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Behind the Man in the Suit: Interview with the Chancellor

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Quill & Scope (QS): To start off, for someone who has never met you, how would you describe yourself?

Dr. Edward Halperin (EH): As a pediatric radiation oncologist, as an administrator. People who spend their lives deciding whether or not to irradiate children with cancer, how to aim beams, and what are the best beam arrangements are usually very thoughtful, meticulous, and contemplative people.

QS: What set you on the path to be a pediatric radiation oncologist, or a physician in general?

EH: The system at Yale Medical School was that you were assigned a faculty advisor. The faculty advisors were often volunteers, not full-time members of the faculty. I was assigned to a private practice psychiatrist in Waterbury, Connecticut named Irwin Greenberg. Dr. Greenberg established a custom of meeting at the Connecticut Mental Health Center, where we would get two cups of tea from the vending machine, and he would talk to me. That was my advising system.

When I was a first semester, first-year medical student, he asked me how school was. I told him that Embryology was very hard, and asked if he had any advice. He told me to study, and that Embryology was very important. When I was a second semester, first-year student, he asked me how things were going and I told him that Gross Anatomy was very hard. He told me to study, and that Gross Anatomy was very important. For three years, once per semester, Irwin Greenberg told me that I needed to study. That was his general proposal to my problems. At the end of the third year of medical school, he asked me what I was going to go in to, and I said that I didn't know—that I hadn't found anything that particularly caught my attention. He said to me, "You should be a radiation oncologist. It's very hard, and has a lot of physics. The patients are very sick, and you'd be good at that." After that, I took a two-week elective in radiation oncology because a psychiatrist from Waterbury, Connecticut thought I might be a good radiation oncologist, and I hadn't found anything else that I wanted to be. That's how I ended up as a radiation oncologist.

I ended up as a pediatric radiation oncologist because I was always concerned with what I thought was the most consequential, high-risk thing a person could do; I decided that for radiation oncology it was taking care of kids with cancer.

QS: That really speaks to the importance of mentors in your life. Has anyone else been a mentor to you?

EH: The literature on mentorship is actually quite mixed. What you just said is standard in medicine: that mentors are very important. If you look critically at that literature in medical education, it's debatable whether they are or not.

But if I had to pick people, I would say my chief-of-service when I was a resident. Dr. Herman Suit is known as the inventor of the Fletcher-Suit Apparatus for treatment of carcinoma of the cervix, for the identification of hypoxia as an important issue in tumor radio-resistance, and for the limb sparing surgery for sarcomas. He is a very polite, very thoughtful man with extremely high standards. He never raised his voice, never belittled anyone who worked for him, and is quite genteel. I think the proudest moment I ever had in my career in academic medicine was to say that I was a House Officer of the Massachusetts General Hospital, and that I was Herman Suit's Chief Resident.

Where I went to medical school, you had to write a thesis for your MD, the same way that you have to write a thesis for a PhD. My thesis advisors were Samuel Thier and Leon Rosenberg. Thier later became President of Brandeis, President of the Institute of

Medicine, and Physician-in-Chief of Massachusetts General Hospital. Rosenberg was later the Dean of Yale Medical School. I admired them.

I suppose the last person I could tell you about was my uncle *[Dr. Halperin shows us a picture he keeps on his bookshelf].* Justice Nathan Jacobs of the New Jersey Supreme Court was the judge who desegregated the schools of New Jersey, issued the rulings on administrative law—what the difference is between laws made by government commissions versus the elected officials of the legislature—and he also wrote a well-known decision on freedom of speech. When I was a little boy, I wanted either to grow up to be my uncle Nat and be a judge on the Supreme Court or to grow up to be Nicholas Katzenbach, the Associate Attorney General *[who took an active role in the Justice Department's fight for civil rights].*

QS: So you didn't always want to be a doctor?

EH: No. I wanted to be a lawyer and a judge. When I was your age, there was a famous picture of a balding man, perspiring profusely, mopping his brow with a handkerchief, standing in the door of the University of Alabama followed by federal marshals, telling George Wallace to get out of the way because the University of Alabama was going to be desegregated. Then, the same man stood at the University of Mississippi. His name was Nicholas Katzenbach. He died about a year ago. He was the Associate Attorney General under Bobby Kennedy, and I thought that the most glorious thing must be the person whose job it was to create equal opportunities in education. I wanted to be a lawyer.

