Oral History #42

An Interview With
Stewart Zuckerbrod, MD

Place of Interview: Houston, TX
Interviewer: Renee Tappe
Terms of use: Open
Approved: (Initials)
Date: 4/2/15
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RENNÉE TAPPE: This is Renée Tappe interviewing Stewart Zuckerbrod for The oH Project, Oral Histories of HIV/AIDS in Houston, Harris County, and Southeast Texas. The interview is taking place on April 21, 2018, in Houston, Texas. The purpose of this interview is to document Dr. Zuckerbrod’s recollections concerning the HIV/AIDS epidemic in Houston.

Hi, Stewart. Thank you for joining us today.

STEWART ZUCKERBROD: Glad to be here, Renée.

RENNÉE TAPPE: Let’s get started with some of your early history. Tell me where you were born and a little bit about your family.

STEWART ZUCKERBROD: I was actually born in Frankfurt, Germany. My dad was in the Army at that time, and my mom went over from New York in the last stages of pregnancy to deliver me with my father around. We stayed in Germany until I was nine months old and then came back to New York. My dad was an attorney and was in practice in New York City. We grew up, until I was about 13, in New York, and then moved to Long Island, where I finished my high school.

I then went to school at the State University of New York in Binghamton. During my last years there, I decided that I was going to pursue a medical/research degree, so I actually took a year off after college and did research at Cornell Downstate and then ended up coming to Baylor College of Medicine here in Houston to pursue the dual degree.

I kept with that for several years and then decided not to finish the Ph.D.,
thought I was going to go into endocrinology, but I got enticed into ophthalmology, and that’s what I am doing now. The interesting thing with ophthalmology is, you don’t go into ophthalmology residency directly out of medical school. You do a year in another field and then come back to ophthalmology as a specialty, so I ended up going back to New York for a year, where I worked at Medical College of New York in Valhalla.

What’s interesting about that, that’s going to relate to today’s discussion, is that this was in 1983. We knew about AIDS, which in those days I think was still called the wrath of God syndrome. I don’t think they called it AIDS yet. We didn’t know what caused it, but it was particularly common among gay men; IV [intravenous] drug abusers; and prisoners, who tended to share both of those qualities. Valhalla happened to be the site of a very large prison, and so as a result of that, that particular institution had one of the largest inpatient populations of AIDS patients anywhere in the country, so I actually worked with a lot of AIDS patients in my residency, which was an internal medicine residency.

I guess we’ll get to this, but because we had no idea what caused it, all of these people were put in isolation, so they were in separate rooms, you had to gown and glove, put masks on every time you walked in or out of the room. They were very isolated, and a lot of these people were sort of sociopathic to begin with, so there was a very interesting culture and client base that you were dealing with.

TAPPE: Did you have doctors or any medical staff that did not want to work with these particular patients or prisoners?

ZUCKERBROD: I don’t remember that being an issue or an option, so I would say the
answer to that is no. The big thing was just level of fear because we really had no idea how this was being transmitted, and so you had the sense that you could be taking your life in your hands when you were dealing with these patients because you really didn’t know if you were going to get this or not.

TAPPE: Truly, you were taking your life in your hands because we didn’t know about the blood, if you pricked yourself or them, or if it was airborne.

ZUCKERBROD: Well, we didn’t know if you could transmit it by a cough or by touching someone.

TAPPE: That’s exactly right.

ZUCKERBROD: We sort of had a sense that it was harder to get, at that time, but there was nothing definitive and, of course, there were no definitive tests for it. The only thing that you could do was to have blood drawn and do — I think we used to do T-cell ratios in those days, because it was noted that there was a T-cell-ratio inversion, and that was the only test that we had.

TAPPE: You said you were kind of lured into ophthalmology. How did that happen?

ZUCKERBROD: It was a funny story, really. At Baylor, we used to take call in the emergency room if we were doing a surgery rotation. I was on call one night at Ben Taub, and I got called in to see someone who had gotten into a knife fight and their eyelid was cut. I was a medical student, I wasn’t able to take care of that, but we called in the ophthalmology resident, who as I remember was an extremely handsome man, and he asked me to come up to the clinic and help him with this.

In the course of the 45 minutes or an hour that it took to sew this eyelid back together, he kind of talked me into doing a rotation in ophthalmology. I had
done some research that was related to the eye, but I really had never seen myself going into that as a field. The things that he talked about that were particularly appealing was the fact that you see all age groups, which was an issue with pediatrics or some of the other things that I was looking at, and that there was long-term follow-up with patients, which I was very interested in, and also, even though I didn’t think it was something I’d be attracted to, the mix of surgery and medicine. By the time I finished doing the rotation, I realized that it was something that I was very excited about.

TAPPE: So you weren’t planning on doing any type of surgery?

ZUCKERBROD: No. In fact, I didn’t even plan to do medicine. When I was trying to do the M.D./Ph.D. program, I thought that I would go into research and teaching, and just kind of assumed that I would never touch a patient except maybe to draw blood or something like that, so it was a real surprise to me. But the thing that I think was very appealing was, particularly with cataract surgery, it was very delicate, very precise, and that was something that appealed to me, and, of course, you got very good results. Now, this was the very early days of putting intraocular lenses in the eye. Actually, when I was a medical student, we didn’t do that, but you could still tell that patients were having a big improvement in their vision almost immediately after the operation, so it was very gratifying.

TAPPE: When you finished your residency at Baylor, you were doing some lecturing in Germany. Tell me about that.

ZUCKERBROD: Well, the story with that is, the fact that I was born in Germany, even though my parents didn’t speak a word of it, ended up with a series of coincidences where I kept getting stuck in German classes, and so I actually
double-majored in German and biology when I was in college, and I had some really wonderful experiences there. At the end of high school, I ended up living with a family in Germany and forming a wonderful, lifelong relationship with them.

I went ahead and studied in Austria when I was a junior in college and really became fluent in the language and then kind of maintained that through frequent visits back there. During residency, I did some research on a project which was looking at an unusual aspect of a systemic disease that had some ophthalmologic findings, and I guess at the end of my residency, we had a visiting professor from Germany who was so impressed that I spoke fluent German that he invited me to come over and lecture, so I talked about the project. I also spoke about the differences between the American and German training systems, which were really pretty profound.

TAPPE: One better than the other, or just different?

