Cooperstown Graduate Program
Research and Fieldwork Course (HMUS 520)
Oral History Project
Fall 2016

Interview with Dr. Marc Heller by Erin Russell

Interviewer: Russell, Erin
Interviewee: Heller, Marc
Date: November 19, 2016
Location of interview: Dr. Heller's Home, Cooperstown, NY

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Description:

Dr. Marc Heller was born in Westchester, New York in 1948. He is a retired board certified obstetrician/gynecologist (OB/GYN). Dr. Heller first came to Cooperstown in 1973 as an intern at Mary Imogene Bassett Hospital. He worked at the hospital for thirty years and acted as chief of their OB/GYN department for eleven years. In 2003, he left Bassett due to pushback he faced for performing abortions. After leaving Bassett, he worked at Planned Parenthood Mohawk Hudson for twelve years as Medical Director. During his career, Dr. Heller delivered babies, explained birth control options to women, and performed abortions, in addition to other services.

During this interview, Dr. Heller discusses the influence of 1970s feminism on his practice and the field in general. As a result, doctors started encouraging breastfeeding and granted women more control over the delivery process than before. Many types of birth control were discovered and developed during this period, including controversial ones such as Dalkon Shield and Depo-Provera. Dr. Heller also reveals some of the difficulties he faced because he performed abortions, including backlash from colleagues, incidents with protesters, and the isolation he felt from the medical field. New York State

legalized abortion in 1970, before Dr. Heller started practicing medicine. In the decades that followed, Dr. Heller claims protestors became more violent and active. During this interview, he also mentions some issues he faced that are specific to rural healthcare. Ultimately, Dr. Heller was drawn to being an obstetrician because of his interactions with patients and their stories.

In the interview, we also discuss his relationship with his mother and father and how it shaped his future career choice. He also touches on his alcoholism and recovery.

I interviewed Dr. Heller at his home in Cooperstown, New York on November 19, 2016. Dr. Heller felt that sharing his experiences and stories was especially important in light of the current political climate in the United States. He does not speak as a representative of any of the institutions mentioned in the interview, but as a private citizen.

In the transcript, I edited for grammar and eliminated false starts unless I thought they contributed to meaning. Researchers are encouraged to consult the audio recording in order to get the full sense of the interview.

Key Terms

Bassett Hospital
Cooperstown, NY
Rural Healthcare
Obstetrics/ Gynecology (OB/GYN)
Medical school
Feminism
La Leche League
Birth control
Rural Healthcare
Abortion
Depo-Provera
IUD
Planned Parenthood
Protestors
Alcoholism

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MH = Marc Heller
ER = Erin Russell

[START OF TRACK 1, 0:00]

ER:

This is the November 19, 2016 interview of Dr. Marc Heller by Erin Russell for the Cooperstown Graduate Program's Research and Fieldwork course, recorded at Dr. Heller's home in Cooperstown, New York. So, Dr. Heller, how did you decide to become a doctor?

MH:

I was a sophomore in college and I had the opportunity to get a job as what was called a prep orderly. What I would do is shave and give enemas to patients the night before surgery and I liked it because I found that by being kind it made a big difference to those people who are really in a very vulnerable situation. I started out as an engineer and had various possible careers, but I was also allowed to observe some surgery and I thought this is really interesting. I met a guy who was going to medical school and it felt like an exciting thing to do.

ER:

Tell me about your medical training.

MH:

After college, I went to the University of Buffalo Medical School and that was for four years. Then I came to Cooperstown in 1973 and I was an intern for one year.

Then I was a resident for four years and then I went to England for a year to study pediatric gynecology, which was mainly about developmental defects.

ER:

Can you tell about your time in England a little bit more?

MH:

The time in England was not all that satisfying honestly, because it was a much more different culture. It was hard to get adjusted to. The medical profession there was extremely hierarchical. Informed consent was really not even an issue. It was an interesting cultural experience more than a medical experience of living in a different culture, because my father fled from Vienna from the Nazis in 1939. He was Jewish and I came to understand how hard it is to adapt to a new world.