Because my uncle had gone to The Wharton School and Harvard Law School, that seemed like the right thing to do. I was an undergraduate at The Wharton School and I decided partway through Wharton that lawyers spend a lot of time getting people out of trouble that they got themselves into, whereas doctors spend more time grappling with the fundamental forces of evil in the world.

I had dinner with my parents and told them that I didn't want to go to law school anymore; I was going to medical school. But I never dropped out of Wharton. I graduated from Wharton and then went to medical school. I have no stories for you about always wanting to be a doctor as a little boy. I got the idea when I was about eighteen or nineteen.

QS: You mentioned that when you were meeting with your advisor while at The Yale School of Medicine, medical school was hard for you. That is certainly something medical students today would agree with. What are some other similarities and differences that you see between your experiences as a medical student and being a medical student today?

EH: If you were to give me a psychological test, you would find that I score high on the introversion scale. I am not an outgoing person. I was not at ease talking to strangers. When I was assigned to walk into the hospital and find any patient at all to do a history and physical, I was too embarrassed to do it. I couldn't do it. I wasn't going to walk up to some stranger. I wrote a case history about myself in order to complete the assignment because I was too embarrassed to interview anyone else.

Medical school was hard because I was an Economics major. When I went to Yale, some of my classmates had already published in the peer-reviewed scientific literature, while I had never taken biochemistry. For the first couple of weeks, I didn't think medical school was that hard because I thought, "You don't have to know that much detail. You just have to know the broad concepts." Then I did terribly on my first exams and thought, "This is serious. This is very hard. I had better get out little index cards and write everything down."

I don't know about similarities with current students. I never had a car until I was an intern, so I couldn't go anywhere for rotations that I couldn't either walk to or take the bus to. I lived in the dormitory for all four years in New Haven, and walked everywhere that I had to.

The faculty thought I was unusually serious for a medical student. Even when I was a resident, the other residents used to call me "The Professor." I was 24 or 25, and I didn't seem to act as young as they thought typical. Even though I was much younger than they were, I always took things very seriously.

I was single until well into my residency, so my life was school and work. That's what I did. That, indeed, was almost everything I did. I used to say that a lot of the patients are not going to do well, but if I make a mistake they definitely won't do well, so I had better not make any mistakes. I was very attentive to the patients.

I started medical school in 1975. Statistically, that was one of the hardest years to get into medical school out of the last 40 or 50 years. The ratio of available medical school seats to applicants was least favorable to applicants in those years. There was still a war in Vietnam. Some people were going into medicine, divinity, and public health not because they were interested in it, but because they just wanted to stay out of the war. The probability of not getting into medical school at all was very high in my years, but I never had any idea of doing anything else. Whether I was foolish or not, I never had a Plan B.

QS: I think many of the students here will relate to a lot of the experiences that you have just described. If you could go back to the young Dr. Halperin in training and give him any words of advice or warnings, what would you say to him?

EH: *[contemplative pause]* Patients are perishable; you always remember that. Everything that a patient tells you is a potential clue to what's wrong. People have diseases, organs don't. Therefore, I took detailed histories and made long lists. I decided when I was your age that you didn't have to be William Osler and have enormous insights to be a good doctor. What you have to be is extremely compulsive. If that meant that Mr. Jones had a chest x-ray, and you put it on your list of things to do, then you didn't go home until you checked the results of Mr. Jones' x-ray. Therefore, I always walked around with my pocket full of index cards and my lists, and I didn't go home until everything was checked off of my lists or I was sure that somebody was going to follow-up on something on my list. I was the same way as a resident.

I learned, I think, as a young doctor, to always ask for help from people who knew more than I did. I got into the habit, very early, of spending a lot of time on the phone calling people who didn't know who I was for advice about patients. When email came along, I started sending emails to people asking for advice, "Is this the best thing to do for my patient?" I was compulsive about my reading. I read about every patient I take care of and also read general medical journals so I know what's going in medicine.

I decided, when I was your age, that I wasn't going to get sick being a doctor. I wasn't going to get into the habit of eating take-out and junk. People who don't eat and don't sleep eventually get sick and aren't very good doctors. Before I became an intern I had my mother give me a lesson in how to shop for food and how to cook so I knew how to make a small number of things, enough so that I knew how to feed myself. I would go to the supermarket and I would buy real food. I swore that I wasn't going to end up with bags of greasy take-out. I was going to sleep when I had time to sleep so that I wouldn't get sick. That doesn't sound like the most profound advice, but it's the advice I followed when I was young.

