. He didn't like women. He always had some negative things to say about them even though we had Jews, we had women, we had minorities like myself but one of the interesting things was we never had really an African American in our department except for one in our department never really. So now we have three

Puerto Ricans in this department but never really had an African American except for one. So somehow that continued through the years. But he would say, "No, no. You are not Puerto Rican. You are not Hispanic. All the other Hispanics are lazy people but you are different."

[00:55:00] So somehow he liked me and people used to say I'm one of the Fitzpatrick boys when I came here. So it was a very interesting experience which obviously made my professional career. As I told you my father died so early in my life that I really never had a paternal figure but he was my paternal professional figure. I always admired him. I always aspired to be as good as he was. We had a very, very close relationship and it was beyond just professional things. He always was aware of my family needs, my children. He always embellished my things, the things that I would do. He would say that I was the best to everybody especially the Hispanic work in dermatology which was very narrow, very small at the time. He would always say that I was the best dermatologist there was and whatever. Which again, to me, was a lot of embellishment. But we had that excellent relationship and I still consider him the one who made my life career wise.

JJ: And so he brought you back to --

EG: Yes, four years after when I finished my training here in '72, I went back to Puerto Rico thinking that I will never come back to the United States. I was supposed to develop an immunology lab there which is one of the things that I trained when I was there in the University of Puerto Rico and I started to work with the University of Puerto Rico Medical School in dermatology there as a faculty member there. And we used to see each other once a year at the academy meetings of dermatology. We used to say hello and things like that, always asking me, "Are you interested in coming?" I would say, "No, no, no. I'm set in Puerto Rico. I don't want to be far away from my family again, my mother especially." And then in '75 he sent me a letter. It said, "Ernesto, would you consider coming back?" And at that point, I was ready because I had a lot of aspirations in Puerto Rico that did not materialize professional. I was happy with my family life and everything but professionally I didn't feel that I was going to be making any impact working in Puerto Rico. So I accepted the position. The position was to become the first director of phototherapy in the nation. That was because part of the studies that we did in Puerto Rico was to develop a treatment for people with a dermatology disease called psoriasis. And the treatment was to offer these patients

light treatment mimicking what sunlight does, and developing units that provide UV light to treat people with psoriasis. And so it was all developed here. And so I was part of the study essentially because this was the genesis of what I did in Puerto Rico with him in research. And so he gave me a position for two years, it was a contract for two years to become the first director of a phototherapy unit and that would be, again, patients with psoriasis that will have these units in this hospital at the [MGHs?] and get the treatment with light which turned out to be a huge thing because it revolutionized not only psoriasis treatment but revolutionized about 20 other diseases that are amenable to be treated with lights. So all that was developed here. So in a sense I was a pioneer. Obviously, Fitzpatrick and [John Pizer?] are the ones who developed the whole system but I was the one who used to see the patients, administer the treatment, follow these patients for many, many years. So that's how I came. And my salary was \$35,000 which back then might've looked good but it was a very, very, very small amount of money bringing in a family with three children to Boston for the second time. But I accepted it. And then [01:00:00] it grew very quickly. After a year and a half they made me the chief of the whole dermatology clinic at the MGH which I did for ten

years. And obviously my salary increased as I moved along. But that was a big risk for us to take, me and my family. But my wife was ready to come back again. She always felt that she's more a continental person than a Puerto Rican person. I'm the opposite. And she was ready to come back to the United States. So we struggled for a few years financially but eventually it was the right decision. And unfortunately the only regret that I have is that it was '65 when I left my mother in Puerto Rico, when I came in '76 she was already 65 years of age. And you don't think about those things because she was still relatively healthy and I was so involved with my professional career and also my family issues too that I never really thought that I was going to abandon my mother at such a late age in her life. But she was always very positive about anything that would be for progress. And she would go along with it. She would say, "Forget about me. Go and do it. This is tremendous progress for you and for your professional career." My brother was the same, stimulating me all the time to go further. So I had the support from my family even though later on when she got sick and older, then I realized that it might've been a big mistake for me to leave Puerto Rico. And I always regret that. I always



have a guilty feeling that I abandoned my mother at that late age in life.

(break in audio)

END OF AUDIO FILE 1

EG: But that's life.

JI: And you came to Boston. You've been here ever since.

EG: Thirty nine years now. Yeah, 39 years.

JI: So when you came to work at the Mass General, you also began to teach through Harvard Medical School.

EG: Yes.

JI: Could you tell me a bit about what that was like, what being a teacher was like? If you could describe the faculty and the students and your impression of it.

