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NORMA BRAUN: This will be our first oral history interview with Theodore B. VanItallie, former Chief of Medicine at St. Luke's Hospital. And we're going to be taking a history from him with questions from us, and whatever he wants to tell us about his career, his life, and any other comments. So we're so thrilled and honored to be here, that he's welcomed us to his home, and we have wonderful surroundings at the same time that we have the honor of getting all this rich history from one of our most loyal physicians

So, I met Dr. VanItallie when I was a medical student and then when I was a fellow at St. Luke's. So that was a long time ago, but I'd like to more focus on him, and that is we'll start with where were you born?

THEODORE VANITALLIE: I was born in the Hackensack Hospital in Hackensack, New Jersey, Bergen County.

NB: Okay. Did you grow up there? Did you grow up somewhere else?

TVI: I grew up in Ridgewood, New Jersey until college years, when I moved to Franklin Lakes where my family had a –let's call it a gentleman's farm. [Laughs]

NB: [Laughs] And then where did you go to college?

TVI: I went to Harvard [University].

NB: And did you get your interest in medicine then, or before, or after?

TVI: I think my interest in medicine was generated in my last year of high school, boarding school, and I was inspired by a book by Sinclair Lewis called *Arrowsmith,* about a doctor. And I'd read some other books about doctors who had made contributions to the world around them, and I found that I had an interest in science, and also an interest in doing something worthwhile, rather than simply trying to earn money.

NB: That sounds wonderful. Was that something that came from your family, this more altruistic approach to life?

TVI: Well, I wouldn't say that. The family pretty much left me to make my own decisions, and I think I was fortunate in that I tended to make fairly good ones because, I guess, they had confidence in my judgment.

NB: What did your father do?

TVI: My father was a businessman, and he was a manufacturer of drills and grinding wheels, and abrasive tools.

NB: How about your mom?

TVI: My mother was just a lovely woman. [Laughs]

NB: She was a mother.

TVI: She was a good mother, and she was a prominent figure in the community. She was a member of the board of the Valley Hospital in Ridgewood, and she was chairman of the history and travel department of the local women's club, and did other things in the community that I thought were useful. And I used to, when she showed films at her committee meetings, I was the technician who took care of the projector.

NB: Oh, you're pre-Brian. [Laughs] Were you the eldest sibling in your family? [referring to Brian Caraveo is the videographer recording this interview.]

TVI: Yes. I was the eldest.

NB: So that's wonderful that your parents could support you. So you went to Harvard. What did you study at Harvard? What was your major?

TVI: Well, I was pre-medical but my field of concentration was really comparative literature and philosophy.

NB: So then what medical school did you go to?

TVI: Went to Columbia, P&S [Columbia University College of Physicians and Surgeons], class of 1945.

NB: God bless. They just had a reunion. Did you go?

TVI: Beg pardon?

NB: They just had a reunion. I don't know whether you went. The most recent—last week was the reunion.

TVI: Well, there only about seven or eight living members of my class left.

NB: Are you the president? [Laughs]

TVI: One of my roommates, Dr. Richard Ward, is still alive, and we've communicated by phone and decided that it would be too much of a problem to try to persuade a small group of nonagenarians to attend a meeting in New York. So we thought we'd just not worry about it.

NB: Well, that sounds like a good reason. But at any rate, then what drew you to what you wound up spending your life doing—an interest in nutrition and metabolism?

TVI: Well, I was always interested in metabolism because I felt it was a more basic part of internal medicine, which was the field that I specialized in formally.

NB: Did that interest start at Columbia or during your residency?

TVI: No, I think it started during my residency.

NB: And where was that?

TVI: St. Luke's [Hospital].

NB: Hey! So who was your mentor at St. Luke's?

TVI: Well, I don't know that I had a mentor. When I was an intern there, Dr. Goodwin [George M. Goodwin, MD] was the Chief of Medicine, and I was impressed by the fact that he used to go on rounds with Dr. Dotti [Louis M. Dotti, PhD] who was the Chief of the biochemistry lab. And so he emphasized "the scientific aspects of the medical experience." And these rounds were very useful, but I felt that overall, when I had attended these rounds, there was too much emphasis on what might be called anecdotal experiences with medicine, and not enough specialized knowledge. In those days sub-specialties really didn't—

NB: Exist.

TVI: —exist, in the sense they subsequently did. But I always felt that it was not good teaching to listen to an attending talk about one case, and that's all he had to say about a given medical problem. I wanted to be taught by someone who specialized in that field. If it was a hematology case, I wanted to hear from somebody who knew [laughs] hematology. So that formed the basis for my later goals for St. Luke's when it became possible for me to change the Department of Medicine.