QS: Does it sound similar to the advice you might give your students now going forward? To take care of yourself?

EH: Medicine is the most important secular work a human can engage in. If there is holy work in our secular lives, it's medicine. It's a calling; therefore, you devote yourself to it. But you're of no use to your patients if you're not taking care of yourself. In the years since I went to medical school, there's been lots more interest in self-actualization and self-awareness and being in a good mental place yourself. I am clearly not of that generation. I doubt that my professors ever spent any time worrying whether Edward Halperin was feeling good about himself or comfortable in his space, and all the sorts of mental health things that people talk about now. I'm sure they're important, but when I was your age you took care of your patients and tried to "take care of yourself."

QS: What are some of your crazy stories from your time in medical school?

EH: I don't have any stories to tell you about my wild younger years because there are not any stories to tell. I never had a taste for beer. I couldn't understand the point of it. I have no moral objection to peo-

ple who drink liquor but it didn't taste good to me. If I was thirsty I wanted to drink something so I wasn't thirsty anymore. I have no stories of drunken binges in college or medical school. I drank some beer and thought, "This tastes like burnt bread to me. I don't know what the point of this stuff is." And that was the end of that.

I have no stories for you about experimenting with drugs. I wasn't interested. I never was involved in it. I never was on any soap boxes preaching against it; I was just indifferent.

My first interview for admission to medical school was at Hahnemann [Drexel University]. I walked 25 blocks to my interview in downtown Philadelphia. The interviewer's first question to me at my first admissions interview was, "Tell me, young man. What do you think of all this illicit, immoral, outrageous, disgusting, premarital sex that is rampant in your generation?" I said to him, "You know Sir, I've been raised in a somewhat religious household. I am told there is a sexual revolution going on in this country but I am a noncombatant. Perhaps we could talk about something else this afternoon?" He looked back at me and said, "Oh. Ok." That concluded that part of the conversation. I'm sure if anyone asked such a question now they'd be up on charges.

> *"Patients are perishable. You always remember that."*

I don't have any fabulous stories about my wild and dissolute youth. I missed all that.

QS: You told us in the History of Medicine class about how medical school admissions started, and that is a very interesting start to your medical school admissions journey. Do you have any more stories that stick out in your mind about that time in your life, when you were trying to get into medical school?

EH: I remember my interview for admission to Yale. The man who interviewed me was in a tiny office, an oversized closet, and it was January in New Haven. He had the windows open. The wind was blowing off of Long Island Sound. It was freezing. I was wearing my little interview Harris Tweed sport coat, and his office was covered with plaques of silly little slogans like, "When the going gets tough, the tough get going." He had longhorns bolted on his wall because he'd gone to the University of Texas. I sat down and said, "Interesting office, Sir." And he told me his life story for the next 59 and ½ minutes. He didn't ask me a single question. I listened politely and after I left, since I didn't drive, my sister picked me up and asked, "How'd it go?" I said, "I don't know. The man didn't ask me a single question!"

I was admitted to Yale.

I was working as a janitor that summer at the end of college, cleaning a typewriter factory and a bank, and a woman called me one afternoon and said, "This is Lilian Dalton, the Registrar of the Yale School of Medicine. I am instructed to offer you a position in the incoming class. Do you accept?" I said, "Well, thank you very much. I'll have to think about that." (I was planning to go to Einstein at that time.) She said, "I beg your pardon?" I said, "I'm on my way to work now, Ma'am, and I'll have to think about this. I'll get back to you in a few days." There was a pause, and Mrs. Dalton said, "Young man. People usually know if they want to go to Yale." I said something like, "Well, this one needs to think about it, Ma'am." Eventually I decided not to go to Einstein and to go to Yale. I had to tell the foreman for the janitorial service that I was leaving. He said, "Where are you going?" I said, "I'm going to Yale." He said, "You're leaving me for a lock company?"

QS: Can you tell us a little bit about your path to academic medicine?

