

Interview with Augustus White III, MD, PhD

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Equal Access Oral History Project

Interview 2 - 2 December 2014

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JOAN ILACQUA: Today is December 2, 2014. I'm Joan Ilacqua here speaking with Dr. Augustus White at the Landmark Center in Boston, Massachusetts. This is our second interview for the Center of the History of Medicine Civil Rights Oral History Project. Dr. White, do I have your permission to record the interview?

AUGUSTUS WHITE: Yes.

JI: Excellent. And in our last interview you talked about your experience with diversity and Brown University and you began to explore how that influenced your actions at Harvard Medical School back in Boston. So my first question today is about the executive committee of the combined Harvard orthopedic program. And really I'd love if you could talk about how the residency program changed during your time on it and maybe what you think influenced those changes.

AW: Well, thank you. I'm happy to be with you again and to continue with this project about which I have great

enthusiasm. And just to pick up on the Harvard combined executive committee, that committee was a number of things and among the list of things it was is a polite, reasonably intense, oftentimes somewhat disruptive, battleground. Having said that, it's a group of gentlemen and it wasn't only a battleground. It made a lot of good, worthwhile, useful decisions, but it was an interesting complexity of advocacy and opposition and various types of profound negative attitudes. And I don't want to paint it only as negative or mostly as negative because that would be inaccurate, but I think it goes, at least from my perspective, as I saw it, as I lived it, it was clearly a battleground. And there were all the issues of how many residents went where when and who was going to come in the program and not come in and who was pleased with the ones who came in and displeased with the ones who came in and who felt like they lost in someone that they advocated for. And did that carry bitterness? Yes, it did in some cases when it shouldn't have perhaps. So those things were going on and here I come along, not the only one by any means, but I would mention Dr. Henry Mankin as another person who was concerned about this issue of diversity in the residency program. And I was concerned about it for lots of reasons. I always wanted to advocate for trying to help

others, African-Americans and women and other minority groups, to come to the table and to have a chance to be able to move forward. And again, I don't by any means claim to be the only person doing that, but that was always part of my agenda and I guess that wasn't any surprise to anyone else and I guess probably every time I opened my mouth I guess they assumed OK, what's he going to say about it this time? And probably assumed that's all I ever thought about or cared about, which obviously is not the case.

But here we are. So I was motivated for lots of reasons. Even I had a mentor, Dr. Montague Cobb, I may have mentioned him earlier, a distinguished African-American scholar and leader, civil rights leader, and I had the good fortune of having him as a mentor and we spent time together. And one of the things he espoused and addressed everyone with, he said, "You know, you've gotten through, you've come through and you've had opportunity to move along, you want to make sure you do everything you can to help others to do the same." So it was something that was part of my business on the executive committee. And then I had all the other responsibilities of advocating for the Beth Israel as it competed with Mass General and Brigham

and Women's and Children's Hospital for residency slots. Although it was a combined program it was still lots of negotiations within the combined program for protecting one's turf as it were. So what I think I brought from Brown was confidence that this is the right thing to [00:05:00] do and confidence that it's right in terms of it's in everybody's interests. It's not just in the interest of women or minorities or to get a piece of the pie, but the whole society works better, I think. So that's a given. People write about that all the time and I think that's something that one had an opportunity to advocate for.

I don't want to leave the executive committee topic without trying to make certain that it was not all negative, it wasn't just a battleground, as I've said. It wasn't just diversity that was contentious, but it was a part of it. And it's a little unusual too in that most orthopedic departments have one chairman, one leader, and one ideology if you will, so it's easier than to have four people who individually each have their personality that would get them to being the chairman, I guess, and the competitive spirit and advocacy and so forth, independence. But it worked and the program survived. It's recognized as one of

the best in the country. So that's what I would say about the executive committee. Maybe thoughts will bring me back to that at some point.

So what about the Oliver Wendell Holmes Society? Shall we go to that now or do you want to follow up on anything that I said about the executive committee?