NB: Is that what led you to St. Luke's? Because where were you, before St. Luke's when you'd already begun your research?

TVI: Well, I went from Columbia directly to St. Luke's.

NB: Oh, so you basically took it over. Well, James Keating, as I know from the story—and you can correct me—seemed to believe that the Department of Medicine needed to develop more scientific basis, and he wanted a more research footprint at the St. Luke's site.

TVI: Yes, John Keating [John H. Keating, Sr., MD].

NB: Yes.

TVI: Yeah. Blackjack Keating, we called him.

NB: Blackjack Keating, right.

TVI: Now, he was, in a sense, my mentor. But he was one of the physicians at St. Luke's that had the vision to see that our relationship with Columbia could strengthen us as a teaching and research institution.

NB: Yes, and that was my understanding, that was one of the things that he promised you.

TVI: But what's more important is that Dr. Keating raised the money to do these things. And he had money from the Charles E. Merrill Foundation, which supported cardiology during my career at St. Luke's.

NB: So when you came to St. Luke's, what was the character at the time when you took over the chair? It was what, 1958, right?

TVI: You mean came as an intern?

NB: No, as a chair.

TVI: Well, when I went as a Chairman, I'd had the experience of having spent time at the Peter Brent Brigham Hospital in Boston, and visiting at the Mass General [Massachusetts General Hospital] as well, and I'd seen really first rate, world class physicians at work. That's also where I met Dr. [Sami A.] Hashim, who was a dynamic resident at the Brigham. And I think that it became clear to me that if I were to take responsibilities at St. Luke's, I would try to create a teaching program for house staff that would be based on first rate specialists teaching. And it seemed to me that if we were going to develop as a hospital, we should attract the best intern applicants possible, and the best ones we could find were usually from P&S or Harvard Medical School. So that was where our focus lay.

And I felt that the better interns we could attract, that some number of those interns would remain on the staff and would form the basis for the future of the staff of the hospital, and that if we had sub-specialty divisions, then we could do the teaching

that I thought was necessary to attract the best students. The idea of sub-specialties wasn't original with me, of course. I read an article by Walter Bauer, [MD] who was Chairman of the Department of Medicine at the Mass General. It was published I think in the *JAMA* [*Journal of the American Medical Association*], but it was on specialty—sub-specialties, and at that time it was a new idea, in a way, and it was still scorned by the people at Presbyterian [New York-Presbyterian Hospital], and others.

So then when we set up our sub-specialty divisions, we were ahead of Presbyterian and we were doing a better job than they were in that respect. I'm not saying we had better people. I'm just saying that we had better ideas.

NB: Do these become sort of the recruitment principles from which you tried to get people to come, to give them opportunity to develop their own division, and so on?

TVI: Yeah. Yes. And part of that whole business had to do with strengthening our academic relationship with Columbia [University]. So one of my primary goals was to become what we called a full university hospital of Columbia, which meant, in effect, giving Columbia a role in the decision making at St. Luke's. I saw that as being the ultimate salvation of the hospital. But a number of departments failed to understand that, and they felt that giving more to Columbia would take away some of their own prerogatives, and they preferred to have this independence, and felt that Columbia should not interfere in the workings of their department.

But my personal belief is that they lacked vision, and that if they had thought this thing through and had the ability to look into the future, they could have seen that the survival of St. Luke's would have been possible at a high level, had they done what I started out to do. But because of the number of departments that lacked this vision, the lack of vision of the trustees, and particularly the lack of vision of the administrators, we didn't succeed in having a full permanent relationship with Columbia.

It was my hope originally that St. Luke's could be the Peter Bent Brigham of Columbia, and that we would be the teaching hospital on the campus—teaching and research. And that vision was shared with a few people at St. Luke's.

We had a trustee, Henry Guthrie, who I got to know pretty well. He was chairman of the board, and he understood this enough so that he was the one who helped me put through this arrangement with Columbia. Although it was opposed by Stanley Bradley [Stanley E. Bradley, MD], who was then the Chief of Medicine at Columbia, we bypassed him and worked with the Provost, Polykarp Kusch, [PhD], who was a Nobel laureate and outperformed Bradley. And Kusch agreed with us that we should be academic—not only St. Luke's but also Roosevelt [Hospital; now Mount Sinai West]—connected, academically connected to Columbia as a full university hospital status.

