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NORMA BRAUN: Hi. I'm Dr. Norma Braun, Chairman of the Archives Committee of the Medical Board of Mount Sinai St. Luke's, Mount Sinai West, formerly Roosevelt [Hospital]. I'm also the senior attending and clinical professor of medicine at the Icahn School of Medicine. We've begun the oral history project to record our illustrious alumni, who've contributed so much to care at St. Luke's and the world at large from the work that they have been doing through their long careers. So, today I'm so happy to introduce Dr. Peter Holt, who has been a very central part of our St. Luke's family, and very active in gastroenterology. I'll let him tell us about his career.

So, Peter, we like to start with where you were born, and how you came to be coming here, through your education process, and then finally arriving at St. Luke's.

PETER HOLT: It's quite a long story.

NB: Oh, please.

PH: All right. I was born in Berlin, Germany, of middle class Jewish family who were happily German until towards the middle of the 1930s, when things became a little uncomfortable, and they did so progressively. In fact, my first memory, true memory, was on November the 10th, 1938 when literally I—my mother went to get a visa to go to England, and we had to walk to the tram to go to the British Embassy. And I could still feel the glass under my feet, because that was the morning after Kristallnacht. And that's really when my memory started. Anyway, that's one story.

My father and I got to England. My mother came a few months later. I was thrown into an English school, not knowing any English, but learned. A typical memory, if I may diverge, is some time, let's say a month after I joined that school, I could suddenly put my hand up, because the teacher had asked a question in arithmetics—arithmetic. So I could go up to the board and do the answer, but I couldn't answer it in English. But anyway, so I grew up in the outskirts of London, and came the Second World War. Sort of after most of the Blitz my mother and I became camp followers, which meant that my father was in the army, and so we follow wherever he was much of the time. And then finally, I sort of started my schooling in a grammar school when I was about twelve, and went to grammar school. In England, you could go after your high school, grammar school, straight to medical school, which is what I did at the age of nineteen.

NB: Marvelous

PH: Graduated 1954, long time ago, [Laughs] and did my house jobs, my internship at The [London] Hospital, the University Hospital that I was at. Then we had to go in the army for two years. And somewhere in the middle of that I decided the English system was still in the thirties and you sort of slowly walked your way up, and I thought, well, why don't I come to North America for a year? So most English people would go to Canada, but I said, "Well, if I'm going for a year I might as well get to the States, and if I going to go to the States I'm going to try to get to New York."

Although, what I then did—this was in the spring of the year that I came to this country, in 1957—I sort of applied. So what… who did I apply to: to the Massachusetts General Hospital (MGH), Johns Hopkins, Columbia-Presbyterian [Medical Center], and so on. Of course, I got no answers from those places except from Columbia-Presbyterian, where the chair is an anglophile—was an anglophile. And so he said, "Well, why don't you write to the New York Academy of Medicine? They sometimes have residency positions open." Which I did, and actually, he must have called them because I got a letter: there's this place, St. Luke's, which of course I didn't know anything about. And it was signed Dr. Coffin [G. Jarvis Coffin, MD], and I thought, well, that's interesting. And when I came here of course it was Dr. Coffin, Dr. ---- [name unclear], so it was an unusual combination of names.

NB: Was that Jarvis Coffin?

PH: That was Jarvis Coffin.

NB: Oh!

PH: So then finally, I stepped—set foot at St. Luke's for the first time on July 22nd, 1957.

NB: Sixty years ago.

PH: Sixty years ago. That's right, so that's how I sort of came here and I was a resident in medicine. Those days, it was sort of interesting. You know, now, they have to work a certain number of hours, and have no time to do anything else. We were able to have two months off for research, which I did with Bob Case [Robert B. Case, MD]. Yes, it was that paper, "The Dying Heart." That was also the time in which I swatted, if you know that English word, for the exams, because I had to take all my exams again. I took everything from Anatomy, Physiology, every single exam in New York State, and of course, I can't really practice anywhere except New York State because that's the only exam I ever took here. So that was an

interesting time at St. Luke's. There were six residents, I think. That was it, and we were on every second night, right? Yes.

NB: Oh, yes, every other night, every other weekend. That was the schedule.

PH: Mind you, the internship in London, I was on the whole time. We had no time off [laughs] unless you were sick.

NB: Hm.

PH: Anyway, St. Luke's then, it was a remarkably friendly place. I mean, the house staff was small, so you knew virtually everybody. You, of course, would get together on—for vespers [evening Episcopal church service] on Friday afternoon at four or five, and yes, it was… you helped each other. You were there to—a lot of camaraderie. You remember the house staff shows?

NB: Mm-hm. Yes.