EH: I never went through a stage of either going into private practice or thinking much about going into private practice. When I finished my residency, I interviewed for a couple of jobs in private practice. I

tried to calculate what my income would be and how I would run a practice. By that point, Sharon and I had just gotten married and we tried to think it through. I went back to talk to my chief at Massachusetts General where I was Chief Resident. I told him about the jobs that I was looking at. When I mentioned that I had interviewed for some private practice jobs, he took his left hand, and went [*waving it across his body in a dismissive fashion],* "Oh no, no, no, no, no, no, no." That ended my thoughts about ever going into private practice.

The job I wanted was the position of pediatric radiotherapist at the Hospital for Sick Children in London. I interviewed by phone in an era before cell phones. It was a big deal to have a long distance call. I got the job. I asked what the salary was going to be. The man said, "Why... £10,000." And I said, "Per?" He said, "Year." I thought, "I've just been offered $18,000 a year to live in London and I'm married and have a baby. I can't afford it." I watched my career in London disappear. Therefore, I interviewed for a few other academic jobs at Hopkins, Yale, and Duke. The only place that I had a really good offer that didn't already have somebody doing pediatric radiotherapy was Duke. They had fired the entire department of Radiation Oncology and were rebuilding from scratch. The new chairman needed people. I was 29, an Assistant Professor, and I was in charge of Pediatric Radiation Oncology at Duke. I stayed at Duke for 23 years.

I do not have any stories for you about any time in private practice. It never substantively occurred to me.

QS: You came to New York Medical College from the University of Louisville School of Medicine. What's been the biggest adjustment for you?

EH: I was the chairman of radiation oncology at Duke, then I was vice dean of Duke University School of Medicine, then I was the dean of the School of Medicine of the University of Louisville, and then I came here. What are the biggest adjustments? In academic medicine, there are actually relatively easy transitions. There's a hierarchy. There are professors, associate professors, and assistant professors. There are attendings, residents, and medical students. There are departments and divisions. The patients have different accents, but you can plop an academic physician down in another academic medical center and, in my experience, you're ready to go to work in about an hour or so, once you figure out what floor the diagnostic radiologists are on, where the pathology department is, where the linear accelerators are, and how to do the medical records. All the discussions about getting oriented have to do with life outside of medicine in my experience: Where is the supermarket? How do I pay taxes? How do I get a driver's license?

The transition from Louisville to here is mostly about the transition from being dean of the medical school to being Chancellor of the college and being Provost for Touro. When you're dean of the school of medicine, you are concerned with the MD students, the residents, and hospital relations. In this job, I have to be responsible for that, plus the Ph.D. students, the Masters students, the D.P.T. and M.P.H. students, the audiology students, things in the Touro system, buildings and grounds on this property, fundraising, the budget of the college, etc.

I could answer your question by doing stand-up comedy about New Yorkers compared to Kentuckians and North Carolinians, but people are people; they have somewhat different accents, and the weather is different, but I don't think there are any substantive differences.

QS: How do you balance all of your various roles?

EH: This is the longest I've gone in my life without practicing medicine and I'm not happy about that. I still don't have my credentials to practice. I'm going to resume practicing medicine as soon as that paperwork is done. That's very important to me. Once I'm back practicing medicine, the most important thing is taking care of patients. And I have to be responsible for teaching. When you are an administrator, all sorts of people come rushing around saying, "This is a crisis." A crisis is a 9 year old with a brain tumor. Whether someone has their laboratory equipment delivered on the wrong day or preparing press releases... these are not crises. When you continue to practice medicine, then you will understand how to keep things in perspective. Whenever I would have a difficult time at work as dean, Mrs. Halperin would say, "Don't wor-

ry. It'll be Wednesday soon, and you can relax. You'll see people with cancer." What she meant by that was, "Once you're practicing clinical medicine again you'll be okay and things will be in perspective."

How do you maintain balance? It's a marathon, it's not a sprint. You figure out what needs to be done and you put things in order. In academic administration it's more important that you get things right than that you get them fast.

QS: You already told us a little bit about the importance of teaching. You've already managed to add a History of Medicine class to the first year curriculum—can you tell us a little bit about where that interest came from?

EH: When I was an assistant professor I started to wonder how the hospitals had been desegregated in North Carolina. Who had decided how to desegregate a hospital? What did it mean to desegregate a hospital? What does it mean to racially integrate a medical staff? I started driving around North Carolina with my Dictaphone and interviewed black and white physicians, dentists, and hospital administrators who had lived through the desegregation of the hospitals in the 1960s. That is when I did my first article on the history of medicine, which I ended up publishing in the New England Journal of Medicine. I probably should have retired then.