So with Henry Guthrie's power behind us, we accomplished that. Nick Christy [Nicholas P. Christy, MD] was the Chief at Roosevelt and he and I did this together. So that was useful. But there were some basic mistakes that were made. When I say mistakes, I think we didn't think through the weaknesses in my plan. The basic weakness was that I should have insisted that the administrator of the hospital be a Columbia appointed administrator, because the administrators of the hospital had no understanding, or little understanding, of the importance of what I was trying to do, and they were thinking only in terms of money.

NB: That's what they're charged with, unfortunately.

TVI: It was sad and tragic that people like—I won't mention them by name, but sold out to other hospitals. They in fact sold us to Beth Israel [Medical Center] originally [Note: Beth Israel merged with St. Luke's-Roosevelt Hospital Center in 1997 and the new enterprise was called the Continuum Partners, LLC.], and then they sold us to Mount Sinai [Medical Center], and this was totally irresponsible, treacherous behavior, from my standpoint. And the fact that Mount Sinai agreed to this arrangement was also unfortunate, because it was not appropriate for Mount Sinai to run a hospital so close to Columbia University, when Columbia should have done it.

And of course, it would have worked if we had had an administrative president of the Hospital who was a Columbia person, and if we'd had some Columbia trustees on the board in addition to myself. I was one of a few doctors who was also a member of the Board of Trustees, but I couldn't swing it by myself. While we're on the subject of Mount Sinai, I think that there must be people at Mount Sinai who have the sensitivity and understanding to realize that St. Luke's and Roosevelt were distinguished hospitals that had wonderful traditions and fine staff members, and that it would have been—it would be a serious mishap, or a serious unfortunate event, if Mount Sinai were to wipe the memory of these wonderful institutions off the map, not only their scientific achievements, their clinical achievements, and their traditions, but also their philosophies of patient care and kindness.

When Jarvis Cromwell was president of that board of the Hospitals, he emphasized the importance of kindness to patients and to each other. As a result of this atmosphere, the climate at St. Luke's was a friendly climate. When people came and worked with us, they always said that this was the kind of atmosphere in which they could be stimulated, but also feel happy to work because the people were considerate of each other and helped each other, instead of being competitive in a rather disagreeable way with each other. So I think it's most unfortunate that we now are the property of Mount Sinai, which seems not to have been fully aware of these wonderful traditions, and the advantage that they would give to Mount Sinai if they were to adopt some of these philosophical approaches.

So I think that they have a long way to go to have the considerateness to the understanding, and the sensitivity to respect the wonderful things that St. Luke's and Roosevelt have done. And the failure to do that is a lack of what I would call desirable behavior, and I hope that they reflect and try to improve this attitude.

NB: When you were working through the first decade, what were the biggest triumphs or achievements and what were the biggest disappointments?

TVI: Well, the biggest triumphs, I think, were the ability to attract outstanding doctors to run our divisions, people like Dr. Hashim, Jack Bertles [John F. Bertles, MD] from Harvard, Peter Holt [Peter R. Holt, MD]. We had many fine—

NB: Loomis Bell? [A.L. Loomis Bell, Jr., MD]

TVI: Loomis Bell was part of the family to begin with. Red Barrett [C. Redington Barrett, Jr., MD], people like that. And I think that was not my achievement; I just took advantage of what was possible. But my achievement was to create the conditions in which we could bring division heads to the Hospital and put them to work. I think that at that time we became one of the most popular places for intern applicants from Columbia, and that was very gratifying. So that was another thing that was really a keystone of my objectives. The drive towards getting full academic relationship to Columbia was another slowly achieved accomplishment.

NB: Was that hard, getting them academic appointments at Columbia as part of their—?

TVI: Yes. We were able to get—you know, if you're not a true university hospital, you become a clinical professor, and in the academic world the clinical professor doesn't mean very much.

NB: It's true.

TVI: So when we became academically affiliated, Dr. Hashim—well, he was one of the few people who always had a full academic appointment, but he had that through Dr. Sebrell [W. Henry Sebrell, Jr., MD], who was head of the Institute of Human Nutrition. But then I became a full professor of medicine, not just because I had engineered this relationship with Columbia, but, I hope, because my qualifications as a teacher and researcher were good enough to get me through the committee that would pass on that kind of thing. So that was the good part. But the unfortunate part was the lack of—what I call-a lack of vision of other department heads in the Hospital, which did not make it possible for us to have a uniform arrangement with Columbia.

NB: How much did the administration help, or not help, as the case may be, at that time?

TVI: The administration, to my recollection, was of no help. They had to be pushed into everything we tried to do. First of all, they lacked any understanding of what it is we

TVI: were accomplishing. They did not understand the importance, or seemed not to understand the importance, of attracting superior house staff so as to build up a staff at St. Luke's that would be second to none, in terms of ability and qualifications.