ZUCKERBROD: It’s not a better or worse, but it was a different attitude. In the United States, we as medical students tend to get a lot of hands-on experience, mostly with patients that are indigent. Of course, in Germany everyone is protected by socialized medicine, so the idea of a different class of patients is completely foreign to them, and they actually don’t touch patients until they’re doing a fellowship. It was an interesting juxtaposition because in the States, I think we’re all very proud of the fact that we can operate on patients when we’re first- or second-year medical students, and they were actually horrified by the idea that I had done hundreds of surgeries on patients as a resident because they didn’t do any. The reaction was, “Why should you get to practice on people just because
they don’t have insurance?” It was very interesting feedback.

Of course, then I said to them, “Well, great, you get your fellowship, and then you have to practice on paying patients, and you’ve never done a surgery, so which is the better system?” It all works out, I guess.

TAPPE: That is interesting because here it is a class, for the most part, money issue, I think, in terms of the medical students and who they work with.

ZUCKERBROD: Yes, absolutely, absolutely. Most of the surgeries I did were either on patients at Ben Taub Hospital, which was, of course, a county hospital, or at the VA [Veterans Administration]. I wouldn’t say it’s a different class of patients, but it’s a different mind-set.

TAPPE: Yes, there’s a similarity there. I understand you were doing some volunteer work in Nigeria; is that correct?

ZUCKERBROD: I did. When I finished residency, I didn’t have a specific plan of what I wanted to do work-wise, and so I decided to do something called locum tenens, which is sort of like Kelly Girls for doctors, where they place you temporarily in practices where a doctor may be on extended leave or vacation. The idea behind that was to raise enough money so that I could do overseas volunteer work, and I did get to go to Nigeria, where I had about a two- or three-week experience, and then the plan was eventually to go to some other areas, but I ended up being offered a permanent job here in Houston, and so the travels kind of faded out.

TAPPE: That was the end of that.

ZUCKERBROD: Yeah.

TAPPE: You stated earlier that you graduated from medical school and then worked some in New York, and you were working with some of the prisoners. What is
your very first recollection of there being a health issue among gay men?

ZUCKERBROD: Earlier than that. I can’t tell you an absolute, down-to-the-day date on this, but it certainly was in either the very late 1970s or early 1980s, where the newspapers were full of this gay disease that was going around, Kaposi’s sarcoma being on the rise, young people dying of immune deficiency disease with very unusual types of problems like pneumocystis pneumonia. So it was certainly something that we were becoming aware of, and by the time I graduated in 1983, we were very aware of it as a condition. I don’t remember seeing a lot of it as a medical student, but some; and certainly as a resident, I did.

Now, interestingly, I was doing an ophthalmology rotation, I think my junior or senior year of medical school, at the VA, and I remember seeing a veteran, we had dilated his eye, and he had a really unusual problem in the eye, and our attending came over and said that he thought this was probably pneumocystis affecting the eyeball, which had just been described and we’d never seen a case of it before, so that made a lot of impact.

TAPPE: Because of the suppressed immune system and the various physical conditions that are common among the HIV patients, unusual things do happen to them, as you were just saying. Tell me about some of the various eye conditions and diseases that you saw and have observed and treated in HIV patients.

ZUCKERBROD: Probably the most common one was CMV retinitis. CMV is a cytomegalovirus, and it’s basically a benign virus that lives in our systems pretty much all the time and doesn’t really cause any problems unless the immune system is severely compromised. The appearance in the eye is what we used to call eggs and ketchup, so you have sort of a yellowish-white exudate retinal issue
associated with bleeding, and that was pretty much a telltale sign of CMV.

Pneumocystis could land in the eye. That had a different appearance.

People were very prone to infections of unusual strains of Mycobacteria. Mycobacteria is the causative agent in tuberculosis, but there are other types of Mycobacteria that would end up in the eye as well.

Toxoplasmosis is a parasite that also tends to live commensally with us, but when the immune system is compromised, it causes massive inflammation in the eye.

Then the HIV virus itself causes what we call retinopathy, which is a disease of the retina, usually fairly benign by itself, but in the case of a severe immune-compromised patient, then it could cause visual loss as well.

TAPPE: How are they diagnosed, these different diseases?

ZUCKERBROD: Initially people would come in because they would have a loss of vision in the eye. Sometimes they would come in, although this was relatively unusual, with pain in the eye, because some of these conditions would cause an inflammation, and inflammation in the eye tends to be very painful.

Now, the interesting thing about patients with HIV is because their immune systems were so compromised, they often couldn’t launch an immune response, so they wouldn’t necessarily have that inflammatory response that you would expect to see in somebody who had a more intact immune system, so the big one was vision loss.

Now, once we began to understand the fact that these things were going on, we started screening patients with HIV on a routine basis to try to catch some of these conditions before they became visually compromising.
TAPPE: Did you have specific treatments for some of these?

ZUCKERBROD: I can’t remember exactly the year. What I remember about that first time when I saw toxoplasmosis in the eye, by that time we understood that these were manifestations of very late-stage HIV, which, of course, we didn’t know was HIV in those days, so basically what we began to realize was that for people to get these unusual infections in the eye, their immune systems had to be severely compromised, and so the diagnosis of something bad going on in the eye basically was saying that the patient was going to die very soon because their immune system was basically shot, so there really were no treatments at the beginning. That person was moribund.

Now, as time went on, and I think we’re already looking at the late 1980s, early 1990s, we had specific antiviral treatments for CMV retinitis, and so you could actually treat the patient for that. There wasn’t anything to treat the underlying HIV, but we were able to treat this virus.

Now, what I will tell you is that the treatment was not easy. You had to administer these medications intravenously. They had to be done frequently. I think the dosing initially was several times a day, and it was done by IV drip, so basically you were tied up to an IV for hours a day. Initially this was done inpatient, so there were hospitals where patients were being treated, and they really didn’t have much of a life at that point because they were basically spending their time in the hospital.

As we became more sophisticated with it, we began to understand that you didn’t have to do this continuously; that people could get maybe a day off every three days or whatever it was. The protocols evolved rapidly with this.
Then what happened was that we started seeing the development of home healthcare infusion companies, where people could stay at home and a nurse or some registered professional would come and actually give the treatments intravenously.

Then a couple of things happened, and I’m a little fuzzy on the timeline on this, but an insertable, slow-release form of medication was developed that you could actually implant into the eye, and it would directly release the drug to the retina over a period of six months, I think it was, which in those days was pretty good. Remember, the life span was not expected to be very long in these patients, so if you could get them off of the IV drip for six months at a time, you were making a pretty big improvement in their lifestyle.