JJ: No, I think it's a great transition to the Master Holmes Society. So you had mentioned the last time you had become the president of the society and I was wondering if you could just describe that experience. How did you become president? What did you do once you became president? What sort of changes did you make?

AW: Harvard Medical School I think was the first, under Dean Tosteson, to establish the society program. And the way I describe it is the medical school is the incoming class, each incoming class is divided into five equal groups, so to say, and each of those groups goes into one of five societies and the students remain there throughout their medical school career and throughout to their graduation. And the way I think of it, I don't know what the charter says, but I think of it as the society's role is there to be supportive of the students and to help them in their professional development. You know, not the science and

the biochemistry, I mean help with that too, but their professional development in terms of their attitudes, ideas and ideals, understanding and insight, ability to cope in the profession. And so the societies usually have a master who's the leader and the person who's there and several associate masters. And these are usually senior professors and they work with the students, provide -- to be available and to guide and counsel them. And one of the major benefits, I think, is that when or if the student gets in trouble, of whatever sort, whether it's personal or whether it's professional related to their schooling, there is a faculty member who knows them as a student. And that's very, very helpful. It gives a very positive jumpstart in terms of problem solving and advancement and so forth. The other thing is that you don't grade the students in any way and you're not there to judge them, but rather to help them to move along through the various issues that they have.

And I don't know how to compare myself with anyone else really in terms of my quote, unquote interest in the professional side of medicine or interest in the humane side of medicine or interest in the philosophical side of medicine. I really don't know how to compare myself. I can tell you that I've really enjoyed and got excited about

the teaching that I had that related to that and coincidentally I think it's a pretty rich heritage. And I didn't create it, I just stumbled into it, so I don't feel self conscious bragging about it. It just was there. What I'm alluding to is Stanford Medical School. It's a small school, 60 students, and it just so happened they had a collection of professors who really enjoyed [00:10:00] teaching, enjoyed medicine, enjoyed the humanitarian aspects of medicine, the humorous aspects of medicine, and they came from a rich heritage in that regard. In particular Johns Hopkins. Johns Hopkins, we all know, is sort of the center of America's richest heritage. And for example, one of our professor, the professor, senior professor of surgery at Stanford, gave a wonderful lecture. It was only two hours long, but he gave it many times and it was called Reminiscences of Osler, Cushing and Halsted.

Now, you're not a historian, I'm not either, but if you spent years studying American medical history three of the greatest icons, the greatest luminaries, were Sir William Osler, Halsted and Osler [sic]. Osler, Halsted and Cushing. And so Professor Holman gave the lecture called Reminiscences and he talked about some of their philosophy, some of their maxims and much of their teaching, some of

their humor, and it's a fantastic lecture. He also, Dr. Holman, trained Professor Richards who was one of my heroes and one of my mentors at Stanford who was a wonderful, wonderful surgeon and a great, great teacher. And he taught that whole heritage from -- and the heritage, the surgical heritage in particular, Halsted, and trained Dr. Holman who trained Dr. Richards who trained us as medical students. So this was up front in my thinking and I enjoyed trying to share that. And students ask me now for advice and I lean very heavily on that heritage and in particular, I mean there are several things that I tell them, but I almost always include the following which was the teaching of Sir William Osler. Sir William Osler gave a lecture to Yale medical students in 1913, graduating Yale medical students, called the Silliman Lecture Series.

And in this lecture he said, "I'm going to tell you a number of things and one of the things that's most important I'm going to tell you and you're probably not going to believe it, but I think it's so important that I'm going to share it with you and it is the following." He said, "You may think that I'm something special as a visiting professor here, a professor of medicine, and I've been professor of medicine at Johns Hopkins and at McGill

Medical School, at Oxford Medical School and at University of Pennsylvania. I've been professor of these schools and I've written actually the definitive textbook of medicine and you may think I'm something extra, extra special, but let me tell you, the way I've achieved this, I'm going to tell you how I did it, but I'm not genius. It's not that I'm any genius, but here it is and most of you aren't going to believe me, but I'm going to tell you anyway just in case even one believes me. And I've followed a very simple dictum to achieve all of these things and the dictum is do today's work today. Don't agonize about yesterday, don't fear tomorrow, just do today's work today." And there's a whole lecture that he gives on this. And so that's what I always tell students. So I say all that to say that to have a chance to be master of the Holmes Society where my job is to talk to students, I really, really got into that and enjoyed doing that. And it was a natural talking about diversity and talking about the humanitarian aspects of medicine and philosophy of medicine and so forth. And along comes this huge problem of health care disparities and 13 groups people in our society experience disparate care and what are we going to do about it? What can we do about it?