EG: Well one of the interesting things that I see as a physician and as an educator is the fact that there's a notion by the people who are not in our field that all physicians are educators, that once you become a physician you automatically are an educator. And the fact is that we're not trained to be an educator, we're trained to be physicians. It's a service oriented practice. You're supposed to be a provider of services to the community but the teaching aspect is not really. Nobody really teaches at Harvard Medical School, in those four years hope to

become a teacher or an educator. That you either have the passion for it and develops some skills later after you finish your training or you just don't do it. There's a lot of physicians for example assigned to hospitals who prefer not to do any education, not to teach, even though by being a physician at the MGH, you automatically receive a level of instructor at Harvard Medical School. Those two things go together. If you become an educator then you can continue to be promoted along the echelons of academia promotion. But most of the physicians decide, "No, I'm here to provide service to the community or do research, but I'm not here to do teaching." So it's something that many people expect that you're going to be an educator. I don't know why I enjoy the educational component of it. I probably was good in my developing years as a resident, as a student of teaching, but I think I also had to grow and give a lot of honor to my brother because my brother was a tremendous teacher. But that was his intention. In the University of Puerto Rico you teach, you're not a physician, you teach. But he was such a great teacher because I remember students of him, ten years after still remember his teachings. And even now after many years that he's retired now, there's people still looking up to him as a tremendous educator. I think that also instilled on me

that service part of being an educator. And it probably also came from my mother. My mother always raised us to serve without expecting any recognition almost to the point of servitude which is basically what many times we are trained as poor people to do, you just serve. It's like slave, you just serve. You don't expect anything in return. So I was raised in that kind of environment. You just serve. You don't expect anything. If they give you a thank you, that's OK. So I think between my brother, my mother's upbringing, and then the passion. You have to have a passion to do that because one of the interesting things is until probably about seven years ago, eight years ago, Harvard did not provide any academic promotions based on educational skills. All was on how much you published, how much research you do, and the other things don't count. I told you 17 years serving in the admission committee, that didn't count. That was nowhere to be found, teaching, getting kudos for the best teacher or for doing this and that, community service. None of those were part of the promotional parameters of medical school until about eight years ago and then slowly they changed and that's why many people, very good people at Harvard, had to [00:05:00] go someplace else because all that they wanted to do was to teach. Teach was not a way to become promoted at Harvard.

And in a sense when I was made professor, I gave a speech and I said, "I did it my way," because I kind of broke the rule in the sense that I was not a big researcher, I was primarily a provider of care, a good dermatologist, and a good teacher, a good academician. And finally they started to see the light on the component of being a good teacher. And I was promoted taking all of those things into consideration before Harvard changed their promotional parameters to include teacher activities and community service and things of that. So I did all of those things and luckily in my case they were accepted in my promotion to become the professor in '88, about six years now. So teaching at Harvard at that point when I began was just a passion. You knew that you were not going to be promoted based on spending a lot of time teaching but it was my passion. I enjoyed doing it. And I think every teacher has some egocentric thinking or narcissist thinking. We need to be a center of attention. If you're a teacher, if you're not a center of attention, you're not a good teacher. You need to make sure that the people who listen to you believe what you say and are looking up to you for the messages that you transfer to them, the knowledge that you pass on to them, the wisdom of whatever. And so I think each one of us knowingly or not, I think we do have

that center of attention that we like to. And it's funny because in my case I had always stage fright. I was afraid of being in a group, certainly in a large group, talking to a group of people because I was always afraid that somebody would say, "Well what you're saying is not true," or, "What you're saying is way behind. You're not up to date, your information." But that was the stimulus for me to become the best teacher I could in terms of learning as much as I could, reading as much as I could, so I would never wanted to be exposed to somebody, especially Harvard medical students that challenge you all the time, to say, "I don't think you said the correct thing." So I became a very good teacher I think based on the kudos that I get and all these things, accolades that I get from the medical school and even from the MGH and the Academy of Dermatology, that I think I became a very, very good teacher. But you need that passion. And hopefully now people will stay at Harvard because now they can be promoted based on the teaching and the development that they provide to the students. This is an educational institute. It's mind boggling not to think that teaching is the most important thing, that the promotion to keep people around as faculty members that are good teachers, it makes no sense. But now Harvard has learned to change their environment.

JJ: I'm going to almost get ahead of ourselves with this. But, you pioneered the Hispanic Student --

EG: Mentorship Program.

JJ: Yeah, the Hispanic Student Mentorship Program. And it just sounds like through your career and through your teaching that having a mentor and being a mentor is something that is really important to you. And I was wondering if you could tell me a bit about that program. And we'll jump back to the Harvard Medical School stuff but I think it's right to bring up now.

EG: One of the things that I learned when I was in the subcommittee for the admission process was the struggles that minority students had to get to Harvard, not only to Harvard but to any medical school. Again, that notion that [00:10:00] minority students are not as bright as the non minority students was still an undercurrent at the medical school and as well as other places. That's why you always see all of these minority affirmative action development occur because there was definitely discrimination against minorities. And it's true that some minorities don't have the amenities that non minority students have in the sense that, for example in my case, I didn't travel any place. Traveling is a way to educate yourself. Communicating with people at high levels is a way that you learn as part of

your education. When you are a minority, when you are in that kind of cocoon environment where you don't expose yourself to any of those things, you have to suffer the consequences of not being exposed and not being educated. And this is why many times minorities identify as people who don't have the same amenities. And this is primarily because we come from an environment that is very limited. So one of the things that I learned interviewing minority candidates, specifically Hispanics, how much they had to do aside from being good students, how much they had to do to work 10 hours, 15 hours, 20 hours a week and still have to maintain good grades in school just to keep the family moving. Some of the students were the solo winner of income in the family. So they had no time to do anything else. To see that kind of effort of a student to maintain a GPA high enough that would qualify to apply to a medical school like Harvard and at the same time doing this additional work, even not only additional work but also volunteering services with the community because in that community they need a lot of people who can help. So these students were helping communities, going to emergency room, serving as interpreter in hospitals, and all that. I said, "Geez, I mean, my life was easy even though I grew up in this limitations as well." But seeing a student doing all

