

JOHNS HOPKINS UNIVERSITY  
ORAL HISTORY PROGRAM

Myron Weisfeldt

Interviewed by Jennifer Kinniff

September 24, 2015

Johns Hopkins University  
Oral History Program

Interviewee: Myron Weisfeldt

Interviewer: Jennifer Kinniff

Subject: Life of Myron Weisfeldt

Date: September 24, 2015

JK: Today is September 24, 2015. This is Jenny Kinniff, Program Manager of Hopkins Retrospective. I'm here today with Dr. Myron Weisfeldt, Johns Hopkins alumnus and professor, physician, and administrator of Johns Hopkins Medicine. Thank you for being here today.

MW: It's a pleasure.

JK: Could we start by talking about your family and your early life?

MW: Sure. I was born in Milwaukee, Wisconsin. My father was a primary care physician, a real doctor. Not like me. My mother was a school teacher. During medical school, I married Linda, my wife, who is also a school teacher. I can assure you she had a big contribution and she used her professional teaching skills to keep me in line from time to time. I have three daughters, who are also doing well and supportive. One of them is actually in the video business. She produces for CNN in Denver and is in the media. We enjoy biking and being on the Eastern Shore, and I even enjoy skiing even now.

JK: What was it like – your education in Milwaukee – when did your interest in medicine develop?

MW: I sort of floated into it. My father was very vigorous and active. He delivered babies, set fractures and took care of heart attacks. And I got interested in heart attacks and why people died, even in high school. That sort of floated me into the idea that I wanted to do medicine. I went to Northwestern for two years and then Hopkins had a five-year program. There's a little story here. My father went

to medical school in the Depression and had only two years of undergraduate training.

He was not going to support me through four years of undergraduate training. So I outfoxed him and I got into this two-five program at Johns Hopkins, which was really the event of my life. He and my mother drove me to Hopkins for my interview. He told me when we finished the interview that if I get into Johns Hopkins he knows I will never come back to Milwaukee and practice medicine. And he was right.

JK: What was his feeling or emotion when he said that?

MW: They both had the vision that I would come back and join the clinic that he founded in Milwaukee and practice medicine there. So that leads us to my arrival at Johns Hopkins.

JK: So you were at Northwestern for two years.

MW: Yes.

JK: A science major, I presume?

MW: Yes. If I remember correctly, I was a biology major. I did some research there, malaria in chickens. I made a mistake that cost the whole summer's research to nothing. I did research back in Milwaukee in a cardiac surgeon's laboratory learning about what was really exciting in coronary bypass surgery and doing a study with some very famous people that did get finished and did get published eventually.

JK: So you heard about the accelerated program at Hopkins while you were at Northwestern and applied.

MW: Yes.

JK: What was it like when you first came here? Because you were kind of a transfer student, right? But still an undergraduate.

MW: Yes. We spent the first year [at Homewood], and since we were already in medical school we could load up on courses, and I loaded up on courses and enjoyed my time at the undergraduate school. The medical school was another question. There were aspects of my experience that were of great concern. Being from the Midwest, the society was pretty open. I learned very quickly

that the hospital had a tradition of segregation: the blood bank and nursery had only recently been integrated.

And I also learned that on the surgical service there was still a black service and a white service. And what I even learned that distressed me even more, was that tradition was that there were two chief residents in surgery. And the chief resident who was the new chief resident learning how to be a chief resident, how to operate, worked on the black service the first six months and on the white service the second six months.

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And that really, really affected a young boy from Milwaukee in a very adverse way. I also learned that Jewish doctors were not received well in the hospital and that they were forced to practice across the street at what was at that time Mount Sinai Hospital. And I also learned that there was some pride in the fact that until about the time I was a medical student there had been no known Jewish professor who had been promoted to full professor at Johns Hopkins. That did happen and that did break during the time I was a student. But those emotions were part of some negative feelings that generated during my medical school days that impacted on things that I did at Hopkins once I got into a position of responsibility.

JK: Did you personally ever experience any sort of negative treatment?

MW: The Pithotomy Club was a social club giving a raunchy [yearly show] – they did not admit Jews.

JK: Okay.

MW: Period.

JK: That's interesting, because in Hopkins' early history some of the most notable professors were Jewish.

MW: That is true also.

JK: So they changed in the early twentieth century.

MW: Yeah. And now it's unbelievable. Different.

JK: Were you taking classes on the Homewood campus and then also in East Baltimore?

MW: Yes. Right.

JK: And where were you living?

MW: We lived in East Baltimore and we took a bus to Homewood everyday.

JK: Really? And how many of you were there?

MW: About 21, and that class has maintained a very great collegiality now for 50 years, roughly. We celebrated our 50<sup>th</sup> reunion recently.

