D.A. HENDERSON, MPH ’60

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Mame Warren,
interviewer

Warren: This is Mame Warren. Today is the twenty-first of December, 1999. I’m in Baltimore, Maryland, with Dr. D.A. Henderson. I want to concentrate here today on Johns Hopkins. I know you have some remarkable things on your resume not necessarily related to Johns Hopkins.

Henderson: Right.

Warren: But I want to concentrate on your relationship to Hopkins today. I understand you’re a graduate of the School of Public Health.


Warren: What made you decide to do that, to come to Hopkins and to go into public health?

Henderson: Well, those are two different questions. The first, I would opt going into public health because we had to serve two years of military duty at some point at that time of history, and I’d been postponed and postponed until I got through internship. Then at that point it looked like I was going to be drafted for the Air Force or Army or Navy, and along came somebody from Public Health Service and said, “How would you like to serve two years in the Public Health Service?” No uniforms, no marching, no basic training, and so forth. I thought that sounded very interesting, and besides which, I could work in communicable diseases in Atlanta.

So I figured, well, it’d be two years of learning something rather than perhaps doing entry-level physical examinations in one of the other services, and so with that much in the way of
motivation, I joined up with the Public Health Service, in epidemiology, in something called the Epidemic Intelligence Service, a program which had been founded in 1951, four years before I came, by a man by the name of Dr. Alexander Langmere, who had been an associate professor of epidemiology at Hopkins. He went down to the Centers for Disease Control as, in fact, the chief epidemiologist for the Public Health Service, and founded this group of young people he made into epidemiologists for a training program which basically was our introductory biostatistics and introductory epidemiology for a month.

Then you were assigned to various places to be on call to go to epidemics wherever they might occur. It was the most exciting two years I think I'd ever spent. It was just adventure and getting involved with disease in a totally different way, not only the disease, the people, the community, how to control it. It was wonderful.

So I went back for two years of residency and did that, decided that I was never going to be an internist; I had to be an epidemiologist. At that time it was generally being said that we'd defeated the infectious diseases, that this is over now, that basically we've got the polio vaccine, we've got smallpox vaccine, diphtheria, whooping cough, tetanus, so forth. We've got antibiotics that treat many of the bacterial diseases. So the era of infectious diseases is over. We must turn our attention to the chronic diseases—heart disease and cancer and so forth.

So in truth, I came to Johns Hopkins at that time figuring that having been an infectious disease epidemiologist, I now had to learn about chronic disease—epidemiology. And clearly the outstanding person in the country at that time was a Dr. Abraham Lillianfeld, who was chairman of the Department of Epidemiology, and he suggested I come down and spend a year with him, which I did, to learn chronic disease epidemiology. So, one, that's how I got into public health,
quite by accident, into Johns Hopkins, coming to study chronic disease epidemiology.

**Warren:** So what was the School of Public Health like when you arrived? Describe it for me then.

**Henderson:** Well, the School of Public Health at the time I came was really quite small in terms of faculty and students. In physical size, compared to what it is now, it really was small enough so that one really got to know most of one’s classmates. The classes were small enough. And the faculty as well. You had an opportunity to interact. There were not that many faculty. There was a place in the basement where everybody took their lunch, mainly just brown-bag lunch, and picked up something to drink, so you ate together very often, and I think in a sense it was a small graduate school environment.

In fact, when I came, Dr. Lillianfeld suggested that I have an office as a master of public health student. And, goodness, we would never assign an office today. We just don’t have the space to give to a MPH student. So I shared an office with one of his young new faculty members, so I had an opportunity, really, to participate more as a faculty member, practically, than as a student. So it was very interesting from that standpoint.

**Warren:** So who were faculty members at that point? Who made a difference to you?

**Henderson:** Well, I think Abe Lillianfeld was clearly the individual with whom I spent most of the time.

**Warren:** Tell me about him. What was he like?

**Henderson:** Well, Abe was a person with great compassion and interest, I would say, in his fellow man. He was a dedicated scholar. Never have I encountered anybody who worked any harder, who had an encyclopedia knowledge of literature and the people and investigation, who
was extremely down to earth. He treated you as really an equal, never as a student, so you really, at least for myself, I really felt like it was very easy to approach him, very easy to discuss things with him, and just, I’d say, a great person.

Warren: What was the makeup of the student body at that time? Where were people coming from?

Henderson: Student body was very international at that point. There were quite a number from a number of different countries, and I would say that the opportunity to meet and talk with and work with students from a number of different countries constituted, I would say, one of the most important attributes of the school.

Warren: Why?

Henderson: Well, I think for many of us, myself among others, we had not traveled very much. I had been out of the country a couple of times, but basically I knew the U.S., but I really knew very little about so many of the other countries. To have, as we did, we made very good friends with several people. One was an Afghani, one was a Hindu, an Indian, one was a Burmese. These three became kind of very close friends with my wife and myself, and we saw them again and again over the years and kept in touch with them. But there were others as well from different countries.

One talked about all sorts of things, not only science, but culture and attitudes, what have you. You got a view of America which was different, got a view of the world which was a very different view than you’d had, and I would say this may have been one of the most important factors in impelling me to do more in the international health world.

Warren: How did these people from all these different countries find their way to Baltimore?
Henderson: Well, Hopkins was the first school of public health created, and it was created by the Rockefeller Foundation. The intent at that time was that of training physicians in the field of public health simply because there were so very few. There was no training program, and the base of knowledge that was out there was certainly not being conveyed in medical schools. So this School of Public Health was established.