[TRACK 1, 2:52]

ER:

How did you make the decision to specialize in obstetrics and gynecology?

MH:

I think that I liked it at first because I was happy and it was a happy specialty. It was about life and delivering babies and women in general were happy. I had a mother who was a very kind and loving woman. I think that it was her unrestricted love for me that made me comfortable around women. I had a rather difficult father so that pretty much explains it I think.

ER:

How did you come to work at the hospital in Cooperstown?

MH:

My mother was dying of cancer, colon cancer, and happened to come across an article in *Time* magazine about [Mary Imogene] Bassett [Hospital] and she sent it to me. Also, there was a friend of a friend who lived here as well. So I applied for what was called a rotating zero internship and what that meant is that we spent a few months, or a month and a half, on every single specialty. So that's pretty much the answer to that.

ER:

What was that like, going through all the different specialties?

MH:

It was great, because I got a broader perspective of medical practice in general. I retained that sort of broader perspective throughout my career. I think it was a very critical thing because I didn't focus only on the gynecological aspect of women's health, but gained a more holistic view.

ER:

What was the hospital like when you arrived?

MH:

The hospital was a very small, insular institution with 25 doctors, attending physicians, and a few interns at each level. It was quite provincial in those days. Women's health in particular was difficult for women. For example, they were strapped down to the delivery table with leather straps on their arms and legs. They were given enemas without—they had no choice. Breastfeeding was discouraged. Women were given shots of large male hormones and their breasts were bound. And the babies were taken away from their mothers and put in the

nursery except during regulated feeding times. Otherwise, I would say my overall experience though was a good one. There were a lot of kind physicians and we got a lot of attention.

ER:

What was it like working specifically at a teaching hospital?

MH:

An important part of our experience was education and I think that I was well educated. It was a lot of one-to-one attention. It wasn't like being at a huge hospital where you were sort of lost. There were a lot of doctors who cared a great deal about education and a lot of doctors who were interested in us, but it was small.

[TRACK 1, 7:08]

ER:

What was it like being a man and working with women?

MH:

First of all, it was pretty much only men working with women in those days. For example, our medical school class of a hundred, it was the first time in its entire history that they had admitted more than one woman and there were three. I always felt more comfortable about being around women than around men in this world and our culture. So I thought it was comfortable as long as one was respectful and the other thing was in those days there was active feminism, *very* active feminism, which made some big changes in medical practice and as long as

one was respectful and even if I couldn't give them exactly what they wanted I think it worked out well and I think my patients felt that as well.

ER:

Can you talk some more about the active feminism and how that changed things?

MH:

Yes, it changed things a lot. There was for instance an active La Leche League in Cooperstown. I collaborated with them. We got more women to breastfeed. We didn't force them, but we supported and they, specifically not we, supported breastfeeding. They had meetings. They had troubleshooting for women supporting them to breastfeed. Women said that for instance they didn't want to be shaved for deliveries. They felt it was demeaning. They wanted to be able to move around more. They wanted their babies with them after they delivered. They wanted more choices in terms of contraception. They wanted more respect than they were given at the time. So it was good. It was important and I think this goes back to my mother because my mother was a very unsure, nervous, worried person who was basically emotionally abused as a child and by my father. She was unsure at times and that was more difficult for me as a little boy, but when she was certain and strong that was important.

ER:

Can you tell me about how you got involved working with the League that you mentioned?

MH:

You mean the La Leche League?

ER:

Mhmm

MH:

I just talked to the woman in charge and was supportive. I mean I wouldn't have gone to their meetings or anything, but when women wanted to breastfeed I just gave them this one woman's number. It was one woman who really headed it up.

ER:

How did societal attitudes shift regarding birth control and women's reproductive health over your career?

