HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

George Saslow

Interview conducted June 13, 2001

by

Joe Bloom

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[Begin Track One.]

SIMEK: Okay. Again, Joe, if you could give me a slate. And go ahead.

BLOOM: Okay, this is Dr. Joe Bloom. It's my pleasure today to interview Dr. George Saslow. It's June 13, 2001, and we're working here at the Oregon Medical Association. George, we have a certain amount of time for our interview here. And I thought I'd like to start by maybe having you give us just a brief story of your background: where you were born and grew up and went to school and went to medical school.

SASLOW: I was born in Brooklyn, New York, in the first decade of the century. At that time, the part of Brooklyn we lived in was a few blocks away from a farm. I have vivid memories of a bunch of us as youngsters living on that block, stealing into that farm and stealing apples and tomatoes and things of that kind. Now that's all, of course, paved over. I couldn't recognize it if I went back. I stayed there until I was about fifteen, and then I left and never returned. Because I crossed the river, the East River, for the first time in my life at fifteen, about a five or six miles trip, and lived in Manhattan, where I went to college for the next four years.

I went to college starting out with, attempting to take an evening course. But the dean, looking at my high school record, I had been valedictorian at the best high school in New York, called the Boys' High School, he thought I ought to go to college full time. And I told him I didn't have any money to do that except for one course. He offered to give me a part time teaching job as an elementary biology teacher. So that's how I went through college.

BLOOM: Which college did you go to?

SASLOW: That was Washington Square College, a brand new college, only a couple of years old at that time, a part of New York University. Now it's the major part, I graduated there in 1926. I had no idea what I would do next. But the same dean of the medical school, who invited me to go to college full time instead of part time, was the son of a man who was the chancellor of one of the only new medical schools in the country at that time, the University of Rochester Medical School. And he said I could go to medical school, which I'd never thought of doing. I expected to go to work right after going to college, finding a teaching job or something. But he made it possible by supporting me while I went to medical school at the University of Rochester.

At that time, you didn't have to take any SAT tests, or medical, what do you call that medical school thing? You just were admitted. And I was, the class was one of twenty-four students from different parts of the country and abroad. I was the youngest

student in the class. I was nineteen. And I became a friend with the oldest student in the class, a Norwegian engineer, whose work had collapsed in the Depression. And he came from a medical family and decided to go into medicine. And we taught him medicine. We became such close friends that I named my older daughter after his daughter. Her name was Rondi, a Norwegian name.

Well I stayed at the medical school for two years, and then I left because my family needed financial support. I decided to get married, and I left. I was out for nine years. And I took graduate work at New York University while teaching there, and got a PhD in physiology. So after that time, I left New York University and I reentered the Harvard Medical School after the dean of the School of Public Health, who was editing the *American Journal of Physiology* showed interest in a paper I submitted, invited me to talk with him. And on discovering that I had not completed my medical school course, asked if I would like to. I said I would, but I couldn't possibly afford it. He said well, we'll help you afford it. Engaged me to do research part time for the remaining two years I needed to complete my medical school work. Took me three years to do that. I did research working on problems he and I were both interested in. The activity of the lymphatic system.

BLOOM: And what year did you graduate?

SASLOW: And then I graduated from the Harvard Medical School in 1940. I was still uncertain what to do. I'd always thought I would do research in internal medicine. But the same dean of the School of Public Health, Cecil Drinker, asked me to talk with him before I made my final plans, when I was finishing my third year at the Harvard Medical School. He said, "I'd like to point out to you that at the present time, there's a field called psychoanalysis." I'd read some of Freud, but knew nothing else about it. "And the people in that field, practically not one of them has had any training in the basic biological science. You have had, because you have a PhD. You might, if you went into psychiatry, be able to make some important contributions. So I suggest you think about that."

Well the way you thought about it was you could get a couple of months off out of your regular Harvard Medical School senior program if you worked eleven months of the year, didn't take a vacation, you could then take an elective for five or six months in the field that you were testing yourself out in. So I tried psychiatry. And after the first couple of interviews, I was absolutely hooked. I saw an interviewer do extraordinary things with nonverbal communication I hadn't imagined possible. And I became fascinated. I then decided I would go into psychiatry. So then–

BLOOM: And so where did you train in psychiatry?

SASLOW: My first training was at the Boston City Hospital. I spent a year on the neurology and neurosurgery service. That was a service where you did all of your own medical work. And again, the advice I received was I would save, I would not have to do two years of internship; I could do one if I work on a service like that where you did

all of your own medical work. I did that. I learned a tremendous amount of neurology and neurosurgery and so on, and did a lot of excellent work in taking histories and so on. And after that, I went to Wooster State Hospital for my first year of psychiatry residency. At that time, that was considered one of the best psychiatric hospitals in the country because a certain amount of research was going on. (?) mainly in defining carefully by mental status examinations by a very skillful examiner, Dr. Malamud, you defined the various psychotic disorders in a way that nobody else in the country was apparently able to do.

So I spent my first psychiatry residency at the Wooster State Hospital. At the end of it I was made into an assistant resident, and for the first time I received some salary. Up to that time, I'd received nothing from Boston City Hospital or from Wooster State Hospital.

And after finishing that year at the Wooster State Hospital, I went back to the Massachusetts General Hospital, where I'd first seen this interviewing done by Dr. Eric Lindemann. And I was the chief resident on that service for the next year. At the end of that, I had to find a job. I was offered a position at Harvard. But they paid you about six hundred dollars a year, on which I could not live. You had to come from a well to do family to take a position at Harvard in those days. So I had to reject that.

And I took the first job which came up, which was at Washington University School of Medicine. I had, at that time, the dominant attitude in psychiatry was psychoanalysis. Harvard was completely overwhelmed by Freud's work. I spent a year in psychoanalysis with one of Freud's collaborators, Hans Sachs. At the end of which, he and I decided psychoanalysis was not something I needed to spend my time on. I was about the only resident for a number of years, graduate of the Harvard Medical School Psychiatry Program, who did not go into psychoanalysis. I did not. And that became widely known. The people with whom I was associated was psychoanalysts, and I was severely criticized for having failed to convert me.

Excuse me!

Can we just pause here for a moment?

Can we just interrupt you for a second, David?

Okay, ready, and take it away.

BLOOM: George, so tell me, what year did you move to St. Louis?

SASLOW: I moved to St. Louis when I finished my residency, chief residency at Massachusetts General Hospital in 1943.

BLOOM: 1943. And the economics of your training, you were not paid as an intern at all?

SASLOW: Paid zero. And paid only the second half of that year at Wooster State Hospital. Of course, I was given a new title, assistant resident.