I remained interested in the history of racial, religious, and gender discrimination in medicine. Subsequently I did projects on anti-Semitic quotas for admission to medical school, on bias against women in standardized tests, and on the role of white physicians in the care of enslaved African Americans.

How did I get interested? I'm nosy. I think there are interesting stories in the world. Medicine is fundamentally a story-telling field. That's why clinical medicine includes a medical history.

When I was vice dean at Duke, I went to graduate school and got an MA degree (going to school during my lunch hour and at night) to get some formal training.

QS: Are there any other humanities that you'd like to involve in the medical school curriculum going forward, or any other changes that you'd like to see?

EH: The next course I'll offer will be called, "The Intersection of Religion and Medicine" and it will be offered to second year medical students. It will be a medical ethics course, but rather than beginning with lectures about beneficence, nonmaleficence, and justice, we'll talk about practical issues where medicine and religion butt up against each other. How do you handle a patient who says, "I won't eat that. My religion says I can't eat that, doctor," but you think they ought to eat that? How do you handle someone who says, "I won't take a blood transfusion because my religion says I can't take a blood transfusion"? How do you handle a case where a family says, "I won't accept an autopsy for religious reasons"? You may think it's indicated, but they say their religion won't tolerate that. What do you do if someone says, "I hear voices in my head of Satan arguing with Jesus and they're telling me to hurt myself and others"? You reply, "I think we should get a psychiatric consult." The patient says, "That's fine, but I'll only see a Christian psychiatrist." Right now the only psychiatrists on duty are Dr. Vischwanan and Dr. Weinberg. You haven't asked either of them their religion, but you don't think that either of them are going to meet the criterion of 'Christian psychiatrist.'

All of the stories that I just told you are from my practice; I didn't make any of them up. I think an interesting way to start grappling with medical ethics is to have a course about that. So we will.

QS: Is that for the 2013-2014 school year?

EH: Yes.

QS: Let's talk about some of the other changes that are happening on campus. We got an email about plans for a newly purchased building. Can you tell us a little bit about that?

EH: We bought the IBM building at 19 Skyline Drive. It's a quarter of a million square feet. Munger is ninety-thousand square feet. We are going to move everyone out of Munger, "mothball" Munger, and put eve-

ryone in Skyline. I think Munger is an embarrassment and has been an embarrassment since 1971. We ought to have a decent building for academic purposes, where the professors meet with the students. Skyline was used by IBM as an education building and for computer science research. It is in very good condition, and it's very large. It has a 130-seat lecture hall, a full cafeteria, lots of conference rooms, lots of seminar rooms, and lots of offices. It will also allow us to have additional space for the medical ethics program. If we open a nursing school, a P.A. school, and a dental program, I can put them there also, because it's a quarter of a million square feet compared to the ninety thousand in Munger. I'm going to ask the county to take Sunshine Cottage Road and allow us to extend it straight to the back of Skyline Drive. I'm going to try to raise money for a campus gate and money for a garden in the middle of campus with some seats.

> *"My legacy will be if we graduate good physical therapists and doctors and public health professionals."*

Bloomingdale's *[Furniture Outlet]* building is owned by New York Medical College. Bloomingdale's is moving out and I have three proposals to lease Bloomingdale's. Two of them are from exercise companies. If they get a lease, then I am going to insist that it's a lease that includes discounted rates for New York Medical College students. There may be a donor who wants to give a wellness facility for New York Medical College students, but if I get the tenant to agree to discounted rates then what we'll probably do is to build an exercise room with Stairmasters, treadmills, and other exercise equipment for the students in Skyline. If you want a swimming pool, an indoor soccer court, indoor tennis, or racquetball, that will be in the exercise building. So we'll end up with a rather impressive—if this all works—set of exercise facilities for the students on campus, some of which will be free just by using your card (Skyline), and some of which will be for an extra fee.

We'll probably put in more housing on campus. The other big project is Dana Road. Dana Road is under construction. We'll end up with an enormous clinical simulation facility on Dana Road for you folks.

QS: Do you have a timeline for these things?