MH:

I graduated from medical school in 1973 and abortion was legalized in New York State in 1971 [this law passed in 1970]. So I did not see the septic wards and that sort of thing where women were hospitalized. In the early days, abortion was not that much of an issue, but over the decades the people who were against abortion became increasingly more militant, increasingly more violent. That was one thing that happened. The other thing that happened was that the birth control pill was relatively new. The doses were quite high so women had more side effects with it, but that evolved into better products and that was good for women. The other thing that was an interesting one was Depo-Provera, which is a shot, which was given every three months for birth control. There was concern in the sixties that it would be given against women's consent and there was evidence for that certainly in African American populations in the South. So the feminist activist women were against it being approved for birth control. Then of course on the other side

the anti-abortion and anti-birth control people were against it just on moral grounds. That was an interesting conflict. Contraception was illegal in this country and certainly mailing of contraception was illegal since the late 1800s. It was the Comstock Act. When I started, it was the time of women's liberation and sexual liberation too and more freedoms for sexual intimacy than when I was, for example, in high school. So that changed relationships and also fueled opposition to these things.

[TRACK 1, 14:03]

ER:

Can you tell me about how you started performing abortions?

MH:

Yeah, when I was an intern, the first abortion I assisted or did was on a woman who had kidney disease. She was told by her kidney specialist that she should not get pregnant and she did. She desperately, desperately wanted this baby, but her kidney specialist basically said, "You can't have it." I remember vividly going with the attending physician to the operating room. While we were scrubbing he said, "Abortion is murder and it should hurt," and in those days they only gave sedation, no pain medication. She cried and moved all over the table while I was performing this abortion. I just didn't go see her afterwards because I couldn't manage it. For the next twenty years or so, we did about ten abortions a year—very, very few because there was another physician in the community who was providing it and frankly we didn't want to get into it because it was such a mess.

He had protestors at his house in Oneonta all the time for twenty years. I stayed out of it for the most part until he retired.

ER:

What were the circumstances surrounding you leaving the hospital?

MH:

What happened was I started doing more abortions and it became an extremely hostile environment. There were only a few people in the operating room who were willing to assist me. The outpatient clinic, which took three years to set up with a lot of work and details, which allowed us to do the abortions less expensively, was closed when I stopped being the chairman. Staff said things to patients with impunity. There was a sixteen-year-old patient who was extremely scared. We asked that she be sedated before the surgery. She was just terrified in the operating room; until she was put to sleep properly, by that time we were doing that. We went out to the recovery room again and noticed that she had not been given the sedation so we asked the nurse. The nurse said, "I was busy. And besides I have no sympathy for women who get themselves in this situation." There was a surgeon who was very much against, and a nurse that I worked with, who was very much against abortion and would protest on Saturdays with the other protestors. There was protesting every Saturday. There was a patient who had a complication—a serious one—and was saying to me "Dr. Heller, please don't let me die. Am I gonna die?" and we had to send her to the Intensive Care Unit. Fortunately, the doctor was very supportive. But, she told me later that she had asked one of the nurses if God was punishing her and the nurse said, "Yes."

There are more, but those sorts of things happened and I decided that either I would have to stop or leave. I was there thirty years and I never thought I would leave. I was committed because of the stories—the stories of my patients and the stories of what women went through in this ostensibly beautiful, peaceful community. That's what gave me the passion to do the work.

ER:

How did you deal with staff members that disagreed with abortion?

MH:

Well, in fact, I hired an anti-abortion obstetrician and gynecologist. I remember specifically what I said to him. During his interview, I said, "As long as I'm chairman of this department abortions will be done, but I will do everything possible to shield you from them and I don't want to be shot." He didn't smile, but he said, "I would be glad to help you afterwards if there are complications." And so in that case, we did fine. Where it was very difficult was where people refused to work with me and where people said nasty things to my patients, those were situations, which were difficult. Besides, I really couldn't say much. Whereas, if for instance it happened [to] a general surgical patient they probably would have been fired. If I made a big fuss, I knew that the program would be in jeopardy.

[TRACK 1, 20:21]

ER:

Tell me about setting up the outpatient clinic you mentioned.