The Rockefeller Foundation for many years, a great many years, provided scholarships for what they called Rockefeller Foundation fellows, and a great many of these people came to Johns Hopkins. Now, the people that they identified—and I don’t know how they did it—were really outstanding individuals, they became outstanding individuals. My guess is that they were young professionals who were identified as having promise, and then were trained here and went back. One sees over and over again around the world these people taking leadership positions in their own country, in the international organizations, in setting up schools of public health in their own countries.

So that Hopkins, very early on, was well recognized as the leading center in international public health. So that for people to come to Hopkins from abroad was well, I’d say, imbued in the whole sense of public health internationally, that this was really a great place. There were not all that many places that would have ranked with it in a comparable way. I suspect you could say the London School of Tropical Medicine was one. Harvard was a second. And beyond that, there just were not many students, international students, in public health in many of the other schools of public health at that time.

Warren: So for the lay person who, really, even the term “public health” might be foreign to that person, what goes on in the School of Public Health? What’s the point of it?
Henderson: It’s not easy to describe all that goes on in the School of Public Health. It is a very diverse world indeed, and basically our concern is the health of the public, not of individual patients, but what is it that will make for a healthier America or a healthier world.

So we’re concerned about a lot of different things. What causes disease that might be preventable? This leads us very definitely into the area of vaccines that might be used in a very broad scale and a very large set of activities in that area. Very concerned about family-planning issues, concerned about population issues, first of all, and family planning, which has been, of course, very controversial over the years. Here again our school, Johns Hopkins, was involved very much in the first development of Planned Parenthood of Maryland, and the first meetings were actually held in the office of the dean when it was felt that this was too controversial to be dealt with at the hospital or the medical school.

We were involved very much with the development of a research program on AIDS when at the time it was felt if we’re going to have an all-institution approach to AIDS, not only prevention but treatment and all the other factors, social, behavioral aspects of this disease, it was felt to be too sensitive an issue to have a center or an institute in the hospital or the medical school, so it was in the School of Public Health even as recently as this.

Warren: What’s the padding that goes on? It sounds like there’s some protective thing about the School of Public Health as opposed to the hospital.

Henderson: Protective? I’m not sure what you mean.

Warren: Why was it okay to be at the School of Public Health and not at the hospital? It’s an interesting distinction you’re making here.

Henderson: Well, the hospital has a reputation and a persona within the community, and they’re
trying to attract patients to the hospital, and controversial issues are often things that hospitals like to avoid. Did the hospital want to be identified with admitting a large number of AIDS patients, for example? The answer is no. And the medical school reflects very closely the hospital because the chiefs of services are chairmen of departments of the respective clinical departments.

So over at the School of Public Health, we’re quite a different beast altogether, so that’s not really the same issue. And family planning was a very controversial issue in the early days. But our concerns are the community, and we’re concerned about maternal and child health, for example, the health of a mother and the children. We’re concerned that these people get adequate care, that child spacing is in place, nutrition is there. There’s a lot of things that can be done, should be done, that are very important. One can go on. There’s just a whole range of things we’re concerned about, occupational medical things, the environment, what is causing disease in the environment. We’re concerned about mental health, concerned about substance abuse.

And I’d say at one time during the time of the Clinton health plan program, where there was a lot of activity going on as we shape a new health system, I was in the White House at the time. I was actually deputy assistant secretary of health during most of that time, and it was very interesting. The attitude was that now that everybody has a private physician, we don’t need public health anymore. And I asked the question, well, what are the major problems that we had out there?

Let’s say teenage pregnancy. What does the practicing physician do for teenage pregnancy? He takes care of the women after they become pregnant. Our concern is helping them not become pregnant.

What do we do about AIDS? “Well, we have a large clinical service that takes care of the
people after they develop a disease.” Our concern is helping prevent them getting the disease.

What do we do about handguns? Well, again the same paradigm persists. In other words, of all the major problems that we have in the country, public health is at the center of trying to deal with these. And I think illustrative of what I mean is at one time Dr. Richard Ross, who was dean of the School of Medicine during most of the time I was dean of the School of Public Health, he said to me, “You know, it occurred to me the other day that the School of Public Health is probably responsible for saving more lives in a year than we’ve saved in the Johns Hopkins hospital in its entire history.” And I said, “You’re right. Probably several times over.”

So that in my previous incarnation as director of the global program for smallpox eradication, we went in ten years, a little over ten years, from having between ten and fifteen million cases a year to zero, and two million deaths a year to zero, now, during this century we estimate there probably were 500 million died of smallpox. The *New York Times* estimated at one point that during this century 100 million people have died either directly or indirectly as a result of armed conflict. Smallpox killed at least five times that number. In other words, these are very serious problems we have to deal with, and with prevention a lot of things can be done that simply cannot be done in the clinical setting.

Now, the School of Public Health is unique in another way, and that is that there are so many different disciplines represented. We really need to bring to bear not only physicians and nurses; we need statisticians, we need engineers, we need basic scientists, we need people involved in behavioral science, who understand behavioral issues, and so forth. It’s a very diverse group of people. So only a portion of our whole faculty are physicians, and you bring to bear talents from many different areas. This makes for a far more lively, interesting place than one
might have if one has all one discipline and you're looking at any problem simply from the standpoint of a physician or a nurse or an engineer. This makes it a very lively place indeed.