I don't know if you may remember in the book the little incident of the young woman that I sat next on the airplane who had total body tattoos except for her neck and her hands and her face. And in the course of conversation -- I don't usually talk to people on the airplane. I usually save that time for reading and so forth, but somehow we ended up in conversation and so at some point she found out that I was a doctor and she kind of reared back in her seat and got this forlorn [00:15:00] look in her eye and just kind of stared out into space and said, "I just hate to go to the doctor's." And it was just dramatic. I mean it was very striking. So I said, "Why is it?" And she kind of paused again and took a breath. She said, "They just treat me so badly. I'm a tattoo model, I have total body tattoo and they just treat me" -- so I can just imagine what happens. She's in the doctor's office and she takes off her clothes to be examined and the doctor just goes berserk. You know, Joe come in here. You know, he goes out and brings in other doctors to see her and show her. I mean she didn't need to tell me anything else, but I just felt really, really bad about that. And so I decided it's time to try to do something with these health care disparity issues.

So I talked to Dean Dan Lowenstein who was very supportive. Oh, by the way, how did I get the job? Within the school, within the medical school, they do a search to replace and Dan [Goodenoff?] who had done the job for many years wanted to pass on to something else. And so he decided to step down and so they had a search committee and they looked at, I guess, a number of people and Dan Lowenstein asked me if I would consider putting my hat in the ring to be considered for the position. And for all the reason I'm talking about it, it certainly suited me. And I had decided to phase out of clinical surgery, clinical work, at that time. And so anyway and happily I was so thrilled I had an opportunity to do the job. So I looked around and I got stimulated by this woman, and I had been sort of getting more and more curious and concerned about health disparities anyway. And so I asked Dr. Lowenstein -- you know, I took the job, got started, and I said, "What can we do? How can we get started to doing some things with health care disparities?" And he said, "Why don't you collect several people and put together a committee and get started with this?" so I jumped in with great enthusiasm and we ended up working hard with lots of people who were already interested, already concerned, already wanted to work, and we put together this huge committee with all

kinds of sub committees looking at different aspects of it, etc. So that's the way that got rolling and we continue to roll along with that. And I think I gave you -- did I give you a report of that committee, you know, that committee's work? The history of that over several years at Harvard Medical School. So that's kind of -- am I up to date? Is that enough?

h, I guess the other thing is, I don't know if this is recorded anywhere or not, if it matters, but I think I was the first African-American -- I know I was the first African-American to ever be a master of one of the Harvard academic societies and I was happy to be able to function in that role. And I enjoyed mentoring students as well as just talking with them. So is that enough of an answer on that question?

JJ: That's a fantastic answer. And even to speak for as long or as short as you'd like to these questions. But you set up actually a great segue into talking about culturally competent care and how that's taught to students. And I think you had some influence on how we're thinking about that now and I was wondering if you could elaborate.

AW: OK, let me just digress for a minute. Influence. I intended to mention this and I think I told you earlier

that there are a lot of reasons I have interest in history and one of the reasons is I'm a little bit paranoid. And as they say -- there's a great psychiatrist, Price Cobbs, African-American psychiatrist, great psychiatrist, said -- I can't think of the book he wrote now, but it's a great book. If you want I'll look it up. But I had a chance to meet him many years later. But anyway he says if you're African-American in America and you're not paranoid you must be crazy. So I guess I'm paranoid. So I guess my paranoia makes me a little bit -- feeds into my enthusiasm for history. I feel that African-American history [00:20:00] has a phenomenal ability to get lost and overlooked and that's one of the reasons I'm so happy that you and your group at Harvard is willing to not let that happen. I think it's so easy for all the reasons, you know, people just don't think. I mean that's just the way we are. It almost goes with white privilege, unearned privilege. It's kind of the end of that spectrum. If you're a great recipient of unearned privilege how could you be expected to be concerned about some other group? So it fades away.