MH:

Well, there were lots of obstacles. I got contacted by NARAL: National Abortion Rights Action League in Manhattan. They had been looking at the data and they said, "You know you really need to be doing abortions. There's nobody doing abortions here." Since it was done in the inpatient area only, they were hugely expensive, so only Medicaid patients were really being done and very few of them. There were many pieces of the puzzle that had to be put together. I had to find staff. I had to find a place. The department chairman of medicine had a place, a surgical unit, but didn't allow me to use it. So we decided to use the clinic. We had to buy instruments, not a lot of instruments, but the budget was limited to three hundred dollars at a time, otherwise, it was capital budget and that could have taken a long time. There was a rule that all surgical specimens had to go to pathology, which would have cost 150 dollars in itself. So I quietly had to have the medical staff bylaws changed, which I wasn't sure was going to go through. [I changed the bylaws] to say "dermatologic skin tissues and abortion"—I don't know how we phrased it—"didn't have to go." We had to deal with the blood bank because they would do a type and rH2 studies and really all we needed was a type. I could go on and on, but the reason it took me three years to get it going from when I started was that there were just a lot of things that had to be addressed—minute details that would have been deal breakers, because we had to keep the cost down so that they would be affordable.

ER:

Was there any pushback on moral reasons, or just—

MH:

Most of it was logistics and money, to avoid the delays of capital budget and policies like the ones I mentioned. I would say there were two major pushbacks. There were two operating room areas that were underutilized, that could have been used very easily and could have actually brought in a lot of revenue, but I was denied access to them. I would say that's the major pushback and finding staff of course.

ER:

Why were you denied access to them?

MH:

It really wasn't explained. I got a memo that said for various reasons we will not allow you to use this for abortions. So I wound up using our regular clinic at night. The clinic was dark. The halls were darkened. A physician had just been murdered in Buffalo. So a security guard was there for a while and then we didn't use him anymore. When my wife came to visit one night she was horrified, because there were like five or six doors that were open. The lobby was poorly lit and there was just nobody around.

ER:

What was it like scheduling patients to come at night?

MH:

That really was okay. It was a very small—we only did five patients a week, which didn't meet the need. I think they just really needed the service and were glad it was available. That was my experience throughout the career. They just were desperate because they were pregnant and felt they couldn't carry this

pregnancy to term. There was a colleague of mine who said something that I think is very true: “The only reason any woman ever came to me for an abortion is because she wanted to be a good mother.”

[TRACK 1, 25:40]

ER:

Can you talk about how it’s different working in a rural area as opposed to a more urban area?

MH:

When I was here for the thirty years, it was a very different population because I had been in medical school in Buffalo. I think the biggest difference was among the farming, the dairy farmers, and the farming people. This is in terms of general OB/GYN. There were a couple of things. First of all, they were so tough. I mean, uncomplaining. We said after surgery “You can’t do this or that for six weeks” and they said, “Well, we gotta milk. We gotta get the hay in.” I mean a lot of them were [on] small farms with 30-50 head of milking cows and there was nobody else. I remember taking care of an eighty-year-old woman. She had severe heart disease. A standard question is, “Do you get out of breath when you walk up a flight of stairs?” So I asked her that and she said, “Yes.” And I said, “Well, how often do you stop?” and she looked at me and she said, “Stop? I never thought about that.” The other thing is like the farmers couldn’t always be with their wives when they had their babies. Some of the staff thought “Why weren’t they there?” Or they’d come in smelling of manure. They just had to work. They just had no alternative. Twenty-four hours a day, seven days a week. That was pretty

amazing. And then there were the very poor, rural poor, women who were very isolated. We saw lots of abuse and alcoholism. They had a hard time coming here because they may not have had money for gas. That was true and the pregnant population and the abortion population and the gynecological surgery, just getting here to get seen was often a big problem.

ER:

What was it like talking to women about their reproductive health?

MH:

Basically what I talked to them about were the pros and cons of various methods. One of the things that was unfortunate was that there was an IUD called the Dalkon Shield, which caused terrible problems. So a very effective method, the IUD, became after that pretty much unused for many years, because we were afraid that the other IUDs would do the same. In terms of what it was like, they had things that they wanted to do with their lives. They wanted to limit their family size. We're talking more about birth control than about abortion?