BLOOM: And then you got six hundred dollars a year at Mass General?

SASLOW: Mass General, I had to borrow money to live on.

BLOOM: Was your wife working at the time? Or how did you support–

SASLOW: She was working in some kind of social work situation. No, in Boston, no, she was not working. The money we needed to live on came from a college friend who had inherited a metals business. His brother had died. And we were good friends in college before I graduated. He had said if I ever needed any financial help, he knew I had no resources, he would be glad to help me. And he did. So did my younger brother, who had become a lawyer who was practicing.

BLOOM: So these were also the war years. So what was your–

SASLOW: In the war, I was fluent in German as well as French and Spanish and English. And I had read a lot of literature in German that was being published by people who were anti-Hitler. So I knew a great deal that was going on, felt very strongly about what was going on long before we got into the war. And as soon as we got into the war, I offered to enlist. I was rejected by the draft board for two reasons. I had psoriasis, which had appeared a year or two before, and they were very, a tremendous amount of disability among soldiers in North Africa who had psoriasis became very much worse, weeping, and totally disabled them. I also had a history of asthma. And that also was disabling.

So I was assigned, instead, to conduct examinations at a draft session while I was still in Boston. When I went to St. Louis, my job was to educate physicians for the war. That was what I did for the next several years, in one of the accelerated medical training programs to produce more doctors for the war. But I could not be accepted when I tried to enlist.

BLOOM: When you tried to enlist.

SASLOW: And felt very strongly about it.

BLOOM: Well, tell me–

SASLOW: I was at Washington University for twelve years.

BLOOM: Yes, I was going to ask you about that. So maybe kind of describe what you did at Washington University, and then we'll move on to Oregon.

SASLOW: At Washington University, I introduced teaching of psychiatry to the medical service by interviewing patients I had never seen before, before an entire class of

sophomore students. I did that once a week for years. Interviews people often remembered for many years because they would be so, since both I and the patient were new to each other, the most dramatic things would happen in such interviews. Of course, they learned a lot about how to listen and do an interview. And I became, I was promoted to professor there.

And at some point after that promotion, the Commonwealth Fund of New York, having heard of my interest in general medicine, urged me to establish a kind of, it was a special clinic in the Department of Medicine, so that people in the medical clinic would learn psychiatry. All of the medical service residents were assigned by Dr. Barry, then chief of medicine, to rotate through my clinic. A number of them became interested in psychiatry. And one, Sam Guze, became a psychiatrist. Became head of the department and became vice president of Washington University. He died just a short time ago.

Well, in addition to those activities at Washington University Medical School, I was in charge at first of the medical student health service. This rapidly expanded to include health service for nurses, for dental students, and then for the rest of the university, which was across Forest Park, a different part of the city. We became the health service for the entire university, and a number of residents in the department of psychiatry worked with me learning to rotate through that service. So it was a very important health service. [coughing]

Why don't you take a sip of water, Doctor? It might help.

SASLOW: I'm trying to think of what happened next.

BLOOM: Well maybe you could tell me how you got to Oregon.

SASLOW: I'm trying. Some things, I'm missing something. Before I left Washington University of St. Louis, I was suddenly asked to be the psychiatrist at Los Alamos, where the Manhattan Project was going on. The reason for that was that the president of Washington University at that time was a man named Arthur Compton, had won a Nobel Prize for some work he had done in physics. And he, like many of the other people that worked at Los Alamos, had an assumed name. I forget what that was. A lot of the people at the Manhattan Project started at Los Alamos. About two hundred people were involved. They had a small medical detachment headed by a rheumatologist, a Dr. Hagerman, to provide medical care.

Suddenly they were overwhelmed with psychiatric emergencies they had not foreseen, for example, there was a soldier who was driving into Albuquerque down very poor roads at the beginning from Los Alamos when he had some time off. Was drunk, got in a terrible accident, was operated on by the surgeon at Los Alamos who himself had been in the Pacific Theater. Had malaria, but was now practicing surgery, was considered, he was very much admired as a surgeon. But while working on this soldier who kept on spitting up stuff, he told him to stop spitting up stuff. And he got so

infuriated when the soldier could not do it, he beat him to death with a wet towel. This immediately became known to all of the two hundred plus people in Los Alamos.

They had got to Arthur Compton. I was asked to go out and be the psychiatrist at Los Alamos, because I was the only psychiatrist in the faculty at Washington University who had had experience working with sensitivity training groups and communities. I had done that several years before, which I just remembered. So for the next ten or twelve years, I was the consultant to Los Alamos. First going out on the Santa Fe *Chief,* because you couldn't get planes. Later on being flown by planes in emergencies, when something else happened.

There was another emergency like that where a chief and highly regarded surgical chief nurse suddenly committed suicide, or tried suicide with chloroform, for example. I would have to meet with the whole community. I'd be flown out in the middle of the night and deal with these kinds of emergencies. And I went on after that for about ten years coming out regularly for a week at a time, four or five or six times a year until they established their own hospital, began to get medical personnel, and the community began to be allowed to bring family members in who were not research workers. At first, nobody was allowed in but the person actually working on research. Couldn't bring your wife, couldn't bring children, couldn't bring parents. But when that all changed, they began to invite other medical personnel, and then I was no longer necessary after about ten years, and so I stopped.

Now in that, just before that period of going to Los Alamos had gone on very long, the chief at Mass General Hospital had now become Eric Lindemann. Dr. Stanley Cobb, his predecessor, had died. And Dr. Lindemann and I had been very good friends. And through him, I became interested in psychiatry, really. With him I participated in that famous Coconut Grove fire where five hundred people were brought as charred corpses after the fire into the Mass General area. We took care of them, worked with their families.

Lindemann wanted me to come and be his administrative officer. He didn't regard himself as a good administrator. He wasn't interested. I thought very carefully about it, discussed it carefully with my family, and finally decided to do it. When I got there, it turned out that he was really a very poor administrator. He never let a person be a chief of an outpatient clinic or an inpatient (?). Everybody was called an acting chief. He was very suspicious to a degree which amounted to being paranoid about people not respecting him sufficiently. After I'd been there about two weeks, he suddenly got angry at me for no reason which makes any sense to me whatsoever. And from that time on, where I'd been teaching over three hundred and fifty students a year at Washington University, I was allowed to teach one student. I was bored to death for the next two years, not being allowed to function in any way like what he'd invited me to do with him.

