

INTERVIEWEE: Dr. Edward Halperin  
INTERVIEWER: Jessica Roseberry  
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Davison Building

HALPERIN INTERVIEW NO. 1

ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. Edward Halperin. He is formerly the vice dean of the School of Medicine, associate vice chancellor for Academic Affairs, and professor, Department of Radiation Oncology. He is the newly appointed dean of the School of Medicine at the University of Louisville in Kentucky. Today is October 10, 2006, and we are here in his office in the Davison Building. I appreciate your willingness to be interviewed today, Dr. Halperin; it's wonderful. I would also like to congratulate you on this future position of yours and wish you the best of luck.

HALPERIN: Thank you.

ROSEBERRY: I thought I might start by asking a little bit about your background, and, if you don't mind my asking, when you were born.

HALPERIN: I was born in 1953. I grew up in Somerville, New Jersey. I grew up the son of a retail pharmacist. My father owned a pharmacy called Halperin's Pharmacy back in an era when there still were places called Halperin's Pharmacy on Main Street, before there were CVSs, and Walgreens, and Eckerds, and Carr. But my father was behind the prescription counter, and my mother and sisters worked variously in the soda fountain and in the card department. My mother later went back to work, and was the entire eighth-grade English department of the Branchbrook Middle School of Branchbrook, New Jersey. So I can diagram a sentence. I graduated from the public

schools in Somerville, New Jersey and went to college at the Wharton School, at the University of Pennsylvania. And I went to medical school at Yale. Yale is one of the few medical schools that requires a thesis for an MD, and I wrote my thesis on cystinuria, which is an inherited disease of amino acid transport that causes kidney stones and protein malabsorption. And my thesis advisers were Samuel Thier and Leon Rosenberg. The reason that might matter is that Leon Rosenberg later became dean of Yale Medical School and vice president of Squibb, and Samuel Thier was later president of Brandeis University, director of the Institute of Medicine, and physician in chief of the Massachusetts General Hospital. I was an intern at Stanford in California, in internal medicine, and I was a resident in radiation oncology at the Massachusetts General Hospital.

ROSEBERRY: What was interesting to you about medicine?

HALPERIN: When I was a college student, I wanted to grow up and be my uncle. My uncle, Nathan Jacobs, had gone to Wharton, had gone to Harvard Law School, and had been the director of the Alcoholic Beverage Commission in New Jersey. And he had been a delegate to the Constitutional Convention in New Jersey that wrote the state constitution in 1948. He had helped author the Judicial Act of the Constitution for New Jersey. And as a relatively young man, he had been appointed associate justice of the New Jersey Supreme Court. And he spent his career as a justice on the New Jersey Supreme Court. He wrote what some people think are landmark decisions, including decisions that desegregated the schools in New Jersey. And when I was a little boy, I wanted to grow up to be my Uncle Nat. So I wanted to go to Wharton like he did, and I wanted to go to Harvard Law School like he did. And about the sophomore year of

college, I came to the decision that lawyers spent a lot of their time getting people out of trouble they got themselves into. And that no one was likely to promise me a seat on the Supreme Court by the time I was forty years old. I might actually have to make a living practicing law and doing traffic tickets and house closings and divorces. And I thought, at the age of twenty, Maybe doctors spent more getting people out of trouble they didn't get themselves into. The distinction between justice and injustice and good and evil was more clear in medicine than in law. So I decided to go to medical school. And what was peculiar, I should think, was that I did not transfer out of the Wharton School. I graduated with an economics major from Wharton and went straight to medical school. I didn't go through a childhood crisis and decide to transfer into arts and sciences or transfer to a different school. I stayed where I was.

ROSEBERRY: And radiation oncology. How did that become?