PH: They don't occur anymore. [Laughs] Where my English accent would occasionally sort of be encouraged to come out, let's put it that way.

NB: You entertained them.

PH: Oh, yes, we did, by Jove.

NB: How, then, did you get into gastroenterology?

PH: I became interested in gastroenterology as a medical student, because the chair, the consultant—in England you're attached to two consultants in medicine and two in surgery, usually, when you are there--the consultant was interested in sort of mind/body. And so, he got all the ulcers.

NB: Oh.

PH: And there were a lot of ulcers. So I got interested in that, and then continued to have interest as a house officer. And in fact, what's probably the best piece of clinical research I ever did, which was done during my residency here, was—the thought was initiated by observations, by talking to patients, and I noticed that a fair number of patients who were admitted bleeding from their ulcers had taken aspirin. So that stuck with me. Then, again, we were allowed to do more research for one month. And in a month, for $100, which was spent on getting Chromium 51 to label red cells, I did a study with 24, 25 patients who were given aspirin. And I took their stool and ground them up and studied the loss of the Chromium 51 as a reflection of red cells. That whole study was done in one month.

NB: Mm.

PH: And was written up about a year and a half later. And actually, Dick Pierson [Richard N. Pierson, MD], whom I'm sure you will interview at one point, will say that that study got him into nuclear medicine, because he followed that with a number of other studies. What was interesting is how much time we were given to what I call "playing." In other words, I took two months at the East Orange VA Hospital doing gastroenterology, because I really wanted to find out what it was like. They had a very good gastroenterologist there. And then there was another two months, so that the ability, as I would say, to play, which is what I always call—or what I used to say to fellows in gastroenterology, "This is the one time in your life that you can find your way. You can play. You can try something. If it doesn't work, you can go to something else." And that, I think, was even present even during residency here, which was really quite remarkable. It allowed you to flourish, to fly a little bit, you know. [Laughs]

NB: Well, I know that Dr. Keating's [John H. Keating, Sr., MD], one of his main goals was to introduce the concept of research early on in the training of the residents here at this Hospital, and he went to a great deal of effort to ensure that.

PH: Right.

NB: One of the reasons Dr. VanItallie [Theodore B. VanItallie, MD] was recruited to come here.

PH: Right, right, right, right. Of course, Ted came after—

NB: Right.

PH: —my residency, but, yes. It was quite remarkable and it still is, although life's different these days.

NB: Yeah. Then you spread out to lipid research.

PH: Yes.

NB: So, how did that leap occur?

PH: Well, when I decided to go into GI, I sort of took a trip across the country, which was wonderful in its own right, and sort of looked at various places to do a fellowship, and fortunately ended up at the Mass General in Boston with a remarkable mentor, who was about three years older than I was.

NB: [Laughs]

PH: Who had been to the NIH, Kurt Isselbacher [Kurt J. Isselbacher, MD], and he brought biochemistry into gastroenterology, basically. And so when there [at MGH], I was—the research I did, amongst others, was to study the effect of fats on the intestine, and

to a number of the biochemical features of the intestine. This was in the rat, in those days, and that really got me into lipids. [I studied the effect of fats on the intestine, and a number of the biochemical features of the intestine.] But that was another period in which I could play. And so, it's interesting. I made something that allowed one to measure protein-losing enteropathy, loss of protein through the gut the long way, and resulting in hypoalbuminemia. And so I did studies there at the Children's [Boston Children's Hospital], and at a number of [other Boston] hospitals and was able to do grand rounds as a fellow in four different university hospitals while I was a fellow.

I mean, again, it was different, and I think I was always inquisitive, so I could [laughs]—I found my way to do things. I mean, when I came here as the chief of GI—I'll tell you in a minute—I initiated immediately medical/surgical GI conference, and the reason was because that's what I experienced up there [in Boston]. At least that's what I went to, and I was with these most senior surgeons at Harvard [University], arguing, the only medical person arguing for something [laughs] and able to interact, and obviously, learned incredible amount in that process. So again, a different time, very much so.

So when I went into gastroenterology, I assumed I was going to be a practitioner of gastroenterology. I was offered the chance to go to Mount Sinai and so forth, but then Ted VanItallie said, well, "Why don't you start a division of gastroenterology here?", because there wasn't any.

NB: Right. It was also Keating's view that we should develop expertise in sub-specialties in medicine, so that was Ted's charge, which then allowed this to go forth.

PH: Yes. And it was a wonderful time. What did it mean to be chief of gastroenterology here? It meant that I saw all the patients; I did all the teaching and I did all the research, all simultaneously. That's what it meant. [Laughs]

NB: A lot of work.