So having said that, there are a couple of -- one thing I want to find. And I'm looking it up and I'll give it to you, but it meant a lot to me. I had a conversation with

the dean, not our present dean but the past dean, Dean Joe Martin, who was an early outspoken advocate in his deanship and stayed supportive of diversity. And anyway somewhere in our correspondence after he retired, somewhere he said, "After talking to you I put diversity in our mission statement." And I remember very much wanting him to do that and it meant so much that years later I wrote him. I said, "Joe, I have this idea and I don't want to make it up. Am I correct, did you say to me" -- so anyway I've got the two emails and I'll show them to you. But it also connects with the fact that Howard Swearer accepted my suggestion that Brown bring in an outside visiting committee. So it just meant so much to me that that was part of it. And it brings us back around to the issue of diversity in the medical school. So back to your question now, where are we?

JJ: I think my question was basically if you read your book, your memoir *Seeing Patients, Unconscious Bias in Health Care*, there's a lot in there about the fact that medical professionals aren't necessarily seeing what their biases are and they need to be aware of them in order to properly care for and tend to their patients. And that there is a focus that that is being taught in medical schools, that students should be thinking about it and it should run with them through their career. And you talked a lot about your

relationship with the students and mentoring the students and I was wondering if you had experience teaching this aspect of care to students in their medical careers. But that's really a jumping off point for any answer. It doesn't have to be a definitive --

AW: Yeah, I understand. I mean I worked -- as master of the Holmes Society, as master of any society, you are thrown into the bowels, the real internal functioning of the educational aspects of the medical school. So you're sitting on all these ad hoc committees and people are talking about this and how to do a good discussion session, how to run a -- you can give a lecture, you know how to give a lecture, or your job may be to run a seminar, a symposium or discussion group, and that was the teaching method of Dr. Tosteson. So you learn those skills, so you talk about those skills and you talk about how to best do that, and you get involved with the admissions committee a little bit and you get involved with the committee of students who are in trouble, who may for academic reasons or for other reasons may be at risk to be leaving the school. So you sit in on those. So you're right in the heart of the medical education enterprise of the medical school, which is phenomenal. It's exciting, very challenging. In the midst of all that is yeah, the health

care disparities and students need to be taught cultural competence. And we don't know exactly how to teach that and none of us were ever taught that as faculty when we were in medical school, [00:25:00] right? So it's not a slam dunk by any means.

So there was a chance to latch onto that. Other people who were enthusiastic about it were involved and you see their names on the committee members that participated. So I worked on this committee and I tried to produce materials that would be related to moving the agenda in whatever way we saw fit. And as I said, many people weighed in. And that momentum is still going. I think I must have sent you a copy, maybe not, of the paper we're trying to publish, self awareness, submitted to the *Academic Medicine Journal*. So that's one spin-off from these things and there's a lot more. And of course the center that Joe Betancourt has led at Mass General is exemplary, and somewhere between that and Johns Hopkins that's probably the most advanced institutes of culturally competent care education in the country. I don't know that as a fact, but it's close. I mean in fact, Mass General won an award for its success in providing equitable care and Joe is highly credited for that. And he's a minority dude too, you know. And by the

way, I've been giving you names and so forth, but I've just been giving you African-American. I guess we're doing that first. Maybe you'll do the Latino another time or --

JI: No, we're --

AW: Are you working on that already?

JI: We're working on everyone concurrently.