JK: That's great. So would you say you felt more like a young medical student than an undergraduate at the time you were at Hopkins? Just because you were more –

MW: The Homewood people were also not terribly receptive because most of us got good grades while we were there and they were more competitive. We were sort of visitors, but it was a good year and I learned a lot. It put me in very good shape to become a medical student. The one thing I can say is that Tommy Turner was the dean of the medical school and on the first day of the first year of the five-year we were greeted by him, along with all the other medical students.

He said, "You're here at Hopkins to learn all the science to become a great doctor like Osler. But you're also here to contribute something." And it took a long while before I actually understood what contribution meant, but that was a very great driving force to continue my interest in research, which began at the beginning of my time here and then blossomed during medical school and then after medical school.

JK: And so during that time you were going home during the summers to work in the laboratory and do research?

MW: Yes.

JK: Can you talk more about that experience?

MW: I'd rather talk about the big experience I did in research as a medical student, which was that I applied for and received what was called a post sophomore fellowship that allowed me to leave medical school for a year, but actually come back and still graduate with my class. And during that year, I applied for a position in the

Laboratory of Cardiovascular Science of Dr. Stanley Sarnoff at the National Institutes of Health in Bethesda. I moved to Bethesda and I worked for a year in his laboratory. I didn't know this at the time, but I was the only medical student who had ever worked in his laboratory.

Dr. Sarnoff – not only did I learn how to do research in a major program, major laboratory, and get excited about cardiovascular research, but Dr. Sarnoff a couple of years after I left the laboratory or was in the laboratory became an entrepreneur and became very wealthy. And about 20 years later he decided to contribute back to the field of cardiovascular science and decided to create the Stanley J. Sarnoff Foundation for Cardiovascular Science, which supports about 15 medical students per year to take a year out of medical school and go into the laboratory, modeled after what I had done in his laboratory.

JK: You must have enjoyed it, then.

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MW: Right. This is a major foundation and has a very large endowment and continues to support this vision of the value to medical students of taking a year out and doing a year of research.

JK: That's wonderful. I'm always curious when doctors choose their specializations. What is it about cardiovascular science that intrigues you?

MW: It really is that you can understand it. It's a visual, simple issue that is obviously part of life. Heart disease, when I started my interest in cardiology, killed men in their 50s and women in their late 50s in very dramatic ways, both in sudden death and acute myocardial infarction. Totally not understood, terrible, devastating illness, plus heart failure and chronic heart disease. So there were plenty of areas, as it turns out, to make progress and to learn and to improve human health and to save lives, and that's been a major aspect of my involvement in cardiology – my leadership of the cardiology division at Hopkins.

JK: And so you married your wife in 1964, which is while you were still in medical school. Is that right?

MW: We got married in '63.

JK: '63?

MW: Yes.

JK: And so she was here with you while you –

MW: Yes. She joined me while I was in the laboratory of Dr. Sarnoff. She was amused by him and enjoyed that time. Six months, she was with me there, and then we returned for a year of medical school and then we went to where I had my internship at Columbia in New York. And then we moved back to Baltimore for two years at the NIH in Baltimore under Nathan Shock, who founded American geriatrics. I worked directly in his laboratory for two years and met with him once a week. He worked on my brain and my thinking just the way Sarnoff had done during the other year of research. And then I did my final cardiology training at the Massachusetts General Hospital and it turned out that there were two people from Dr. Sarnoff's laboratory who had laboratories there.

We had one year of clinical training and one year of research, during the year of research I had a research programs in both of the two laboratories of the former Sarnoff people and developed my ideas about one aspect of my research, which was how the heart relaxes. Everybody was interested in how the heart contracts and beats. I was interested in how it relaxed, because it was clear to me that you can't fill the heart without the heart relaxing. And if the heart relaxes too slow, it's not going to fill. But nobody had looked at disease or the physiology issues related to relaxation and I decided that would be an area I would work on in a long-term sense.

JK: During these times when you were going to the various hospitals for training, did you always have in your mind that you would like to return to Hopkins? Or was it –

MW: It was never in my mind.

JK: Really? Okay. Tell me about that.

MW: In part because when I came back from Dr. Sarnoff's laboratory I insisted that I present my work to the cardiology group and there was no animal laboratory, no basic science laboratory in cardiology, and they had no interest in what I had done. And I left happily. But it then happened that Dr. Richard Ross, who then was head of cardiology when I was finishing my fellowship in Boston, he had a patient who succumbed to congenital heart disease by the

name of Peter Belfer, and his father gave Dr. Ross \$50,000 to found a basic science laboratory at Hopkins.