So we had one of our directors, when he was approaching retirement, was approached by Beth Israel to make it possible for them to acquire St. Luke's. And part of that involved his having a very fine retirement package. He was on our board ex-officio, so when the time came to vote on this, he voted in favor of it. When I objected to this, and said I thought this was a conflict of interest, I was the victim of some fury of a trustee, Walter Rothschild, who thought I was being mean and disagreeable, but he was the one [laughs] I think who was more disagreeable.

So that my recollection of this is that this whole business went through, because our administrator was not on board with this concept that I had tried to develop over the years. That was towards the end, the beginning of the end, of St. Luke's. It's such a tragedy because, in my opinion, if we had developed a full academic relationship with Columbia, we could have been an extraordinarily successful teaching hospital with the backing of Columbia, and with a fine reputation right on the Columbia campus. And that would have been ideal, but people didn't seem to see it the way that I saw it.

So that was, I think, one of the big disappointments of my career. And I think sensing this was one reason, I think, that I finally decided to resign as Chief of Medicine, which was in 1975. I was Chief from 1957 to 1975, which is a pretty good number of years. And I might say that I was an extraordinarily lucky Chief of Medicine at that point because I had so much sympathy and support from my staff, the senior medical staff, who are really sort of my cabinet. People like Eppy Childs [Edward P. Childs, MD], Will Norton [William S. Norton II, MD], and Myron Wright, [MD] and some others, were exceptionally supportive of what I was trying to accomplish. And they realized what I was trying to do. So we had a—isn't that correct-don't you think we had a happy atmosphere among the Senior Attendings?

NB: Your core group.

TVI: Yeah. Well, I had to deal with two groups. I had to deal with the academic research group and with the clinical group, and to have them respect one another as people who were important to the well-being of the hospital.

NB: How did you, with all your responsibilities, work in your research to be able to continue your passion, which you're still doing, I understand?

TVI: Well, in the research, I was very lucky to have a partner who was very dynamic, Dr. Hashim. And between the two of us, we got quite a few things done.

NB: When did Dr. Pi-Sunyer [F. Xavier Pi-Sunyer, MD], come on the scene?

TVI: Well, he came in fairly early in the game, and he was originally an assistant to the Director. Then he became more than that, but he worked with us and developed an interest in diabetes, and became a really a prominent man nationally in the field of diabetes, and published very fine papers. So he was certainly a wonderful asset and a good example of—

NB: …what you accomplished.

TVI: —of what we could accomplish. P&S, he was a P&S graduate, and a third generation scientist. His grandfather had been a scientist in Spain at—what's that wonderful town in Spain where the architecture of the cathedral is so interesting?

NB: In Madrid? Madrid?

TVI: No. No.

NB: Barcelona?

TVI: Barcelona, yeah. And that's the Catalan part of Spain. So that the Pi-Sunyer family were well known medical scientists. So he was another great asset. So I think I was very lucky to have colleagues of this quality, but I think the basic mistake that I made, because I couldn't see, didn't understand it well enough, was not to realize what damage could be done by an administrator who lacked the vision that we would have liked to have that person to have had.

NB: Well, some people are obviously harkening to another drum, so the administrator's responding to who—the trustees? And was it the fiduciary issues that dictated the decisions that were made -because clearly, that became an increasing pressure in the whole medical establishment.

TVI: Well, the big problem at St. Luke's was that the trustees did not think for themselves. They depended too heavily on the administrator. It's so easy to say, "Okay he knows the finances and the problems. We'll just do what he recommends." So I think the trustees were delinquent—we were delinquent in our duty, because I was a trustee--and not overriding the Director, or getting a new one if he didn't conform to what was best for the Hospital.

NB: Well, the administrator that was active in that time is now—has severe Alzheimer's and would benefit from what you're developing now to treat Alzheimer's, which is very, very important. So it's the way of life.

Now, during this time of your tenure, also there were more and more foreign medical graduates that started to come over here [applying to be on the House Staff]. How did you see that impacting on your goals and on the education program?

TVI: Well, that was after I left.

NB: There was none before you left? Okay.

TVI: The only foreign graduates I took were American University of Beirut.

NB: Oh, yeah.

TVI: And they were a wonderful asset to the department. But what you're talking about is a drop in standards, and a lack of attention to them. When I stepped down as Chief of Medicine, I think the—what was his name? Gerry Turino [Gerard M. Turino, MD] was asked to be my successor.