**Warren:** Are you drawing those people from other parts of Johns Hopkins? The engineers, are they coming from the Whiting School?

**Henderson:** At one time, I would say when I first came, it was felt that the school was pretty much self-contained and there was very little communication with the School of Medicine, even, or the College of Arts and Sciences. As time has progressed, that has changed quite significantly so that there is a lot of communication and collaborative projects with the School of Medicine and significantly with the arts and sciences.

Interestingly, there's an intersession course for public health, which is taught from the School of Public Health, which has become immensely popular. In fact, for many of the undergraduates now, there is a public health major that's possible, and many of them, this has become quite popular. Really quite amazing. In fact, I would say public health has changed so dramatically since I became dean that it is almost unrecognizable. There's been a sea change.

**Warren:** Tell me more about what you mean. What kinds of things?

**Henderson:** Well, I would say that there's been a recognition of the importance of public health, what it can do, and an interest on the part of many people who have obtained degrees in a number of different areas, whether in law or engineering or what have you, in taking courses at the school and taking degrees. So that we're beginning to see here, I think, remarkable changes taking place.

Let me put it this way. Ten, twelve years ago, it seemed to us—I was dean during this period—that we began to see a tremendous increase in the quality of people that we were getting, applying to the school, physicians already with residency training and specialists in different areas.
We had a number of faculty from the School of Medicine who recruited to the School of Medicine, who came on the condition that they could get a master of public health degree during the course of their employment on the faculty. This is a huge change, and it came along about the mid '80s that we noticed this.

Then with the demand both in the proportion and quality of students, the number of students applying and the quality of students, really rose dramatically. And what we’re seeing now across the country are schools of public health, one after the other, springing up with many schools of medicine that can’t put together enough of a faculty to have a school, arranging enough in the way of faculty to give a master of public health degree. There’s a recognition of the need of the quantitative sciences, whether it’s epidemiology, biostatistics, the behavioral sciences and what they can contribute, of the engineering and occupational medicine, that area. I don’t know what that contributes and how necessary that is, a whole series of things that are not found in the ordinary clinical setting unless the school broadens out and begins to think more broadly of its role vis-a-vis the community, vis-a-vis the state, vis-a-vis the world. That’s what public health brings to it, and I think we’ve seen changes across the world in terms of the numbers of students, the number of schools, and the interest in public health.

Warren: There’s somebody who I started hearing about just as soon as I arrived here, in addition to yourself, and I don’t know whether he was connected with the School of Public Health, but it seems like he might have been, and a natural–Abel Wolman.

Henderson: Oh, Abel Wolman. Oh, he certainly was.

Warren: Tell me about his connection here.

Henderson: Well, I’m a little uncertain myself as to specifically what his position was in terms of
officially, but effectively he was head of our Department of—it’s called Environmental Health Sciences at this point in time, and at the same time that he was occupying a position over at Homewood. He also had, of course, a career with the city, advising them and running things there.

Quite honestly, I’m confused as to exactly what he did and when, but Abel was such an extraordinary person that he could do any number of different things in any number of different settings. He was widely respected, and an immense capacity to do just about everything. Encyclopedic knowledge of the field, highly respected, innovative, creative, what have you. So the School of Public Health claims ownership of him, I’m sure, just as much as Homewood does, too, and he’s somebody we all appreciate.

Warren: What exactly did he do? I know you can’t tell me his whole life, but why is he so revered?

Henderson: Well, it’s the whole issue of chlorination of water and the design and establishment of water supplies was certainly his baby, which is some contribution to make. But I think he was so broadly knowledgeable on the whole issue of both water and sewage, or wastewater, I guess as we now call it, and the design of programs for cities, the importance of this to cities, as an engineer, what he brought to public health was the whole area of concern for the environment, whether it’s air or water or what have you, that he played a major role in advancing the subject, the science of the subject.

Now, it’s rather interesting, historically there’s a real question of where the home of public health should be, because public health basically at one time was kind of equated with sanitation, of better housing, of clean water, of sewage disposal. And in the earlier days, many diseases were
associated with filth and miasms, as they called them, bad air. And the answer to all of this was
the draining of swamps, which cut down the mosquitoes, cut down the malaria, cut down the
yellow fever. The better housing provided people less crowding, less transmission of disease,
better food, nutrition, of course, came along. All of these things tie in in a major way with the
engineers more than with the physicians.

So that there was a kind of pull and tug for a long time as to which would dominate the
field of public health and inevitably with the professions as they were, there was, yes, a
collaboration, but one or the other was going to dominate in their thinking, and it became
medicine rather than engineering. But this is only to say that the engineering was extremely
important, and Abel brought to the school this component, which was so critical and so
important, so valuable, that you had to accord this, I would say, equal importance to the medical
interventions or, if you will, public medicine interventions.

Warren: It's like, is it public or is it health?

Henderson: Yes. This is where people have difficulty defining what are the outer limits of public
health, because, indeed, we do get far afield and some do go very far afield. One can correlate
income levels with health, in other words, longevity can be equated with different income levels,
and should we be concerned about equity in salaries, if you will, across, so that everybody has a
certain level of income, minimum level of income? And there are those who certainly argue this
very strongly.

There's a question of really everything that you do in the way of public policy, which
relates to income–health, housing, the roads, for goodness sakes, transportation and roads. Well,
you can build safe roads, or safer roads, and that requires certainly a lot of engineering, but what
constitutes a safe road and how do you measure whether this road is safer than another road?
The public health, you get the statisticians involved here. These are illustrations of really what
amounts to we’re just involved with about everything.