those things and I said, "I need to become an advocate to this student." It just put a light on me that I was not doing enough just to teach medical learning activities but to get involved in these things. And that's when I got more involved. And then some of the Hispanic medical students felt completely disenfranchised. You have to realize that most of the Hispanic medical students come from either Texas or Los Angeles. So they are basically trans located almost across the whole United States to come to a new place in Boston, get used to the community in Boston which at the time the Boston community was also very bigot, and get used to all that. I said, "You know, I think we need to develop some kind of program that we support these students." In that process one of the students that came from California killed herself, she committed suicide during the first three months of her entering the medical school at Harvard. And I never knew her well but I knew a lot of the Hispanic students that were very close to her and I saw the amount of suffering. I saw a lot of the suffering also by the dean of education at that time who came also from California. So I talked to him, I talked to the students, and I said, "I need to develop something." At the time Bush was the president of the United States and they had provided some seed money to



develop programs for diversity programs. So I applied for this Hispanic Mentorship Program. And I made a proposal. It was accepted. The government gave me \$100,000 to start the program [00:15:00] and then I organized the program with the emphasis of the Harvard Hispanic medical students but also I included the Hispanic medical students from BU, from UMass, and from Tufts as well. So there were four medical schools involved in that. Harvard was way ahead of being aware of minority issues. The other institutions were not as much. At least Harvard had an office of minority and [OMRA?] which is the office of minority recruitment who Al Poussaint was the director and still is. So at least I knew that Harvard had a structure for minority students. The other ones were not as structured. So anyways, I developed it at the MGH with -- at that time I was the associate director of the multicultural affairs office of the MGH. And through that with [Elena?] also who was working in that office at that time, we decided to organize the whole thing and then develop. It lasted about nine, ten years. And it was very well organized because I used to interview all the students, a participative interview, all of the faculty members who were interested. And one of the tenants of this program was that I would prefer to have no minority faculty being mentors to the

minority students because otherwise we get minorities with minorities and we never really expand the horizons and the non minorities will never know that this happened. So most of the mentors were faculties that were non minority faculty that expressed a feeling that they wanted to contribute. I interviewed them for an hour to make sure that they were committed to that. Alana also did a lot of that. And eventually we got this group together. And we eventually had about 80 students involved through the years in the process. Many of them eventually went on and were successful in their lives and always thank us for some of the success that they had in their live because they were exposed. We used to organize seminars by prominent people at Harvard to teach them how they did it and how to do things to make you progressing in the future. And so they were exposed to a lot of prominent people in the process. As well as the mentors were very close to them for four years. So I think it really did provide an immense opportunity for the Hispanic medical students to develop and feel a part of the system. The other medical schools and the other institutions were not as good because there was not a leader of those institutions even though some of them did very well as well. I continued to interview them and talk to them and they used to come and mingle with the

Harvard medical students. Eventually after ten years Harvard decided that they wanted to develop their own program because, by the way, these \$100,000 that the government gave me, they took it away next year. So for the next nine years it was the MGH Peter Slavin who supported that program for nine years out of the ten. And he was very committed. Well the thinking process of Peter is that if we have those students well educated, they can come to be faculty members at the MGH and improve the diversity movement of the MGH. And indeed it happened. So many of those minority Hispanic students eventually came to be faculty members at the MGH. To me it really served the purpose that I wanted to do. Eventually Harvard decided, "Well, we want to do our own." And so they took the same thing that we had done for the Hispanics, they did it for the whole minority groups. So it included African Americans and Indian Americans. So it really became more of a minority group but it's ongoing. And it works out of the [OMRA?] office at Harvard Medical School and it continues to do [00:20:00] very well. But the genesis started with that mentorship program with the Hispanic. And it was the first one in the nation, the thing is part of the pioneer of what we have done here.

JJ: You started it in 2000s during the Bush administration. So it was relatively recent.

EG: Right '99, 1999.

JJ: But you mentioned -- and now we're jumping back. Like I said, I went out of order but you mentioned that your work with the subcommittee for of the admissions committee was something that started to bring these issues to light in your mind. So could we talk about the admissions committee, about the admissions process at Harvard, and how you became involved with admissions at Harvard Medical School?

EG: Yeah. Well the historically background, again, was that in '65 or '69, when the affirmative action was established at Harvard, it was basically they decided to bring Al Poussaint as a faculty member to establish, at least give visibility to somebody who was African American at the medical school and start to see if they can recruit, in that process, minority students to the medical school. From there on they were able to bring minority students to Harvard Medical School which prior to that it was nonexistent. And then at some point they decided to do a subcommittee of minority students. And basically what that entailed was to have a small subcommittee interviewing the minority medical students which officially were Mexican