Dr. Ross went around the country and I know invited several people as candidates for this position, and ultimately decided to recruit me back. And this was by far the best job offer I had because he actually wanted me for research work purposes, not just as another clinical cardiologist with good training. Although I had offers from Yale and UCLA, none of the other offers were substantially committed to research with \$50,000 at that time. Boy, that was a lot of money. And it took me four years to spend the \$50,000, but it was a very serious commitment to want to have a laboratory in cardiology that attracted me to come back to Hopkins at that time.

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JK: And was that unusual at the time, to have that sort of laboratory attached to a cardiology division?

MW: It was growing in its presence in many cardiology programs in the country. And it was true that at the NIH with Dr. Sarnoff and then Dr. Eugene Braunwald that the closeness between the laboratory and clinical cardiology grew as an effective way of bringing new ideas into the treatment and management of heart disease.

JK: So you had the opportunity to shape this laboratory that was just coming online.

MW: Yes.

JK: So what were your early days then here as a physician like?

MW: Well, as I commented, I got interested in left [ventricular] relaxation, and my first fellow at Hopkins in my laboratory was Jim Weiss, who is now the dean of admissions for Johns Hopkins School of Medicine. Dr. Weiss and I went into the laboratory with another fellow and we [pursued] an idea that I had for my research in Boston that the time course of relaxation of the heart, when it finishes contraction, is characterized by an exponential function of pressure fall called the time constant of left ventricular relaxation.

And at that time, we proved in animals and ultimately in man that this was a really accurate, fine index, and it has persisted to this day as being the index for left ventricular relaxation. So when I got here, I had this idea about the time course of relaxation already and

I wrote an NIH grant and within a year I had an NIH grant – a real NIH grant, not a training grant, to support this work. There was a program called a Myocardial Infarction Research Unit, [and I was funded] for a project in that grant to start doing some work on cardiopulmonary resuscitation, which I had some ideas about also.

And then two years later, the American Heart Association gave me an Established Investigator award. So I was essentially fully funded for my salary and time. I did do clinical work and was an attending in the coronary care unit and loved teaching. In the coronary care unit, we started the work that I did on cardiopulmonary resuscitation. So I got off to a pretty rapid start.

JK: It sounds like it. And so you got your medical degree in '65 and you came back to Hopkins in '72. Is that right?

MW: That's correct.

JK: Had anything changed from your initial impressions of the picture?

MW: I felt that the institution had deepened and broadened its involvement in biomedical research to bring research toward clinical activities. Outstanding clinical programs and people existed. And I saw a lessening of some of the troubled aspects that I had seen as a medical student. I was very pleased to see that.

JK: And then, so one thing that I also noticed about your research is that it seems like you've done a lot, or at least there's been a lot of practical application or discussion of the things that you've done. I'm thinking about the things about refining CPR technique. Is that something that was important to you in your research that it have practical applications?

MW: As I think you know, three years after I joined the faculty I was appointed the head of cardiology when Richard Ross became the dean of the medical school. I felt that as head of cardiology I could not have just an image of being a coronary care unit doctor and going into the laboratory and spending time in basic science. But I really needed to have projects that I was working on that were directly involved in patients, in clinical research. Because I wanted my fellows and people who I recruited to be enthusiastic with me about research in any aspect of cardiovascular medicine that got them excited.

But particularly, those who were more clinically oriented, I wanted them to do important work and I wanted to try to guide some of the

work and indicate to them that I was enthusiastic about what they were doing. So that really [led to] this interest in cardiopulmonary resuscitation because there's nothing more Hopkins and there's nothing more directly involving patients than resuscitating them from sudden death or cardiac arrest.

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The head of the medical intensive care unit at that time was Leigh Thompson and he instructed people to compress the chest and hold for an instant [with each] compression. And he said that makes it work better. And I said that can't be right, because if you're compressing the heart between the sternum and the vertebral column, it's just how many times you compress and how well the heart fills. It doesn't have to do with how long you compress. So we got a computerized chest compression device that we could precisely change [compression].

And we measured not only arterial blood pressure, but we used a Doppler probe to measure carotid blood flow and we found that Dr. Thompson was absolutely right. And that doesn't make any sense, as I said. It doesn't fit. And that, by the way, that paper was my first paper in the *New England Journal of Medicine*. George Taylor was the first author and we showed that regardless of rate, as long as you compressed longer you would get more blood flow to the brain. And that led back into the basic science laboratory with Nisha Chandra and then Henry Halperin and Alan Guerci, as fellows of mine, where we really discovered that for most circumstances in most patients, the reason blood flows during CPR is not you compress the heart between the [sternum and the vertebral column] – but it's because you increase the general intrathoracic pressure.