HALPERIN: Radiation oncology is a very unusual specialty. It's one of the smallest specialties in American medicine. Almost nobody encounters radiation oncology as a medical student. It is very unusual for people of my generation to have found somebody who decided to be a radiation oncologist as a medical student. My story was that at Yale, you were assigned a faculty adviser. The faculty adviser was someone who was supposed to meet with you and check on your academic progress. These were voluntary jobs. I was, by the luck of the draw, assigned to Dr. Irwin Greenberg, a private practice psychiatrist from Waterbury, Connecticut. He would have a cup of tea with me once per semester. When I was a first-year medical student, first semester, he would say things like, "How's it going, young man?" And I would say, "Embryology is really hard." And Dr. Greenberg would say, "Embryology is really important; you have to study really

hard.” And I would say, “Thank you, Dr. Greenberg.” Second semester, “How is anatomy going, young man?” “Anatomy is really hard; what do you recommend, Dr. Greenberg?” “I recommend studying. It’s really important; you need to know your anatomy.” And for three years of medical school, Dr. Greenberg told me to study. That was his advice. And near the end of my third year of medical school, he asked me what I wanted to specialize in. And I told him I hadn’t really found anything I liked that much. That I thought I would be a pediatrician since that seemed okay, but I wasn’t really that enthusiastic about anything. And this private practice psychiatrist in Waterbury, Connecticut said, “You need to take a rotation in something called radiation therapy; it’s really hard.” I remember that. He said, “It’s really hard. It’s a lot of math and physics. That would be good for you. That would be a good specialty for you. Go take a rotation in that.” And I took a two-week rotation in radiation therapy and then later, in my third year or early in my fourth year, another two-week rotation. And that’s how I ended up in radiation therapy, what is now called radiation oncology, because a private practice psychiatrist in Waterbury, Connecticut must have seen something in a twenty-three or twenty-four year old that made him think that that would be a good specialty for me.

ROSEBERRY: So was that math and physics something that is appealing to you?

HALPERIN: Radiation oncology appeals to people on different levels. Many people like it because everybody has cancer, and almost everyone is dealing with a life-threatening situation. Some people like it because they are basically engineers or physicists at heart, and they want some way to use that body of knowledge. Some people like it because they are fascinated by computers and technology, and they want to use that. Some people like it because they like doing procedures. They like sticking

radioactive material in people and their tumors. Some people hate procedures and they like doing everything with the computer and at a distance. Some people like radiation oncology because they like research and want their time heavily scheduled and easy to manage. Some people like radiation oncology because they like the hours. Some because they like the income. What I was looking for as I was looking for a specialty in medicine where the stakes were very high. I kept looking for something where it was a high-risk specialty. Not high-risk in the sense of malpractice. High-risk in the sense of there being a lot at stake whatever you did. When I was seventeen and people said, Why did you want to major in economics? I would say, "Because the issues are consequential. Because the decision about guns or butter--the famous speech of Hitler in the 1930's: 'we can spend money on guns or butter,'-- the decisions about high employment or low employment, the decisions about how much to spend on roads versus national defense--I thought economics was very consequential. There was a lot riding on it. And I was somehow looking for a specialty in medicine where there was a lot riding on everything that I did. Thus, radiation oncology and thus why I ended up doing pediatric radiation oncology. Because within the specialty of radiation oncology, that seemed to me to be absolutely the highest stakes that one could engage in. Would the child live or die? If the child lived, would there be deformities? Would the IQ be normal? Would the boney skeleton develop normally? It all seemed to me to be a lot at stake.

ROSEBERRY: How did you come to Duke?

HALPERIN: At the time I was a resident, you had to do one year of medicine surgery or pediatrics and three years of radiation oncology. That has now changed to one plus four. But at the time I did it, it was one plus three. And I wanted to do pediatric radiation

oncology, and I was also interested in the problem of organ transplantation. At the time I finished my residency, what some people considered an exciting area of research was the notion that you could use radiation to the immune system to suppress the immune system and allow improved engraftment of heart, liver, kidneys, or pancreas transplants. And I was experimenting in human-to-human transplants and monkey-to-monkey transplants. And I also eventually became interested in the notion of transplanting from pigs to human, what is called xenotransplantation. And I had won the award given in the United States for the outstanding resident research project in 1983 for my work on the use of total lymphoid irradiation as an immunosuppressive for organ transplants. So, I was looking for a job where I could do pediatric radiation oncology, and where someone would be interested in my area of research, and I could continue that. The jobs that were available in 1983 were to stay at Harvard. I had a job offer to go to the Hospital for Sick Children in London, a couple of private practice jobs, a job at the University of Connecticut, a job at Yale. And the job I wanted was either to go to the Hospital for Sick Children in London, or to the Hadassah Hospital in Jerusalem. The man in charge of the Hadassah Hospital in Jerusalem never seemed to be able to return my phone calls or answer my letters. The Hospital for Sick Children in London offered me the job, and so I had now gotten my dream job, and I said, "And the salary will be?" And he said, "10,000 pounds." And I said, "Per?" And he said, "Year." So I did a quick mental calculation and calculated that I had just been offered \$17 or \$18,000 a year to go to London. And at that time, the chief resident made \$28,000, so I couldn't imagine taking a 40 percent salary cut and going and trying to live in London. So, Duke had just gotten rid of almost all their radiation oncologists. Duke had just hired a new chief of the division of