Then an oral form of it was developed, and so that released people from the constant intravenous infusion.

And then AZT [azidothymidine], and then some of the other medications.

So what happened was, we went from a period of years where people would come in with CMV retinitis, initially plan to go blind and die; then go to a period where we could hopefully keep them from going blind before they died; and then starting to become a treatable disease. I went from seeing dozens and dozens of patients that had severe eye infections in the early 1990s to basically by about 2000 not seeing any new cases of it. I don’t think I’ve seen a new case of CMV retinitis probably in 15 years, now.

TAPPE: Is that right?

ZUCKERBROD: Yeah. And I still see a fair number of HIV patients.

TAPPE: But because of all the other medications that are taking care of the immune
system —

ZUCKERBROD: That’s right. Well, what happens is, once you can maintain a T-cell count above about 100, that’s enough of a functioning immune system to be able to prevent any of the other conditions. Of course, with the cocktails nowadays, it’s pretty easy to do that.

TAPPE: You obviously worked very closely with patients that were seriously ill. What were some of your observations in terms of what they experienced on an emotional level? Did they have family support? Support from friends? What were your observations, standing back and watching?

ZUCKERBROD: Again, this is a bit of an evolution. When I worked at Westchester County in Valhalla, again, a lot of these patients were incarcerated, so they were prisoners, they were either gay or IV-drug abusers, and so you’re not talking about a population that comes from wonderful, loving family support. I remember being sort of taken aback dealing with these patients in isolation because they seemed so remote, and it was hard for me to know if I was dealing with sort of an isolation psychosis or sociopathy or denial or what was going on? It was really a tough group of people. I often felt like I was a caretaker rather than a physician being able to offer anything. A lot of them wouldn’t talk. There was just no interaction. It was a very bizarre group.

TAPPE: So many different factors going on.

ZUCKERBROD: Yeah. I do remember, and this is one of the tougher anecdotes that I had to deal with. The prisoner intensive care ward was sort of isolated from the rest of the hospital because it had to be a lockdown. I was on call one night, and the nurse called me up and said, “There’s a patient in this bed. He’s got” —
whatever they were calling HIV in those days. It wasn’t HIV, but he’s got AIDS or the wrath of God or whatever it was.

TAPPE: The gay disease.

ZUCKERBROD: He has toxoplasmosis of the brain. This microorganism would get in the brain and actually eat away at the brain, so basically the guy had lost any ability to communicate or any real, observable awareness of the outside world. I think what was happening was, he was going into respiratory distress, which meant that his breathing was being affected, probably from the infection affecting the brain stem. This was a patient I’d never seen before, had no interaction with, young man. As I remember, he was 24 years old. I’m a first-year intern trying to figure out what to do on this very complicated case, and I said, “Is there any family?”

She said, “No, nobody ever visits him. He really has no interaction with anyone.”

The nurses knew a lot more than we did, of course, and I said, “Well, what do you think I should do?”

She said, “I think you should leave him alone, and we’ll call you very slowly when he starts to go down the tubes.” What she was basically saying, let him die a merciful death because he’s going to die anyway and he doesn’t have any brain function left, which I thought was pretty reasonable.

But at that stage of my career, I wasn’t the one making decisions on life-and-death things like that, so I called up the second-year resident and let her know what was going on, and she wasn’t very comfortable with the whole thing, so we ended up calling the attending, who was the M.D. on this. And I’ll never
forget. I remember his name, which I’m not going to mention, but he was not someone that any of us respected. We called him up at home, it was late at night, and we told him what was going on, and I said, “What do you think we should do?”

And he said, “Well, what do you think you should do?”

I said, “Well, this is someone who has a fatal disease. We have no cure for it. He doesn’t have any brain function. There’s no family that is involved in his care, and he’s going to die, so I think probably it would be merciful to let it happen sooner rather than later.”

So what the option was, we could put him on intubation and maintain the breathing artificially until every system in the body failed, and I didn’t think that was a particularly merciful thing to do. But remember, these were the days before living wills and things like that that were just starting to come into discussion.

TAPPE: “Keep them alive at all cost.”

ZUCKERBROD: Right. I went to bed that night with the understanding that the nurses were not going to call me until basically it was to pronounce a death, and when I got up the next morning, we had rounds every day called M and M rounds, morbidity and mortality rounds, and it turned out that the second-year resident had gone and intubated him and moved him to the ICU [intensive care unit], and so he was kept alive for, I think, another two or three weeks.

It was a very, very difficult time, and I saw that repeated over and over again, not just with HIV patients, but there was just a lot of trouble making end-of-life decisions. I found myself, on a number of occasions, kind of in the role of what I thought was patient advocate for the right to die, and I had gone
through that experience. My grandmother had metastatic colon cancer, and after having a colostomy, a colectomy, chemotherapy, everything else, she eventually chose just to stay at home and die, and so I got to witness that firsthand, and I thought there comes a point where this is a reasonable decision for someone who understands the options and wants to maintain a quality of life, because the chemotherapy had been miserable for her.

I think having had that experience put me in a slightly different mind-set from a lot of the people that I was training with or working under, who really were, “Keep them alive until the last cell gives up,” and so there were a couple of times that I was sort of the advocate for what I thought were the patient’s wishes, and I don’t feel badly about any of that, but it got me in trouble a few times.

[END OF AUDIO PART 1]

TAPPE: Nor should you, but you see how the trend has moved through the years.

ZUCKERBROD: I think there’s more recognition now. The other thing that I saw with this is that you can never predict this in advance. My first clinical experience, ever, was working in a burn-care unit, which is about one of the most miserable places you can work, and I saw people who had 90 percent burns all over their bodies, were never going to have anything remotely approaching a normal life, horribly disfigured, horribly maimed, and yet they did not want to die. You just can’t put yourself in that position until you’re in that position.

TAPPE: That’s right.

ZUCKERBROD: So I never presumed anything, but I guess I did sort of presume someone who was basically brain dead with a fatal disease that we had no treatment for basically didn’t need to be kept alive another two or three weeks just
to prove we could do it.

TAPPE: That’s right, and that’s where the trend comes, I think, and people overall are looking at end-of-life decisions in a much different way.