And as long as you're pressing on the arteries and heart, you continue to get blood flow to the brain. So that's why duration was important. This was very controversial. If you want to be famous in American medicine, you take a theory that everybody believes and you destroy it and you'll have debates at the American Heart meetings. People will write editorials about how wrong your ideas are. But of course, if you are right and you continue to prove that over time, then obviously your reputation will be enhanced for being a good scientist and being an interesting person because you're thinking about novel ideas.

There were many, many advancements that occurred during my 15-year tenure, 16-year tenure as head of cardiology. We proved

that [TPA worked in heart attacks.] Eric Topol came to the division as a fellow. He brought a contact with Genentech with him and that led us to do the definitive study of TPA as a thrombolytic agent in acute myocardial infarction that led to the FDA approval of that drug for heart attack, a major advance in human health. Also a lead paper, by the way, in the *New England Journal of Medicine*. Alan Guerci, the first author.

And then Michel Mirowski at Sinai Hospital in Baltimore was developing the automatic implantable defibrillator idea and he proved that it worked in dogs. And I decided that we needed to put this device into human beings and we needed to do this at Johns Hopkins. Nowhere else. Mirowski was a part-time member of the Hopkins faculty, so he was part of the team and led the technical team. But when we went to the IRB to get permission to open the patient's chest, put leads on to put this device in, and then after we put the device in we also had permission to induce ventricular fibrillation to see that the device worked in each patient. I needed, and the IRB needed the absolute confidence that this thing was going to work.

So we went to the Applied Physics Laboratory of Hopkins and got them to get half a million dollars from NASA to do the check out on this device to make sure it was going to work, and it worked wonderfully. And of course now there are, I don't know, three million people in the United States with these devices in place. This is a major advance in human health. And that led to my interest in [bystander defibrillation]. Since defibrillation quickly saves lives, why not develop a device that any person can use that's easy and reliable and so forth. During my tenure as president of the American Heart Association, I summoned a committee to look at the future of CPR. And they endorsed the idea that we should encourage industry to develop cheap, reliable, self-diagnosing, automatic defibrillators.

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And three years later [after I worked with one of the manufacturers on the design], the American Heart Association asked me to head up a program during my time in New York to gain the public interest in doing defibrillation, getting the government interested in promoting this, getting the FDA to think that this was not an illegal use of a medical device, (which was what they said). This was viewed by FDA as over-the-counter illegal use of a medical device to be only used by physicians or trained professionals.

This is a device that you could use to save lives and anybody who thinks they can use it should be able to use it. And then we did a government sponsored study in which we proved that it worked by putting it in facilities that were either equipped with an AED or not equipped with an AED.

I want to go back to my time in cardiology and say something about people. I never knew whether what I did in cardiology was really something unique or it was just that we could recruit the best of people, who were just so creative and wonderful.

The very first person that I appointed as a faculty member in the cardiology division was at that time Bernadine Bulkley, later Bernadine Healy. She became also president of the American Heart Association, started Women and Heart Disease and then became head of the National Institutes of Health. A truly amazing leader.

MW:

So again, talking about people who were around cardiology at that time, one of the major people that I worked with in part of the imaging projects that we got involved with was Elias Zerhouni. Dr. Zerhouni was at that time an assistant professor of radiology, but we provoked him into developing the tagging technique for quantifying how the heart functioned using MRI, and that was a base for Dr. Zerhouni's long-term research career in radiology and he also became the head of the NIH.

So there were two heads of the NIH coming out of this program. A final comment about that MRI or NMR program is that the instrument that Dr. Zerhouni and I did our research on was manufactured by a company in California whose president was a man by the name of William Brody. William Brody headed this company until he was clearly not going to be an industrialist in MRI, and I invited him to be a candidate for head of radiology at Hopkins. I was on the search committee to pick the next head and eventually he came to interview and was hired and that led of course to my working with him as head of cardiology and him as head of radiology.

And of course, the short story here is that he became the head of Johns Hopkins University and the president. But he probably would never have been at Hopkins were it not for the strength of our imaging program and our desire to have a really strong radiologist in charge. So it was an interesting [Hopkins story] – so where do you want to go from here?

JK: Well, the question I have hearing about these people that went on to be leaders in your field, how were you training cardiologists to be leaders and not just doctors and researchers?

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Do you think that's something –

MW: I use the Turner principle. I told every fellow they were here not just to become a great cardiologist. They were here to make a contribution. And it didn't matter whether it was in medical history or it didn't matter whether it was in clinical medicine or clinical cardiology or whether you were going into the laboratory playing with molecules. But you were here to learn and you were here to start making a contribution. And there was enormous success of the trainees who were in that program, many of whom are still at Hopkins and are leaders in their field and leaders in their area of interest.

JK: I also want to jump back to—you gave an example of working with the Applied Physics Laboratory on the AED device, and I saw that you were listed for a long time as a member of their principal staff. What was that relationship like?