You could go on beyond this. Let’s say what about global warming? The implications of
global warming, in a major sense, translate themselves into effects on the human population, and
with potential for disease occurring in areas where it didn’t before because of change in climate,
with large areas losing water, I’ll say becoming drought areas, and where food supplies may be in
jeopardy in areas or you’ve got flooding, displacement of populations, refugees. All of these
things tie in with public health. So that one, in a sense, one has difficulty identifying what it is that
is not important to the health of the public. Virtually everything is.

So I think there is at times within the school and among our profession a need for focus. I
think sometimes we get just a little too far afield, beyond, working in areas where we have very
little idea of what practically can be done in dealing with some of the problems.

Warren: All these things you’re talking about, of course, make me think of other aspects of
Johns Hopkins. Of course, my mission in doing a book about all of Johns Hopkins is to
understand the interrelationships within the various places. Do people within the School of Public
Health, when they’re looking for advice or expertise on something that’s out of their realm, do
they turn to Homewood? Do they turn to the Applied Physics Lab? Or do they go out into the
world? Or both? I’m sure the answer is both, but is there real interconnectiveness with
Homewood or APL?

Henderson: There is some interconnectiveness, but there’s, I think, been the feeling that this has
never been as optimal as it could be. That is to say, I think there is much advantage that could be
gained were there greater number of interconnections, but basically institutions are institutions, and people often have difficulty sort of relating across to other institutions.

How do you effect this? As a dean, I found it not easy to do. The best way to effect this was around a program or set of activities which we drew others in so that we had a goal, but you had to first really focus this on a problem. If it were just generally an interest in “Let us work more closely with those at the Whiting School,” people at the Whiting School say it’s a nice idea, and at hygiene say it’s a nice idea. Work together with what? To do what? And kind of a general schmoozing doesn’t really help in this area. So mainly the interconnections you develop are professional more than anything else.

Consequently, one often winds up, I think, making the connections with other professionals in your field at other schools, say, other universities, rather than with somebody who may be working in a particular subject area which is at another school at Hopkins, but doesn’t directly tie in with particular programs that you might have.

Down at SAIS there was a woman down there very much interested in basically behavioral science, anthropological issues, and we had several meetings and actually I think we gave a few lectures down there at her course. But she was working in an area which we really didn’t have anybody working that particular defined area of the program or specialty, and so there really wasn’t anything that impelled faculty to get together. So it’s a little more difficult here.

Now, one of the, I think, great successes we had with the AIDS program, because this did a lot to bring together people within our own departments, because even within departments we had troubles. You have trouble as a dean getting those in one department to work with another department, again because of the affiliations that people have. But with AIDS it was very useful,
because here you had a disease which was very complex, a whole set of new areas we were going into. It gave a special impetus to the behavioral sciences, which are very hard, one, to get funded and, number two, to really build into some of the working relationships. That helped a lot.

Infectious diseases at that time were kind of almost passe. We were having our infectious disease contingent at the school was becoming rather long in the tooth, and there wasn’t too much in the way of funding for infectious disease, epidemiology, and the type of activity which we felt would be useful to have, and AIDS helped transform that.

Then there was, with the setting up of an institute, there were a whole series of regular meetings of investigators from medicine, from public health, some from Homewood, working around this area of AIDS, and I think this did a lot because of the program, the particular problem that all were interested in. They did get together. So that was a big plus. But I think you need to do something like that.

There are efforts being made now with different centers to bring together people from different parts of the university. In the case here, our own center, small as it is, we are a product both of medicine and public health. This is not a center from either school, but it is the Johns Hopkins Center. John Bartlett from the School of Medicine, infectious disease, is a co-director of the center, and he’s head of infectious disease, and one of my faculty here is Tom Inglesby [phonetic], who was chief resident in the medical service and is a faculty member in the School of Medicine. The woman who just joined us got a Ph.D. in anthropology from Homewood, and she’s concerned, very interested in the whole area of how people react under epidemic circumstances. What happens if we have a bioterrorist event? And she has a great interest in this area. In fact, we have some students working with us from Homewood, as well as some from
hygiene and some from medicine.

So we have here a mixture from the different schools and we are now working with, I should say, with Applied Physics Laboratory, because, indeed, they have a number of, let’s say, devices that are of potential importance in the detection area, and they’re working now on surveillance techniques, electronic surveillance, which may be useful. So these things do happen around programs.

Warren: So how would you recruit students from Homewood? How does that happen?

Henderson: Well, the word goes out. I would say much of this is word of mouth as anything, and we’ve had no shortage of students coming to us, because the issue is a very important one, very critical one. Many people are very worried about it. So we’ve had any number of people showing up on the doorstep saying, “I’m doing this and this. I’m majoring here. I’m a doctoral student here,” what have you. “Can I work with you?” And so we have accommodated a number of these students who, indeed, are working with us.

But it’s interesting, I would say the potential at Hopkins is rather unusual, in a way, here, I think needs to be talked about. The difference between being on a Hopkins campus and being on a campus of a number of other universities is really quite different, and that is that you see here a willingness on the part of people who are professors, heads of departments, or what have you, to you can walk in on them, ask for advice, they’ll sit down, work with you. Door is open. In so many areas, so many other universities, the various centers and activities are very tightly walled off and very independent and very little communication.