PH: A lot of work. But, you know, you both learned, and were able to find other people who enjoyed that. I mean, my first so-called Fellow was actually a Chief Resident who had enough time out of his chief residency to do a couple of research projects, one of which was published in the *Journal of Clinical Investigation*. Again, different time. And it was fun. I mean, it was hard work [laughs], but it was fun.

NB: So is that when you began to recruit other Attendings?

PH: Yes. I mean, we were fortunate enough—Charles Flood, [Charles A. Flood MD], Charlie Flood, was a wonderful gastroenterologist, wonderful human being at

Columbia-Presbyterian, and so he was kind enough to come down. At least he would do semi-rigid, semi-flexible endoscopy in the side room of Stuyvesant IV.

NB: Mm.

PH: And at least he would be there to give some advice from time to time, even though his primary position was at Columbia-Presbyterian. He was just giving his time to us and to me. So that really was the first. Miles Schwartz [Miles J. Schwartz, MD], when I came here, said, "We don't need gastroenterology. Any internist can do anything that gastroenterologists do."

NB: Sounds like Miles.

PH: [Laughs] But he just didn't foresee endoscopy, I think, which was just about starting in the early sixties, mid-sixties. I think the most important recruit that I made was Dick McCray [Richard S. McCray, MD], who came here as a resident, or intern-resident, in '62, and sort of said he was interested in gastroenterology. So off he went to Boston and came back, and so we started the first endoscopy unit in New York City, which kept him there for the next 30 years. We recruited volunteers. We recruited one hepatologist for a while. But at first I think we had Residents who would stay and do some Fellowship. Then I got the first one, I think, David Chalfin [David Chalfin, MD, PhD]. And I presume, I can't remember now, that Ted got the money for the Fellowship, although I think David got an NIH Fellowship.

NB: Mm-hm.

PH: He was, I think, 1964. Steven Mezey, [MD], who was a Fellow for three years and did some nice research, and ended up as a head of hepatology at Johns Hopkins some years later. So, it was really through the fellowships that we developed and then Attendings who became interested, because they had some decent people to train. And then actually we got the NIH training program for Columbia when I was the PI [primary investigator], because there were no, really no gastroenterologists up at Columbia-Presbyterian. Stan Bradley, [Stanley E. Bradley, MD] who was a—

NB: Hepatologist.

PH: Yeah, a renal man, really, and he was interested in ascites, so [laughs] that meant that he was supposed to be a hepatologist, and that was all they had. So for nine years we were the site for the NIH training program in gastroenterology. We tremendously expanded our program here, with people coming, Norton Rosenzweig, [MD] and a number of people started to come. So, it was a slow but steady process. Ted VanItallie was crucial in supporting all of this, but he basically let us do—let us fly. He was there to help if you asked, but he never intruded himself. I suppose I had sort of studied naiveté, as I call it, and naively managed to

get the division to get bigger. And in the sixties and seventies, it was as good as any division in New York City, I think.

NB: What was the relationship that you had too, with the nursing staff, the non-professional Hospital staff, and all things that happened between, because they were the supporting people.

PH: Oh, yeah. Well. It was very close, but it was also, I would say, a little English. Again, I'll tell you a story. When I came here as a resident initially, some of the medical beds were on the second floor, Muhlenberg II, … Minturn II. And the head nurse was a surgical head nurse … [Dottie] Bottinger? I don't remember… And she was—she was a terror for the surgical residents. So anyway, the first day I did rounds, she was sitting at the desk. So I went over and said, "Are you ill?" And she said, "What do you mean?" "Well, you must be ill because you haven't joined our rounds." [Laughs] Big mouth. And she always came afterwards. It was not normal for the head nurse to come on rounds with us, but my training said it was crucial to have that interaction between what the nurse saw and what we saw.

NB: Well, I've been trying to get that back here for the last ten years. They miss so much because of the lack of communication.

PH: Yes, yes. They're separate estates, as you might say, these days. So I think certainly as far as the endoscopy unit is concerned, we were all a big family. Almost everything that was decided was decided with knowledge on each side, one way or the other. I agree. We lost a lot from not continuing to—and I probably was one of the last Attendings on Medicine who would always go to the bedside. I mean, so many of the rounds now, or used to when I was still around fifteen years ago, was made in the side room, looking at the computer.

NB: We switched from three dimensions to two.

PH: Two. [Laughs]

NB: Somehow, we think that's progress.

PH: That's wonderful, yes. That's very true.

NB: So, how did you intertwine your family life with this hectic schedule? And what was its impact?