MW: There were a number of engineers that I recruited into the division who wanted to be a clinical cardiologist as well as engineers. So we started having trainees work with the Applied Physics Laboratory on projects and a number of those projects were really quite successful. For example, Frank Yin was one of the people, [an engineer] fellow, and then he became a cardiologist at Hopkins, worked with the Applied Physics Laboratory on bidirectional stress strain of heart muscle, and then he left cardiology and became the first chairman of the department of biomedical engineering at Washington University at St. Louis.

So it was a very strong relationship. I didn't really function in a direct relationship with the Applied Physics Lab, but I promoted and encouraged the right people to make contacts there and to use the enormous positive resource that they had toward technology. And certainly many of the people at the Applied Physics Laboratory enjoyed the idea that some of what they were doing was not just related to the military or spying or what have you, but was related to improving human health.

JK: Yeah, I find that very interesting because I think they have a reputation of being very isolated at Hopkins. But there are exceptions that –

MW: And it's growing even now. It's a positive relationship between cardiology and the Applied Physics Laboratory.

JK: At some point, I guess in 1991, you made a change. You left Hopkins to move to Columbia.

MW: Yes. Three years before that I was a candidate for Chair at Hopkins. I think Bill Hazzard and I were the two inside candidates for the chair of medicine. But, in fact, Jack Stobo was picked. Jack had been at Hopkins as a trainee, left and then came back. My relationship with Jack Stobo was a very positive one until I really decided that 15 – 16 years was long enough for somebody to be in an administrative position. Anything good needs a change, and I looked around at a number of kinds of jobs – industry, government, the NIH.

But I decided that what I wanted to do was become chair of medicine in a department that was in a good institution of quality that wanted to make contributions, but where the department of medicine wasn't so good. I had been at Columbia. I interned [and did] one year of residency and some people remembered me from that time. I got these very long personal letters from a fellow by the name of Hamilton Southworth to come back and to become the chair of medicine at Columbia, and in the short, I went there. It was actually ten years exactly to the day that I was at Columbia.

I think I left the department much better than when I arrived. When I arrived, it was not ranked nationally at all, and when I left it was in the top ten departments in the country. When I accepted the job to come back to Hopkins, they offered me a bigger salary at Columbia, but both I and my wife wanted to come back to Hopkins. And again, I thought ten years was about the right amount of time to be a chair of medicine and that a department ought to go on and have a new face and a new leader at that time. So that led to my returning to Hopkins.

JK: What were your ideas for Hopkins Medicine when you came back? What were the things that you wanted to jump in and work on?

[0:35:00]

MW:

I was amazed that within the department of medicine there was a very strong leadership group of women toward advancing women in their careers, and that was started by Jack Stobo and it was a terrific effort that was already showing great signs of success. I deeply wanted to see that continue. But when I looked for minorities, particularly African American, in the department of medicine, no matter where I looked – housestaff, fellows, faculty – it was one to three percent, and I knew what that meant. I knew that there was no program, no effort to really enhance, despite our commitment to patients in the East Baltimore community, our presence in East Baltimore – I knew that that represented an absence of what there ought to be in this day and age, which is a positive program.

So that was a very major goal, the second goal – sustaining the women's effort and beginning a serious effort at enhancing minority. And then more of the traditional issues of let's recruit really great people and augment our searches and let's get Hopkins to be consistently number one in the country. I would say that I was quite proud that we sort of vacillated between Hopkins and Harvard with U.S. News and the academic ratings, but three of the last four years Hopkins was number one and Harvard was number two in their ratings. I look at that as a sign that the people around me were working hard and creative and that the creativity and forward-looking nature of what we were doing was succeeding.

So I actually had, from my time at Columbia I really had an idea about what being chair of medicine meant and what was important. So I had three things that I told everybody were my most important jobs. Number one was recruiting, training, and developing the best and the most independent division chiefs that I could find for the department. My second job was to make sure that the Osler medical housestaff knew that I was totally behind their training and their careers and their advancement and to excite them about research. The Hopkins housestaff program was already and sustained itself as by far the best training program in American medicine. And the third job was to tell the people I work for how to do their job better without getting fired.

JK:

That sounds like the hardest one.

MW:

And we can talk about how we did that a little bit. I met monthly at least with my whole clinical group, and Ron Peterson, the head of the Johns Hopkins Hospital. And I also had a very close relationship to the Bayview Medical Center. Dave Hellmann was head of medicine at Bayview, and he and I really partnered in

advancing the Bayview program. And I got very much involved in therefore in the leadership of the Bayview campus and the Bayview program, as well as Johns Hopkins.