radiation oncology named Leonard Prosnitz from Yale. I had had Prosnitz as a professor when I was in medical school, and I interviewed for the job, which became vacant at Yale because of Prosnitz leaving, and the job that was being created at Duke because Prosnitz was coming. And Duke offered me a job doing pediatric radiation oncology and doing radiation induced immunosuppressive research. That was the good news. The bad news was it was in North Carolina, which struck me as being nowhere. It struck my wife as being very nowhere, and she couldn't imagine coming to this place, and she agreed to come take a look. But this seemed like a high-risk proposition to her to come to this place which was nowhere. But I took the job, and that's how I ended up here.

ROSEBERRY: How did you find Duke?

HALPERIN: My initial impressions of Duke were that it was very different from the Mass General. I had the impression when I was at Harvard that if the scientific idea had not been thought of at Harvard, then it wasn't a particularly good idea. That they were reasonably convinced that anything was really good and thought of there, and that there was a fair amount of binning. That people were placed in various categories. You will do this. You will do this. You will follow, and you will work in the queue, working your way up. But Duke had, as I said, had dismissed almost all of their radiation oncologists. Radiation oncology was a mess here in 1982 when Dr. Prosnitz came to take over. The number of referrals had fallen, the quality of the care was quite poor, and Duke was therefore wide open to remake the place in a way that we wanted. And thus, you had what was viewed as a first-tier medical center with very high quality surgical and medical services, and horrific radiation oncology. There was no place to go but up. I had told people at the time in the 1980s that the bus was new. It had gas in it, there was a driver,

and we just had to load it up and figure out where to go. Or I would tell people that it was like the way Will Rogers described the coming of the Democratic administration in 1933: that, compared to Herbert Hoover, if Franklin Roosevelt had set fire in Washington, the people would be thrilled, because at least he was doing something. So we would have had a hard time messing up when Dr. Prosnitz in Montana and Duncan and I came, because it would have been hard to get it any worse.

ROSEBERRY: Why was it in such disarray?

HALPERIN: Many people don't pay much attention to radiation oncology as a medical specialty. It is viewed, or was viewed at that time, as the button pushers in the basement. While between 50 and 60 percent of everyone with cancer gets radiation therapy as part of their therapy, radiation oncology was often the province of foreign medical graduates. People who hadn't found themselves someplace else. There was very small cadre of people who actually trained in it, and really wanted to do it. So, to answer your question, radiation oncology was often something that administrators didn't pay much attention to. It was frequently a division of diagnostic radiology, which was what it was at Duke, and it needed to be fixed. And at this point, you have to enter the story of Charles Putman. Charles Putman, of course, is well known in the history of Duke. Putman trains in diagnostic radiology and internal medicine at the University of California at San Francisco and elsewhere. He comes to Yale as a young faculty member. He happened to be the man who interviewed me for admission for Yale Medical School in the winter of 1975. He leaves Yale around 1977 to become chairman of Radiology at Duke. After being here for a few years, he turns his attention to fixing radiation oncology. And he recruits Prosnitz from Yale to come to Duke. And thus, Putman, who interviewed me for



admission to medical school in 1975, also interviewed me for a job at Duke in 1982. And when I came on the faculty, I was therefore a member of his department of radiology. Radiation oncology got fixed because eventually Putman decided it was time to turn his attention to fixing that. He had a lot to do with fixing diagnostic radiology, which the history of Duke clearly shows he did, and then he turned his attention to radiation oncology.

ROSEBERRY: It eventually became its own department; is that correct?