AW: All right. Well, Betancourt and Alex Green and others are the major players there. And yeah, it's very exciting and very important, but there's so much inertia and so much difficulty. And I am not cheering for -- well, let me -- how should I say that? I think we've made phenomenal progress given where we started. We being Harvard Medical School. But it can be and should be and is already in many ways the best medical school in the world. However, there is not the commitment to excellence in providing equitable care that exists for so many other areas of medicine. And we're amiss in not doing more of that better. We should be working just as hard as we are on these other programs. Even the fundraising. I mean I don't think that -- and they're going to give me a little time in court, I believe, but the fundraising doesn't, in my opinion, have enough emphasis on trying to get support. I believe there are many people out there who are willing to support equitable health care, willing to say that women should get the same

health care that everybody else gets, or old folks, elderly folks, their grandmother and grandfather should get the same help, right? I mean that's not a hard sell. But somehow it doesn't get that level of importance. Sooner or later it'll come.

School of Public Health just donated \$350 million -- you know about that? And somewhere in their mission they talk about global understanding and global working together. And I think there's a place to allocate some funds to say how can we better more thoroughly educate our students and our faculty to teach culturally competent care and to provide equitable care. And as you know, I sent you the thing we did with *US News and World Report*. That's floating out there and so forth. It's there. So how did I get off on that? We're doing good, we're doing more than we did before, we're making progress, but we're not doing enough, in my opinion. But it still has good momentum and we should continue to work very hard because it's part of the humanitarian mission of us as physicians and caregivers.

JJ: Excellent. So those are really the questions that I had set aside for today. I'm curious if -- are there any other stories that we haven't gone over that you think should be

included in [00:30:00] this project? It's a very off the cuff question to hit you with but --

AW: No, I hear you. It's a very sensible question. Well, I don't know the whole story. It's not so important, the details of the whole story, but clearly part of the history of Harvard Medical School, particularly when you're talking about issues of diversity and cultural competence and equity and cultural literacy, has to do with this story which I don't know if you've heard it. It's an anecdotal story, but it's true. There was a Halloween party back during the time of the Anita Hill/Clarence Thomas hearings. Do you remember all that excitement? Be worth checking when it was. But it came right down to the hearings when they had all these Yale professors in there testifying one way or another and things were going, but basically Anita Hill called out Clarence Thomas for sexual harassment. Believe it or not -- geez, I'm just thinking about the whole situation now with Cosby and so forth. But it was not a rape accusation, it was just sexual harassment. Anyway that was going strong, all over the television and so forth, and a Halloween party. Two Harvard medical students, speaking about cultural literacy now, how educated -- they must have been a little bit educated, they got into Harvard Medical School, but two Harvard medical

students showed up at this Halloween party, white students, with blackface as Clarence Thomas and Anita Hill. You haven't heard this one obviously.

JI: No.

AW: So and there was a young black medical student there who was very upset, thought it was inappropriate and asked them to leave the party. And they sort of didn't leave. They stayed at the party and he left. He said, "I'm leaving but when I come back I don't want to have to come back and see this. It's just not appropriate." Whatever, something like that he said. So he did come back and they were still there and there were words exchanged again and he ended up attacking -- the black guy attacked the white guy. And it was all over the newspapers and everywhere. And that stimulated Dan Goodenoff, who was a professor of cell biology and one of the creators of this course on self awareness, and he was on the vanguard of getting things moving. This was before I came in to the society. Anyway he got the dean to support some pretty extensive research that he did with the help -- in fact, they hired a psychologist named Roxana Llerena-Quinn -- I'm giving you her name -- and they worked together and they did a kind of almost like a corporate research analysis of look, we have a problem here, how do we address this problem that was

just represented by this incident? And so Dan did a lot of work. I think he's written some of it up, but he did a lot of work. And it was to a large part that this course evolved out of the work that he did. He was disappointed again, the resources were not as much as he needed. So rather than doing these broad or corporate cultural change of the medical school I think there was that kind of more grandiose approach, but the money ran out. He can explain it better than I can, but it's something like that. And so but what did evolve was this course on self awareness and how to explore one's biases and prejudices and so forth. So that's a part of the civil rights history of Harvard Medical School. It would be interesting to look at some of those newspaper articles which I've never seen.