ZUCKERBROD: Sure. Now, jump ahead a few years, in private practice, and we’re dealing with a very different clientele and a very different set of situations. These are outpatients that I’m seeing in the office, who have advanced HIV and are developing eye infections, and so I’m seeing them for that aspect of the care. That was a difficult time also because these were young men, often my age, younger or maybe a little bit older, that basically had been healthy and productive, and then you diagnose them with an eye disease which could blind them, and often did, and not only are they realizing that they could lose their vision, but they’re also realizing that this is a signal that the end is coming from this disease way too young.

I saw many of them that were shunned by their families. There was one case that I remember of a really, really sweet young man who basically told me that his family was just waiting for him to die so that they could collect his life insurance. Just to hear someone talk about this recognition that his family not only didn’t want him, but didn’t want him alive, I can’t even imagine how you live with something like that.

TAPPE: How did you support them just in your office? How do you interact with someone like that?

ZUCKERBROD: I just try to be sympathetic and listen, try to be encouraging about the treatment, and try not to cry when I was listening to it, and sometimes I did, and maybe that was beneficial. I don’t really know. I think it really was a tough time.
I don’t think people were partnered as much in those days. We were coming out of the 1960s and the 1970s, where it was the sexual revolution and people, I think in general, straight or homosexual, were looking at “Is marriage really necessary? Do we need these types of pairings?” Particularly in the gay population, it was kind of like, “We don’t want to replicate the straight model. We want to be able to have multiple sex partners and live a carefree life.” Gay marriage was not a topic of conversation in the 1970s.

TAPPE: No, it was not.

ZUCKERBROD: So a lot of these guys were isolated. Now, I certainly saw people with partners, and I think the partners were incredibly supportive and scared. I think the gay community really rallied around this. The lesbian community really rallied around this.

The thing that I found frustrating from a sort of political point of view at that time was there were multiple AIDS support organizations that sprung up, but they tended to work autonomously and fiercely independently so that there was often a reduplication of resources, at least in this city, that you didn’t see in other places. I mean, New York developed the Gay Men’s Health Crisis. L.A. had a Gay & Lesbian Community Center that opened pretty early on and was actually the housing organization, as I remember, for a clinic that was dealing with HIV. In Houston we had multiple organizations all going off after the same limited resources and in many cases reduplicating resources unnecessarily. Of course, those have consolidated over the years, which is really wonderful.

TAPPE: In listening to some of the other histories, I’ve learned — well, I was here as well — but have learned a lot about what you just said, about how there were so
many different organizations, all of them with wonderful intentions and
dedication and strong people, but sometimes to the detriment of the community
that they were trying to help.

ZUCKERBROD: Absolutely, yeah. It was very interesting to see how that developed.

TAPPE: Do you remember any government programs going on at that time, or was it
really the community itself?

ZUCKERBROD: I don’t. The government in many ways was actively working against
anything that would have been beneficial. I mean, certainly under the Reagan
years, we had official denial that this was even a condition, and sort of a, “Well, it
affects gay men, so who cares?”

What I was very aware of, because of my ties with Germany — and by the
way, my German adopted family were physicians. Interestingly in Germany, the
branch of medicine that took care of AIDS patients were the dermatologists.

TAPPE: Really?

ZUCKERBROD: Yeah, because a lot of sexually transmitted diseases have skin
manifestation, and of course, with AIDS, it was Kaposi’s sarcoma, so my German
brother, who was a dermatologist, had a huge HIV population. Unlike the United
States, which put its head in the sand, Germany recognized that this was an issue
immediately and immediately started on safe-sex campaigns, use condoms, giving
out free condoms. They managed to take the growing number of AIDS patients
and level it off and actually decrease it over the same period that we were seeing
an exponential explosion here, so it really was a case of the government not
benefiting at all.

Again, my memory on dates becomes a little bit shady with this, but you
had Ryan White, who died of HIV through no fault of his own, you know, as if having sex was something that you were going to fault people for, and then I think Magic Johnson around the same time.

TAPPE: A little bit later, I think.

ZUCKERBROD: Then people like Elizabeth Taylor, with Rock Hudson. These were major, I think, turning points in the mainstream consciousness; that people that were either, quote-unquote, innocent or that were held up as masculine role models were also developing this disease and that there were people in Hollywood who were willing to stand up and fight for them. Then you started getting government funding. What I remember is that the Ryan White funds were really the first major government infusion. I may be wrong.

TAPPE: I think you’re right, for the large money. And the activists at that time were so vocal about medications and trying to get the process to move along faster.

ZUCKERBROD: Yes, but a lot of it was almost underground. I mean, people were loud about it, but it was happening under the radar, in some ways, of the government. I mean, you certainly weren’t getting the government wildly supportive of this.

TAPPE: Oh, no. We’ve yet to get there.

Do you recall, from your observations as a physician and as a member of the community, at the time of the major part of the crisis or even today, is there discrimination within the community against people that are HIV positive, or was there at that time?

ZUCKERBROD: I don’t remember any sort of active discrimination against HIV. In fact, I really think that there was almost, within the community, kind of a protective stance. I think people really rallied around their friends who were HIV
positive. I mean, there’s certainly a fear level. I think there was a sadness. So many of us saw close friends die, people our age dying. There was that, but I don’t ever remember anyone shunning these people at all.

TAPPE: Or losing their circle of friends because of it?

ZUCKERBROD: I don’t think so. Families, I think, that were already shunning people because they were gay, I think the illness was just another manifestation of “God’s wrath on these deviants.”

Now, dating was a different thing. You know, I had some mixed experiences myself. I’m HIV negative, and I dated a guy, I want to say in the 1990s, who was positive, and we broke up because he couldn’t deal with the guilt of the possibility of transmitting it to me. I was fine with protected sex. Of course, this was before there was any medication that you could take, but I just felt like I was into the relationship and I guess I really didn’t care, but he broke it off because he really didn’t want to deal with the possibility of infecting me.

I had another story, and I think I may have told you this before, when we interviewed. I took care of a man who had CMV retinitis, and his partner used to come in with him and was also a patient of mine and told me that he was HIV negative. By that time, we had the testing. The man with the CMV died. The partner and I were in a social circle together, so we interacted outside of the office. Eventually after time had gone on, he asked me out, and we went out on a date or two. I wasn’t really all that interested in him, but I did like him as a friend.

Then one time when we went out, he wanted to get things physical, and he said, “Oh, by the way, I’m HIV positive.” I wasn’t all that interested in the
physical anyway, but I was really stunned by the fact that not only had he misled me personally, but that he had misled me as a physician, because that makes a big difference in what you’re looking for, and so I was really put out by the fact that he had lied about this.