And I kept on being told by the head of the medical school who was, what was his name, Barry? Barry? He was a professor of infectious disease at Rochester (?) before, I had known him. He was now dean at Harvard. And the head of the hospital, Dr. Clark,

they both told me they would try to solve this problem somehow so I could stay there. I waited for two years while they tried to solve this problem, which they never succeeded in doing. It turned out that Dr. Clark was an alcoholic. And the dean of the medical school was unsuccessful in persuading any kind of solution to be found unless I left the department of psychiatry, joined a neurologist named Adams, whom I knew well, and (?) the psychiatry department. I would be in a perpetual conflict situation if I decided to do that. So I went through two years of misery waiting for them to solve the problem. They never did. I became quite depressed, as my family noticed. Lost interest in everything except seeing large numbers of faculty of Harvard patients. Earned a lot of money, more than ever before, but I was bored to death.

And then I began to be invited by the head of the medical school here, Dr. Howard Lewis, to consider coming out to Oregon. He was on the board of internal medicine for the country, and on the board, also, with him was a man named Chester Jones, who was chief of a gastroenterology clinic at the Mass General Hospital with whom I had worked in collaboration. I showed him how a psychiatrist could help his gastroenterology residents and doctors without taking over the patient. And Jones thought very highly of that way of psychiatrists working. So he kept on recommending me to Dr. Lewis. He kept telling me to go and at least look. And after two years, I gave up on the dean of the medical school and the head of the hospital solving the problem, which they said they could solve. And I began to look around other places for jobs. I tried a number of places.

And I was delighted when I came out, finally, to Oregon. I was received very cordially by Dean Baird, who told me he would do everything possible to help me create a contemporary psychiatry department. Psychiatry had just become familiar with a new drug, Thorazine, which had not existed until about 1954. It was discovered in France, I think. And the treatment of psychotic patients, that completely changed as a result of that. But the hospital, which had finished in 1950, South Hospital had been finished in 1956. It had been designed in 1950, ’51, before this drug had been discovered. At that time, people were treating psychotic patients as I had been treating them at Wooster, which is the way they were treated without medicine, effective medicine. Dating from about the 1870s, modeled on English hospitals, they used the hot tubs, they used ice cold (packages?) to wrap patients in. They used electric shock with great frequency and so on, with many injuries as a result. The treatment had changed entirely by the time the hospital was open.

And so I found a hospital which was conceived in terms of advances that had not yet been made. It was about a twenty-five-ward unit with a wall down one side, five rooms along that side, each supposed to be a seclusion room for a psychotic patient, of whom they were deathly afraid. And at the end of that little corridor, there was a nursing station where there were three shifts of nurses all covering through the twenty-four hours for these five patients. There were no offices for any residents. There was just one office for the head of the service. There was no office for a psychologist or people like that.

BLOOM: So you came in 19–

SASLOW: I came in 1957.

BLOOM: '57.

SASLOW: The hospital was designed in terms of 1872. [laughs]

BLOOM: Okay. Let's take a step back for a minute. When you first came to Oregon and you took over this job, what was the state of psychiatry in the medical school? And then in the community, in Portland or in Oregon at the time. What were your recollections of that?

SASLOW: The things that were striking were the kind of treatment that was the rage in Boston psychoanalysis was hardly known. There was one person practicing psychoanalysis, Dr. (Berthlestore?). But he wasn't tied up with people at the medical school. There was much opposition to the medical school building a hospital on the part of the physicians in private practice. But the hospital was built, nevertheless, through the influence of Dean Baird on some of the legislators, I think, whose families he had treated and convinced that we needed a new hospital.

At that time, the psychiatrists who were most active with the patients were Dr., what was Deckle's uncle's name?

BLOOM: Herman?

SASLOW: No. Herman Deckle was a–

BLOOM: Dickson?

SASLOW: Yes, Dr. Dickson and his nephew, Herman Deckle. They both had learned in the training that Dr. Dickson had had in Colorado, they had learned to call all psychiatric disorders manifestations of a fundamental general anxiety. And they practiced methods called anxiety tension relief. Various kinds of relaxation as the main kind of treatment they used. Plus things like Phenobarbital and a few sedatives that were then known. But that was the main kind of treatment which was going on when I came to Portland. They were highly regarded. I had many very grateful patients. But that was what they did.

Deckle himself had, unfortunately, very severe rheumatoid arthritis. Walked with great difficulty, was often in great pain. But he was a very kind and gentle man. His patients really admired him and felt very sympathetically and kindly towards him. And he was the first psychiatrist who was president of the Oregon Medical Association. We now have another psychiatrist, Dr. Connie Powell, who's the president, she's the president-elect–

BLOOM: Yes.

SASLOW: –of the Oregon Medical Association. Well, I didn't have much to do with Dr. Dickson, but I got to know Dr. Deckle pretty well. I established, I changed the entire operation on the ward immediately because there was no longer any reason to be afraid of psychotic patients. And in my work at the Mass General Hospital, we had an open ward where there were mixtures of both psychotic and non-psychotic patients. Nobody was in seclusion. Very rarely was electric shock used and so on. And so my inclination was to make that ward an open ward without the fear of psychotic patients that had governed its initial inception.

And so with Dean Baird's help, we got rid of that wall that was down that corridor. We got rid of a number of wonderfully expensive hot tubs with wonderful new chrome fixtures that were put in to carry out the old kinds of treatment for violent schizophrenic patients.

And the way Dr. Baird could help me do this had a severe limitation on it. There was a rule the legislature followed that any institution newly built could not make changes because of defects or new things that were thought to be necessary if they cost more than ten thousand dollars. So Dr. Baird planned very carefully a series of changes to get rid of that rule, open up those seclusion rooms so that we'd have an office for a resident or two, a psychologist. We got rid of that nursing station. He did that by a series of maneuvers that took two years, each carefully labeled under ten thousand. And every time I had a problem about running an open ward, I would have people try to develop work habits in the community by going out into the city or working on some of the things on the medical school campus, like a printing shop under supervision of a person who ran that to help them learn habits of work. Every time I wanted to do something like that, I had to find out from Dean Baird and was very glad to do so, and he was always willing to listen, to help me. Am I putting the medical school in danger of some kind of suit if there's an accident or something like that. He couldn't always answer the questions which I had to raise, but he would ask his assistant, Dr. [Charles N.] Holman, who later became dean, at the next meeting of hospital administrators to find out what guidance could they get about what to do if we tried these new things. And I almost always came back with yes, it's all right, it's safe to go ahead. And we had no accidents, really.

BLOOM: Well now, aside from doctors Dickson and Deckle and yourself at the medical school and Dr. Berthel (?) who practiced psychoanalysis, were there other psychiatrists in Portland at that time?