NB: Correct. He was the first Keating chief. [The John H. Keating, Sr., Professor of Medicine]

TVI: And I was pleased that Gerry was appointed. But then Gerry was fired by the administrator because he was asking what the administrator thought was too much for the department. I thought that's an example of very unfortunate management, because Gerry was—he had the right philosophy and the right connections, and the administrator had no real understanding that getting rid of Gerry Turino was getting rid of some very good person who—

NB: Well, Gerry's still active. He's still doing research, as well.

TVI: Yes, but he should have been Chief of Medicine.

NB: That's correct.

TVI: So that's a good example of an unfortunate action of an administrator who didn't get the picture.

NB: What are your fondest memories?

TVI: Well, I think that just the day-to-day work with a wonderful group of people was… We had some amusing episodes. We had a resident named—I think his name was

Mueller--went to Vietnam. And he was Chief Resident. He sent me a gong from Vietnam as a present. So I put it in my office, hanging it from the wall. This is when I was in the Clark Building. And somehow I had a meeting scheduled with Eugene Mullen [E. Eugene Mullen, MD], who was an Attending Physician, and I said, “Gene, why don’t you come and have tea with me, and we’ll talk about these things?” So he said, “Sure, I’ll be there.” I think he came at about three o’clock. And before he came, I asked one of the secretaries—the name was Eileen—I said, “Eileen, Dr. Mullen is coming to have tea with me. So when he’s in my office I’m going to hit this gong and I want you to come in and say, “Yes sir?” [TVI stands and bows]

NB: [Laughs] Kowtow!

TV: And I’ll say, “Please bring some tea for Dr. Mullen.”

NB: [Laughs] Lovely! How often did you use it?

TV: So he was in there, and I said, “Are you ready for some tea?” And he said, “Yes, thank you.” So I hit the gong and Eileen came in and bowed and said, “Yes, sir?” And I said, “Please bring some tea for Dr. Mullen.” So he had no idea that this was a spoof, so he must have thought either I was crazy [laughs] or something else was going on. But he kept his poise. [Laughs]

NB: And had nice tea.

TVI: And he had tea. No, it was regular tea. So anyway that was an example sort of the fun [laughs] that we had. We also had these wonderful Christmas theatricals from the house staff.

NB: Oh, yeah. The skits. [Editing cut]

TVI: How do I maintain what?

NB: Your vitality and your work? And you’re still doing work, and what do you consider your greatest contributions there? Of course, it’s to me, anything that you started.

Sami Hashim: And cognition. [Laughs]

NB: Oh well, that’s why he’s working of Alzheimer’s, because he’s got the secret.

TVI: Well, I wish I had more vitality, but I think what I need is more physical exercise.

NB: Oh, there you are. We have to do Tai chi, to teach you Tai chi.

TVI: Well, I have a trainer who comes in twice a week to do strength training and flexibility training. Ann [Ann Pierson, MD, neighbor and companion of Dr. VanItallie] tries to encourage me to remain physically active. She herself is so active that she's a wonderful role model. But I think my problem is not spending too much time behind my computer working on these issues, because I get very involved in them.

But I'm really inspired by this problem of Alzheimer's disease, and I think that the product that Dr. Hashim is developing may be the best thing available in the foreseeable future to prevent it or control it. So we're constantly trying to push the manufacturer to get the thing ready so we can…

NB: Do clinical trials.

TVI: …actually give it to patients. And we have a whole list of people, including St. Luke's people, who need to be treated. And they're just waiting. So there are a lot of questions. One of them is whether, at an earlier stage of Alzheimer's, memory loss is reversible. And I have some belief that that's the case.

[Editing cut]

TVI: Oh, really? My goodness, it just stays.

NB: Once it's in – it's like syphilis. Once it's in, it never leaves—never leaves. So that's one of my reasons for telling people to get vaccinated. If you get vaccinated, there's less chance of them getting in. If they can't get in the door, they can't stay. So I try to help them to understand why vaccination is important, because now there's this natural ridiculousness, right? Natural? I said natural is death and disease.

TVI: But the question is why, in Alzheimer's disease, people start getting a disease at the age of 65.

NB: Sometimes earlier.

TVI: Something happens earlier.

NB: Yeah, because the Alzheimer's original description was somebody in their forties.

TVI: Yeah, well that was—

NB: That was originally—among neurologists, they called original Alzheimer's disease, Premature Senility.

TVI: Pre-Senile. Pre-Senile.

NB: Right. Now, as we're getting more brain pathology, we're beginning to understand, "Wait a minute, this is exactly like the younger one, it just happens later on."
TVI: Late onset.

NB: Right. So we don't understand the mechanisms by which this occurs, which is losing synapses, or ability to make new synapses. That to me it forces [unclear].