Americans, African Americans, Puerto Ricans, mainland Puerto Rican, and the American Indians. Those were the four officially considered minorities. So then that's when I, at some point, became a member of that committee. I guess, why I guess he was the dean of education at the time, when he asked me to be a member of it. One of the problems that the committee had was the fact that because that was not important for promotion. Nobody wanted to do it. It was a lot of work. The reason why I stayed for so many years was because it was a three year commitment, at the end of the three years you're supposed to get out and they'll name somebody after you to take your place. And there was no other Hispanic faculty member that would be interested in doing this. So the dean of admissions kept on saying, "Ernesto, come for a year and just do a year and then next year will be the same." I tried to recruit, myself, other people to replace me because there was a lot of work. And nobody wanted to do it. It was a lot of work and there was no academic promotion to go along with it. So I stayed for many, many years. I got to interview a lot of the applicants in the process. And it was not until the affirmative action was struck down by the justice department that finally they had to do away with these committees so that they would not be looked as people that

are minorities who are getting some kind of advantage. So, not only we would interview and discuss these candidates in the subcommittee for, we also became advocates to the students that we considered good because then those students would go to the main committee to compete with all the other non minority groups, to compete with them for positions. And so we used to come and present these students at the main committee and defend them to make sure that they had a fair share. And many of them were accepted. Harvard never wanted to talk about quarters but I remember when this was very active during my time, I remember that we accepted I think it was [00:25:00] 65 minority students out of 165 that are accepted as first year medical students. That was a tremendous gain during that year. But it usually hovered at about 47 students out of 165, 50, most of them obviously were African American, Mexican Americans, a few Puerto Ricans here and there. But I think we really enhanced the possibilities of these minority students which was [the more?] excellent student not only because of their academic status in college but also because they were doing a lot of the things that Harvard was promoting which is to be a leader in your community, community service, working in different environments, and also being exposed to a service oriented

practice which is what physicians are supposed to be oriented to. For example, non minority students who had never done anything other than being students getting four point GPAs but nothing else. When they came to be interviewed, many of them had no idea that medicine is a service oriented thing. You're going to be serving the community. I mean, you might do research, you might do other things. But really the impact of what you do as a physician is to serve as a provider of care. So those minority students had done a lot of that on their own voluntarily. But unfortunately the medical school was looking mostly for GPAs, for a good exam, the entrance examination, and things like that, and many times would forget the other components of it. We were the ones who tried to expose the biased committees that these people deserve to be because they were also leaders. They were also community people and they needed to be given the opportunity to eventually become physicians and go and serve the community. And there was several publications showing that physicians that had minority physicians will usually go back to their environment. They will go and serve their environment, meaning that they go back to underserved communities as physicians which many non minorities won't do that. They will usually go to places

that will be more economically feasible for them to develop financially. So that was another thing that proved to Harvard that bringing these minority students is important. And then the pressure from the hospitals, the hospitals started to put pressure on the medical that we need to be diverse in the hospital. We need to look like the community we serve. So we have a diverse community, we need to develop employees in the hospital, particularly physicians that will look like the communities that we serve. So we wanted the medical school to train people that are minorities and diverse groups so that they can come to hospitals and serve the community. So that kind of triangle became very important to Harvard. Because the important thing with Harvard as an educational institution, they don't have to serve the community. They just basically do what they're supposed to do, educate students and then send them out. The hospital is a business imperative to have diversity. They eventually became a culture due to the fact that these -- a lot of other motivations for being diversity driven. But the original thing was, "How can we bring patients into the hospital?" And the way to do it is to provide a community in the hospital that look like the people that we serve.



JJ: And Mass General, particularly, you were involved with a multicultural office here but I think you had also mentioned you were involved with bilingual signs and serving communities that were coming to the hospital. Could you talk about that a bit?

EG: Yeah. I don't know how many years now, there was a committee to develop the first of the MGH, the entrance of the MGH which was [00:30:00] kind of dark and people never pay attention to it. You just go through. I'm talking about the White?building. And so there was a committee to redo the area of the entrance of the hospital that would be more appealing to patients coming in. And I was a member of the committee and one of the things that I proposed was we need to do bilingual signs. We're going to get only non minorities, non Hispanic into the hospital that's one thing, well we were getting people who come in from Chelsea and Revere, places like that that are Spanish speaking. We need to accept them and make them feel comfortable. We need to develop the bilingual signs. The committee was opposed to it. They were looking at the money aspect of it, "Oh, we're going to have to spend a lot of money to bring consultants to do all this bilingual." And I said, "No, I can do that. I'll do it for free. You don't have to." My son, he had worked at the Brigham's and Womens

with Partners and my son has developed, he was the one who designed a lot of the bilingual signs of Brigham's and Womens. You have to remember that Brigham's and Womens is surrounded by a poor community. And a lot of them are Hispanic. MGH is basically surrounded mostly by big names, executive people, and non minorities. So the MGH didn't see the same need that the Brigham. So I said, "I can do the science." And there was another person that we worked together and basically we put the science together, the bilingual signs together. That was probably about 15, 18 years ago. But there was a lot of opposition. One of the things I told him go to emergency room of the MGH and see how many Hispanics come through there from Chelsea, Revere, other places. How do they navigate with no bilingual signs there? And they finally did some statistics, the committee, and they realized there was a lot of Hispanic, I think it was 65% of people coming through the emergency room were Hispanic and many of them just spoke Spanish. So that gives them some credence to the fact that they needed to do that. And now it's accepted and it's like that never happened, that the scores of opposition because they felt that there was no need for it. That was many years ago.

JJ: But that's just one example of changing attitudes towards serving communities through hospitals, through institutions

like MGH and Brigham. So my official question is please tell me about your role in developing community connections. Were there other programs at Mass General that you were involved with or initiatives?