It’s said that Hopkins works much more like a family, and this is true. There is no question about it, that you do have a lot of rather easy interchange between people in different departments
at very high levels, who are quite willing to meet with junior faculty or quite willing to meet with students, quite willing to work with. And this is, I know—I reflect this from other faculty who have come here from other schools and commented upon this, or go to other places and come back and say, “This is so different than Hopkins.” Hopkins has a marvelous ambiance and feeling of being a very large family.

Warren: It certainly feels that way to me, as a relative newcomer.

I need to turn the tape over.

[Begin Tape 1, Side 2]

Warren: Now, a couple of times you’ve made reference to having been dean, and I know that there came a time when you didn’t want to be dean anymore. What does it mean to be dean, as opposed to being faculty, and why did one seem more attractive to you than the other?

Henderson: Well, I came to the school as dean, having never been on the faculty, so in that sense this was a rather unusual appointment. They do tend to appoint deans from individuals who have been members of faculty, but I had been in Geneva, Switzerland for eleven years at that point, and they’d ask if I would come and be dean of the school. So that my experience is not that of before and after, coming in and being dean.

I’ve always enjoyed the challenge of working with a group of people and, if you will, it’s trying to orchestrate an effort which is a very broad-based one. I guess I’ve had enough in the way of bureaucracy and government and what have you, that you can look at this from the standpoint of a dean and you can say to the faculty in your group that you’re working with, “We’re creating our own bureaucracy. We want red tape? We can create it or we can do away with it.” And you have a wonderful freedom to work in a private institution such as this, that you
just do not have within government, flexibility to move quickly, flexibility to do a lot of things that you cannot do within the strictures of a federal or state establishment.

So coming in to be dean in this school was, I'd say, a great adventure, and personally I loved it. I can say this, that I came—I turned down the job originally. I indicated I did not wish to interview for the position. They called me. The president called me and asked me if I'd come to Hopkins and interview for being dean, and I said, no, I wouldn't, that I really wasn't interested and it was not worth his money or my time to fly from Geneva. But I said that I would come if they really wanted me to come, at some point if I got to the States, I'd be happy to drive up from Washington or what have you.

So I had to come to the U.S. The U.S. Government wanted to give us $2 million for the Ethiopian program, which we badly needed, but they wanted publicity for this, so they wanted pictures and signing ceremonies and so forth. So could I come to Washington. For $2 million, yes, I could come to Washington. So I indicated I was interested in—I'd be willing to come up and talk about why I would not be dean of the School of Public Health, which I did.

Basically the feeling I had was quite simply this, that having been, as I had been at the Centers for Disease Control for a number of years before going to Geneva, I had some feeling for the School of Public Health, having had a year at the school, as to where they were strong and where they weren't strong. What concerned me was that so many of the schools of public health, including Hopkins, as I saw it, was very ingrown in the sense of they were basically doing research on public health, with very little involvement in the community or in activities outside of the school.

Now, there were exceptions to that, and there were some important ones, but, by and
large, it tended to be, as we would describe it, more of a graduate school rather than a
professional school. In other words, not training people specifically for a profession, but basically
a graduate research program which leads on to a Ph.D. degree. As I interpreted the history of the
founding of the schools of public health and what they’re intended to do, they’re intended to be
professional schools, like a school of medicine.

My simple-minded analogy at that time was, can you imagine a Department of Surgery,
where the surgeons do research on surgery and they teach surgery, but they never perform
surgery. They’d be pretty irrelevant pretty fast. And that was my view, that this is where schools
of public health were; they were irrelevant and becoming more irrelevant and more isolated and
totally out of touch with what needed to be done in the community and what the problems were
out in the population.

So after three days of discussion about this, sort of the gauntlet was thrown down. “How
can you turn down being dean and be critical and be a critic on the outside, when you owe it to
try to put these into practice at the school?”

Well, I had a job at that point. In fact, I’d been recruited to be head of the international
division of the Rockefeller Foundation. So with the challenge thrown down, I thought about it
and finally said, “All right, but we’ve got to change. We’ve got to do some things differently.”
And there was wide agreement that that was a good idea. Translating it became more difficult.
But gradually things did transform, so that the school is extremely active in the community, in the
state, in a lot of areas, really involved in very practical problems and programs.

There’s no way, in my experience, having run programs in government, there’s just no
substitute for actually having had to run a program, with all the problems that are there—personal,
budget, publicity, and all the problems. It’s going to be a real headache, and you’ve got to keep a number of balls in the air. It’s complicated. You can’t read about it. You’ve got to be there and you’ve got to know what it’s like. So this, I think, has had an important influence on the School of Public Health.

One of the first things that came up after I came was one of the foundations whom I called on to introduce myself and suggest that we’d like a little help, they said, “What would be your highest priority?” And I said, “What I would like to do is to see that the patients—that we get the faculty and students to the bedside of the public health patient.” In other words, in medicine we talk about teaching at the bedside, and my feeling was, in public health what we needed to do was get our students and faculty into the community, the public health bedside. And so they said, “Write that up and give it to us. Two pages would be enough.”

I sent a two-page suggestion in, and they mailed back a check for $500,000. And so began what we called the Health Program Alliance, to try to build the links between the city health department, state health department, and other organizations within the area so that faculty and students would begin to work more closely and really gain those practical experiences.