TVI: I spend all my spare time working on this.

NB: How much time do you have? [Laughs]
TVI: Not much.

NB: I mean, you can't help thinking about it, but then you need the tools to begin to unravel, and it's a very complex thing.

TVI: Okay, you have a question to ask me.

NB: I do. One of the questions I wanted to ask you is for the different transitions—first the St. Luke's-Roosevelt merger in 1979, then the second merger with Beth Israel in 1997, and now finally the Mount Sinai merger in 2013. How do you see that as impacting on the work, the legacy, and the future of St. Luke's?

SH: Are you recording him? [Directed at Brian, the videographer] Brian: yes

TVI: Well, I think these mergers were different, in the sense that the St. Luke's-Roosevelt merger was a merger of equals, and I think we'd call it a voluntary or synergistic merger, so that we gave to each other. Roosevelt had an excellent surgical department and other characteristics. St. Luke's had its virtues and advantages, and I think it was a productive merger. I think the next merger, with Beth Israel, was a merger of weakness, where because of inadequate administration at the hospital, at St. Luke's, and the superior strength of Beth Israel financially, this merger was presumably to preserve St. Luke's existence, but not necessarily its character.

So I think that what happened, in effect, that St. Luke's was gradually losing its strength and vitality, for reasons that we've discussed earlier in this interview that we've had. And I think that this further downhill situation was advanced with the merger with Mount Sinai, which was an acquisition by Mount Sinai; was not really a merger. I think that the Mount Sinai has its own culture, which is a culture which is entirely different from that of St. Luke's. I think this emphasis on productivity is an emphasis which is ill-conceived and damaging to the practice of good medicine and good behavior. So I think that some of the unattractive features of Mount Sinai's culture, of which I think there are a number, have been imposed on St. Luke's, to its detriment. And I think it's unfortunate that the Mount Sinai people seem to be trapped in this situation. They now have, think, a name, called the Icahn—?

NB: Icahn School of Medicine.

TVI: —School of Medicine. I may be wrong on this, but I have the impression that Mr. Icahn had a reputation as a corporate raider, and that some of his acquisitions may have been less than creative, in terms of helping the companies that he took over. How many ways did he improve employment? How did he improve the quality of life of the companies that he took over? What has he done to advance the cause of, humanitarian cause, in business? So I think this emphasis is opposed to this philosophy at St. Luke's, which is one that is based very much on the treatment of a patient as a guest in your home, rather than as someone who is a financial—some kind of unit of finance. So if I had the opportunity, I would certainly like to advise Mount Sinai to change some of its cultural attributes. And if they can't change their own attributes, they should have left St. Luke's with what I think was a very good system.

NB: Well, I think the belief was that St. Luke's was not sufficiently viable as a financial institution and one of the reasons for them willing to be acquired, if you will. So how much do you think in our common day, across the country in the United States, is the financial imperative drives are really dictating what we're doing? I feel as physicians, personally, that we have been derelict in our first duty, which is to the patient, to listen to only the money changers.

TVI: Yes. Well, I agree. I think that the ideal of the physician is to provide optimal patient care, and that whatever it takes financially to do that should be done. I think to put the dollar bill in front of—ahead of good care--is immoral. It should not be done. The problem is that in the early days that I was at St. Luke's, it was the doctors who were in charge of the policies of the hospital, and the administrators were the people who were there to make these goals possible, to help the doctors achieve their goals in patient care. And after a while the administrators gradually proliferated and began to take power, and the doctors, for a variety of reasons, relinquished that power, and then pretty soon they became employees of the very people that they had hired to do their own job for them. So it's a sad state of affairs that the administrators, who should be there to help doctors do their job, are now employing the doctors and taking a role of control, which is entirely inappropriate.

NB: Do you have any suggestions for how we can change this? Do you have any words for somebody just starting out?

TVI: I think it's tough. I believe we need to have doctors back in control, and therefore I think more doctors should be encouraged to develop business experience, and having an MBA and an MD would—might be a good idea, and then put that MD/MBA in charge. But I think it would be helpful if the senior hospital administrators were physicians and not accountants.

NB: Or something else.

TVI: Or something even worse.