HALPERIN: Dr. Prosnitz's agreement with Dr. Anlyan when he accepted the job as division chief in 1982/83 was that eventually radiation oncology would become a department. In the history of Duke Medical School, there had been very few clinical departments which have been created. Since 1930, the only clinical departments that had been created was Anesthesiology-- used to be a division of Surgery. It became a department when Merel Harmel became chairman. Diagnostic radiology was considered a hospital service division. It eventually becomes a department. The only department which has, to my knowledge, been created in the clinical departments at Duke perhaps since 1960 or 1965 would be the creation of radiation oncology as a department around 1988 to 1990.

ROSEBERRY: And you eventually became chair of that department.

HALPERIN: Dr. Prosnitz was the last division chief of Radiation Oncology and the first department chair. When Dr. Prosnitz announced he was stepping down as department chair, there was a year-long search for the second chairman of the department. There were external and internal candidates, and I was selected to be the second chairman of Radiation Oncology in 1996. I had been very interested in fundraising, and helped raise

money for the Leonard Prosnitz Endowment to create the first endowed chair in Radiation Oncology. So I became department chair and the first Prosnitz Professor in 1996. I told Dr. Synderman my ideas, if I became chairman, for who I would appoint as the Prosnitz Professor, and he told me I wasn't appointing anybody. He was appointing the first Prosnitz Professor, and it was going to be me. And I also created at that time the Butler-Harris Endowed Assistant Professorship, which is, to my knowledge, the first chair at Duke that only can be held by a woman or underrepresented minority. And it is an assistant professorship based on the notion that you would recruit bright young people who would choose to come to Duke, and then progress to associate professor and full professor, and thus vacate the chair. And you could roll the chair over someone else to use it.

ROSEBERRY: What were some of the other visions that you might have had for the department as chair?

HALPERIN: In the period of time that I was department chair, the pressing issue was the condition of the physical plant. The average life expectancy of a linear accelerator for cancer treatment in the United States is about eight years. When I became department chair, the ages of the equipment ranged roughly between ten and twenty-four years. We had three aged linear accelerators which needed to be replaced. The machines were also the most heavily used machines in the state of North Carolina, based on data from the state office that oversees such things. I wanted, therefore, to replace the three old machines with five new machines. In addition, I was very interested in growing the radiation oncology business for Duke. And wanted to open a variety of, what were called at that time, satellite facilities: treatment facilities in Martinsville, Virginia; Asheville,

North Carolina; Greensboro, North Carolina; Raleigh-Durham Regional Hospital in Durham; even had notions of a facility in Naples, Florida. So I came to realize within my first year as chair that none of the groundwork had been done with the state for the filing of the Certificate of Need applications. And there was not in place a financing plan for such a large construction project. And I devoted a fair amount of my time as chairman to obtaining the certificates of need and to building a roughly \$28,000,000 building here in Durham and a \$5,000,000 building on the grounds of Raleigh Community Hospital. I may not have those numbers exactly right, but those roughly right. I also wanted to create an intraoperative radiotherapy unit: a lead-lined operating room in Duke North so that radiation therapy could be given to anesthetized patients while their abdomens and pelvises were open for tumorous sections. And that was another major project of my first few years as chairman. We took part of the side off of Duke North Hospital and swung these two thousand pound lead sheets in with a crane and lead-lined an operating area to create the intraoperative radiotherapy unit, which was, I think, the first one in North Carolina. The answer to your question, therefore: my vision was to build a new radiation oncology department in Durham, open a variety of satellite facilities, build a facility at Raleigh Community Hospital, build an intraoperative radiotherapy unit, and grow the research agenda. The Raleigh Community Hospital project was complicated, because there was a private practitioner there who didn't want to leave. There was a peculiar aspect of the purchase agreement between Duke and Columbia HCA which said that if there were unresolved disputes between Duke and Columbia HCA in the purchase of Raleigh Community Hospital, it would go to binding arbitration. And so I persisted in taking it to binding arbitration and by peculiar happenstance, the arbitrator found that

since there was not a clear statement about radiation oncology in the purchase agreement, that the contract with the private practitioner could be voided. And we won, in my view, not through any skill of legal arguments or persuasion about quality, but because of this peculiar aspect of the contract. And that's how we acquired the radiation oncology facility at Raleigh Community Hospital. So by the time I finished as chairman, we were the busiest academic radiation oncology department in the southeastern United States. To find a place of comparable size, you would have had to travel west to M. D. Anderson Hospital in Houston or north to the University of Pennsylvania or Sloan-Kettering. And we also ranked first in research presentations in the radiation oncology meetings.