I think I was pretty clear about the fact that the lying was the big issue, but he really turned this against me, and he started telling people in the community that I was discriminating against HIV patients, and it had some impact on my practice. It was really hurtful because I’ve never discriminated against anyone, even in my dating life, so it was just —

TAPPE: And you had had scores of clients through the years, correct, that were HIV positive?

ZUCKERBROD: Well, his partner was HIV positive. There was nothing to it. It was just someone who was rejected, who chose a very painful way of dealing with the rejection, yeah.

TAPPE: But your friends, of course, knew better?

ZUCKERBROD: Well, I don’t know. It’s funny, because it becomes a “he said he said” type of thing. My practice was not by any stretch exclusively gay. There were some doctors in town, ophthalmologists, who saw almost exclusively gay patients. I think it tended to shunt people toward other people who saw gay patients, within this circle. I don’t know. I learned that slander is a tough thing to fight, and it was interesting how that worked out.

TAPPE: There’s only so much you can do about it.

ZUCKERBROD: Yeah.

TAPPE: Well, you just continue to be yourself.
ZUCKERBROD: Yeah, I mean, I had never stopped seeing patients. I used to volunteer at the Montrose Clinic and see HIV patients in the ophthalmology clinic there. I mean, there’s no merit to it.

TAPPE: You are involved with a number of different organizations, and have been in the past, in the community. Tell me a little bit about the organizations you’ve been working with.

ZUCKERBROD: This sounds like it’s off, but it’s not. I was very interested in theatre when I was younger and actually considered going into it, and so the first organizations that I was involved with, and nonprofits, were theatre organizations. I was on the board of directors of Stages and then HITS Unicorn Theatre. When I got some experience with those organizations, being part of a nonprofit board, I then started understanding how much you could do as a board member, and then I started getting much more involved with gay organizations, although theatre was sort of a gay organization in those days, too.

TAPPE: Yeah, that’s right, just kind of unofficial.

ZUCKERBROD: Unofficial. I was on the boards of a number of organizations. There was a successful attempt in the 1990s to start a Gay & Lesbian Chamber of Commerce, and I was an officer in that group. That group tried to support a Gay & Lesbian Community Center, which I was very, very interested in. I started singing with the Gay Men’s Chorus in the mid-1990s and eventually got on the board of that organization. I was asked to become one of the directors of Body Positive, which was an organization geared to promoting fitness in HIV patients, and then also served on the board of the Montrose Counseling Center, which was predominantly gearing itself to a gay and lesbian population.
TAPPE: Are you involved now with any of these organizations?

ZUCKERBROD: I’m not, no. Once I became a parent, it became a little harder to do any of that.

TAPPE: Your time is spent in different ways now.

ZUCKERBROD: Yeah.

TAPPE: You have a long history of teaching at Baylor and the University of Texas Health & Science Center; is that correct?

ZUCKERBROD: Well, yes and no. I went to medical school at Baylor College of Medicine, and then when I graduated from residency, I stayed on as a volunteer faculty member, so I would go in and teach mostly surgery. Then in the early 1990s, early to mid-1990s, I was asked to come on as a volunteer faculty at the University of Texas, also to teach surgery. At that time, UT had a shakeup in their faculty, and I had gotten very good reviews from the residents, so the chairman of the department asked me to come on actually full-time as a faculty member, and so I taught as a faculty member at UT for about 10 years. Then from that, I was asked to lecture for a national organization that was training ophthalmology residents from around the country, and I’ve been doing that up until this year. I think it’s actually going to stop this year.

TAPPE: Is that right?

ZUCKERBROD: Yes. So I did that for almost 20 years, 15, 20 years.

TAPPE: You probably like to do that, don’t you?

ZUCKERBROD: Yeah, you know, as I said, my original goal was to go into teaching and research. It was never to practice medicine, and I’m not sorry about the direction things went in, but I really enjoyed the teaching. There’s a lot of
gratification in that kind of aha moment when you see someone connect things because you’re kind of leading them into it. I think teaching surgery is a skill, and it takes a certain amount of, first of all, self-confidence. You have to be pretty comfortable that you can handle about any emergency that comes up. And also a level of calmness that I found a lot of my colleagues didn’t have when they were training residents, and that makes a big difference. So, I miss it, but —

TAPPE: If your teacher or your professor is a little bit uncomfortable in terms of teaching surgery, I think that would make me, as the student, a little bit nervous.

ZUCKERBROD: Yes, and I think because I had done — I taught, actually, some German classes when I was in college, and I did some other teaching along the way, so I had sort of an interest in that and a recognition that it wasn’t just something you sat down and did; that you actually had to think about what you were doing, which I think some teachers don’t seem to consider, especially in academic medicine, because I think a lot of people see it as a chore rather than a part of a profession.

TAPPE: They don’t necessarily want to be doing it.

ZUCKERBROD: Right.

TAPPE: Interesting, with your lecturing in Germany, you were lecturing about research, right? So your vocabulary had to be well beyond simple fluency in German. You had to have the medical vocabulary.

ZUCKERBROD: Well, actually, it’s very interesting. As I said, I’ve maintained contact with this family that I lived with, and the younger brother is a dermatologist, the older one is a forensic pathologist. The lecture took place in Munich, and at that time the forensic pathologist was living in Munich. I had put together a slide set
that I translated into German, and the night before, I practiced it with him, and he just looked at me and he said, “None of this makes any sense at all.” The reason was, I was fluent in the language by then, but there’s a big difference between speaking conversationally and presenting a scientific lecture, and the vocabulary is very different, just as if you talk to doctors, there’s a jargon that we speak to that I think a lot of patients don’t understand unless you translate it, and so we ended up staying up most of the night with him translating this thing for me.

I was terrified. I went in the next day, and I didn’t know if I was going to be able to pull this off, but he really helped me along with it, and I’ve translated a number of papers for him over the years, so it sort of traded out.

TAPPE: That’s right, because when you were talking earlier about that, I thought, oh, my gosh, that’s a whole different vocabulary that you would have to know.

ZUCKERBROD: Yes.

TAPPE: So you had some help with editing.

ZUCKERBROD: I did. I had a lot of help with it.

TAPPE: Outside of your professional self, how did HIV affect you personally? Socially? How did you deal with the loss of friends?