NB: Exactly, exactly. It's how to restructure this. So I know that I have a young physician who is getting married to a physician here, so she's moving. She's been practicing in India for several years as a physician. She has her degree. She's got all the things she needs. And for some reason she wants to come and shadow me for a period of time—a year she thinks, which is fine. I love the opportunity to have fresh approach and to learn from her as well as vice versa. The number of steps she has had to go through—and it's separate from terrorism; it's just Mount Sinai—the number of things they have to go through to "get the opportunity" is Herculean. There are barriers to open education, because this is what it's about. We've always been open. St. Luke's always has in my experience, St. Luke's-Roosevelt. So when somebody wanted to come, we went through the chairs of departments, we wrote letters for each other, and then we'd just have to follow up with the State Department travel regulations, whatever they are. But now it's just overwhelming. And the fact that they were willing to do it says their testament to their persistence.

TVI: Well, administrators think administratively. And I think we need people who think creatively, and keep their eyes on the ball, the ball here being excellent patient care with the least administrative obstruction to the delivery of that care. If you have to go through all sorts of—

NB: Hurdles.

TVI: —administrative hurdles—over them, that is, including writing in your computer when you should be talking to the patient about his problem, I think that's typical of the depths to which we've fallen in doing the job we should be doing. So I think these administrative complications are like a—well, maybe like a cancer or some malign process that is growing out of control and is interfering with the desirable approach to taking care of people who are sick. We talk about health care, but a doctor's job is really disease management, not health care. So we ought to face up to what we're doing.

NB: Well, the emphasis is on prevention and wellness now, and physicians, according to Medicare regulations, is that you'll be paid for the quality of care you develop to prevent things, and not for the individual care of a disease as has been in the past, because that's been too costly. So this shift, allegedly, of being recompensed for prevention rather than disease management—how will that shape how we functions as physicians?

TVI: Well, it can be abused, I think. I think we still have to take care of sick patients, and I think what we can do to prevent disease is a bonus, and it should be given as a bonus.

I quite agree that physicians should be thinking of ways that they can prevent recurrence of illness and help patients prevent illness in the first place, or delay it. And it's not just something that can be limited to hospital practice. It has to be taught in medical school, and it has to be created as a medical part of the culture of medical practice.

NB: The last thing is probably more other aspects of your time at St. Luke's, and that is do you remember fun times, funny times, skit times, holiday celebrations—things of that type that has a lasting memory for you of some joy?

TVI: Well, as I said, the thing that made working at St. Luke's a joy was the support and friendliness of the staff. I don't think that any other hospital that I'm aware of did that as well as St. Luke's did it.

NB: Better than Roosevelt?

TVI: Certainly better than Roosevelt, and I'm pretty sure better than Mount Sinai. I think that it's totally wrong to create an atmosphere of tension and discomfort, and anxiety in young doctors at a time when they need to be reassured and given a sense of security. And making—embarrassing people for not knowing everything is, in my mind, a negative. There was a doctor who was the Chief of Medicine at Mount Sinai, Sol Berson [Solomon A. Berson, MD]. Berson and Yalow [Rosalyn Yalow, PhD] together were the first to develop a method for the immunoassay of insulin. And when I was chief of medicine at St. Luke's, I created a group of chiefs of medicine of major hospitals in Manhattan, and we met once a month to talk about mutual problems. So I got to know the other chiefs.

And Sol Berson was a nice guy, but Sol was an extremely hard working fellow. He had to know everything about everything, and he had to be all things to all people. I think he was also a heavy smoker. But he was an incredibly hard worker. I called him up one morning because I wanted to meet with him about this immunoassay insulin method, and his secretary told me he had just died of a heart attack. And I think it was very clearly related to the stress that he put himself under day after day after day. That, I think, was the part of the Mount Sinai culture, but the price was pretty high. And not too long after that the Chief of Medicine at Presbyterian, who was a similar type of personality, also dropped dead of a heart attack. So that reminded me that would be a good time to take a vacation.

SH: And Yalow got the Nobel Prize.

TVI: Beg pardon?

NB: Yalow got the Nobel Prize.

TVI: Yes, she won the Nobel Prize.

NB: And she actually worked at the VA Hospital in the Bronx. That's where she did most of her work.

TVI: He was the guiding force, but they had to give it to somebody so they gave it to her.

NB: Well, she'd done some work with him. She had worked with him.

TVI: She's a good person. No doubt that she was deserving, but Sol was the star.

NB: Yeah. To me it sounded like he was a person who felt very insecure. The fact that he had to know everything, do everything. I mean, just people who are insecure do that, because—

TVI: Yes.

NB: —they constantly have to prove to themselves they're good enough, they're good enough, they're good enough. But part of it is the culture.

TVI: If you're in that culture, and you feel that people are looking down on you if you don't know something you should know.

NB: Right, right, right. But I know from—

TVI: And you're right. If you're insecure then you'll only feel comfortable if you know everything.

NB: Right. Or you think you can get to know everything, because that's the other problem, which is impossible.