SASLOW: Yes, Dr. John Mortimer was a child psychiatrist. Dr. Morrison was a child psychiatrist from Michigan. Dr. Morrison's wife, Dr. Mortimer's wife, was a social worker. He, she and I often made trips to numerous county medical societies in the state. We had meetings where we invited people to ask questions where we could be helpful. We demonstrated interview procedures for difficult patients and so on. We did that for a number of years. We couldn't always get back to Portland if there was a snowstorm or something. We'd sleep overnight at Eugene, something like that. But we worked together in collaboration all the time.

Now in addition to that, there was another thing about my coming to the medical school that was very important for me. When I had been in Washington University, I was well known by the department of medicine to be one interested in comprehensive medicine. And second, to attend medicine grand rounds more regularly than any faculty member except the chief, Dr. Wood. And I was a member of Dr. Wood's executive committee in the department of medicine where they considered morbidity and mortality statistics every week.

BLOOM: Dr. Lewis or Dr. Wood?

SASLOW: Dr. Wood.

BLOOM: Dr. Wood.

SASLOW: When I came out here, I told Dr. Lewis about this and he invited me to be a member of the executive committee. And a year after I came out here, Dr. John Benson came out. And Dr. Benson remembers I conducted a series of group meetings with the faculty of the department of medicine where we discussed what kinds of persons they would recommend for chief residency and so on, but also, we also learned a lot of how new people learn. We studied a book that was written about how learning takes place and so on. John Benson remembered that for many years. So I was an active member of the department of medicine in a way right from the very beginning. And that was very important. Of course, when I came out, there was no residency program. I was the only psychiatrist, supposed to run everything.

BLOOM: At the medical school?

SASLOW: At the medical school. I couldn't do it. I talked with Dr. Lewis and Dr. Baird about this. It turned out that they had one resident in internal medicine, Bob Grover, who was just about ready to have an (elective period?) He'd been–

[End Track One. Begin Track Two.]

SASLOW: –just his major requirements. He came from Cornell. He was always interested in brain activity. And he, Dr. Lewis and Dr. Baird and I agreed that he would be helping me, as my first resident to help me get started. He did that, and later on he became interested in psychiatry. And later on he became an assistant dean, as you know.

Well the reason there was no residency program, but I guess they have multiple reasons. One of them was that this state never wanted to accept money from the federal government, because they didn't trust its continuing to give them money. But after a while, we were able to get residency support of the medical schools. We were about the, one of the, I think the last twelve medical schools after World War Two in this country which had very few full time faculty members. Dean Baird had become full time only a few years before 1957. Howard Lewis had become full time from private practice a few years after 1957. There was a chief of surgery at that time, and a chief of anesthesia. And

that's why they decided that they wanted a full time chief of psychiatry. They'd reached the point where the medical school now was like the other ninety plus medical schools in the country. They had the funds and they had the attitude and they had the support from the appropriate people, I guess, in the legislature. So that's how I started.

BLOOM: And what was happening at that time in the state mental health system? I know you were close to them at times and–

SASLOW: I have very (few?) memories of that. But Hatfield was governor. And I guess through Dean Brooks, who was the head of the Oregon State Hospital, and one of the, one of the psychiatrists, no, it must have been one of the judges, they were interested in establishing a mental health division. And on Hatfield's invitation, I was a member of the group that established the mental health division, which has persisted to this day.

BLOOM: Yes.

SASLOW: That was new at that time. Oregon did not have such an organization.

BLOOM: So you were able after a little bit of time to get the residency program going, and you got federal funds. And what about faculty? Were you still doing this all by yourself?

SASLOW: No, I began to, I invited Jack Butler the year after I came out here. And after that, there were a small number of others. But there were people who were already living in Portland. I think Jack Butler was the only one who came from another state, from Idaho. But the residency program steadily grew. I don't know how many residents there are now. There are eight or nine new every year.

BLOOM: Yes.

SASLOW: But the total number is thirty or forty.

BLOOM: Thirty-five now.

SASLOW: (?) Starting from zero. That's what's happened.

BLOOM: Now what about your philosophy? I mean, you had a unique background.

(?) Can we just pause for a second?

BLOOM: Sure.

George, if you'd like to sip a little more water.

SASLOW: Yes, I would. I need some.

Yeah.

Okay, ready? And continue, please.

BLOOM: Now George, in your approach to psychiatry, you had a unique background and training. And having shared some of that myself in Boston you developed a unique brand of psychiatry from my point of view in Oregon. So tell us a little bit about your philosophy of psychiatry. And then as the years progressed, you've been here most of the time from 1957 to now. Kind of take us through the changes that you've seen in psychiatry. But first, tell us a little of your view of what psychiatry's all about, and how you tried to train your residents.

SASLOW: Well, I decided that psychoanalysis was not the pathway for me, nor the way to train residents. And it was for a particular reason. While I was at the Mass General Hospital, before I finished my training there and left for St. Louis, I went to occasional meetings of the New York Psychoanalytic Society, we followed the American Psychoanalytic Association to see what it was like. And I can never forget a meeting which made it, had its final influence on me. There was a discussion on the causes of alcohol dependence and alcohol addiction. And four or five well known people whose names I knew, senior analysts in the American Psychoanalytic Association, whose names I'd seen in what I'd read, would get up and each would propose a different hypothesis about the cause of alcohol addiction. It never occurred to any one of them to raise the question, since a lot of these different points of view, they all sound as if they're based on individual speculation and ignore observation. What about setting up a series of hypotheses which you could test by some way? Never occurred to a single one of them to do that, and I realized that was not for me.

Years later, in 1959, I attended a meeting headed by Carl Rogers, dealing with a surgeon's psychotherapy. It was so immature at that time. There were no really good ways of doing psychiatric research. And I had already been spending years studying the psychiatric interview in a research way. So I was interested in finding evidence on which to base various kinds of psychiatric treatment. So I experimented with, I introduced the residents to different types of individual therapy, couples therapy, family therapy, group therapy, sensitivity training. I did all of that to introduce to them the variety of approaches that psychiatry now had, other than psychoanalysis.

I didn't ridicule psychoanalysis. But such, the contributions that I thought that Freud had made, such as relating later experience or earlier experience, and listening carefully, were very valuable. But the rest of it, I couldn't see any point in teaching them. And I did not.

Now once a medicine like Thorazine appeared, it became possible now to have psychotic patients on the same ward as non psychotic patients. People were not dangerous anymore. I would invite the families of patients to live on our ward with them. Sometimes if there were several psychotic members of one family, we'd have all of them

present at the same time, being studied. An open ward. Open itself and to the community in various ways for various kinds of experiences. That was a general background that I used.