ROSEBERRY: It sounds like that division and then department grew very quickly and became solid. And then---

HALPERIN: At the time that Dr. Prosnitz began, there were four attending radiation oncologists on the faculty. I'm sorry, five on the faculty at Duke. At the time that I finished as chairman, there were approximately fourteen or fifteen attending physicians, and then another twenty-six members of the faculty in Medical Physics and Cancer Biology. I had about forty faculty and about 190 staff.

ROSEBERRY: Did you have any thoughts about administration at that time, or were your plans to continue in Radiation Oncology?

HALPERIN: I became department chairman when I was forty-two years old. There was, of course, a tradition at Duke of very long-serving chairs. If you look at the history of Duke chairs, while many medical schools chairs turn over in four to six years, the original department chairs at Duke served thirty years. Duke's currently on the fourth chairman of surgery in seventy-six years. So Duke has a tradition of long-serving chairs,

but I did not envision myself as one of them. I did not imagine, when I became chair, that I would serve as chair for twenty-three years, and then retire as chair at sixty-five. I thought I would do something else. I was always interested in medical administration. I had taken a sabbatical at the time that I was about an associate professor as an American Council on Education fellow, and spent about seven months in a formal training program in academic administration. And I had published some articles in the realm of medical school administration and library administration, and so I had notions of doing something else.

ROSEBERRY: Tell me about the vice deanship in the School of Medicine and how that arose.

HALPERIN: When I was department chair, I had looked for two visits at the job as provost at M. D. Anderson Hospital. M. D. Anderson Hospital is a division of the University of Texas, so it is considered a separate campus. But during that search process, M. D. Anderson decided to get a new president, and they dropped the whole search. So much for that job. I had thought about looking at other jobs, but when Dr. Holmes, after a brief time as dean, left to go to the University of California in San Diego, there was, of course, a search for his successor. As I recall, there were about 150 candidates for the dean's job at Duke. And the two finalists were the outside candidate, Dr. Williams, and the inside candidate, Dr. Halperin. And Dr. Snyderman selected Dr. Williams. And I continued as department chair. After about six to nine months, Dr. Williams decided that he wanted to have a vice dean, and because Dr. Kaufmann had resigned as vice dean for education to go to the Wistar Institute in Philadelphia, Dr. Williams wanted a replacement for the vice dean for education. I was not interested in

that job. I did not want a job that only involved the schoolhouse functions. But Duke was facing a significant problem in 2002, and that was the economic problem that if you viewed each clinical division as a tub on its own bottom, there were considerable disincentives for some clinical chiefs to hire new clinicians. For example, if you wanted to grow the cardiology business, you needed to have endocrinologists to take care of the many diabetics who develop cardiac problems. But endocrinology doesn't make money by hiring endocrinologists, whereas cardiology does make money by doing cardiac procedures. You needed to have a system where there would be an incentive to hire those endocrinologists to grow the cardiac business, for example. So Dr. Synderman, Mr. Donelan, and Dean Williams decided they needed to have a vice dean who would worry about the clinical enterprise. That became an interesting job for me. So we created a job description in which I would be responsible for the eleven clinical departments. We're trying to deal with the log-jam in hiring clinicians, and I would also be responsible for the doctor of medicine program, the medical school library, admissions, financial aid, curriculum, the registrar function, and then a host of other projects that came along on behalf of the dean's office. That's how I became vice dean. The notion initially was that I would serve as vice dean and department chairman simultaneously for a year or two. That lasted about six to nine months, and it was exhausting to try to be department chair and vice dean. So we proceeded to announce a search for my successor as chairman of Radiation Oncology. I stepped down as department chair to be vice dean. Although throughout all of this, I never stopped seeing patients or working on my research projects.

ROSEBERRY: You were talking about those clinical departments as tubs on their own bottom and it was difficult to recruit endocrinologists to work with other endocrinologists, and I wondered how that was able to be resolved.