EG: Yeah, well as a member of the multicultural office I was the associate director. We wanted to bring the hospital back to the community. The hospital was always identified by the community around it, primarily by the poor community, places like Jamaica Plain and other places, Roxbury. They always felt that the MGH was not only too far physically but also very insensitive to the needs of the communities here and not only because of the language barrier but because there was hardly any faculty or physicians that would look black or Hispanic. There was no employees that would speak Spanish to accept patients coming through. So we decided we need to bring out the hospital to the community and tell the community that the MGH was welcoming everybody. And so there was a lot of plans that never materialized but one of the things that I had proposed was to have an office at the entrance of the hospital that would talk different languages. So instead of having an interpreter service in the basement of the MGH, we bring it to the first floor. So if you speak Khmer like Cambodians do in Revere [00:35:00] then at least there

will be an interpreter that will welcome them and tell them, "You go there. You go here," navigate the whole process. That never really materialized but at the same time we did bring, we went out to the community. I became obviously the spokesperson of the hospital for the Hispanic community, mostly in [Via Victoria?] which is a Hispanic community right on Tremont Street in South End, also in Jamaica Plain, I used to go out and talk to them about the fact that we were changing the environment. But also a lot of the changes happened internally. The bilingual signs was the first thing but then there was a diversity committee that was mandated by the board of trustees of the MGH in 1995, '96. As they named the president of the MGH, [Jim Morgan?] who replaced another chief of the hospital. Jim Morgan was given the task of developing a diversity movement at the MGH which was nonexistent prior to 1995, '96. So Jim gathered eight of us. I was a member of that committee to see what we wanted to do to improve diversity in the hospital. And it was amazing how much resistance we had from many of the chief of departments, chief of services. For one thing, many of them didn't even know what diversity meant. So we had to retrain them. So the committee asked each department and service to bring a plan for diversity of each department or service. So we spent a

whole year. They would come and make a presentation of what they're planning to do because there was nothing in place. What they were planning to do to improve diversity in their different departments and services and that's how the whole thing evolved. And we used to meet two hours every other week, two hours for a full year just looking into this aspect, inviting people, inviting experts from outside to tell us how to do things. It was a very intense thing but Jim Morgan who was the president was very committed to make that change and not only because it was a mandate from the board of trustees but because he believed in it. And so after a year then we had a plan based on all the things that we heard from the different departments. We had plan. We asked the board of trustees to give us money to support some of the ideas so that they can be carried because obviously none of the department would like to do it on their own especially if they had to pay their own money. So the hospital gave us \$2 million to start the development of diversity movement. So with that money based on the ideas that we had generated of one of year of meetings, then we developed a plan and the plan was, for example, to offer managerial services to employees that were working primarily in the basement, in menial work, jobs working in the cafeteria, working in maintenance to

offer those people some kind of skills and education that would mold them into men. So basically the concept back then was then we need to remove the color of the basement and make it to the next level, to bring people who are black, Hispanic, my color, to bring them too. And then we had a recruitment movement to bring faculty, to bring employees that will represent diversity, and also go out to the community to tell people what we were trying to do. And that's how the whole diversity movement started in 1995. So it's not really too long.

Jl: Yeah, 20 years.

EG: Yeah, but we have moved forward very well through those years. And Jim Morgan and then Peter Slavin took over and he continued with the same movement. So I think the MGH has done very well. Now there's still a lot of things to do but the important thing is that I think we changed the culture of the hospital [00:40:00]. Now all of these chief of department, chief of services, they are now sold on doing this. Now you don't have to press them to do it. They have plans of their own. And they feel very proud of doing that. So it was a big change, definitely a big change. And I'm very proud to be part of, not proud of the committee but proud of being an MGH person because I think they have really tremendous taken very seriously this

movement of diversity. And I always say that, about the MGH, is that when the MGH decided to take some activity to do something, they do it better than anybody else. The reason why they don't do it many times is because they don't believe in it and they don't care about it. But if they decide to take an issue and make it an issue, I think they do it better than anybody else. And if you look at the history of diversity in the hospital we've been basically first on many of the things that other institutions have began before and they have not advanced as fast as the MGH has done in those 20 years. We have, for example, the first center for health disparities and solutions in the country. And that is run by somebody that you should probably do an interview, Joe Betancourt, Joseph Betancourt, and is the first in the country supported by Partners at the MGH. They put \$5 million to do that center and eventually the Wood Johnson Foundation also provided additional money. But that's the first center. And basically what they're doing is when you go to a hospital or to a medical facility, what are the services provided to you versus me, you as a non minority, me as a minority, and see what disparities in the way that patients are approached because you're different. If you go to an emergent room service for example, the black people receive

less pain medication than the white people because they feel that the black people are less sensitive to pain. It doesn't make any sense. But those are notions probably from slavery that continues to be a part of the biases of the way that you deal with your population. So the health disparity is basically looking to all these different things, not only look at them but also provide solutions.

JJ: So I have, I think, maybe three more questions, maybe four. But you've talked a lot about the great things that MGH has done and some of the strides that Harvard Medical School has made. Could you tell me about maybe what they haven't done as well in your opinion, what you think that they could do better at?