But in those once a month meetings with Ron Peterson I could bring up every creative idea. I could come with data and information that Ron Peterson always loved about why we should do things that were advancing the state of the art of taking care of patients in his hospital. Those were, I think, very effective and very appreciated sessions by Ron Peterson. On the medical school side, we had a similar meeting every month with Rich Grossi, the chief financial and I would say also the chief operating officer. I had full access to Ed Miller, and I'll just say one little anecdote about that. But these meetings with Rich Grossi I could bring up and push any issue that I wanted to push.

I often got a no answer, but I knew how to take a no answer. If you over push your ideas, that's how you get fired. If you suggest good ideas and they don't like them, fine. You go onto the next great idea. That's how progress is made. It turns out that Ed Miller was the vice chair of the search committee that brought me from Hopkins to Columbia and he could not tolerate the pressure at Columbia that was intense on the hospital side, and left for the same position at Hopkins and then became the dean and CEO.

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And of course he is the one who hired me as chair of medicine at Hopkins. So his joke, which he told every time he introduced me, was that he had recruited me to Columbia and in fact had gotten me a round trip ticket on the airplane so that he would be able to recruit me back to Hopkins when he wanted me back at Hopkins. So I clearly had access to Ed Miller at any time, but I didn't use that access very often. And when I did, Ed Miller paid full attention.

So I really did have a very close relationship to the leadership in a functional way and in a supportive way and where there were problems, I could easily admit problems. I could solve where there were failures and my time was extremely enjoyable. Another anecdote about duration and tenure – when I accepted the job at Hopkins, I had a letter that described an eight-year tenure and that was consistent with the then tradition that chairs of departments at Hopkins did not continue as chair beyond age 68. So when the calendar kept moving and I was now 70, I decided that there was too much conversation about when Mike was going to leave and I

went to Ed Miller on this occasion and I said, "Ed, it's not good that we don't have a real plan.

So I want to understand what you would like me to do, because I'm fine if you want to set up a committee tomorrow morning or you want to appoint an interim head of medicine that would be fine." So his answer was, "You won't leave until I leave." So I said, "Fine. That's clear because you made it clear when you are stepping down in two years." So I said, "That's perfect for me, and so the new chair will set up a committee, the first thing that new chair does." As life would have it, the next dean, Paul Rothman, had been a junior faculty member in the department of medicine at Columbia during my tenure. He was somebody who I respected and promoted as a division chief and encouraged him as he did to go to Iowa from Columbia as the chair of medicine there. Then he became the dean at Iowa and was an obvious candidate to be dean at Hopkins.

So on my first formal meeting with Dr. Rothman, I said, "Okay, you're going to set up a search committee now." This was the plan and there will be a new chair in the year. He said, "No, I've got some other problems I've got to solve first. I want you to stay for one more year before I set up a committee." So that meant two more years. And I said fine, and I was very pleased to see Mark Anderson take over, another cardiologist, a basic scientist in fact, as chair of medicine. And my efforts, particularly in the last year, were to make sure that the transition went well and went smoothly and I think it was wonderful to have Mark Anderson come on as chair.

JK: Sounds all very collegial. You talked about kind of having these meetings where big ideas were discussed about the direction of the school and the hospital. What were some of the sticking points or the things that you guys really had to debate and consider? What were the big issues that you were grappling with?

MW: Let me go back to the minority issue and give an example. There's a young woman, Sophie Lanzkron, in hematology that I got to know, who was not a minority herself but was interested in the care and management of patients with sickle cell anemia, a terrible condition where patients have terrible pain. They come to emergency department. They're looked at as drug seeking. They have a horrible social life and horrible care and I made a pact with Sophie Lanzkron that I would work hard to make Hopkins a pillar of quality care for patients with sickle cell anemia.

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I went to Ron Peterson and this was something I talked about month after month. Told him I wanted to create a day hospital. That's what Sophie said we needed. A comprehensive center that would offer urgent care and better care, and we identified a space near one of the entrances to the hospital, so patients could get in there easily. And I eventually went to Ron Peterson, and believe it or not he gave me a half a million dollars to renovate and create an absolutely beautiful sickle center that could treat up to four or five patients with sickle cell anemia all at the same time. Television in every room so to speak, nursing staff, social workers, psychiatrists on call where she or nurse practitioners would actually deliver the care.

And then Sophie had the overall oversight. That not only satisfied and improved patient care, but we objectively and quantitatively reduced the cost of care, reduced the hospitalization rate for patients with sickle cell anemia and became a regional and national recognized center for the quality care of patients with sickle cell anemia. And obviously that fit right into my whole ideas about minorities. By recruitment and identification and openness, we began recruiting at the housestaff level, minority physicians, and we very quickly came to 15 to 20 percent of the Osler housestaff were minority. Same percentage on the Bayview campus.