TVI: If you're really comfortable with yourself, then you could admit to not knowing certain things.

NB: Thank goodness. [Laughs]

TVI: Thank goodness.

NB: One anecdote I'll bring up, only because I don't know if you remember it—I remember it. And the reason I'm bringing it up is because of the support you gave your staff. I was a Fellow with Loomis Bell, and I'd consulted on a patient for Bill Fielding [J. William Fielding, MD] in orthopedics. The patient was an eighteen-year-old sickler with skip lesions of her vertebral spine for pox [for Potts tuberculosis in

cervical, thoracic & lumbar vertebrae], and it was probably related to her sickling because of thrombosis [of the vessels] in these areas.

But be that as it may, they had asked for consultation as a preoperative clearance for this girl. And when I went to do my history and physical, I realized that she was not in impending paresthesia or paraparesis from the lesions, and she had not actually gotten chemotherapy for tuberculosis. And I felt that in the absence of risk of developing paralysis, that chemotherapy should be given first, and given a time to work, and then continue to follow her in case she developed any impairment. She had no impairment at that point.

They had decided that she should have surgery, because Bill Fielding was a superb clinician of cervical spine surgery and she had cervical spine lesions, thoracic spine lesions, and lumbar spine lesions. So he was going to fuse her from stem to stern. And I felt that this was not timely. It should be done only if she had a compromise, physical compromise. And I felt that it was not indicated. And he went ballistic when a Fellow said that a surgical procedure an Attending had decided was needed was not needed at that time. That was not enough of an injury, if you will, for him to come to you.

But I went to the AS meetings, American Thoracic Society meetings, and I was concerned about the patient. I called her. I said, "If they get you to sign consent [form], ask you to sign consent for surgery, unless you have weakness in your legs or anywhere else, you don't have to sign." So they would come to her at night, wake her up at night, to sign the consent form. And she said, "No." Well, on one of the occasions she said, "Dr. Braun said to tell you no." And that was what made Bill ballistic, and he went to straight to you, and he complained bitterly both to Loomis and to you about my hutzpah in telling the patient not to sign a surgical consent! [Laughs]

And you called me in. You asked me for the facts; I gave you the facts. And you supported me completely. And in fact, I felt we should have medical grand rounds on the topic, and to invite Bill Fielding and another orthopod who treats tuberculosis of the bone to be the pro and con, because it would be bone doctor to bone doctor, not just an internist. And that happened. And from then on, Bill Fielding would not call me Doctor. He called me Mrs. Braun. But you supported me. That's why I never forgot it.

TVI: Of course I did. [Laughs]

NB: Well, that was very important, because if you feel supported by your Chief then you feel you can do the right thing, and you're learning a little bit about the whole process of how you support your staff. I think you would have called me on the carpet if I was

wrong. I had no worry and no concern that that would be something you wouldn't do, if that were the case.

TVI: I wouldn't blindly support you.

NB: Exactly.

TVI: But I would support you if I thought you were right.

NB: Yeah, that's what happened.

TVI: And you were.

NB: And that was a big help to me, because obviously when you're a small fish in a big pond, you don't know where you're going to get eaten by the big fish, and so that's a little worrisome.

TVI: You remember Nancy Kemeny? [Nancy Kemeny, MD]

NB: Yeah.

TVI: She got into an argument with an Attending because she didn't like the orders that the Attending had written. The way I did it was that the house staff had to write the orders, and that gave them a chance to see what they were doing, and if they didn't like it they could discuss it. So Nancy infuriated the Attending, and I told the Attending, I said, "Well, the fact is you're wrong."

NB: That's important. I mean, obviously, taking the younger person, the less powerful person's position based on what's right and what's wrong rather than based on position, I think, is really very important. That, to me, is part of the culture that created the sense of family belonging, friendliness, support.

TVI: Well, the senior physician who dictates the orders—if it is called to his attention that he is wrong or might be wrong, he should be a secure enough and a big enough person to admit it, and then say, "Okay, let's look into this further." He doesn't have to say yes or no. He might say, "Well, you have a point. Let's put this off, and then we'll see what so and so has to say or what—"

NB: Let's look it up.

TVI: "—what's in the literature."

NB: Yeah. What's available, what helps us here, what can help us? [Editing cut this question out: Would you please look at the camera and state your name and title?]

TVI: My name is Theodore VanItallie, and my title at the moment is Professor Emeritus of Medicine, Columbia University College of Physicians and Surgeons.

[End of Interview]

Video adds in images of Drs. VanItallie, Braun, and Hashim walking in the back garden and around the house.