EH: The Dana Road facility is supposed to be done in April. We move into Skyline between Labor Day and Christmas. The exercise facility in Skyline depends upon if we raise the money. Bloomingdale's—if we pull it off—probably a year from now.

QS: Is the Dana Road facility the biotech incubator? Can you tell us a little about that?

EH: Yes. Dana Road was built as a mutagenesis research facility in the 1960s for the National Cancer Institute. It contains a vivarium and several pods for research. We'll put the clinical simulation facility in Dana Road, and we're going to take one of the Pods and make it into the biotech incubator, leaving two pods for future expansion. A biotech incubator is a facility which leases space to startup pharmaceutical companies and medical equipment manufacturers who think they've got a product that will make a big hit, but they want to have a place to get their company launched. It might be a company that makes a new drug, makes a new hearing aid, makes a new anti-head trauma device, makes a new pin for orthopedic surgery, or makes medical software for your iPad. All those kinds of companies would be prospective tenants.

QS: Will this have the NYMC name attached to it?

EH: It will be the NYMC Hudson Valley Biotech Incubator.

QS: Those are big changes. What do you see as your legacy here? Is it this kind of thing, with new build-

ings and expanding? What's your vision?

EH: My legacy will be if I cure or ameliorate any of the symptoms of children with cancer when I resume practice. My legacy will be if we graduate good physical therapists and doctors and public health professionals. My legacy will not be buildings and grounds, although that's usually what people attach to legacies. It will not be how I perceive my legacy. Simeon the Righteous said, "A person is known by three things: by acts of charity, by knowledge, and by their good name." Your most important legacy is your good name.

QS: Where do you see yourself in 5 years, 10 years, or 20 years?

EH: I think my last job will be taking care of patients and teaching history and ethics. Whether my last job will be here or someplace else, I don't know. I would envision after I'm done being an administrator I will continue as a clinician and teacher.

What is unusual about what you just asked me is that very few people with jobs like mine still take care of patients and still teach. They administrate and go to meetings. There are several reasons why I do not agree with that. I think that people who administrate should remember what business the school is really in. The business that the school is really in is not administrating, it's doing science, providing education, and taking care of patients. I should be doing it like everybody else.

There is an old expression in academics: "What is the definition of a spayed administrator? The definition of a spayed administrator is one who is unwilling to be fired or quit over a matter of principle." People who are spayed administrators are people who don't know how to do anything else except administrate. I decided when I was your age that I would never be in a position where I was afraid to be fired or to quit if I thought something was wrong, because I was afraid I wouldn't be able to make a living except as an administrator. I have never been in such a position in my life. I'm always in a position where, if I think that there is a matter of principle, I could resign and go back to practicing medicine or teaching. That's the long answer to your question, but that's what I think.

QS: Do you think that there are some hospital administrators who might not have that sort of insight or vision? If so, does that cause a clash between the physicians who are willing to quit or move on for their vision? Conflict between physicians and administrators seems to be an essential clash.

EH: You may encounter people who you think are doing the wrong thing but they have decided that they have a mortgage to pay or a family to support and they back down because playing in the back of their mind is the thought, "I need this job." Therefore they will make compromises. If you want to read about this concept, I published an article called "The battle of Louisville: money, power, politics, and publicity at an academic medical center." It was published a year or two ago.

In that article, I describe how the entire Department of Neurosurgery threatened to resign from the University of Louisville and close a Level 1 Trauma Center, and what I did in response to that. I felt it was a test of my will. We were going to see what I was made of. I was not going to lose. I thought that it was racist to threaten a Level 1 Trauma Center. I thought that the doctors were worried about their own personal incomes rather than the care of the poor, black, and marginalized of Louisville. I thought they were going to destroy the school. I said, "I will fight this to the end. I will not lose. I am prepared to be fired or resign over this." I think other people might back down in situations of crisis, because they say, "I need this job."

QS: You know what the real crises are, as you told us. If we could segue to a not-as-serious part of the interview: a lot of the students know you as "the man in the suit" when they see you in the cafeteria during lunchtime. In the History of Medicine Course, first-year medical students got a little bit of a taste of the things you do outside of the office. You told us about your stamp collection and we've seen pictures of you traveling around the world. What are some of your hobbies? What else do you do for fun?