And then each of the fellowship programs was encouraged with using the same techniques of openness for interviews, advocacy for recruiting minorities. The last four or five years 15 percent of all the new physicians we hired on the faculty, and scientists were minority members. So we changed the complexion of the department. That was recognized by Ed Miller, who then took this at an institutional level as an important issue, took the leadership on a retreat, talked about what was being accomplished in the department of medicine, why can't this go on everywhere.

And even recently I had an opportunity with Ron Daniels' auspices to address all the deans of all the schools at Johns Hopkins University talking about our program and how we did it, what the mechanisms were, what the successes were, what the challenges were. The most important aspect of this was that we found picking talented people, giving them Hopkins education, they were the best physicians and the best people in the world. We had a terrible time in keeping the minority housestaff at Hopkins because they could walk into any fellowship program in the country having the Hopkins brand of training as a house officer.

And many, many of these minority physicians have been enormously successful either at Hopkins or elsewhere. So a very, very exciting end product of all these efforts. I did receive a national award from my peer group for the minority activities, and I'd have given a number of talks to other institutions about how you enhance your programs and minorities in a successful way.

JK: Great. And so the programs that you're talking about, does this relate to the Urban Health Residency Program or is that –

MW: That goes on into a related part of this. Once we had Osler housestaff that were minority in significant numbers, and at least 50 percent of our patients in the hospital are African American, I needed to be able to stand up to those housestaff and say even though so many of the people who are minority and are patients don't have resources, don't have good quality healthcare, here's what we are doing to improve the quality of care for the East Baltimore community. And we worked hard with the leadership of East Baltimore Medical Center to improve the quality of care and improve the way our housestaff were trained or clinical experience at EBMC.

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We had many research programs that focused on reducing risk factors for disease, particularly cardiovascular disease, in the East Baltimore community. And then, with all of these efforts going in a positive direction, I sat down with two of my faculty and I said, "We're going to start a new Osler residency program." I told them I was sick and tired of telling Osler housestaff that they ought to go into primary care and outpatient care and have them all go into cardiology and oncology because of all the excitement. The kind of people we recruited were interested in specialization medicine.

So I decided that we would start a brand new residency called the Johns Hopkins Urban Health Residency. We debated whether it should be a med/peds program, combine medicine and pediatrics, or medicine only. We started with a med/peds program and then added a medicine program a year later. At least to this day they are taking in four people per year in each of the two programs. And at least the first graduating class is in fact doing what we hoped they would do, which is developing careers in clinical care and research and education in the underserved community – many in Baltimore.

But many are going elsewhere to take on the challenge of urban [care] – so that allowed me to tell the Osler housestaff how much we were really trying to do to improve the quality of care of minorities. And there are some data we put together that support that idea.

JK: So that started around 2010.

MW: Yes.

JK: And there was also an earlier program that Bill Brody started, right? The Urban Health Institute?

MW: Yes. That's a program in the School of Public Health that does not really focus on the training of physicians, but it did add and it does add measurably to the effort to improve the quality of care and health care in East Baltimore.

JK: And does the School of Medicine have an affiliation with that program?

MW: Yes, in large part through the Department of Medicine Welch Center. There is a lot of joint activities between faculty in the Urban Health Institute of the School Public Health and faculty in the Department of Medicine and the School of Medicine.

JK: You have metrics showing the success or the changes that these programs have led to. Have you found, at least during your tenure as chair, that there was a difference in the community perception of the hospital? That's harder to measure, I know.

MW: I think it's very hard to measure. I think the tension about the new part of the neighborhood, the EBDI, was very significant and there was great concern that Hopkins was really just tearing down housing in East Baltimore for its own purpose and not really contributing money or living space for community residents. I think that's over. I think the hiring and the practices of Hopkins have convinced the East Baltimore community that having Johns Hopkins in East Baltimore is of great value. When there are flare ups, the flare ups have tended to be West Baltimore rather than East Baltimore, as far as I view those episodes.

JK: And were you involved – did you work at all with Dr. Levi Watkins on diversity issues?

MW: There was a lot of respect between Levi Watkins and myself. Back to the real contact with Levi Watkins. He was the surgeon who put in the first automatic implantable defibrillators. So I worked with him on serious health issues long before I started trying to influence the Department of Medicine on minorities. Levi gave me ample credit for what I accomplished and did. He was aware of everything I was up to and I think he was very respectful of the idea that somebody who was Caucasian had really attempted to make a big difference in Johns Hopkins in what goes on.

So there was a lot of bonding between the two of us. He used to give a dinner for all the incoming minority medical students and housestaff and fellows at the beginning of each academic year, and I was invited to come to those dinners and sit down with some of the minority students and talk about what was going on in the Department of Medicine at Hopkins in general.