EG: Yeah. By the way, Jeffrey Flier has done a tremendous job since he became the dean because I've been involved in this process with three different deans, Dean Tosteson, and then Dean Joe Martin, Dr. Martin, and now Flier. And I think in terms of diversity, he's the most sensitized to do it and the more that he has done to it. But not only in terms of diversity, he also realizes that we have lost a lot of potential good faculty members, excellent educators, people who have done a lot of community service, women that had to deal with the fact that they have a professional and family life. Harvard just kind of dismissed them because they



could not publish sufficiently or they couldn't do this or that. And Flier has changed that significantly. And now I think women feel that they're more comfortable because basically if you're in an academic environment, promotion is the only thing that you get [00:45:00] credit for. If you stay as an instructor for 30 years, then obviously that doesn't speak too well of you or the institution that doesn't recognize what you're doing. So promotion is an important thing. We would not be educators if we don't feel that promotion is part of the message that the medical school provides us to stay. In the hospital it's different. The hospital, basically you provide service, you get compensated moneywise for the services that you provided. Then you do other things, community activities and things of that. But in the hospital, it's money driven. In medical school, it's promotion driven. So the medical school was never sensitized to it until it changed as I told you before. And I think Jeff Flier has done a lot to do that. I've been involved in committees to help promotes people who've been, as an instructor for 10, 15 years, and they don't have any idea that would be moving any further. Well we have a committee now that if you have spent ten years and you do good teaching, you can be promoted to the next level just by doing the teaching.

Before if you didn't publish, that was it. You stay as an instructor for the rest of your life. So the medical school I think needs to continue to move along those lines. And it's not that you will dilute the quality of the people that you, but you do have to recognize a lot of the things that in the old times were not recognized from the academic standpoint, that you have to recognize those are values that you offer to the medical school and the medical school is better recognized by doing things like that, voluntary service for example, community service, that some of us now do. That was never recognized by Harvard. So I think Harvard has to continue moving along those lines. So you don't necessarily have to be the most proficient in terms of doing research or writing papers or doing the scholarship that Harvard has always been known for. But you also have to recognize all these sort of things. And if Harvard continues to do that, I think it's going to be an institution that will be really a model for the rest. Everybody assumes that Harvard is the best, no question about it. But I think there's still areas that Harvard can do much better.

JJ: Good and speaking of, this is sort of doing community service, doing that sort of work. I'd like to ask you, you work with the homeless and you've done that for a very long

time. And I was wondering if you could talk a little bit about that service that you do outside of the hospital as well?

EG: Again the genesis of it comes from my mother when she used to tell me that she used to be a homeless person even though I never really saw it. But then when I was the chief of the clinic, I realized that the homeless that came to be served by the MGH, the Boston Health Community Program, is probably the best program in the whole United States. So Boston has the best homeless commitment to service in the United States. And the way that it works is that the patients go to either dispensaries or shelters or the McInnis House which is kind of a specialty hospital for homeless people. And if there's a need for tertiary services for example, if they need a dermatologist, then they'll have to go to the MGH or to the Boston Medical Center. Those are the tertiary facilities that they have to go to. So when I was the chief of the clinics, a lot of these homeless patients used to be sent to the MGH. I used to see them at the MGH. And I used to see how they suffer at the MGH. Why? Because they didn't look presentable compared to the people that we serve in the hospital. Some of them were derelicts but some of them were just economically [00:50:00] disenfranchised, good people, smart

people, they just didn't have a home. But because of that and because they didn't look presentable, the patients didn't want to sit next to them, the secretaries didn't want to deal with them, the physicians didn't want to deal with them, and I felt so bad for them. And again remembering what my mother would have experienced if she would be homeless in that setting. I said, "I should do something." Jim Morgan who was the founder of the homeless system in Boston was a resident when I was the chief of the clinics. And eventually, he was asked if he wanted to develop a homeless program by the chief of medicine here at the MGH. And he did develop it. And at some point he asked me if I wanted to come and see what he had developed. I went. And I knew him and I admired him a lot because he was a great guy when he was in the training program. So I went to visit the place and I got enamored with the way that he and his people had developed this program not only because of the services that they provide but because the way that it was provide. There was a lot of respect for the homeless people. There was a lot of empathy to the people that they were serving. All the secretaries, all the nurses, all the doctors, it was a loving experience. I go enamored as soon as I got the interaction that I saw between them. So I wrote a letter too after that day that

I went to see it. I wrote a letter to him and said, "Jim, I would like to go and offer my services for free in dermatology, just go there and see patients in a clinic and then advise you what to do with it. I wouldn't even prescribe anything, I'd just go there and tell you and you prescribe." And he obviously loved the idea. And so that's how it started back in, I don't remember, 1998, 1997, 1999. So I used to go there Fridays and see patients. Interesting at the beginning, the patients thought that this was all a show, typical of a defensive thing that they have because they see a lot of politicians, a lot of people just to say that they do the service and then just appear and then never appear again. That they're always very defensive, the patients there. At the beginning they were, and eventually then. And I remember a case that I always use as an anecdote was a patient that I used to see at the MGH when she had a home. She had psoriasis, a disease of the skin. And she was the one who told me the story. I don't remember her. But when I saw her at the homeless shelter, when I went to see her there, she told me, "Doctor, I will never go and see you at the MGH because I feel ashamed that I am now homeless and I used to go and see you when I had a home and I had economic situation better than I have now." And I said, "Don't