PH: Well, to be honest, not all the impact was perfect. But because I did go through a divorce, which, umm, wasn't St. Luke's' fault, wasn't even the work fault, but it didn't help. The needs of my ex-wife were not—could not be satisfied with the sort of life that I had to lead, had to live and work with. My kids, we spent a lot of time, but again, I think there are some regrets. I do think that academic medicine,

at least the way I experienced it, and presumably my own personality, takes an enormous toll out of the family. It really does.

And it took—well, it took finding the right person in the end, and I think that right person, at least for me, in my role as an academic teacher/researcher, even later, was that she was also—she knew about academics. She was an academic herself in a totally different field, so there was a part of life that each of us put a lot of effort into, and the rest we could get together, understanding that time and not being envious of the time, which is what destroys a lot of families, when one or the other—

NB: Well, especially when your children are small.

PH: Yes. Yeah.

NB: They're more demanding. So what did your children wind up doing? Did they follow a course in medicine or did they do something else? What do your children do?

PH: None of them in medicine. My son is in business, basically in developing, essentially, computer, back story part of business. My older daughter is in the food business as a consultant, rather well. She had a number of good positions but then she ended up being a consultant, which doesn't please me too much. It isn't exactly safe, but she's managing. And my younger daughter has done extraordinarily well, and is nationally known now. She manages quite well in business. She's in Uber. She runs North America for Uber. But again, her husband got his own political life, and they manage very well. But it's personality. It's a balance.

NB: Well, there's no question. Did you have any role models in school, either in England or here in the United States? Did they support you in a particular way?

PH: Yeah, it's interesting. You know, I've asked myself that, and the answer, I think, is really no. Not as a person, if anything… No. Why no? My background made me have to stand on my own feet pretty early. My father was in the army six years during the war. I'm the only child. We were in bombed London, and so forth. My mother was very sensible because she didn't keep me close to her breast, so she pushed me out to become independent. I think that independence almost made it more difficult to accept some individual model. I certainly didn't have a role model in my family. For one thing, my family spread all over the place. My immediate family, my father, was in the army, and so there wasn't time to get a role model. And at school I didn't have one. In medical school there was no one, no single individual. So I think maybe I took little pieces.

NB: Different people.

PH: And different people, and integrated into my sort of personality, my tough personality. [Laughs] And people know that.

NB: Well, the reputation that I have of you is that meticulous attention to detail, and no fooling around, was sort of the sense I got.

PH: No fooling around. You're right. Yeah. And as a teacher I always felt that I—it was for me to push people just a little further than they thought they could go, and the inner delight that most of them had when they actually found themselves going further, was worth it all. It's very interesting. As you know, Richard McCray, [MD] died recently, and so I had to think quite often about our very differing personalities.

NB: Yes.

PH: And how they worked. I think for the Fellows it was perfect, because I could be the tough guy pushing, and Dick could be the—could be outgoing with kids, pulling people in and putting his hands around their shoulder, and making them feel that they're better than anyone else in the world, you know. So it was interesting, and I actually recognized it and thought it was very good. It was a good marriage, in terms of teaching and developing people.

NB: So, what led to your decision to retire in 2000 from these clinical responsibilities- because obviously, you were still very interested in doing other things?

PH: Yeah.

NB: So, was it anything to do with the mergers going on, or personalities or change in funding? Because gastroenterology has exponentially expanded as a field throughout the world, so it's not because of a lack of things to do, or lack of research opportunities.

PH: The most expansive time in the division as far as research was concerned was in the 1990s, and that was because we first recruited Steve Moss [Steven Moss, MD], who was from England, who had been at the equivalent of NIH in England, who then through the Fellowship then stayed here for a while, and now is professor of medicine at Brown [University]. And then I got two—separately—two Israeli fellows, or people who had already finished their fellowship, to come and work partly with me and partly with [Bernard] Weinstein, uptown [at Columbia-Presbyterian Medical Center]. And in that period of time we did a lot of research work. It was just the whole group. It was a nice group of people.

NB: Do you think size makes a difference?

PH: I think, yes, it does. When you have—a critical mass is sort of important if you really want things to explode, even a small explosion. And that's what we had, and

real interaction. And then, they went home. Steve left about that time. But I had just decided—I mean, I was Chief when I left; it was 39 years. What I sort of decided was, 'okay, I've done it, and have gone through a period. What would I like to do?' We had labs, still, I mean wet labs, that is research labs, and doing clinical translational research. What I decided is what I wanted to do was just clinical translational research. So, having decided that, I sort of put out messages that I was interested in.