ER:

Yes.

MH:

They wanted control over their lives and some choices in their lives that they felt were important. They wanted to care for their kids. My job was to explain

[START TRACK 2, 0:00]

MH:

what worked and what didn't. It was fairly straightforward. It was providing a service and honoring their choices and letting them know whether it was rhythm or whatever, what kind of success rate they would probably have and listening to what they wanted.

ER:

How did you start working at the Planned Parenthood clinic?

MH:

Well, when things got tough here I went to interview in—by the way I am not speaking for either Planned Parenthood or Cooperstown Hospital. It's very important to understand that. I went there and I was offered a job as medical director. While I was still working here I took that job, which involved supervising about 25-26 nurse practitioners and physician assistants. We saw about 40,000 patients a year and 20,000 different patients. We had 13 clinics in 13 counties. We did about 3,000 abortions so 20,000 patients, 3,000 abortions each year. I liked them and they treated me well. The situation here became really impossible for me given what I wanted to do and I left.

ER:

How was your day-to-day work at the clinic different from the hospital?

MH:

Well there were a couple things. When I decided to leave the hospital and be medical director, I became professionally completely isolated. There was no other doctor around when I worked mainly in Utica and Schenectady. There were virtually no sympathetic doctors in Utica and there was one in Schenectady, but I

didn't see them. At the hospital here there was a whole cadre of specialists and sub-specialists so that if there were medical problems I could turn to them. I could see my colleagues every day. One never knew at the clinic how one would be received when one called the patient's primary doctor or specialist if they had a medical problem. So it was always sort of like a deep breath; give them a call. Some were fine. Some weren't that nice at all. And also for instance emergency room access, sometimes rarely, very rarely, we had to send somebody to the emergency room. I would always go, because I felt that I had privileges, which I really didn't use much, but there were a few times I went. As opposed to emergency services [at Bassett] which were available and easy. Even if people didn't like abortion, they would take care of my patient's medical problems. There, it was always like you never knew. The transfers were very rare, but we always said to the ambulance, "Please come to the back entrance. Please don't use any sirens or lights," because we knew that the protestors that were there every day would call the press. And there would be a press thing about "another botched abortion." So we went quietly out and then I drove along and sat there until either they were admitted to the hospital, which only happened a couple times, or they were discharged. I tried to be quiet and nice to people. Sometimes they were nice and sometimes they weren't, but I was an outsider and I think being an outsider was characteristic of all doctors who performed abortions across this entire country. You lose your colleagues.

ER:

So did you feel that isolation as well when you were working at the hospital in Cooperstown?

MH:

No, not really. Doing abortions became problematic, but I knew a lot of people here. You know, people in other specialties and I interacted every day. No, it was community. It was home, here.

[TRACK 2, 5:45]

ER:

How did you cope with protestors?

MH:

I avoided them. I never interacted with them. There was one guy I remember that I had to drive by once. He was in a Dracula mask with red paint plastered on it and a scrub suit, which was plastered with red paint. I had to drive right by him. He had a three-foot long sign that said "Abortionist" that he pointed at me. I parked as far away from him as I could. I had my key ready and I walked quickly into the clinic. That was basically the way I always went in. Get my key, open the door, scan the rooftops, take a look at the parking lot, be aware of my surroundings, and go in. I remember once, Christine, my wife, came with me. She started to have a conversation about something. I said, "We are not having a conversation here. We need to either go inside or you need to leave." I wasn't directly threatened, but my colleagues were being shot. Clinics were being firebombed. Violent protestors; things were happening. Once somebody came in requesting condoms and went into the middle of the waiting room and threw a

rock through the window and put his hands up and said, “Arrest me.” Everybody’s terrified. The patients were terrified. Patients came in terrified all the time.

ER;

Did that affect how you were able to work there?