EH: I decided, when my children were born, that I

was never going to miss a ballet recital or a dance performance, or the school songfests; so I never did. I would always work my schedule around what the children needed. I suppose, if you ask what are my hobbies: they're my children. My children are all grown now. They're all your age. I went to every school trip, every school recital, and every school performance. I fixed little ballet shoes and Barbie dolls and playhouses and dollhouses. Whatever the girls wanted.

I rode my bicycle to work for 6 years when I worked in Louisville. When I took this job, I asked about a place to live where I could ride my bike to work. The real estate agent told me I'd die if I tried to do that. I ride my bike around where I live in Greenwich.

What the students thought about me in Louisville was that I was the funny man in the suit on the bicycle who pedals by and says, "Good morning!"

I collect stamps. I play the piano badly.

> *"I really like pie. I think they should give the Nobel Prize to whoever thought of pie."*

QS: What was the last book that you read?

EH: I'm reading The Emperor of All Maladies. I just finished Mark My Words, the autobiography of the chairman of the board of Touro. I'm reading The Lander Legacy, about the founder of Touro. I have a couple of books on slavery and medicine that I have to get to.

QS: Do you have any favorite films?

EH: Z. It's a French movie about the military coup in Greece. It traces the behavior of an investigating judge in Greece. He identifies and prosecutes a group of Greek generals for the murder of a politician. It has a lot of flashbacks—it's a movie from the 1960s. You're way too young, but it was considered quite the cutting-edge film.

I know a lot of the Marx Brothers movies by heart. If you said something from Horsefeathers, Monkey Business, or Duck Soup, I could keep reciting it. For example, the scene about President Wagstaff of Huxley College at the beginning of Horsefeathers. I can do the whole bit.

QS: What about music? What's on your iPod or mp3 player right now?

EH: Showtunes: Guys and Dolls. Pete Seeger, Joan Baez. I was probably the only student at The Wharton School who, if I ended up working in labor relations, I wanted to work for the union, not labor. I know all kinds of union-organizing songs and I have a lot of those on my iPad. When I think about who won the minimum wage, the 40-hour workweek, the end of the sweatshops— those were the unions. On my iPad are a lot of folk songs and union songs. Aren't you impressed that I even have one of those little i-somethings? My children gave it to me. I figured out how to use it.

QS: You already said you didn't have a Plan B when you decided to go into medicine. But if you had to have a Plan B—if you couldn't be a doctor—what would you do?

EH: When I was your age, I wanted to be an attorney. I went through periods of time when I thought I wanted to be a Professor of Theology at a liberal arts school.

I went through a stage when I thought I might be a sufficiently good percussionist in the school orchestra to pursue that. I am not good enough at playing the piano, but I was the percussionist in the university orchestra: tympani, xylophone, snare drum, bass drum, and all those things that get whack-banged and crashed in the back of the orchestra. I know how to play all those sorts of things. I played all those in classical music, so I may have gone through a stage where I thought I may be able to do that.

QS: If you could have a dinner party with any three people, dead or alive, who would you pick?

EH: Maimonides. David Dubinsky. Henry Sigerist.

QS: And why would you pick these three?

EH: I would want Maimonides to talk about the balance of faith or religion and science. David Dubinsky was one of the great labor leaders of American history. I wrote a paper about him when I was in college. I think it would be interesting to talk to him. Henry Sigerist was the great historian of medicine. He would be interesting dinner company.

QS: And what foods would you serve your dinner guests? Do you have any favorites in particular?

EH: I like a toasted bagel with cream cheese and chocolate milk. That's my favorite. Another favorite is cottage cheese and sour cream with fruit. I like a hot dog. I like delicatessen food. I could have a potato knish with a corned beef sandwich and a Dr. Brown's Black Cherry Soda five days a week, and I would be happy too. I like pie. I really like pie. I think they should give the Nobel Prize to whoever thought of pie.

QS: Favorite kind?

EH: I like Boston cream pie, coconut custard pie, pecan pie, and blueberry pie. I really dislike peach pie.

I think there is no reason on Earth for there to be asparagus. I actively dislike asparagus. Whoever came up with asparagus—that was a mistake of evolution.

QS: To wrap up, what's the best advice that you've ever received?

EH: My father and mother were married for over 60 years. I asked them for their advice regarding success in marriage. They both replied, "Be quiet. Remember to listen. People talk too much. Spend more time listening." The fact that I have talked to you about myself for an hour is agony for me. So that would be a good way to end.