Then I got a position at the American Health Foundation, who wanted to do—which was a very good organization, about 150 researchers up at Valhalla, [NY], and was one of the first—when Nixon [President Richard Nixon]—one of his first research centers, NIH research centers, the only one for prevention, and I'd become interested in colorectal cancer prevention. So they wanted to develop a translational program. They didn't have much. So that's where I went there. Unfortunately, after about three and a half, four years there, they went bankrupt, because they spent too much money—I've never heard of a foundation going bankrupt, but they apparently spent the NIH money before they had the money, so. [Laughs]

So then I went to the Strang Cancer Prevention [Strang Cancer Prevention Center, Beth Israel Medical Center] program here, as head of the colorectal cancer prevention program, which allowed me to do research. They actually had a lab at Rockefeller, Rockefeller University. We got some grants for doing work in humans to do with calcium and Vitamin D, and trying to understand the mechanism. If these work as preventives for colorectal cancer, try to understand the mechanisms involved. And in essence, what we started then is really the concept I've continued to have, which is that people—first of all, only do small numbers of subjects rather than large number of subjects, and then use the subject as his or her own control.

And so the concept for all those studies since then is: you study the person at baseline. You do the intervention. You wait till when you think the intervention has worked, and then you do the studies again in each individual subject. And the studies in those days were done on the colon, so we would take biopsies and then examine them histologically, biochemically, molecular biology, and see what changed. And if you kept the subjects in—often kept them in the Hospital at the Rockefeller—that's how I got to the Rockefeller and I'll tell you more in a minute—if you kept them like in cotton, and without outside events as little as possible, then the change you could examine and say, "Well this change is most likely due to the intervention, because nothing else changed." And so that's the concept.

So I started that for one NIH study in 2003, and so I got on the adjunct faculty at Rockefeller. And then continued—they liked the fact I could bring subjects into their beds, and continued until 2007. Then I actually went on the faculty, which is

unusual with gray hairs over there, but I became accepted. It takes time at the Rockefeller to become accepted.

NB: Oh, yes. Yes.

PH: [Laughs]

NB: It's its own club.

PH: Yes. I've tried to sort of pull some of them, kicking and screaming, out of the [laughs] club and into the real world. But I think one of the things that not only my research there, but one of the things is that I was able to—because I knew some people and so much in general, and much of the work at the Rockefeller is rather narrow, so that they wanted that as well.

NB: Mm.

PH: So for example, I head the committee that oversees all the clinical research programs at the Rockefeller for that reason. So, yes, then I came on the faculty there, which has kept my mind [laughs]—the environment has kept my mind going. But how? It's just extraordinary. And as I always say, I walk to the Rockefeller from the West Side, about two and a quarter miles in the morning, virtually every morning unless the weather is impossible, and I walk with my spry feet because it is so good to be going somewhere where one can enjoy [laughs] what one is doing.

NB: One can look forward to it.

PH: Look forward to it, yeah.

NB: Well, that's grand. That's grand. Did the merger in '79 with Roosevelt alter the program or your vision of what would happen to G.I.? And what happened when Beth Israel [Medical Center] came on board?

PH: I think it took, for most divisions, specialty divisions in medicine quite a long time before there was any real integration. Al Attia [Albert Attia, MD] was running a good division. We got on well. But I think we didn't really integrate for eight years, something like that?

NB: Mm.

PH: Six or eight years. We would have joint conferences, but real integration came later and until it became a single program. I just had no desire to expand [laughs] for the sake of expansion. I thought the program was good, an excellent clinical program. We offered some—I think some people did some research up here, as I recall, but not—but that's because they wanted it, rather than we forced it. And it

took quite a few years, around eight years, I think, before we really integrated. And I still and Al was still was my [Roosevelt] Chief, and crucial. As I say, you make the very best with what you have, and when it's pretty good, then it can only get better. [Laughs] So that was my attitude.

NB: Did the changing Chiefs of Medicine alter this relationship?

PH: Well, yes. I mean, I'm a very independent personality, as I think you know.

NB: Mm. That's where you started.

PH: [Laughs] Some Chiefs, I think, accepted or even liked that independence. I think others were not so sure about that. [Laughs]

NB: Mm. Right. Right, right. Were you then officially gone with the Continuum [Health Partners, Inc.] establishment when we joined with B.I.?

PH: Well, no. I was never—we were never integrated. BI had its own program.

NB: Right. It still does.

PH: During my time. And again, they had a very good clinical program. I knew them all and it was a good program, but it really didn't in my time. So I think my view was not expanding it. It was to make everything better, that's fine.

NB: What was something about your career that was the most catastrophic or negative that you could see, and were you able to circumvent it or overcome it? Because things happen all the time.

PH: It's an interesting question.

NB: Difficult events, yeah.