ZUCKERBROD: It’s interesting, because I didn’t really come out until 1995, and I had my first gay relationship when I was in early years of medical school, so about 1980, 1981, and it was a disastrous relationship, which kind of scared me off of gay relationships for a while. Also, I was going through medical school and residency, which was just not a time to be in relationships anyway, so the upshot of all that was that I wasn’t really actively involved with the gay community, and so I didn’t really have close friends that were dying of the disease. Now, I did
have an acquaintance that died of AIDS in the late 1980s, but it was a bit of a
remove from me.

I think the thing that was — and it took years for this to sort of settle in —
I told you earlier I did research in New York for a year before I came to medical
school, and during that time, there was a man working in the lab that — this was
the late 1970s, and while the sexual revolution had taken place, it still was not —
you didn’t go into a room and announce that you were gay. So this guy was gay,
but it took him about eight months to tell me in a very roundabout way that he
was, and at that time I was really struggling with sexuality. I didn’t know if I was
straight or gay or what, and I was going for therapy, and the therapist said, “You
know, this is clearly something that makes you very anxious. Just don’t get
involved with anyone sexually,” so I didn’t.

This guy came onto me, and I just kind of let it pass, and kicked myself for
years afterwards. But about four or five years later, I found out that he was one of
the early people to die of AIDS, and I did actually get to see him once before he
passed away. What kind of came up in my mind was sort of a cautionary tale,
because I felt like if I had gone to bed with him in 1978, he probably was infected
already, I’d probably be dead, and so it was kind of this awakening thing.

TAPPE: Every possibility.

ZUCKERBROD: Years later, I thought, "Well, suppose we had gone to bed together and
we had formed a couple and he never got sick,” so there was that flip side of it,
but it was just kind of this thing of you never know what’s going to happen.
Anyway, I would say I can’t look back and say that there was anyone that I was
close to that I lost to HIV. I did lose some friends to suicide and other illnesses
and things, so it was a different awareness for me.

TAPPE: That was different for you.

ZUCKERBROD: Yeah.

TAPPE: But you, I’m sure, lost a number of patients that you saw?

ZUCKERBROD: A lot of patients died, and also once I came out, of course, people were still dying of the disease and people were still shell shocked from the loss of their circles, so it affected me somewhat indirectly.

TAPPE: Yes. Today as we’re talking about history, I think today’s community is a little bit different, just like many facets of our society. Now there’s the introduction of PrEP [pre-exposure prophylaxis].

Tell me about PrEP, what you know about it in general, and then how you think it perhaps has had an impact on sexual practices within the gay community, if it has.

ZUCKERBROD: First, I’ll preface this by saying I’m 62 years old, and I’m not a monk, but I’m a little bit out of the younger generation mainstream. I do think that once the cocktails were developed and once the concept of AIDS as a fatal disease changed to AIDS or HIV as a manageable condition, that the mind-set of the community shifted a lot from, “This is a death sentence,” to, “Oh, if I get it, it’s okay because I can be managed,” and so I think that risk aversion shifted completely. Of course, now with the PrEP, it’s become a totally different ballgame because theoretically if you take that, your risk of transmission becomes almost nothing, so I do think that there’s a much greater incidence, probably, of risky behavior.

Now, there are some trends, and I have to, again, qualify this by saying
that I’m older, I’m a parent, my social circle does not revolve around the bars or even large gay friendship circles, so I can’t speak to a lot of direct observation, but I think a number of things have happened: First of all, one of the issues that I think was a huge factor in the high risk-taking in the gay population and the high use of drugs and alcohol was that we were such a marginalized population and there was so much guilt associated with coming out as gay and so much stigma attached to it.

I do remember, when I was 12 or 13 and questioning my sexuality, the book *Everything You Always Wanted to Know About Sex: But Were Afraid to Ask* just came out, and for people who are unaware of this, this was the first popular book that really addressed issues of sex and sexuality, ever, at least that I know of. I think in the 1890s, there was something in Germany, but this was a big, big deal. I remember my parents had a copy of this, which of course I took, and I remember there was a one-page thing about homosexuality which said that gay men were deviants who were looking for vaginas in the wrong place.

[END OF AUDIO PART 2]

TAPPE: Oh, my gosh.

ZUCKERBROD: I mean, it was so negative about homosexuality, I can’t even tell you, and I remember reading that and shaking because I thought, “Oh, my God, I think this might be me, and obviously I’m sick.” I mean, it was still in those days classified as a mental illness. I grew up in a liberal, Jewish household, but that was the societal image of homosexuality; that there was something wrong, it was deviant, it was to be avoided at all costs. Fortunately, for whatever reason, I think I grew up with a little bit more sense of self-worth, although it probably took me
20 years of therapy to get there, but when you have a class of people that’s marginalized for being who they are, they’re not going to grow up with healthy self-images.

I think it’s really important from a historical perspective to understand that that was where we grew up, and I was in a liberal household as compared to a lot of the patients that I was seeing in the late 1980s and 1990s who grew up in Southern Baptist homes or strict Catholic homes or some other religious subgroup that was very, very rigid about their thinking about sexuality. These people were absolutely demonized when they came out and never developed a sense of self-worth, so it’s no wonder that they were drinking themselves to death or feeling themselves incapable of being worthy of ongoing relationships.

I think what’s happened over the years is when you start having the Ellen’s and the Family Guy’s or whatever it is, one television show after another, one movie after another that’s normalizing homosexuality, that people are able to grow up with role models.

I dated a man in the mid-1990s, when I finally came out, who was the assistant conductor of the Houston Symphony. His name was Steven Stein, and I’m happy to use his name, and I think he’d be happy with it. He was the first of the major arts people in Houston to officially come out in the media. Now, the conductor of the symphony was gay. The head of several of the theatres were gay. The ballet director was gay. All of these people were gay, everyone knew it, but it was all hush-hush. Nobody would ever talk about them. They were never interviewed.

Stephen was out there conducting interviews, and when the two of us
started dating and I was really in the early stages of really officially coming out, he said, “Look, if we’re going to be out together, you’re going to hold my hand in public, you’re going to acknowledge that we’re in a relationship, and we’re going to show people that there’s nothing wrong with this,” and I was terrified. I was a physician. I thought if people know I’m gay, they’re not going to come to me, and that did happen a couple of times. It took me a lot of time to realize, so what? If they’re not willing to take me on as who I am, then what difference does it make?

TAPPE: A lot of personal growth there on your part.