worry. I can see you here every month. Come here and I'll see you and we'll do everything here instead of doing that." Then I realized the importance of me going there and providing service because I know that those patients feel so disenfranchised when they come to the MGH. Through Jim Morgan, we sent letters out to invite all the physicians on the hospital to provide similar services because that was the only specialty service that was provided there. Now they have, I think, psychiatry and other services but I was the only specialty doctor that used to go to do the services. And about 20 doctors offered their names voluntarily to offer their service but it was never really organized too well. So I continued to do it and about four years ago there was one of our residents who had a very similar demeanor to me, Jen. And she started to come with me to the clinics and got enamored with the whole concept as well. So when she finished she decided to write a proposal to my department about the fact that she wanted to develop a dermatology service there that would be enhanced beyond what I had been offering but also could service as an educational tool so that our residents in dermatology will spend time with her and me and develop some empathy for seeing these poor people there. And so we developed [00:55:00] that about four years ago. Now it's

mandatory for all our residents to go and spend time in the homeless shelter seeing patients with her or me providing the service. And they love it, they enjoy that experience. I also loved it because I didn't have to deal with the insurance companies. It was voluntary service so I didn't have to charge the patients. So if I needed to spend half an hour talking to a patient because the patient needed that interaction I would spend half an hour. In the hospital, if I go beyond 10, 15 minutes, the insurance will say, "Well you're not efficient. We don't want you." So it was an oasis for me to provide the services that way. I wanted to provide a service with no limitations attached to it but also because the environment there is so respectful. The dignity of the people are so important to everybody that serves there that I love to go there. Unfortunately I got sick. I got a kidney transplant. I'm not allowed to go there because I'm not supposed to be exposed to people that I could get infections with. But Jen continues to go there and now we have another faculty member that goes there. We have residents that rotate through there so they all know about homelessness, about empathy, about the service that we need to be, aware of the fact that this is what physicians is all about is to provide service, and the problem is that most of the physicians do it for money not

necessarily that offices like to do it that way, but you get well compensated for it. There's no doctors that is destitute. And the problem is that we need to be aware of the fact that we should dedicate some time to say, "OK, I'll do the service to the community without expecting any compensation but just the satisfaction of providing the service." And that's the concept. That's what I like to propose to the people, physicians and other people. And I think this goes back to the minority students at Harvard, many of them go to provide that kind of service to the minorities communities that they were raised because they have that connection. And if more of us feel that same urge or need to satisfy ourselves by providing these services for free to people that are underserved and need it, I think we will have a much better society. So I'll continue to do that even though I'm kind of distant but I'm still identify as the person. And then I have a patient of mine who's a tremendous benefactor to this hospital and to other activities who I invited with Jim to go and see the homeless operation. He got enamored too. So now he uses a certain amount of every year on my name so that we can continue to expand the dermatology service there. So with that now, we don't depend as much of the MGH service, neither of the Boston Medical Center because we can do



procedures there. We can do a lot of things that we could not do before because now we have the money to buy equipment and supplies provided by this benefactor. So it turned out to be an excellent thing. By the way, there's a pathology when we do biopsies who read the biopsies for free. And that's his contribution to the homeless population. Normally those biopsies would cost about 300 bucks. So he does these biopsies for free and the homeless don't have to pay for that. So it's very satisfying for me to do that. And again it's the memory of my mother, not only because she suffered that but because that's what she wanted me to do, to serve the community, not expect any money in return. Obviously you have to live your life so you need some income but there's always, we can instead of spending two hours on watching TV or playing golf or whatever you could use that time to do that. And I think it would be much more satisfying. Many physicians I'm sure that would love to do that. Many times what happened is that they are not [01:00:00] exposed to it. They don't know how to start doing things like that. And this is why we have the residents going there because at least they're exposed to it. And if they like it, they might continue to do that once they finish. So hopefully that will be the message and the intent.

JJ: That's wonderful. All of it is really wonderful. The next question I had for you was a question about legacy but I can already see and hear from the stories that you told and the changes that you made at Mass General and at Harvard Medical School and your work with the homeless that you've done a lot of very important things in your career that have far reaching effects. And I'm curious about the Ernesto Gonzalez Award for Outstanding Service to the Latino Community if you wouldn't mind talking about that.

EG: I guess that was a decision made by the hospital, the president of the hospital I think was Peter Slavin or Jim Morgan. There's a Hispanic month that is now celebrated. It's in September to October and for many years it was kind of nobody knew about it and the institutions were not really doing anything specific about that celebration but slowly as this diversity movement developed, then they started to pay more attention to it. And I remember during the early years when I was kind of the spokesperson for the whole thing because I was the only faculty at a high level that was Hispanic. There was not too many Hispanics at a level --

(break in audio)