Furthermore, at one point, after I'd arrived, it was clear a number of the residents who were married were having marital problems. And so my wife and I, she was a psychologist, we arranged to have group sessions with the residents, which were very helpful in helping them with their marital problems. We both did the same thing for fourth year medical students who were married and facing where would they go after they graduated? Would they go to the same place? Would they go to different places? And what would it do to their relationship and so forth?

So we introduced the various members of the department to all these different ways of looking at psychiatry. Always relating it to general medicine. I always urged that people try to brush up on their medical knowledge as they finished their residency, for example. There's a lot that they had forgotten that now they would look at in quite a different way. So I did that, too.

BLOOM: And what was the connection, as you saw it, to general medicine? Why would you ask them to brush up? And how did you see that part of the training?

SASLOW: I had become aware, and this was something which was made very, even more convincing to me. One of the grand rounds given by a member of our department, Dr. Richard U'Ren, I had become aware that when psychiatric problems seemed to be unusually resistant, there was often an unsuspected, undiagnosed medical problem going along simultaneously. And so I thought, I believed it was necessary to have careful medical examinations and to be aware of medical possibilities unrecognized in psychiatric patients as a source of their failure to improve with otherwise effective methods of psychotherapy. So that was my interest in general medicine played that kind of role all the time.

Now as the new medicines came in, as we came to know more and more about various of the transmitters and so on, I became more and more interested and aware and determined to keep up with the knowledge of what these new medicines were. And always did that. So as I supervised residents, I never lacked bringing them up to date if they were not up to date on some of the new kinds of medicines.

I also should mention that I was unusual in my behavior as a chief of a psychiatry department in that I always met with the entire staff when we had only one ward, I met with the staff either every day or several times a week. And every member of the staff was invited to raise any kinds of questions. I always would leave a few minutes at the end of, say, an hour's meeting. "Are there things that some of you have thought of saying but somehow didn't get a chance to say?" So that you could always get hints of questions that needed attention. And that was how the ward was run. And that way I conducted these regular meetings about patients on the ward. I met with the staff regularly, and I kept on

treating patients myself all the time while doing research. I thought all of that was necessary for a chairman to set an appropriate example.

BLOOM: Now you were chairman in Oregon for twenty years, approximately. And then I know you went to UCLA for a bit. So could you tell us a little of that chapter? And then you came back.

SASLOW: Right.

BLOOM: Tell us a little about that. And then what you saw contrasting Oregon and UCLA.

SASLOW: Well, when I reached sixty-five, the policy at the medical school was part of a general policy supported by the federal government, which was when you were about to get to be sixty-five, the dean would call you in and say, "It's time for you to prepare to resign, to retire." So (?) look for a successor. The one who had done that just before me was Howard Lewis. It took four or five years before a suitable successor was found for Dr. Lewis. I assumed something like that would happen to me, but it didn't. The time it was mandatory until President Carter got that law changed. So it is no longer in effect now. So in 1973, I was mandatorily retired from the chairmanship.

And they found somebody in a year who was a disaster, Dr. [Paul] McHugh. Half the department faculty left. They couldn't stand working with him. And I, after being around for a year with him there, got just bored to death. At that time I received an invitation from the chief at UCLA, Jolly West, to come down and help develop a residency program at the Sepulveda VA Hospital. Because the California legislature had mandated an increase in the size of the UCLA medical school class, and they needed some new teaching facilities. So I went down there for five and a half years, developed the residency program, which is still going strong. Made a lot of new friends down there, had a great time. I was the chief of the service for a while, and chief of behavioral education down there for several years.

What I found down there was a very receptive attitude from Jolly West, who also, although he was familiar with psychoanalysis was not a psychoanalyst, he and I were very good friends, and he valued very much what I did and tried very hard to persuade me to stay indefinitely. But I had decided before I went that we would come back to Portland, which we decided to do. I had a good time there. I found a very interesting and stimulating environment in various fields, both within psychiatry and related to psychiatry and neurology. But I had not intended to stay there.

BLOOM: Why did you come back?

SASLOW: Because I wanted to come back to Portland.

BLOOM: Wanted to live here?

SASLOW: All the members of our family but one have preferred to live in Portland. Our older daughter, the one who is named after my Norwegian friend, she thinks Portland is parochial and she likes to live in California. But everybody else was here.

BLOOM: Now let's take, you have basically a fifty or sixty year sweep here of American medicine and psychiatry. Just give us some general themes of what you see has changed over this time.

SASLOW: Well I would say one of the major changes is one that's very rarely mentioned. When I began writing about psychiatry, there was a general notion, mostly influenced by psychoanalysis that psychiatric problems and disorders in general were due to one general kind of problem called anxiety. Well, the notion that there was one kind of common denominator to psychiatric illnesses made it very different from the rest of medicine. For example, there's no general theory of medical disorders. There are separate infectious diseases: tuberculosis and meningitis have nothing to do with each other in the sense of being part of a general medical disorder. And so what I've seen happen over the years is that psychiatry has become more and more related to medicine in this fundamental way of recognizing that there are specific disorders like social phobias, schizophrenia, manic depressive disease, panic attacks, and things of that kind, which can be studied by getting evidence that distinguishes them from other disorders, and by following treatments which are different, one from another. In that way, psychiatry really is very much closer to medicine than anybody ever thought was the case in the first decades of this century. I think that's a major change.

Maybe it's gone a little bit too far in one sense. I notice that our residents have little experience with doing psychotherapy. They tend to look for chemical solutions too soon. You often need both kinds of solutions. They're not very good at that.

BLOOM: Well I was going to ask you that about the residents. You've been a teacher through all this time that we've been talking about. So how have the residents changed? One is, you've just mentioned. But what other ways?

SASLOW: Well, I think they're very able people. A lot of them are socially very interested in what our society is like in a way that was not generally true when I first started. They also are very well paid compared to getting nothing. [laughs] What does a resident get at our place? They get something like over twenty thousand dollars.

BLOOM: Yes. Probably over thirty thousand.

SASLOW: I can't imagine that. [laughs] But they're very well, very well read, and they're interested in quite a number of different things. They're really excellent people.

BLOOM: How about medicine today compared to when you first came to the medical school, or when you went to Washington University?

SASLOW: Oh, I think medicine is also extremely more sophisticated. I learned that through the geriatric care my wife and I both received. She died of heart failure a few months ago. And I had a very serious episode in which an iliac artery ruptured under an aneurism. And my life was saved by a radiologist and medical technicians where (nobody?) used these things called stents. (They stopped the blood?). I had bled so much I needed ten transfusions, for example. My heart didn't have enough blood to work on. I got there just in time for them to put a stent in.