And there's something else that should be on your radar screen and it's something called the incident reports. And this was something that actually sort of came out of some of our committee meetings and some of our activities around issues of equitable care and cultural sensitivity and cultural competence and so forth. And the incident reports were a series of reports published in what was something called *The Focus* which was a publication of *Harvard* magazine. And we have all those collected. There are

about 12 or 13 of them. [00:35:00] And what they are are something that occurs in the hospital that is woefully insensitive, like Clarence Thomas and Anita Hill in blackface essentially. Not quite that dramatic but -- and then the idea is the story is given anonymous as to who the perpetrators were and who the subjects were and then a faculty member writes a comment about it which is intended to be educational and intended to have the perpetrator know that they were perpetrating, if you will. And it's really very, very good. And the thought was -- also they probably gave a little bit of catharsis to the people who were experiencing -- the victims. And it was ultimately though, bottom line, to be an educational experience. The comment by the faculty member, which was known, named, not the one who did the offense if it was a faculty member. Could have been a resident or -- anyway you might want to look at those. The reason they were done and the intent and how much -- we don't know how much good it did, but it had to do some good. And a lot of people don't realize. It also tells you that, again, intelligent, well educated people do have these horrendous blind spots. So the incident reports I think you might want to look at. How were they used? We're still trying to figure out how to use them, other than the fact that they existed initially I think was

useful, but you can't measure the outcomes. I'm sure there are people who read those things and said, "Gosh, I might have made that mistake. I don't want to do that. I don't want to harm anybody that way." So I think they were very, very useful.

So that was something that we were engaged with getting going, getting started. They stopped printing that particular publication, but they also stopped doing the incident reports because they said, they meaning the publication people, said that they didn't have enough faculty to write the responses, the educational responses, which needed to be thoughtful and clear and so forth. But you might want to flip through some of those and see what you think of those. OK, where was I?

JJ: I'd asked if there were any other stories you thought we should include.

AW: Oh, stories, anecdotes, yeah. So I gave you Clarence Thomas and Anita Hill. I gave you -- you know who will have a lot of stories for you is Alvin Poussaint. My goodness, he'll have stories. I mean the Cato Laurencin, Alvin will tell you about him. Cato was a -- he's now an orthopedic surgeon and he was a cum laude, magna cum laude, graduate of Harvard Medical School and graduated MIT with a

PhD from MIT. And he wasn't given -- there were some scholarships around to study in those institutions and do research and somehow he applied and was not granted the scholarship. And this is something that Alvin should explain, but Alvin Poussaint intervened saying how could he not get a scholarship given whatever his credentials were at the time. And so the dean -- but Alvin apparently was about to lay his job on the line about this so the dean revisited -- this is Dean Tosteson at the time -- revisited the whole issue and they decided to go ahead and give Cato a scholarship. And as I said, he went on to graduate magna cum laude with excellent marks in his PhD thesis. And Cato said -- one of the classes he took at MIT, the first class he went in and he was coming in and sitting down, getting seated, and the professor came over to him and said, "This is math 305, are you in the right class, sir?" You know. But those kinds of things happen and that's an incident report. That was before the days of the incident reports, but that would have been an [00:40:00] incident. But Cato's done very well. He's done well in his career and all. And I think he'll be an interesting interview if you get around to him.

JJ: He's on my list. I recognize his name.

AW: Yeah. OK, let's see. I don't think of any other anecdotes at the moment. Let's see if anything happened to me, what happened to me? You can decide if you like it, you don't like it. Let's see, how should I explain it? Bottom line is someone was calling my home with a number of sort of racial incidents anonymously and it went on for, I don't know, several weeks. And it gradually escalated into threats. I don't probably get the language, but you know, sort of obscene language mixed with threats. So I reported it to the Beth Israel Hospital and they really got on the case. They got detectives involved and got the hometown police involved and worked very, very hard to solve the thing. And I've talked to my administrator, the administrator in the department, and also there were some anonymous letters written to the dean saying that I was a bad guy, bad doctor, gave him terrible care. And somehow my administrator connected the dots that this might have been coming from a patient that I had. And I can't -- well, so what I think happened was that he came to me, I evaluated him, took care of him, operated on him, clean, crisp, fast, easy case, herniated disk, appropriate diagnosis, surgery sort of removed the problem and he should have been happy and pain free by all standards. And he was, in retrospect. He was still in the hospital and he

was doing fine, but then at some point in the hospitalization his attitude changed tremendously. And I wouldn't have thought of that unless my assistant had alerted me that this guy seemed disgruntled later on.