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EG: -- that would be recognized by the institution. As I told you a lot of them were working menial jobs in the basement. So we start to organize that and I used to speak every year about why we need to do, why we need to be recognized. One of the things that I always used to talk the Hispanic community but also to the rest is that we don't have, if you think about it, we don't have a national leader in the United States that is Hispanic. Martin Luther King is the African American leader. He's a national figure. There's even a holiday because of all the things that he did. We don't have a similar situation in the United States for a Hispanic. So I think having a leader like Martin Luther King would make a huge difference for the Hispanic community. We just don't have it. And I don't know if that I will ever happen. So we need to deal with it in the trenches, just small groups here and there trying to organize themselves. And then the hospitals slowly started to become more realistic about the fact that we need to recognize the Hispanic month and because of all the things I had done that you're aware of, they decided one year, I think about nine years ago now, do the Ernesto Gonzalez day, whatever. And so I was a speaker and there was other speakers talking about me and things. And at the end Peter Slavin and Jeff who's, Jeff Davis was the vice president of

human resources, decided, "Well we are now making this a permanent honor to you. And from here on every year there will be Ernesto Gonzalez Award for community service and we'll identify every year an employee at the hospital that more or less have gone beyond the duties and recognize that person and there will be a monetary component to the award that is given." So it's been nine years now that the award is given. So what specific thing did I do that I deserve this award? It's probably a combination, in fact, the bilingual signs, my commitment to the community, bring the community to the hospital, and organizing activities within the hospital, fighting -- I had proposed a Hispanic clinic at the MGH which never really materialized but I was the proponent. I wrote a proposal on it. I've written a lot of proposals. Some of them have been accomplished, some of them have not. But I presume that putting all those things together, they decided to give me the award which it's very gratifying but at the same time it puts a lot of responsibility. As I probably mentioned to you before, I think awards should be given post mortem when you have already finished your life because if I change my lifestyle and become a person of regret of the hospital, what are they going to do with the award. So I'm very proud and I'm very appreciative to the institution for doing that which

has become a bigger and bigger event every year. But at the same time it carries certain responsibilities not only because of the fact that I might change my tune but also because of the fact that if you choose an award that is given to an employee and that's it every year, we have one day celebration and everybody forgets about it, I just don't think that would be the legacy that I would like to leave. The legacy that I would like to leave is after they would do something productive for the MGH on behalf of the Hispanic community. And I think now we're starting to approach that. We have now a Hispanic initiative that I founded. We're developing different things that will improve equality of the Hispanic, not all the [00:05:00] employees of the hospital, but the patients coming to the hospital and will be recognized by the institution. And I think that Hispanic initiative hopefully will be my legacy for the future. So I've received a lot of kudos and official titles and official recognition both by the medical school and the MGH. But to me the legacy that I would like to be remembered will be that I was a pioneer in many, many things, that I decided to stay here even though this hospital environment as well as the medical environment were not too prosperous for me as a person. I could've done better in other places both financially and I

didn't have to fight City Hall as I went through all my years. But it was a challenge and I accepted the challenge and I've realized that I'm now a pioneer because a lot of the things that I work for, that I challenge people about have materialized. So I think for the people who believe in diversity, I think we have attained significant gains and some of it is my help and my contribution, some of it contribution from a lot of other people that many times are less recognized than I am but they have probably done much more. I would say that will be my legacy. And the most important legacy to me really is how my mother and my brother feels about me. If my mother looking down feels that I accomplished what she wanted me to accomplish and my brother feels very proud about me, that's the most important thing. Obviously my family and my children and my wife but my brother and I have worked on these things since we were born and my mother was the one who instilled all this interest in us. And I think to me if she's happy, I'm happy.

JJ: I can't see how she could be unhappy. You've done so much. So the very final question just completely is open. If there's anything else, any other story, or any other thought that you haven't shared with us that you think would be important to understand your life and your work

and diversity at MGH and Harvard Medical School, or anything, now's the time to bring it up.

EG: The only thing I can add to it is that what I anticipate is two things; one is that this movement of diversity and minority issues I don't think will go back. I don't foresee that 20 years from now we can say, "Well all that movement that we did for diversity of pro minorities, we don't even use affirmative action, it was all lost because we're back again to where we were." It would be like going back to slavery, for example, in the United States. I don't think we'll ever go back there. So I think this will be a movement that will continue forward. How fast, how effective it is? I don't know. I don't pretend to know that. But considering the fact that we become more and more diverse as a population in the United States, I don't think we'll ever go back again. So it's moving forward and I don't see any moving back. So that to me will be an important concept that I have. The second important concept that I have is that I hope that the minorities don't do what the majorities did the minorities so that we don't turn the clock around and say, "Now I'm the majority because there's more Hispanics or African Americans than the non minorities. Now we're going to step on them. We're going to use now our political and whatever power we

have and we're going to now make them feel like we felt." It would be like African Americans going back and saying, "Well because I was a slave, I'm going to put all the white people in slavery." And that to me will defeat the whole purpose. So I hope that we recognize what we have gained but also respect the fact that differences are important and that white people are as good as minority people and that it was just a cultural thing. And now that we're changing the culture and people are accepting us then we should understand what they are, what they contribute, and respect the same way that we are now expecting them to respect us. If we attain that, obviously there will be no more names for minorities and affirmative action and we'll all be one. And if we attain that in the many years from now which I'll never see, that to me will be the biggest legacy that the people who dealt with this during the early stages will feel. It will be a disaster if we change the whole thing around and then feel that we're now the omnipotent, the *omni sapiens* of the different groups in the United States. And so I hope that we have served our role and improved in our roles but at the same time respect the other people and that we don't stray between minority groups to attain power and whatever. Obviously human nature is not that simple but to me that would be the



biggest thing that I could expect that it will be attained  
by the people in the future.

JI: Excellent. Dr. Gonzalez, thank you so much for having me  
here today and for talking to us.

EG: My pleasure.

JI: This has been wonderful.

EG: Well I'm looking forward for you to send me that [thing?]  
for me to sign it.

JI: Yep and I'm --

(break in audio)

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