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JK: I just wanted to ask about—you mentioned working with APL, and obviously as an undergraduate you were sort of a cross-campus person, but where there any other initiatives you worked on that were cross-campus initiatives with Homewood or – I guess you mentioned Bayview as well.

MW: I think there was a very strong link between cardiology and the Biomedical Engineering Department. I think you know that the Biomedical Engineering Department is the only department that is on two campuses with strong faculty on both campuses. So that was the largest effort that I had with any of the traditional Homewood departments. There were informal, if you will, faculty-to-faculty contacts in the Biology Department and also biophysics and engineering in general, but I would say the Biomedical Engineering Department linkage [was the strongest].

And just in passing, as far as I understand, for the last 14 years that's been the strongest biomedical engineering undergraduate program in the country and the strongest department in the country on a broad base. So that relationship to cardiology and their interest in engineering was a very substantial part of the excellence and the reputation that biomedical engineering obtained.

JK: And so were those undergraduate students having opportunities to work in East Baltimore with the cardiologists?

- MW: Yes. But it was much more, I would say, fellows who came out of cardiology who were working broadly in biomedical engineering. But there was some involvement of students and programs, and that also has grown in recent years in a significant way as well.
- JK: Early in your career you hopped around to a few different places, and then you were at Columbia. What do you think is unique about Hopkins Medicine?
- MW: I think it's what everybody talks about – the collegiality and the spirit. To a minimum, certainly, there is competition. You can't have any complicated group of people with high ambitions and not have some competition. But the truth is that, as most of the Hopkins faculty realize, they do better in their own career direction, the more collaborative and the more welcoming they are to students, to other colleagues, to other faculty, and I believe that's at the core of why Hopkins has been so overwhelmingly successful in being a lead institution.
- Also Hopkins is not afraid to develop programs and excellence in the most fundamental basic science, in safety and healthcare as we have done recently, and the advantage is we're everywhere. We have the best school of public health, we have a lead hospital, we are a lead medical school, we're all together, we work hard, but we can collaborate, we can talk, we can achieve excellence anywhere in the spectrum of academic medicine. That's the strength of the institution. And it's fun to be there. Certainly during my tenure, we underpaid our faculty handsomely but almost none of them left.
- JK: Where do you think that spirit comes from? Why does Hopkins have that unique collegiality?
- MW: I think because our leaders insist on it. And there's a certain amount of spirit that if you're not part of the team, if you don't get what Hopkins is about, then there are plenty of other opportunities for you to pursue your career. And Hopkins is in the export business. At least I always thought of it that you had a hunting license on your wall as a member or trainee or a member of the faculty, and that hunting license said you stay at Hopkins as long as you're growing and advancing. And the minute you're not growing or advancing, we're going to take your hunting license away and you'll find yourself another position.

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It will be a good position because you've been at Hopkins, and you will leave with the Hopkins blessing and of course this tradition nationally of people who've only been at Hopkins for one or two years saying "I was trained at Hopkins. I'm part of Hopkins." It never leaves you. You're always part of Hopkins. That's one of the most amazing parts of the institution, is people who have been here and leave, live on their reputation of having been at Hopkins.

JK: Is there anything else you would like to talk about that I haven't asked you about?

MW: No.

JK: No? Okay. Thank you. This has been really interesting.

MW: If you can get this in, I remember I said that I thought my most important job was my division chiefs and their appointment and their identification. And I am tremendously proud of what those division chiefs have accomplished at Hopkins and those that have left Hopkins, where they have gone.

One of the most glaring examples is I appointed Linda Fried to be the head of geriatrics. An epidemiological investigator, very creative woman, had headed the Women's Task Force among other things. She went as one step from being a division chief of my division to being the dean of the School of Public Health at Columbia University.

Eduardo Marban became head of cardiology and then went to Cedars-Sinai, where he's been an overwhelmingly successful head of their entire cardiovascular cardiac surgical center program at Cedars-Sinai. Dave Thomas I appointed as head of infectious disease. That division now brings in \$58 million a year of external research funding, an enormous, effective leader.

Landon King is now the executive dean of the Johns Hopkins School of Medicine after being the pulmonary division chief. Antony Rosen went from being head of rheumatology to being the dean of the medical school for research.

These are important people. Rob Brodsky, enormously effective head of hematology involving our department in the oncology picture. And then Fred Brancati, who unfortunately died of ALS, was an enormous enthusiast and contributor to general internal medicine, now replaced by Jeanne Clark, who is equally creative and exciting in what she does.

And I mentioned Dave Hellmann before. He really conceptualized the idea of one department on two campuses and has been an enormously effective vice dean on the Bayview campus. Terribly proud of what he's accomplished. So I think that pretty much covers everything I had hoped to cover. You've been an excellent interviewer and I have enjoyed very much my time with you.

JK: Thank you very much.

[End of Audio]