Medicine was not like that when I started. There was a lot that medicine did not know. But when I was still in St. Louis, I would have regular sessions at a tuberculosis hospital out in Springfield, in the western part of the state. When I came out here in '57, there was still a tuberculosis hospital here. But it's gone. So a tremendous amount of treatment that used to be totally hospital-based has become outpatient-based. That's a great difference.

BLOOM: Are you optimistic about medicine and the practice of medicine now? Many physicians aren't. But you sound quite enamored of it, the complexity and new knowledge. How do you view medicine now?

SASLOW: Well, I think it's going to become increasingly interesting and powerful with the work that's been done on the genome, for example. And genetically based medicine will become more and more a part of regular medical training. I see a tremendous future for medicine. But unless things about the way managed care and medicine work together or go on, I see many difficult periods ahead. The pharmaceutical companies, for example, really dominate entirely too much of medicine. They spend as much as ten thousand dollars a year seducing physicians at our medical school to buy their products, for example. So I'm in favor of medicine becoming much more assertive and independent than it's used to being.

After all, the AMA wasn't always willing to do things like supporting things such as social security and things of that kind. I think that it has not been an organization devoted sufficiently to the welfare of its patients. So I think there's much to say about reform in the AMA, which ought to take place. And I think the only way that's ever going to happen is by physicians becoming more activist. Maybe they're going to have to have a union of some kind. It's very difficult (for physicians?) to take.

BLOOM: So you're optimistic about the knowledge in medicine.

SASLOW: Yeah.

BLOOM: You're concerned, what is your concern about managed care? How do you understand the current problems with medicine and managed care?

SASLOW: Well, these problems have come up over and over again in various court battles. Non medically trained persons, for example, are often in the position of

gatekeepers, deciding whether a person has a right to medical care. And so there are things which involve a person having a head injury, for example. And a neurosurgeon deciding he probably has a subdural hematoma. A gatekeeper will say, "That doesn't warrant medical care." And it turns out he hasn't the slightest idea what a subdural hematoma is, or what the risks are if there is one there. And so the business of nonqualified, non medical people making serious medical decisions, I think, is a great disaster. And ought to be fought right down to the bottom line.

BLOOM: Yes. And I think many people are doing that. Let's go back a little bit to psychiatry. You told us a little about drugs and keeping up with medications and pharmaceutical advances. You started in a period where things changed dramatically with Thorazine. What do you look at as the future of psychiatry, with psychotherapy in a way being de-emphasized? Do you see psychiatry and neurology merging again, or not merging? How do you look at the future of psychiatry?

SASLOW: I look at it the way I would if I'd stayed in medicine. I think that both psychiatry and medicine and surgery all have to work under some kind of uniform understanding of what the nature of the evidence that leads you to believe a disorder is mainly in this area or that area. So I think that the future psychiatrist ought to be very well educated in medicine. I think one of the best things that could happen in a psychiatric residency is for a review of about four or five months before they finish in medicine.

BLOOM: Do you think that psychiatry and neurology should be separate fields?

SASLOW: Very hard, well, when I spent a year on neurology neurosurgical service, they could do nothing but diagnose things. There was not treatment that was available. But that's very different now. And I think that neurology is not like what it was when I first started. So I don't have any difficulty imagining neurologists and psychiatrists working closely together. It can be very helpful to each other. The same is true for surgeons, internists, and psychiatrists. But that will happen only if you have a broad medical view, and you accept each other as colleagues of equal status.

And it was a great mistake when Freud, because of the lack of sufficient knowledge about the way the brain functioned, decided that psychoanalysis was entirely to be psychologic. That was a great mistake. Because the evidence we have now from the various kinds of imaging procedures is that if I give you a problem like subtracting serial sevens, while you're carrying out that cognitive activity, your brain circulation is changing, and your brain chemistry. And use various neurotransmitters is changing.

And if I give you a chemical like Ritalin, which changes the way your brain functions, your cognition changes, too. and we are able, actually, to identify areas of the brain in which when the brain undergoes one kind of activity, a particular area can be identified as being predominantly the area involved. Well that's going to increase in the future if research can be done.

But that raises another question. What is the future of research in psychiatry going to be? Who's going to support it? And a lot of that depends on things beyond doctors' control. With a president like Bush, for example, doesn't even have a science advisor at the moment making important decisions about science, that doesn't harbor well for what needs to be done.

BLOOM: Yes. Okay, let's stop for a minute. I want to get from you, Matt, where you want me to, we've got about twenty minutes left.

SIMEK: Okay. I think you're doing great. You're doing great.

BLOOM: So it's okay to range around here?

SIMEK: Yep. It sure is. And as you've been talking– yeah, let's go ahead.

[End Track Two. Begin Track Three.]

Are we ready? Okay. Joe, go ahead.

BLOOM: Okay. This is Dr. Joe Bloom. This is tape number two in our discussion with Dr. George Saslow on June 13, 2001. George, I want to go back to explore some other areas that I know you've been involved with. In 1973 you worked, or prior to that, worked with the mental health division. And you organized the Community Psychology Training Program. Can you recall some of that for us? What you, why you did that, and what you were trying to accomplish?

SASLOW: What I tried to accomplish went back about ten years to 1963, when there was a great movement to get people out of the hospitals, much supported by President Kennedy. The idea was that you could practice deinstitutionalization was no longer so necessary as it used to be thought to be, provided you had adequate community supports outside hospitals. And so the Dammasch Hospital was built of the understanding it would be an acute psychiatric hospital. People would stay there a short time, and then they would be discharged to community resources. The legislature took advantage of the fact that it was much less expensive to have the hospital and to add nothing.

And they added nothing. so for the next ten years, there was no community support while these patients who needed to be taken care of, and used to be in hospitals, wandered all over all the big cities in the country and rural areas, living under terrible conditions and getting sicker and sicker, behaving more and more dysfunctionally.

And so it was important to think of providing some kind of community support. And with the assistance of the person who was then assistant dean, Bob Grover, my son Michael, who was then a PhD in psychology from Berkeley, and there was somebody else. Several of us constructed a funding proposal to establish community psychiatry in this state. Which was supported by the legislature, by the federal government, and from fund from the medical school. And I forget, some other source. But it was an unusual

kind of proposal, which Bob Grover and my son were very helpful in creating and making acceptable to all the parties which needed to give acceptance. And that's when we appointed, what was his name, who became my successor later?

BLOOM: Jim Shore.