PH: What was the most devastating? That's an interesting question. Well, I think I'm looking at, let's say, my relationship with Columbia, Columbia University, which was—I mean, there I was, head of the NIH training program in the sixties and the first half of the seventies, and then—and I was one, really crucially in developing all of the teaching in Abnormal Human Biology at Columbia, and so forth, because we were a small group and we did a fantastic job. We made more gastroenterologists with that course than anything else, I think. So, it came the late seventies for a particular Chief of GI that I was no longer [needed]—they no longer were interested [in us].

NB: Mm.

PH: I don't know that it's devastating, but if I look back it was a disappointment. I mean, at St. Luke's I was fortunate enough to continue to have [good training]—we got an NIH training program in gastroenterology in geriatrics for five years from the NIH, in the late eighties, early nineties. I was thinking, where did the money come from for the fellows? Some of them struggled from time to time. I did get some foundation grants for the training program because more and more, as you well know, I think the institution was chary of spending money on fellowship programs as a whole. They needed endoscopic help in gastroenterology, and once they got that, beyond that it became less important than it was in the sixties. So, I think it was—those were more difficult times. But it's interesting. I can't see—I know some personal problems, but rather than professional problems that were very difficult.

NB: Well, the average house staff now has a large debt, education debt.

PH: Yes, yes.

NB: I don't know how much of that was a limiting factor to training and to people you could select for your training program. All those things obviously govern the regular life that people lead. They make choices for their careers based on the ability to pay their debts, because that's potential.

PH: Well, the advantage of gastroenterology, of course, is that they have some procedures which pay well. And so clearly, I mean, for the last fifteen years of being Chief here, every Fellow who left here the first year would make more money than I was. [Laughs]

NB: As Chief?

PH: As Chief. [Laughs] You know, I always say that Ted, Ted VanItallie's view of an academic place, an academic environment, was how little you could pay and get away with it. If you paid little, then you were a very fine academic institution. [Laughs]

NB: What a way to curry prestige.

PH: Well, yeah. He did it, single-handedly. We can go back, and you were right. All those people who were recruited, he produced a remarkable division in the sixties and did it almost single-handedly. And I don't know where he got the money from but he did. [Laughs]

NB: You mentioned the house staff skits. Were you ever involved in them, or were you pilloried in them?

PH: No. I was involved. When I was in the house staff, *Around the World in Eighty Minutes* we put together. But once I was on the faculty, I think I left it to—and I'm

trying to remember. There was one house—you'll know; it's your time—house staff who was superb at putting together the house staff skits. What was his name? I can see him but I can't remember his name, ended up in New Jersey, but yes.

NB: Roselle [Harry A. Roselle, MD] will remember.

PH: It brought the faculty and the house staff together, because we could laugh; we could laugh at each other. I mean, what better to develop relationship that the ability to laugh together, laugh at each other, and not feel bad about it.

NB: Mm-hm. Oh, there were always two—in the Department of Medicine, two house staff events a year. One was the Christmas party.

PH: Right.

NB: And one was the June picnic.

PH: Picnic, oh, that's right.

NB: In which the graduating house staff was there, and then the incoming new interns would meet for the first time.

PH: Right.

NB: And create, I think, what was the beginning of collegiality.

PH: Right.

NB: In their training, which is no longer a tradition. It makes such a difference.

PH: It's all circumscribed, little fiefdoms, even at the house staff level, I think. But anyway, it's been a long time. I can't even realize that it's seventeen years since I stepped down. I could come to participate in some teaching on Tuesday mornings. That was regular, and I did it until two years ago, when—we used to have two conferences. We used to have grand rounds and then another conference, which was journal club, or some specific topic, which I would run. So for two hours, I would spend an hour and a half getting here, and then going back to Rockefeller, but then they reduced it to one hour. I could no longer justify spending an hour and a half for one hour. Then I stopped. So that's why last night when I was at the graduating GI Fellows' party, I said this will be my last time—

NB: Mm.

PH: Because it's inappropriate for me just to appear, because none of the Fellows would know me. They still did yesterday. So it was sort of a little emotional sort of event because I started the graduating Fellows' party, of course, in the sixties.

NB: Right, right. So it was a tradition.

PH: Yeah. And so this is really, I think, I'm not cutting off my ties, but it's not very likely that I'll spend too much time anymore at St. Luke's. I can't say Mount Sinai St. Luke's. I can't say that yet. [Laughs]

NB: I understand. I understand.

PH: I'm sure you've had other people talk about amalgamation, and the big hospital mergers, and so forth. And I don't think it's necessarily improved the relationships between people at those institutions; let's put it that way. I don't know if they produce even better care either, but I'm not—

NB: It's a different kind of pressure on house staff now, too. I know that one of the Residents was expressing his regret that he's losing his clinical skills because he no longer examines patients, and that to me is a terrible statement to make. But at any rate, you've been here 60 years so you've seen a lot of changes. How much of the changes are extrinsic and how much of the changes are intrinsic? But change is like a given, so how do we—you survived that because of your independence and flexibility, but obviously, there's some feeling of loss.