We changed the nature of what was called the public health residency, which actually up till that time was more learning about—more writing thesis for a degree, and we transformed this into saying what we need for public health residents, they need to have experience like they do in a hospital. You have an internal medicine resident, he goes and spends time on each of a number of different services, getting experience in different areas. And that’s what we need to do with the residents in public health. So we changed the whole program over so that this is what they did and they actually worked with people at the state level, at the federal level, and in different programs
actually getting that experience. So bit by bit, this transformed.

Eventually the Health Program Alliance transformed itself after several years into National Centers for Prevention Research, which was authorized by the federal government and is today. I don’t know what there are today, ten, fifteen centers which are intended to bridge between schools of public health and the community and CDC, so that there’s kind of a working triumvirate partnership. I think, last I heard, I think there are around $30 million that are in that program. There should be much more than that, but it’s coming.

And so that was what brought me into being a dean, and it was sort of trying to get all of these things moving and going. One of the key areas that was of concern to me was international health. In this school, there is very little money. The school itself has very little endowed. It gets tuition revenues for teaching, and the rest of the money you raise by grants and contracts that most faculty are basically about seventy-five percent paid through grants and contracts. They’ve got to be competitive to do that. There’s a constant kind of tension about getting those funds in every year.

And particularly when I came, the budget was around $17 million a year, and most of that was grants and contracts, which you didn’t have in hand as the year began, and you just hoped were going to come in over the course of the year. By the time I left, we were right around $120 million, and there were some anxious moments, because once you’ve committed to faculty, they’re paid. And if they aren’t getting grants and contracts, you’ve got faculty that are heavy on resources, and you’re in real trouble because you can’t really support them. So this makes it a challenge, but we were able to do it.

One of the areas of great concern for me was international health, and which was very
difficult to get funds. The Agency for International Development at that time, and it’s changed somewhat now, just would put no money into academic institutions at all, in any sort of programs to work with other countries on various activities. They just would not do that. So that’s your main source of funds.

The foundations, Rockefeller and Ford were two of the big foundations that invested substantially in this area at one time. Both of them were phasing down those programs in international health. So we were really desperate trying to figure out how do we put together a program that is going to strengthen our international, our traditional international strength. This is where I thought the strength of the school was in a major way, because you’ve got, as I mentioned earlier, the great experience at the School of Public Health was having these people of different nationalities working together, not only different disciplines, but different nationalities. And health looks differently when you see it through different eyes and what the potential is. So this was important that we have an international program, irrespective of anything else. And how to get the funds to do that was not easy.

But eventually we built a series of activities, a population communications program which started in dealing with population issues that now Center for Communications deals with development of communications, a very broad base. A major program in AIDS which extended internationally for obvious reasons. It was important. Family planning, that whole area of population and maternal and child health, again, we were able to develop another major set of activities.

And then we managed to get started with major program on immunization, that is, vaccine development and testing, which, as we’ve moved into it, began to take off. So like investing in
stock early in the stock market, and it really began to take off, and that’s been extremely valuable. So we were able to build a fairly broad-based set of activities in the international world and nutrition, I should say, the other one, which came along later and was even more difficult to get funds for. But each of these has now taken off and this has given us a really solid base in international activities.

So as a dean, you’re involved in orchestrating a whole lot of different things, people, what have you, trying to provide the milieu, the ambiance within which they can realize a real potential. I felt this was a great adventure, and still do. It’s sort of like an artist with a painting. There are no rules as to what you do on a painting. You can paint with oils or acrylics or water color, what have you, and you paint anything you like. And this is really what you have, a vast array of talents out here, there are a thousand different directions you could go, there’s all sorts of different emphases. And the question is, how do you bring all this together so that in the end you have a painting which is pleasing and inspiring? And that’s what it was all about. That’s a great challenge.

Warren: So there came a time when that challenge changed for you and you wanted to step down.

Henderson: When I was in Geneva, I found along about year nine, year ten there, that my feisty nature was kind of being tempered, if you will. It was getting to be a bit old hat, and I was becoming, I would say, a little bit institutionalized. So it was not an immediate reflex reaction to fight the bureaucracy where we had problems, but to go along with it. Well, I caught myself on that and managed to do it, but it wasn’t quite such a reflex action, getting out about nine, ten years. I began to realize that probably one needs a change roughly every ten years. We talked
about this, a number of people and I talked about it. I had the feeling a number of others who had
this feeling, too. Somewhere along that eight- to twelve-year period, people need to be doing
something else.

So as I went on to the deanship, as I got out around nine, ten years, I became conscious of
the fact that a lot had happened, a lot of good things were going on, there were more things
ahead, but in a way it was not quite the same spirit of new adventure that you first had. So I felt it
was time to find another dean. That would make sense.

At that time there weren’t a lot of deans that stayed around for very long. For medical
schools, I think the average life span of a dean was around three or four years, and schools of
public health didn’t turn over quite that rapidly, but by the time I got out to ten years, there were
only a couple that were in service longer than I. So it didn’t last all that long. So at that point it
seemed sensible to think in terms of leaving the position, and so that’s what I did. I suggested that
they set up a search committee and find a new dean.

It didn’t move that quickly, however. I think we finally had to rename the committee a
search-and-find committee. [Laughter] Before they finally did come up with a new dean, and they
got a good one, a terrific guy who brings to the job a lot of different things that I did not bring to
it. Everybody brings different things. He has a different set of approaches and values and what
have you, and he’s done a terrific job with the school. It’s grown, it’s raised a huge amount of
money. It’s really prospered. So it’s fun to see what they’re doing now. It’s a great place.