Anyway so we thought that that might have been the person, but we didn't know, we couldn't prove it. And so I'll tell you how we solved it and I'll tell you what I think happened. It turned out that we had this guy as a suspect, so the police, the detectives, decided to -- he attached some letters and they decided that they would try to get to his house to see if his typewriter matched the typewriter on the letter. So they hired two -- I mean this is like something out of a movie. They hired two attractive young women to go to his house and say they were doing some survey of typewriters. So they asked if he had any old typewriters and they were really interested in trying to -- anyway he let them take his typewriter and type some things and look at it, and so it matched. So they confronted him, the police and the detectives confronted him with this. Anyway, make a long story short they said you can press charges and go to court and do all that or we can just tell him he darn well better shape up and desist from all this. So that's what happened. We didn't press charges, we

didn't -- what I think happened was -- and I don't know what happened, but he was happily going along, we were working well as doctor/patient, but in and around that time I had a book published, I had a TV appearance or somehow I think, and I don't know if this is right or not right, but I think he didn't know when I was -- that I -- [00:45:00] that his surgeon was black. And I think he saw whatever the publicity was that he saw he found that out, he just went berserk, he just went crazy I guess. That could be 300% wrong, but I can't think of any other explanation to explain him going from a patient in a lot of trouble, right diagnosis, right treatment, good outcome initially, and then all of a sudden the outcome goes bad and all these other things go on. So if you want an incident report there's one for you. But there was never any trouble after that. I mean he was quiet, but that was the way that happened.

JJ: Wow. Do you recall around what year that was? When was this happening?

AW: We could look it up. It was --

JJ: Just ball park.

AW: Yeah. I can ask my wife. She's probably better. She'll swear she knows the exact year, but I'm going to say, I

want to say '85ish, something like that. But we could do better than that. Precision.

JJ: That's fine. I'm not here to get a perfect chronology but --

AW: Perfectly reasonable question. I mean I'm terrible with -- you haven't noticed yet, but you will, I'm terrible with remembering dates and years and so forth. But yeah, we could find that out.

JJ: Part of history is the chronology and dates and the shining of knowing of time period, but a lot of it is what you recall and what you talk about and sort of stories and overarching changes. So you don't have to worry too much about the dates. They don't worry about that too much past high school.

AW: OK.

JJ: But so if I can keep you for one more question --

AW: Yeah, sure. Like I said, I want to get this done. I'm with you.

JJ: So I'm wondering, after living and working in the Boston area and at the Harvard Medical School and the associated hospitals, what do you think your legacy is here?

AW: Oh, my.

JJ: It's the biggest question. Or it might be better to phrase it as what do you hope your legacy is?

AW: I would say something like the hard working guy who wanted to be the best doctor and the best surgeon he could possibly be and provide humanitarian care for his patients. And contribute to the field of spine surgery and make some kind of contribution to social justice through humanitarian care and social justice or humanitarian care, social justice. Yeah, societal contributions around issues of race and ethnicity. Yeah, something like that.

JI: I think a lot of the stories that you told me between this interview and the last interview reflect all of that.

AW: I don't know if I said anything about education. Put in the parenthesis at the end of that statement education. Where did I see some -- no, I can't remember right now, but if I find -- I saw a much shorter iteration of that somewhere recently, but [00:50:00] I can't remember. But I'll give it to you at some point if I find it. OK, so is that it for today?

JI: I think that is it for today. Thank you so much for taking the time to speak with me.

AW: My pleasure. I enjoyed it. So we'll keep going here.

[00:50:23]

END OF AUDIO FILE