MH:

Yeah. I think that we used humor a lot. We stuck together. Somebody called it a lifeboat mentality. We were all in it. We had fun actually. We had fun with the patients. There were really sad, tough stories all the time with the patients. There was a young woman who was so scared. I insisted that we have good sedation and relaxation and that people weren’t asleep, but they were in la la land and they were comfortable. I remember doing a pelvic exam and I had gloves on. I said, “I’m just going to check your uterus.” I went to check her uterus. She said “Oo! Your hands are cold, cupcake.” So for a decade after that I was “Dr. Cupcake” and they were merciless. We used that kind of humor with each other. The other thing we did was—I wasn’t able to do this—but we were a team. For example, the nurse or the anesthesia person would say, “Oh you have such beautiful hair” and she would stroke the patient’s hair. Or, “Oh, you have eyelashes to die for.” Or “Where’d you get that tattoo. I really like it. I heard he was a really good guy,” and that sort of thing. When they were scared of the protestors, we just said, “Yeah, we wish we could do something about them.” They called our staff “whores from hell.” There was a man that went in and said, “You’re a fudge packer. You look like a fudge packer.” They had ten-foot high pictures of

mutilated fetuses. They screamed at patients that they would take their baby. Every day that I was there for twelve years there was somebody there.

[TRACK 2, 10:10]

ER:

What were the circumstances when you left the clinic?

MH:

When I left I just couldn't manage it anymore, because I felt that half of the work was connecting with these women, women who'd been sexually abused. One woman had her pinky fingernail pulled out by her boyfriend. One woman was a secretary of a famous professor who had two PhDs. She had an eight-year-old. She was a single parent. In her second trimester, her lover told her that she should start to be teaching her eight year old to masturbate. She suddenly realized that he had paid a lot of attention to her daughter. So she broke it off. He said to her "I'm a famous professor and you are nothing and I'm gonna take this baby." In the second trimester of pregnancy, I did the abortion. She said, "Thank you." She told me when she came back she had a ceremony to say goodbye to her baby because she didn't want her baby to be raised and sexually abused. There were innumerable stories of abuse. I remember one patient who had been abused by her mentally challenged brother from when she was five to when she was fifteen. Even when she came in she said, "You know, I can't even brush my teeth." What happened was that I would connect emotionally with these patients. It doesn't take long. I would introduce myself. I always saw them when they were dressed and I would shake their hand. I would say, "We're gonna take care of you, good

care of you." What happened was that there was a patient who'd been abused, who'd lost her home, who had two kids, who was in a homeless shelter, who had lost their vehicles and who was pregnant again. All I said to her was, "We're gonna take good care of you." She had a fine experience. The nurses were great. I thought, "That's not enough." It never was enough in my practice. I thought I better stop before anybody notices. About six months later I was having lunch with one of the nurses. After I left [the clinic] I said, "Well I wanted to stop, remember when I took care of that patient because I couldn't connect." She said, "Oh well I remember that patient. That wasn't the Dr. Heller I knew." I couldn't practice that way, because the emotional connection, being present, was at least as difficult as doing the procedures, not difficult, but important.

ER:

Can you tell me about where you grew up?

MH:

Yeah, I grew up in Westchester County about thirty miles north of New York City. I had a privileged childhood. I went to private school. We lived first in Elmsford, which was close to New York City and then in Briarcliff Manor, Scarborough, which is on the Hudson River, [the] house overlooking the Hudson River. But my mother had grown up in a working-class family and I remember her saying to me, "Just remember Marc. This could all be gone tomorrow." That had a big effect on me. She was an artist. It was in her art that she became whole and strong. [She was a] photographer, [a] modern dancer, and a sculptor. So I've always had the deepest respect for art as something important that human beings do.

[TRACK 2, 15:16]

ER:

Can you tell me more about your mother?