Warren: But is it they? You’re still part of it.

Henderson: Oh, yes. No, I’m still part of it. You look upon a job like this a little differently
when you’re dean and you’re worrying about all these departments, four hundred, five hundred
faculty and fifteen, seventeen hundred students. There’s always something every day going wrong, and only the really intractable problems wind up on your desk. Impossible problems wind up on your desk. So that when you don’t have that anymore, it’s a little different involvement with the school than you had, and it’s not unwelcome, I would say, to back away from that. But I would say there are also times when one misses it, because it’s so creative and so much fun.

Warren: Now, just the physical plant of the School of Public Health has changed quite a bit in recent years, is that right? When I looked at photographs of East Baltimore and tried to figure out what building is what in early years—

Henderson: The school has grown enormously. It grew throughout the time I was here. I think we figured we needed usually twenty thousand square feet of space, on average, new space a year to accommodate what we had. So we did a number of things. We bought up all the houses down Monument Street beyond the school and across the way, and we used those. When the hospital opened up a new wing, a new big building, they found that the old nurses’ building, which is Hampton House, that they really didn’t have need for all that space, so I struck a deal with the president for the School of Public Health to take that over as the hospital moved out into new space. So we progressed. It’s 100,000 square feet, the building, so progressively we took over that building. It was really an add-on after I came.

Then all these houses down on Monument Street and Wolfe. And then we had the population center or communications center. That was a whole different set of buildings which we rented over on—I guess it was on St. Paul. Every year was a struggle to find more space, and that’s what’s happened. It’s just continued to grow.

We’ve had various retreats when I was dean, and it was felt, well, we’d really reached
maximum size at this point, we really shouldn’t grow larger, and funds are tight and research monies are not available, etc. So I guess when I left, I suggested that the school probably would be doubled in size within twenty years, and everybody went ballistic on this. I think I even said ten years. Went ballistic. “We can’t do that. It’ll never happen.” Well, there’s a lot of building going on now. [Laughter] Of course, we’ve got a lot of space down here, at least two floors, maybe three, that are School of Public Health.

Warren: Here in the Candler Building?

Henderson: In the Candler Building, yes. So we’ve got a lot of space here and they’ve got new wings going up. They no more than finish a new wing than it’s filled. We built space on the main building while I was there, for laboratories, and you finish it, by the time you finished it, there were new research grants in, and it was fully occupied the minute you moved in. There was just no room for maneuver at all. So it’s continued to grow and it’s been growing ever since I took over as dean. It’s continuing.

I’m sure if you talk to the faculty today, they would tell you, “It’s big enough. We’re big enough. We will not grow any further. When these new buildings are built, we’ve got a nice stable size.” I mean, that will be the wish of a great proportion of faculty. But each one of them will have ideas about what they could do if they just had X amount more money and could do this and this, and each one of them is out there hustling money in the program and what have you. So draw your own conclusions.

And I should say, too, all the teaching was done here. The part-time degree program, there was no such thing as a part-time degree program. And we managed to introduce the idea of a part-time degree program and that we could teach down at Shady Grove in the building that
was put up down there. We began offering a number of courses down there. Now they offer courses also at the Rome Building down in Washington. Now we’re looking at distance learning. So it’s a big change.

Warren: Now, you’re offering courses at the Rome Building. Is that through SAIS or is that School of Public Health?

Henderson: School of Public Health is offering courses down there. So the concept that we had to do all of our teaching here within these four walls, the original concept, was you had to be here, everybody had to be in residence here, and, in fact, Hopkins is kind of unusual in a way because we offer an MPH program, master’s degree in public health, in eleven months. For many of the schools it’s two years.

Why eleven months? We have a large proportion of individuals who are already professionals, who have already worked in the field. So that of the group that comes in every year, about seventy-five percent will be physicians, others will be professionals in other areas, they’ll have work experience, they will already have a background. So that you can go with the courses and go at a much faster pace than you could if you’re taking people straight out of a university or what have you, which so many of the School of Public Health, the student body is largely people of very limited or no experience at all beyond a bachelor’s degree in college. So this is a very fast paced eleven months.

I used to interview a group of MPH students at the end of the year to say, “What’s wrong? What can we do better?” And basically spend an afternoon with them on it. One woman, who had just completed, she’s chief resident of medicine at Pennsylvania, Amherst, Pennsylvania, had come down for her MPH degree, said, “I’ve never worked so hard in my life since my first
year of medical school.” So this is an indication.

Further, the biggest complaint we had, and still have, is that there are too many seminars and too many presentations being given. You can’t attend them all. “We just can’t keep up.” And that’s true. Every day you’ll have—these are not for credit, these are just interesting people. You’ll have through this place, you have everybody who is anybody will be here at some point during the year. It’s such a problem, that when I tried to put up a dean’s lecture series, I couldn’t identify anybody to bring who’s not going to be here for some other reason anyway by one of the departments, which gives you an indication of the excellence of the whole operation.

So the attitude early on, however, was that there was something magic about being in residence here, and in the earlier days this was a manageable situation. Well, now it’s a problem because you’re getting more—you’ve got mid-level career people who can’t afford financially to be away. You’ve got a heavy tuition. You’ve got to be away from a job for a year. How many institutions are going to pay for an individual to be away from a job for a year and to pay the tuition? Very few. Fewer and fewer. And so we had, I think, little choice but to look to a future where people would come and take courses part time and would be in residence maybe for a short period of time, but, by and large, it would be on the job. They could continue their own job and continue a paycheck. That was very difficult to sell, but now it’s become very much broader.