SASLOW: Jim Shore was my last appointment before I had the mandatory retirement in 1973 to establish a community psychiatry program. That has gone on with a successor, David Cutler, and is one of the most successful such programs in the country.

BLOOM: Yes.

SASLOW: Oregon has been an example in that. And we got on it very early, when it was clear after a number of years that the original premise of deinstitutionalization had been in and of itself disastrous for thousands of people.

BLOOM: Yes.

SASLOW: That's why Oregon took a very important leadership role in that way.

BLOOM: I think that's very true, and that program has been a unique program. Now the origins of the program also go back into theory about the functioning of individuals in communities, and part of the Kennedy movement related to prevention of mental disorders. And one of the key events that resulted in some very important development of theory was the Coconut Grove fire, which you mentioned earlier. So maybe you could take us back and tell us a little bit about the Coconut Grove fire, and how Dr. Lindemann and the Mass General Hospital and yourself were involved in that. And then what theoretical discoveries came from the Coconut Grove fire and its victims?

SASLOW: As well as I remember, that fire occurred on Thanksgiving in 1940. It was a, the Coconut Grove was a very favorite place for a lot of young people for dancing and so on, and having the usual kinds of fun that they would go to such a place to have. I forget how the fire started, but the exit doors were closed. Nobody could get out. And people were suffocated by smoke. And they were really burned and charred.

And the next morning, when I came to work at the Mass General Hospital, there was a big space which connected the outpatient clinic to the inpatient part of the hospital. And in that tremendous area, there were five hundred charred bodies lying there from the fire. And of course there were relatives and family, survivors and so on, injured, not injured, and so on. And there was simply not enough staff at the Mass General Hospital to deal with all of the people who were grieving about the persons that they'd lost in the fire.

And Lindemann used me and a large, there were not sufficient residents and faculty to use. There were only two residents on that small psychiatric service. [laughs] He used volunteers, ministers, family members, nurses, to meet, after a brief kind of talk

about how you might behave as a consultant to persons who were grieving, to meet with family members of those who had died.

The process went on for quite a long time. And out of it came a paper, the title of which I no longer remember. But it was a basic paper which described what happens when people grieve the loss of a member of their family. And it became an important teaching instrument. I often use it in teaching residents, for example. But it sensitized people to the tremendously intense aspects of grieving as being different from a mental disorder arising in some other way, such as a depression or a manic attack. People had not been aware that grieving was a rather different kind of situation. He laid the groundwork for that.

BLOOM: He laid the groundwork for that. And weren't there also people who did end up with mental disorders and some suicides as well?

SASLOW: Yes, there was (a few?)

BLOOM: How did theoretically did we get from acute grief and its management to mental disorders? That was an important link.

SASLOW: I don't remember that.

BLOOM: Yeah.

SASLOW: I don't remember that Erik did much with that.

BLOOM: Yeah. Well, it was a very–

SASLOW: It turned out years later, really.

BLOOM: Yes. Yes. So that paper and that experience provided one of the cornerstones in community psychiatry, which you later participated in.

SASLOW: Yeah.

BLOOM: So now we're getting kind of close to the end of our time here. So let's again just talk generally. In terms of people who have influenced you in Oregon in your practice, who are, let's say, the three most influential people in your professional life here, and why?

SASLOW: I would say Dean Baird was one. Howard Lewis was another. I can't think of a third. Was there another one?

BLOOM: Well, tell me about, tell me about how each, Dean Baird and Howard Lewis. You mentioned them frequently during our interview. So tell me about each one.

SASLOW: Howard Lewis was a person who had a long experience in private practice. I think he practiced in, where was it, east of here? I forget the town that he practiced in. Anyway, he was a person with a relatively little firsthand experience of contemporary psychiatry who was willing to listen to the things that I would bring up at executive committee meetings, talking about choosing who's the best kind of resident to be a chief resident and so on, and what kinds of things would you want medical students to learn from your teachers, and so forth. And I found him to be very sympathetic, understanding, sensitive, and able to learn new things all the time.

Dean Baird was very similar. He also came from private practice. And I was introducing him to a whole lot of things that he had never seen before. Every one of these things was discussed with him very carefully. And there was only one occasion on which he decided that it was something I should not do. That had to do with, over the years that I worked with him, hundreds of decisions were made jointly.

There was one decision where he said, "No, you shouldn't do this." This had to do with a man who was an intern at one of the local hospitals, I forget whether it was St. Vincent at that time, and was found to be doing something which was considered to be not quite ethical. And who wanted to have a residency appointment in my department. And I didn't know about this event, which I learned about later on. Not from Dean Baird. I thought he'd be a quite good candidate. But Baird said no, like, "Hey, I can't support that appointment. And I can't tell you why." And he said, "I can't tell you why because it would be violating a confidence I agreed to keep." I later on learned from somebody else this man had done something which was quite illegal.

But that was the only one of hundreds of things Dean Baird and I discussed that he showed any kind of determination to say, "No, you can't do this," without giving an explanation. Except to say, "I can't." It was a wonderful relationship when you think of the various new things which I had introduced.

BLOOM: It is a very, very wonderful relationship. How about on the national scene? People who've influenced you, some significant–

SASLOW: Margaret Mead was one of the main ones. I knew her for a long time. So our joint interest, we both had an anthropology, to an anthropologist with whom I worked at the Mass General Hospital and began my work on the psychiatric interview. Margaret Mead said to me at some point after I'd been at Washington University for a while, "Why don't you think, why don't you consider joining and working for the NIMH?" That had just been established after World War Two. I'd never thought about that aspect of public service. And she said, "You certainly could make some useful contribution."

And so I was accepted. And for a number of years, I was a chairman of the second studies section, which evaluates research. They now have about a hundred.

BLOOM: Yes they do. You're talking about the National Institute of Mental Health.

SASLOW: The NIMH.

BLOOM: NIMH, yes.

SASLOW: I was chairman for four years of that second section. And after that, I was asked to be chairman for four years of the education, of education section, which evaluated all sorts of educational procedures. So I worked for the NIMH at least for eight years. But it was through Margaret Mead's suggestion. She had noticed that at various meetings of the Society of Applied Anthropology, I would be listening to the discussions that were going on for a while. And then after a period that she estimated–she apparently was keeping tabs– of about thirty minutes, I would make some comment that would seem to sum up what was said. Apparently my brain worked that way. So that's why she thought I ought to do something for NIMH. [laughs]

She and I together conducted one of the first interviews of color television. And the way they produced the colors is by rotating something.

BLOOM: Now what was her, how did she influence your view of the psychiatric interview?