MH:

She grew up in New Jersey. Her mother didn't want her and made that clear. This was my mother's second marriage. My father was 25 years older than she was. I remember she always called me "Marc Darling." She was very giving. People flocked to her, because she had a dance group for kids [and] she had a dance group called the "Young Mothers Group." Because of her connection with dance, she was around a lot of gay men. She said it was easier because there was no sex involved. She had no prejudice. We have sculptures and photographs of African American friends of hers. And you gotta remember this was in the early 60s and 50s. I remember she once bought a cookbook called "The Gay Cookbook." [The cover] was a picture of a man with a chest and a skirt cooking and I said, "Mom, did you know it meant homosexual?" And she said, "Oh, well I thought it meant cheerful. You get one good recipe out of a cookbook, it's worth it." My favorite sculpture of hers, I still have it. It's right in our kitchen. It's from a children's book called *In Henry's Backyard*. She choreographed a performance, on the basis of it. It's bronze. "And in Henry's backyard there were suddenly people from all over the world." The last scene was battling the demons of hatred and prejudice. All these people in different costumes of different colors and different types were chasing these two devils with their hands down, not with guns or anything, and

just moving forward. I think that probably was most indicative of my mother and who she was.

ER:

Can you tell me about your relationship with your father?

MH:

My relationship with my father was difficult. He was from Austria. He was always critical. You never knew when he would lose his temper and yell. He never physically hit me. When he came home from work he would say [*in Austrian accent*] "Helen! Where are you?!" and if she wasn't right there… And when I was not doing well, he was critical, when I was doing well he was competitive. That relationship, even though I'm in my late sixties, remains something that is still somewhat unresolved. Although my son tells me I didn't treat him that way, which is a great victory. So, I was never comfortable around men or boys. I tended to be bullied. I was unable to really be aggressive, because I was always afraid with him of the consequences of sort of asserting myself. Again, I think that reflects back on my choice of professions.

[TRACK 2, 19:45]

ER:

Concerning your alcoholism, what encouraged you to seek treatment?

MH:

It's an interesting thing. It was two months before my daughter was born. I had had all kinds of treatment. I had had individual psychotherapy, group psychotherapy, marital therapy and some psychoanalysis because I had a lot of

emotional problems, which is why we didn't have kids for such a long time. But two months before my daughter was born I really realized that I didn't want to be a parent and drink. I don't know. It was a gift. It was not so much difficult not to drink, but difficult in overcoming the shame of being a doctor that drank. It wasn't complicated. I just didn't drink and I went to AA [Alcoholics Anonymous] for twelve years. I just made that decision. I guess that's the story of that. It wasn't that complicated really. What it did for me was, besides it was a difficult thing, it also helped me to join the human race in a way that I never could have before. I viewed my patients more and more as fellow travelers. I learned things from street people and bikers and all sorts of people that you would never imagine. I realized that we are the same. That helped me in my work, especially the abortion work, because we do things that are okay and we do things that we regret. Sometimes we're good people and sometimes we're not such good people. It was the ambiguity of life that I really internalized and brought to the work as an abortion provider. AA was wonderful. I remember being worried about having to go to the CEO of the hospital to tell him about my alcoholism. It was the night before and there was a guy there who had some kind of mental illness and was living in a home. He said, "I was a janitor once, but I lost my job when my boss found out I was an alcoholic, but I have my room and I have my bed and I listen to my radio and I brush my teeth everyday and I'm grateful for that." I thought, "Wow, this is something." Actually, he [the CEO] said, "Well there have been no complaints and there's been no problems. You can continue working." There are other stories as well, but I guess that's representative.

ER:

How did your alcoholism affect your career?

MH:

I didn't drink at work. I drank at night to be able to sleep, because I think it was a treatment for my depression and not a good one, but it was what I used to sort of manage it. I used to get panic and anxiety attacks. [Laughter] When patients came with those, there were colleagues who said, "Oh they're just crazy." I was always very comfortable with the crazy patients, because I had known horrible that feeling is; afraid you're gonna live, afraid you're gonna die. It's hard to say. I think I was less crabby. I rarely drank large quantities, but I drank enough pretty much every night to sleep, but it still makes you crabby the next day. So it affected it in that way. I think I became a much nicer person to be around. I didn't take care of a patient drunk. I was lucky. I was really lucky. It was because of my daughter. She's the one; I think her spirit came to me before she was born somehow and gave me that gift.

ER:

So the time's about up. Thank you for taking the time to speak with me today.

MH:

My pleasure.

[END OF TRACK 2, 26:01]