And now the idea of distance learning and courses being given over the Internet and what have you, this is really just really beginning to move rapidly now. And I think this is very good and I think we’re playing a lead role in dealing with that, but originally it was very difficult.

Warren: Do you see—and I guess it would have been more true when you were dean, but still, given what you’re doing now—is the School of Public Health something that you can look at as a
bully pulpit?

Henderson: You have to be careful, well, as a dean in sort of taking the bully pulpit in a number of different areas. That is to say, can you speak for the university? Can you speak for the school? And I can speak for myself and my identification as dean of the School of Public Health, but to take a stand that basically says, “This is what the university or the school supports” or doesn’t support, this becomes a little trickier. So in a way, yes, you can do a lot because of the position of dean or, let’s say, just because you’re from Hopkins. Your views are very positive, very positively weighted because of being on the faculty at Hopkins. The school is clearly head and shoulders above any other school in the country. There’s no issue about that. And to be on the faculty and have things to say from Hopkins gives it a special credibility.

So in that sense, yes, it’s a kind of bully pulpit, but it’s not like being Surgeon General of the United States, where that’s what you’re expected to do. You have an institutional responsibility and responsibility to trustees and a group of other people, and you’ve got to weigh carefully what you take a stand on and in what way you do it, because you can embarrass the school or the university if you get off on some sort of crazy tangent.

Warren: I can’t imagine you off on a crazy tangent. Your tangents seem pretty uncrazy to me.

Henderson: There are some who feel that bioterrorism is a little crazy at this point, but I think they’re beginning to change their mind.

Warren: You were pretty convincing the other night. My husband has talked of little else since that evening.

Henderson: It’s a real worry.

Warren: You have given me everything I walked in this door hoping to get. What haven’t we
talked about that we ought to?

**Henderson:** I think you’ve covered it pretty well. I think one can say there’s something, I think, quite unique about the School of Public Health even in the Hopkins constellation. Whereas we have an excellent School of Medicine, no question about it, but there are a number of other schools of medicine which are really right up with it. The gap between the excellence of eight or ten schools is very small and they’re all up at that level. You go further down on the scale, and clearly larger gaps open up.

The School of Public Health is out there essentially alone in terms of size, of excellence of faculty, of the uniqueness of what they bring, and this whole international set of activities and what have you. It is unique. In the rankings of departments or schools or what have you, the School of Public Health is number one, and then you go down a bit and you find maybe Harvard or North Carolina sort of in number two, but schools are very different. They’re much smaller. They don’t have anywhere near the number of senior people that we attract to the school, mid-level people in their own countries or in the U.S., who are coming back, who bring into any discussion a wealth of information, of experience, and what have you.

I tried at one point to put together a symposium on refugee assistance. You go around the school. We had at least two or three people from every existing refugee operation going on at that time, coming back from wherever, to the school, who just left the field months before. When you have something like that, these people tell you what it’s all about. You don’t take it out of a book. You bring them into the discussion. No other school can begin to offer anything like this in terms of the quality of the students, let alone the faculty.

So the experience at Hopkins is absolutely unique worldwide. As a school among schools,
it stands out far more than arts and sciences or Peabody or SAIS or medicine. It's hard to appreciate just how much it stands out as a totally different institution. So it is a wonderful place.

To illustrate further, I would say that when you do take off on some things, as we began to work with the bioterrorism issue and lectured on this, we've had a couple of people, a number of people have come and said, "Can I work with you? I don't need money. I'll find my own support or I'll do something, but I don't need money." So one of the people here who's been working at the school is a criminal lawyer, is trained as a criminal lawyer, and who has played a major role at the school in the last twenty years. Let's say he developed the theory for suing Ford Motor Company for not having air bags, which was then the basis for the trial, which awards were made and suddenly the auto companies decided air bags were a really good idea. He's also developed the theory by which states and cities can sue the gun manufacturers, and that's in process right now.

Warren: And he's here?

Henderson: Yes. Steven Teret. Steve Teret.

Warren: I've heard his name.

Henderson: He's head of the Center for Handgun Violence. Steve is an incredible guy. Steve came to me and said, "Can I work with you on the bioterrorism? Because this I regard as being the most important problem we have today." So Steve has now joined us on a part-time basis, working with us.

Had another person, who was a senior chief executive officer of a major medical center, who decided he was going to quit and do this because he felt he wanted to contribute. He felt, rather than sitting through board meetings and what have you with a hospital, profits and losses
and what have you, he wanted to make a contribution. So he has joined us and is working with us now in design of response in hospitals and what have you. And I could go on, but there are a number of people with different backgrounds. This guy’s not a physician. As a matter of fact, he got his start as a Peace Corps volunteer in Zaire, Congo, as a smallpox worker.

Warren: We have come full circle. [Laughter] That’s wonderful.

Henderson: Isn’t that wonderful? He spent two years and he said, “Those two years were the most precious of my life.” He said, “I felt I contribute more in those two years than I’ve done since. I want to do that again.”

Warren: This is a very special place.

Henderson: It is.

Warren: And it’s a great honor to sit here with you. Thank you very, very much.

Henderson: You’re very welcome.

[End of interview]