HALPERIN: The problems were most pressing in Neurology, General Internal Medicine, Endocrinology, some of the pediatric specialties, General Internal Medicine. The way we solved the problem was by use of the Building Fund. Many medical schools have what is called the dean's tax, in which a proportion of the clinical revenues are transferred to the dean's office for the good of the school. At Duke, we don't have a dean's tax. We have something called the Building Fund, part of which is paid by the Private Diagnostic Clinic for light, heat, water, for rent and part of which is paid as an academic enrichment fund. Money from the Building Fund can only be spent by joint consent of the chancellor and the Building Fund Committee of the Private Diagnostic Clinic. We created a system where carefully done proformas were created for key clinical hires. The Building Fund was used to subsidize those hires, and the individuals were expected to meet certain benchmarks for clinical performance. We created a system, therefore, which attempted to benefit the collective, even if it didn't benefit the individual division, by using a mechanism where we rewarded hires that were good for the group practice. This is not a unique idea, of course. Anyone in retail is familiar with this. It is called often in retail "a loss leader." For example, why, if you go shopping in a local department store, why do they have a greeting card department or a book department? They lose money on such items. It uses up valuable floor space. The reason the department stores have such departments is that they make money in ladies' cosmetics and in what are called a ladies' better dresses; there is more of a margin there.

They don't want you to leave the store to go across the street to Hallmark to buy a greeting card. They want you to stay in the store in order to do your business in the profit-making departments. In some ways, group practice of medicine is the same way. As a tub on its own bottom, you lose money on general internal medicine, or family practice, or general pediatrics, but you make money in the cardiac cath labs, and in cancer treatment, and in the operating rooms, and CT, and MRI. So you must be prepared as wise business person to take a loss in some areas to make money in others. Many health care decisions are made in families by the mother. Where the mother chooses to take the child for well-baby checks may determine where her husband goes for his elective colostomy. So you must be prepared in all those ways to convince the customer to come to Duke.

ROSEBERY: Now, is this something that the private diagnostic clinic membership was behind or---

HALPERIN: The truth is, it was mixed. Everyone who receives a subsidy is certain that they are under-loved and should receive a higher subsidy. Everyone is taxed is sure they are over-taxed and that they are subsidizing sloth. Some money-making departments don't like to be taxed to subsidize money-losing departments, and money-losing department don't like being treated like they're on welfare and being looked down upon by the money-making departments. It is, of course, has nothing to do with social value or justice. As a matter of justice, why should someone who reads CAT scans make more money than someone who treats HIV patients in a public clinic in Durham? You have no argument on justice to respond to that. It's not about justice. It just happens to be the way the economy works. Why should that person who takes care of HIV positive



patients in a public clinic make less than a short-stop for the Boston Red Sox? Who is of more social value? Well, my point is, that this is not about justice. I can't change the way the United States health care reimbursement system works or why the system rewards proceduralists more than cognitive specialties, but that's the way it works. And if you chose to pay your diagnostic radiologists 40 percent below market rate, you wouldn't have any diagnostic radiologists, so you have to work with the cards the way they are dealt to you in the economy. But, the answer to your question is, yes, there was considerable resistance and long debates, raised voices, anger, and considerable fights over the process I've described to you.

ROSEBERRY: How did that reimbursement process--I mean I know that that is dramatically changed health care, and I wonder if you can speak a little bit about how that's affected that process of kind of evening out--

HALPERIN: Well, the great crises of 1996 through 2001/2002 were that everyone was sure that managed care was going to change the face of health care. That Duke was in the sights of large managed care organizations, including Kaiser, and therefore Dr. Snyderman's notion of the unified health care system that we were going to buy St. Joseph of the Pines for home health care. We were going to buy Frye Community Hospital. We were going to take a lease or purchase Durham Regional Hospital. We needed to own our own pharmacy unit. We needed to own our own insurance company. We needed to have our own managed care product. And if you read the history of Duke in that era, it's all about responding to managed care, and it's coming to get us, and we have been coddled in North Carolina compared to California or New York because it hasn't found us yet, but it will inevitably come. And in many ways, we dodged the

bullet. The collapse of the managed care boom lit, and the collapse of the Clinton health plan. It never really got to North Carolina the way it got to other places in the state.

There were years where the average reimbursement from insurance companies to academic health centers were .8 or .9 of Medicare, whereas the private diagnostic clinic at Duke was getting 1.2 to 1.8 of Medicare paying on the insurance company. We did very well compared to other medical centers either because we were smart, or maybe because we were lucky. And a wise person once told me that in many ways in medicine and management, it's often better to be lucky than smart.