ZUCKERBROD: It took a lot of personal growth, but Stephen’s concept was, he said, you know, “I want some little boy or girl out there to be able to look at me as a gay person and say, ‘Oh, I want to be just like him.’”

That’s really what got me into that mind-set because I thought, you know what? Why not? Why shouldn’t there be gay role models in medicine and the arts and every other field?

Now there are. I think what’s happened is, this has been normalized, not completely, obviously, but to a great extent. I’ll tell you two anecdotes about this that I think are sort of telling with this.

The first is from my kids. My daughters are twins, but I always had separate birthday parties for them. One of them wanted a sleepover for her eighth birthday, so we had eight or 10 girls running around the house, screaming and yelling, and they were running around the kitchen, and one of them came up and stood in front of me and said, “So are you really gay?”

I said, “Yes.”
She said, “Oh, that’s so cool,” and just started running around.

I had sort of been living under this thing of I’m not going to deny that I’m gay, but I’m not going to make a deal out of it, because I don’t want my daughters to suffer for this. It’s just a total nonissue with this generation.

The other story is more recent. I’m involved with EPAH [Executive and Professional Association of Houston], which is a gay and lesbian professional organization, and I went to a mixer a couple of months ago and met this couple. One of them is an optometrist, and the other one is a dentist, and I would say they’re probably in their late twenties. Just listening to the story, they’re from different ethnic backgrounds. One of them, I think, is probably South Indian, and I think the other one is Hispanic. But they grew up in Sugar Land or something like this, met in high school, have been lovers ever since. Their families are totally supportive. The two of them went through college together. They got married. One is supporting the other as he sets up his practice. And the families just want to know when they’re going to have kids.

I mean, it’s wonderful, it’s the way it should be, but this would have been a far-off fantasy, when I was growing up, that my family would ever have been delighted with me bringing home my boyfriend from high school, much less waiting for me to have children.

So I think this is the next thing you want to ask about, and I’ll jump the gun on this.

TAPPE: Yes.

ZUCKERBROD: I have twin daughters. They’re about to turn 18 years old. The story behind that is that I was married to a woman for a brief time in the early 1990s.
She had a son by a previous marriage, who was adopted. The relationship didn’t last for various reasons, but what happened as a result of this was I became sort of a de facto stepfather to this boy for four years, and I loved it. I absolutely loved him. I loved being a parent. When the relationship ended, I really mourned the loss of that parenting relationship, and in fact to the extent that I tried to get custody of this child.

I went to speak to the rabbi who had married us, and I don’t think he realized that I was dealing with sexual issues, but he said, “You’re getting divorced because you want to end the relationship with the mother. Go make your own family.” I doubt that he had any concept of what he was really saying, but it really resonated with me, and I thought, you know what? I can do this. I can do it as a gay man. I can do it as whoever I am.

The fact of the matter is that the tides were changing at that time, not quickly, but the range of possibilities was opening up. I really took this to heart. As I said, my ex-wife’s child had been adopted, and I thought, well, why don’t I just adopt? I started looking into that, and it’s a very long and circuitous story that probably would make an interesting thing, but it has nothing to do with HIV. I ended up looking into surrogacy, and so I signed on with a surrogacy organization in California that had just started, that was exclusively dealing with gay and lesbian clientele, and two years later my daughters were born.

I’ll tell you some interesting things about this. At that time, I was very involved with the Gay Men’s Chorus, and that was a wonderful, supportive organization, but most of the guys were my age or older. You know, in my generation, basically if you came out as gay, you gave up the concept of ever
being a parent because that was just not in the cards. So when I announced that I was going to be a parent, several of the guys in the group said, “Oh, we’re going to throw you a baby shower,” and boy did they throw me a baby shower. There wasn’t anything I needed after that. The sort of universal refrain that I heard was, “We don’t understand why in God’s name you’re doing this, but we support your right to do it,” which was amazing.

When the girls were born, I was cautious about being very open about it, because I did have some straight friends who absolutely rejected me for doing this.

TAPPE: Really?

ZUCKERBROD: Yeah, absolutely rejected it. So I had sort of been burned by it, but I also had done a lot of research about this, about whether it was detrimental for a gay parent to raise children, all of which showed that actually the kids of gay parents do better as a whole than the kids of straight parents. After all, no gay person is going to get knocked up because they don’t want to get pregnant. I mean, that doesn’t happen, so it’s a different environment.

The conclusion I came to was that it takes a village to raise a kid, and I just thought I need the whole community to support me, so I was always completely honest with the girls about being out, even though they didn’t understand what it meant, obviously. I was very open about being gay and being a parent.

Shortly after the girls were born, The Triangle, which was one of the newspapers here, did an article on gay parenting, and they included me in the article. As far as I know, and I’ve never heard anyone contradict this, I was the
first gay man in Houston to do surrogacy. As a result of the article, I just got tons of people, gay and lesbian, contacted me. “How do you do this? What are the downfalls? What’s the legality?” There were some tricky legal issues in those days, and I really think I mentored the parents of a lot of babies. It was really sort of gratifying to see the tide turning at that point, the people recognizing yes, you can do this.

Now, I was far from the first gay and lesbian parent around. We had a very active gay and lesbian parenting group, which I attended for several years before I did this, and the stories were very encouraging. Most of the men who were parents came out of divorces. Many of the women who were parents did not. Some of them had had artificial insemination, or some of them had come out of marriages and already had kids. But for the most part, much to my surprise in Texas, the stories that they told were that the children were accepted in the school communities, that the parents were accepted as being couples, nobody discriminated. And that’s been exactly the experience that we’ve had.

TAPPE: Good. The girls, I’m sure, are very open to all of your friends and the community as a whole?

ZUCKERBROD: Well, yeah. The fact of the matter is, I don’t think they really talk about my sexuality much at all. The thing that they actually seemed to have difficulty with as youngsters was the fact that I was a single parent, where most of their friends were coming from two-parent households. That was the thing that made our family different. It wasn’t so much that I was gay. It was that I was not attached. Then unfortunately, early on, the parents started divorcing and separating and new partners came in, and they realized that they weren’t all that
different.

What I think is really remarkable about what I see and very encouraging is that the kids are colorblind and sexuality-blind. They have friends that are lesbian, gay, questioning, intersex, nonsex, “Don’t use a pronoun with me,” and it’s just all accepted.

When I ask them to describe friends, they’ll tell me about them, and then when I meet these people, it turns out they’re all different colors. It’s not a factor in their awareness of the description to say, “Oh, this one is African American,” you know, or Asian.