PH: Yes. There's a feeling of loss not for me. I feel for the loss the Residents and Fellows are enduring, because again, as I think I said earlier, to my mind, you've got to be able to play. You've got to be able to try things and feel your way, rather than in doing training, both Residency, although that's more difficult in Residency, but you can do something, and certainly during Fellowship. And research. What is research? Why did I always require research? As I said, it's because whatever you do, you will know more about that little subject than 99.9% of the rest of the world, So, A), that makes you feel good, and B), if you can potentially keep it up, you can sort of—because you know more about it, you're more interested, and so you keep up. And in keeping up, even with a tiny piece of your academic world, it pulls, pulls you along. So that's, to me, why everybody should do some research.

And research is playing. It's not just research. It's not just research that I mean by playing. You can try different parts of the specialty that you're in, or different parts of medicine, and see how attractive it is for you as an individual. That's what I mean by playing. And just like experiences outside our academic world, your experiences in traveling, or in people, make you a more interesting individual, make you more—your brain—it broadens your experience. It makes you more open by doing those things in life as a whole. It's the same thing in medicine.

NB: Mm-hm.

PH: And it should be encouraged and stimulated somehow, I think, to continue to make good doctors.

NB: That's the bottom line.

PH: [Laughs]

NB: So, did you have time for hobbies with all of this?

PH: Well, I'm a city boy. I grew up—I was born in one city and I grew up in London, another city, and I lived for a while in Paris and New York and another three years in Boston—or two and a half years in Boston, so I like the city things, the arts sort of stuff. I love walking, hiking. Still did good hiking a couple of years ago in the Italian Mountains [Alps]. I'm not sure I can do it quite as well now. I did some sailing, played some tennis, so a number of things, but no single—no single thing that I couldn't live without.

NB: Mm-hm.

PH: Let's put it that way. I mean, we are married to the profession as well as [laughs – our spouses] what else, and it's still—it's still exciting. Science is still, what is happening scientifically in the world nowadays, the pace is so extraordinary. It's exciting just to see it happen and to catch a little piece of it. You know? Fly with it. [Laughs]

NB: Right. Of course, you've maintained good health, which allows you to do all these things.

PH: Ah, yes, yes, yes.

NB: And to what would you ascribe that?

PH: Well, first of all, luck I think. [Laughs] I suppose genes. Well, my father's family was fairly long-lived. My father died at 81 but all of them reached their 90s, those that weren't—whose life wasn't cut short in Germany. That's one. And I don't have a lot of bad habits. [Laughs]

NB: That helps.

PH: Good health. Some of it is luck. I mean, we all have some things.

NB: Mm.

PH: I think also an attitude. I've had a certain number of things that had to be dealt with, and they just had to be dealt with, so that's part of my personality. I don't fuss about them.

NB: Mm. Mm.

PH: I got good advice, and still, I hope, am getting good advice.

NB: People always ask me, "How do you find a good doctor? How do you find a good doctor?" [Laughs]

PH: [Laughs] The most difficult is if you can find a good internist.

NB: Nowadays.

PH: Nowadays.

NB: True.

PH: That's very difficult, so I have a—

NB: You mean you don't like gatekeepers?

PH: [Laughs] Well, I have a young gatekeeper, relatively young. I mean, everyone is young for me, appear to me. He's probably in his mid-30s or so, at New York Hospital, and he's fine. But as a physician, as long as you're honest with your doctor, then you play an important role in your good health. And then you have the specialists and that's very difficult. I mean, I had major back surgery a year ago. Went to New York Hospital, and it's got a tremendously wonderful reputation. Went, because I'd lost the use of my leg. I went to actually a neurosurgeon as part of that spine service, and too, about medical care. I mean, he was fine. I saw him about twice. I think I saw him once before, once after the surgery, and once in the follow-up, but the house staff I never saw.

NB: Mm.

PH: Because what they knew about me was on the computer.

NB: Mm.

PH: So the computer treated me. I mean it. I mean, I ended up with a bladder full of fluid, 1200 cc. so I had to find out myself and go to—left the Hospital went to [my urologist to get catheterized]. I mean, it was incredible. It reflects what you were talking about before, which is, it's done by numbers, at least in the subspecialties

like that. In fact, I was told, because I said, "You know, I really needed [some more medical care]"—I was obstipated, too. I had taken narcotics before the surgery, because I was in tremendous pain. But they wouldn't let me even talk to a gastroenterologist friend as to what to do, because that wasn't in the protocol.