ROSEBERRY: What were some of the other issues that you were looking at in your role as vice dean?

HALERPIN: Number one was the Duke curriculum reform. The liaison committee on medical education gave a rather negative review of Duke under Dr. Kaufman's time at the watch. And Dr. Kaufman vigorously responded to that with the attempt to reform the curriculum. I inherited the process he created and saw through to closure 150 member committee, a major change in the Duke curriculum, the creation of new courses in the first year and second year, a major restructuring of the third year, and of new course material in the fourth year. And had to take that through the LCME Review, which we went through beautifully. I had to, as vice dean, face the issue of what was the future of medical libraries. People don't go browsing in libraries anymore. The library has become a very expensive warehouse for storing books. What would the future be of medical libraries? We created a plan for changing the library and created the first MD MLS program in the United States for physicians interested in medical librarianship. I dealt with the issue of standards in the medical school. We created the compact between

teachers and learners as a rule at Duke medical school. I was one of the first officers in the medical school in a long time to have expelled medical students, or put medical students on probation or suspension for academic poor performance. I thought it was very important to uphold the standards of the school, and they needed to mean something. We obtained a grant for what is probably one of the first randomized prospective trials on how to teach anatomy: the open access curriculum grant. That research is ongoing; it's a very exciting project about whether computer technology affects the way anatomy is taught. The saddest part of my time as vice dean was the suicide of a medical student in 2006. The risk of a medical student committing suicide in the United States is well known. It, of course, happens. There are articles in the medical literature. But it was something that Duke had not experienced for a decade. The most important thing you need to do in education is maintain a safe learning environment, and I failed in that regard.

ROSEBERRY: Tell me about Dr. Snyderman.

HALPERIN: I first met Dr. Snyderman when I came to Duke because I was interested in a project on immunosuppression, and he was very interested in the monocyte and had published a good deal there. So we had some small acquaintance in my work, in my lab work. Dr. Snyderman left for the pharmaceutical industry in California at the time that I was an associate professor and then came back as chancellor when Dr. Anlyan retired. So my principal encounters with him were when I became department chair. I had to give the annual report to the chancellor. I had to discuss with him the plans for the construction of the new facilities. I had to have approval for the expenditure of a certain amount of money to build the buildings. Dr. Snyderman is a widely read person, and I

thought that he enjoyed talking to me. When I became vice dean, we would meet in group session every Thursday and then we would meet one-on-one at least every three weeks in which we would to some extent discuss medical school business. And we would to some extent discuss what books was he reading, what books am I reading. What do you think about this issue? What do you think about that issue? And I think there is something about me or my personality that always would bring out the reminiscence part of Dr. Snyderman, where he would start telling me stories about his father, or his upbringing, or his early time as a house officer. I would view Dr. Snyderman as a friend and a mentor.

ROSEBERRY: Well, Dr. Halperin, it's closing in on three o'clock and I just wanted to ask you if there was anything that you'd like to say in closing out our time together. We've had a quick tour through your work.

HALPERIN: Well, for the purpose of documentation, there ought to probably be some time set aside in the future for us to do things like talk about Dr. Putman, Dr. Stead, Dr. Worde, Dr. Keenan, Dr. Peete. There are a lot of people that I knew or know. I say in the past tense because they passed away. That would probably be worth getting some recollections down because I actually knew them. There might be time you want to set aside to talk about the creation of Heritage Hall on the first floor and on the fourth floor, and how those came to be. We might want to talk about my research on the history of racial and religious discrimination at Duke Medical School. At some point, we should have a chance to record the hiring of Dr. Jacobs, the hiring of the first African American - the second African American department chair but the chair of Surgery was an issue of no small import, and one of considerable controversy at the time. And I was vice chair of

the search committee and I was vice dean at the time. That needs to be put down for some historian whoever wishes to tackle that. We might want at some point talk about the evolution of the seventy-fifth anniversary history book, and how that came to be. So I suppose we should say that this might end session one, and you'll put me down for a return engagement from Louisville at some point in the future.

ROSEBERRY: Absolutely. I want to formally wish you the best in your new endeavors and thank you very much.

*end of interview*