TAPPE: Which you probably have a certain visual image when you meet somebody, and then you go, “Oh, yeah, you’re Asian. I didn’t somehow picture you that way.”

ZUCKERBROD: Yes, which is wonderful. It’s not that they don’t get it. It’s just that that’s not a descriptor, whereas I think in my generation, people would say, “Oh, he’s black,” as the No. 1 thing that you describe.

TAPPE: Yes, I often do that when I describe someone. Well, congratulations on 18 years of parenting.

ZUCKERBROD: They’ll be 18 in August.

TAPPE: Are they Leos?

ZUCKERBROD: Yeah, and born in the year of the dragon from the Chinese calendar. They’re pretty strong kids.

TAPPE: Your hands are full. That’s wonderful.

I want to ask you just one more question, getting back to the generational issues and education. When we were younger, or you, as you said earlier, may not have been out quite so much, but in the 1980s, when HIV was really at its
peak, in the 1990s, there were a lot of educational programs. We saw a lot of signs and billboards. It was in all of the magazines. It was in the bars. There were faith-based programs. Everybody was educating about transmission of HIV and STD’s [sexually transmitted diseases].

ZUCKERBROD: Right.

TAPPE: I don’t see that anymore, or I see very little of it. In certain populations, HIV is on the rise, sexually transmitted diseases are on the rise. Can you think of anything, or would you have any suggestions, in terms of how to raise the level of awareness again? Not just in the gay community, but in the community that’s sexually active? STD’s are not exclusive to our community.

ZUCKERBROD: It’s interesting because I think I saw a couple of these billboards here. I definitely saw them in California. There was a billboard that’s a takeoff on the famous Japanese woodcut of the wave, and it says “Syphilis Tsunami.” It was trying to educate people about the dangers of syphilis.

TAPPE: Is that current, or you saw that recently?

ZUCKERBROD: Yeah, fairly recently. Certainly within the last year. I think I saw that same one here.

I’m going to expound on this a little bit. I think within our community, going back to our time frame, I think there was a certain level of self-destructiveness in the gay community, not just with drugs and alcohol, but with sex as well. I think there was just this sense of non-deservingness which basically told people that they deserved to die of a bad disease, and so there was almost a sense of inevitability about it.

I’m hoping that that has passed, but one of the things I see with my kids is,
you know, they’ve grown up post-9/11 in a time period of unbelievable growth in technology, but also, I think, with that, a destruction of a lot of social interactive values, and they are also the kids of the *Zombie Apocalypse* movies and *Clear and Present Danger* and recognition that the global warming is coming and meteors are going to smash into the planet. I mean, my kids really, and it’s really sort of shocking to say this, but they don’t have a sense that the world is going to be around much longer, and it’s really a very frightening mind-set.

I try to argue with them about this, but the fact of the matter is, they’re very well-connected. They know that the planet is getting warmer. They know the storms are getting bigger. They know that the population is rising; that the ability to feed — I mean, there’s a lot of negativity about what they see the future bringing, and I think when you grow up with a mind-set like that, it’s kind of hard to worry about a disease that is curable.

I don’t know how you can make people aware that yeah, it may be curable, but the cures are not wonderful. So I don’t know, and again, when you’ve got, especially in this country, and here I’m going to get political on this, but when you’ve got a gun epidemic that randomly kills more people probably than HIV does in a year, and that problem is not being dealt with, it’s kind of hard to make a big deal over a disease that’s seen as treatable.

TAPPE: What an interesting perspective.

ZUCKERBROD: Yeah, well, it’s a perspective as a parent watching kids grow up in this time period. I mean, I’ve had frank talks with my kids about sex from the time they were 10 or 11 and it became apparent that they were getting interested in it, and I think they realize that they need to use condoms if they’re going to have
sex, and they need to be careful about all these things, but I also think that it’s not necessarily a turn-on trigger in their minds like other things are. I don’t know how you deal with it. I think the population in general is numb to so much tragedy, and I don’t know how you turn this into one.

What have other people said to this?

TAPPE: Well, I really appreciate this perspective because I haven’t heard that before. People have different ideas about getting the word out about diseases, but I really have to give this a lot of thought. It’s very interesting, and it makes sense because we are so strained on an emotional level, I think, for a variety of reasons, many of them that you touched on. It also kind of centers around the political atmosphere, and a lot of these are political issues.

ZUCKERBROD: Oh, absolutely.

TAPPE: The earth warming shouldn’t be a political issue, but it is. But when you hear about all these other concerns, you’re right, you get drained, and then this just doesn’t have as much importance.

ZUCKERBROD: You know, it’s interesting, too, I think back when the girls were about six or seven, the exhibit Body World came to the museum here, and I was a little reluctant to bring them to see it, but they saw advertisements for it, and they said, “Oh, we’ve got to go see this. We’ve got to see this.” So I did bring them, and I’ll never forget. They were going around the exhibit. They were fascinated by the whole thing. They didn’t find it morbid at all. But there was a case — I don’t know if you saw the exhibit.

TAPPE: I did see it.

ZUCKERBROD: There was a case of lungs, and it showed three lungs. One was a
normal, healthy lung, which was pink and plump and wonderful looking; one was a coal miner’s lung that looked like a lump of coal; and one was a heavy smoker’s lung that just looked like a piece of gray, horrible Swiss cheese. I remember the girls dragging me to see this, and they said, “Ew, that’s what it looks like when you smoke. We’re never smoking,” and they have never touched a cigarette since. That sticks in my mind as something really graphic that they were able to get, themselves.

I don’t know what would be the equivalent with a sexually transmitted disease that it could relate to. I mean, you could show someone with advanced syphilis, which is not a pretty picture. But basically someone with advanced HIV looks pretty much like anyone else except maybe sunken cheekbones, so they’re not growing up with an awareness of the ravages of these things, and I don’t know how you do it.

TAPPE: Well, it makes perfectly good sense. I’m going to say I’m going to view this in a completely different manner. I truly am.

Thank you so very much for your time.

ZUCKERBROD: My pleasure. Thank you.

TAPPE: It’s been a pleasure. You’ve offered us so much information, background, and history.

ZUCKERBROD: Well, I’m glad. I hope it gets used.

TAPPE: No question. And good luck with your girls. They’re lucky.

ZUCKERBROD: Thank you.

[END OF AUDIO PART 3]

[INTERVIEW CONCLUDED]