NB: Mm. That was a problem. That can be a huge problem.

PH: You know? Yeah.

NB: I know. I deal with it, too.

PH: Yeah. Touch wood, I'm pretty well.

NB: So, the advice is you have to be a smart patient to find a good doctor?

PH: Absolutely. Absolutely. Or you have friends who know. I'll never forget, because I think it answers your question. I had to have cataract surgery, so I went to Bob Newman [Dr. Robert Newman]—he was actually head of BI at the time, administratively. We were friends. I knew a number of people over there in administration. Anyway, I went and asked who would he suggest and he said, "I'll let you know." So what he did was to speak to the head nurse in the operating room, and that's how I got my advice. [Laughs]

NB: Nurses know what's going on and who is very good.

PH: Exactly. Those are the sort of ways I think you really find out. And obviously, if you ask physicians, you should ask physicians who are in everyday practice, because they know, via the grapevine, who is good.

NB: Well, in theory, that's what Castle and Connolly [Castle Connolly Medical Ltd.] does.

PH: Yes. But it—[laughs].

NB: It doesn't. Exactly. Well, great. Did I forget to ask you anything?

PH: I don't know. I think I've been talking a lot. [Laughs]

NB: Well, I hope so, I hope so. Would you like to add anything else? What's the most memorable thing about being here? To me it's your family.

PH: Yes.

NB: And being family means we care about you, and you still care about us.

PH: [Laughs] Absolutely. Absolutely. Yeah, it pains me when things happen that take things away from the St. Luke's-Roosevelt family, but I think I've been extraordinarily lucky. I came here as a very naïve house officer—Englishman, become a house officer. Incidentally, the first thing I was as a Resident—the day I arrived or the day after I arrived here, they put me in the emergency room.

NB: Oh, wow.

PH: So, I learned quickly. [Laughs]

NB: Yes.

PH: In those days you were on, you had four hours. You'd be on sixteen hours at a time.

NB: Yep, yep.

PH: And eight hours in between you could—

NB: crashed.

PH: Right, exactly. So I learned quickly. I learned the vernacular quickly.

NB: Thrown in the fray.

PH: Anyway, I've been very fortunate to have come to this country, to have come by chance to have come to St. Luke's. I think that St. Luke's was, when I was a Resident, was superb for me and to me. I was extraordinarily lucky to get to the Mass General with Kurt Isselbacher, where I could play, and I was very fortunate to be recruited back here. It was a lot of work. [Laughs] You know, I did look at other jobs. The biggest job I looked at, and I did parlay it here into something more, was I was actually offered the Chief of GI in Montreal at the Royal Victoria, back in '65. I decided not to go because I knew that Canada, and particularly Quebec, was in flux at that time. We didn't know what they were going to do. At a minimum, what they did is they didn't [separate from Canada]—a lot of people left in the next four, five years. But anyway, but I was able to come back here, and I got a guarantee of—I actually got the guarantee of my salary here. Guaranteed by the institution and what was then a very large rise, raise, excuse me. Realistically, not very much, but still. [Laughs]

NB: By comparison.

PH: That was by comparison, yeah. Then I looked at two or three other jobs, but chief of medicine jobs, and I decided, no. I was happy in "my little pond," rather than I needed to go up ladders for some reason. And I like New York. As I said, I'm a city boy. So yes, I've been very fortunate, and I've been fortunate and continue to be fortunate, even though some ups and downs after I left here, bankruptcy and so on, but I got something else quickly. And my relationship to Rockefeller and then on the faculty have been fantastic, so I have no complaints. [Laughs]

NB: Well, prevention for colorectal cancer has been a forefront now in the national media, too.

PH: Right, right.

NB: Because people realize how important that is. And, so, you really made a huge impact with the work that you've done.

PH: I am now really looking—I was interested in obesity and colorectal cancer, and now I'm more into obesity itself, because it's probably *the* problem for the next generation.

NB: Hundred years. [Laughs] It looks like.

PH: I'm really interested as to why we get complications in obesity, and how we can reduce the complications, because obesity doesn't kill you. It's the complications that kill you.

NB: Yes, but its stems from becoming obese.

PH: Well, why some people get—some people can be obese and are healthy and stay healthy, and others don't.

NB: Right.

PH: That's a question we don't have the answer to.

NB: What's the difference, yeah. [Question that was edited out: Would you please face the camera and state your name and your titles for the record?]

PH: My name is Peter Holt. My titles now are Senior Research Associate at Rockefeller University; I'm Emeritus Professor of Medicine at Columbia University, and Adjunct Professor of Medicine at Weill Cornell University in New York.

[End of Interview]