SASLOW: Not at all. She had nothing to do with that.

BLOOM: But she helped you with your–

SASLOW: The anthropologists and I worked out an experimental procedure for the psychiatric interview. Nobody had made any study of the psychiatric interview. But by the time I became interested with this anthropologist whose name was Eliot Chapel, by that time, little blue long playing records had been developed. So you could record an interview. So you could record what you said as well as what a patient said, while you carried out various kinds of procedures.

And we devised a procedure which went something like this. You would start an interview with a patient by making some open ended remark, such as, "What would you like to talk about?" And once the patient began talking, for the next twelve, twelve statements, you responded very encouragingly to keep them talking. And after the end of a certain number of statements, you suddenly changed your behavior. And every time you began to talk, you fell silent and said nothing for a certain number of exchanges. And then after that was over, every time you started to talk, you went back to your first procedure. And after that, when they started to talk, you interrupted them as soon as they got out two or three words. Then finally you went back to your first procedure.

By this method, which you could record and study carefully, and measure quantitatively, we were able to distinguish all of the groups of psychiatric disordered

patients. We went to various hospitals, we studied different kinds of patients in different places. I did that fifteen years, I studied the psychiatric interview.

BLOOM: What were the key things you learned from this procedure, from this study?

SASLOW: How a patient's behavior is modified by your behavior.

BLOOM: By your behavior. Yes.

SASLOW: What that's so important. And residents get to learn that. They have to learn to listen.

BLOOM: Now over the course of your career, and having known you now for a number of years, you've never seemed to be subject to burnout, which seems to be a problem for physicians.

SASLOW: I never was.

BLOOM: Is that an accurate observation on my part?

SASLOW: Yeah, that's right.

BLOOM: You've never felt that. What is burnout, from your point of view, and how did you avoid it?

SASLOW: Gee, I remember once being on a plane going to Washington for an NIMH meeting with a man from Stanford who wrote a book on group therapy. Do you know–

BLOOM: Yalom? Irving Yalom?

SASLOW: Yes.

BLOOM: Yeah.

SASLOW: And he told me about burnout and working with geriatric patients. But I heard that from somebody else. I've never experienced it.

BLOOM: You've been–

SASLOW: I never get, I never have gotten too discouraged with the very difficult patients, or resistant patients. I can't explain why.

BLOOM: It's never been a problem for you.

SASLOW: No.

BLOOM: No. Are you still teaching at this point?

SASLOW: Yes.

BLOOM: What are you doing in your teaching?

SASLOW: I do the following. I supervise a fourth-year resident regularly, weekly, once a week. I meet with Dan Labby and the chief of the outpatient clinic, Dr. Pam Edwards. With each year, fourth year residents, for informal discussions that are not treated as if they're in supervision. So they can raise all sorts of questions that trouble them about their future. That's the second thing that I do. And the third thing that I do is that in alternate months I go down to the outpatient clinic and I function as one of the faculty members to whom a resident who is seeing a patient needs to report. And you have to write down whether you agree with what the resident tells you or not. And if there's a new patient, you have to interview the new patient.

So I do those kinds of teaching. I've been invited to consider, also, teaching medical students. But I don't think I have the energy to take on any more.

BLOOM: So you're, how many days a week are you teaching now?

SASLOW: I'm there Tuesday and Wednesday. Alternate months, Thursdays, and I'll occasionally see a patient on Friday.

BLOOM: And as with what you said earlier, are you keeping up with drugs and reading?

SASLOW: Yeah. All the time.

BLOOM: All the time.

SASLOW: Sure.

BLOOM: Yeah. Well, that's wonderful. Well, we just have a few minutes left. Is there anything else that you'd like to say that I haven't covered? To summarize, how do you summarize this?

SASLOW: I wish we could have residents become more skillful in psychotherapy. And I think one way of doing that would be to have a more vigorous program in group therapy for them. I remember introducing that idea to Pam Edwards, who had never experienced group therapy before. She began to attend some national meetings of group therapy people, and now recognizes it as one of the most powerful things you can do. But there's not enough experience with that. There's just kind of an abstract presentation of what it's about in the seminar for the second-year residents. But

they don't actual experience with it, which they all should, I think. So there are some ways in which our program could improve. But they have lots of difficulties in improving the program because of complications with Medicare payments and things of that kind, which I don't fully understand.

BLOOM: Yes, that's true. Why would group therapy be a way for us to improve the program, as opposed to more training in individual therapy? Why do you see the pathway through group therapy?

SASLOW: Well, I don't see it as the only way. But I see it as an additional way. Just as I would see family therapy and couples therapy as experiences every resident ought to have. It makes quite a difference.

I remember, for example, my first exposure to family therapy. At that time, there were very few people who did family therapy. One was living in California. Her name was Virginia Satir. You probably have heard of her. And I invited her to come and demonstrate at a meeting of our residents at that time, and nursing staff, how she works with a family. I had never realized some of the very simple and powerful things that she did. For example, she would always have, as the person to speak first in the family, the person who was least likely to speak up, like a child. She did a number of very simple and powerful things like that. To have the various family members present define what problems are there in our family. And she would then listen and have people work with them.

She also introduced me to things like using a one-way mirror so that you and the family member could listen to some other family member being interviewed by somebody else. Then you could join them, do things like that.

I also experimented at one time with a, what the hell do you call it, a device which allowed you to speak with a resident interviewing a patient. We could watch them through a one-way window. You could hear them. And supposing that the patient had just mentioned that somebody in the family had died, and the resident paid no attention, you could then say, "So and so mentioned that his father died. Would you like to say something?"

BLOOM: Yes.

SASLOW: So this kind of, what do you call this kind of thing?

BLOOM: Well, I remember it as the colloquial bug in the ear.

SASLOW: That's right. That's what it was.

BLOOM: That's what it was called.

SASLOW: I had a number of those bugs in the ear. I still have one in my office.

BLOOM: Yeah. Yeah.

SASLOW: Well, those kinds of teaching. And teaching by means of videos. We did a lot of that. But that's all gone. I think that ought to be reintroduced.

BLOOM: Did you run across a family therapist named Norman Paul? Did you ever meet him?

SASLOW: No.

BLOOM: He was a Boston family therapist. Well, I think we're at the end of our time. I thank you very much.

SASLOW: Okay.

BLOOM: It's been a pleasure for me. We have lots of overlap with the Boston people.

SASLOW: Right. [pause] Okay. Do it.

BLOOM: Good. Thank you very much.

SASLOW: I'm glad my voice held out.

SIMEK: Marvelous, marvelous. Thank you both.

[End Interview.]