HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Dan Labby

Interview conducted May 20, 2003

by

Joe Bloom

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[Begin Track One.]

Okay, Doctor, can you just say a few words?

And do you want any housekeeping, Matt, in terms of (?)

SIMEK: Yeah, this is an interview with Dan Labby on the twentieth of May, 2003. And the interviewer is Joe Bloom. And we're going.

BLOOM: Dan, it's a pleasure to have this opportunity to talk to you. And I think I would like to start with your early years in Portland. And if you could tell us a little bit about your growing up here, and then onto, you decided to pursue a career in medicine.

LABBY: Well, I was a Portland native, and actually born in a house near Lair Hill. And my mother being a nurse and my father, who tried to come to medical school as an immigrant boy, couldn't manage it and became a dentist. So I had two professional parents. I was the oldest, born, actually, in 1914. Or was it 1814? I can't quite remember.

As a little kid growing up, I grew up in a very small little village like area in South Portland, along with a lot of people like my folks who were immigrants. But eventually they emphasized how very, very important it was, education, and particularly sustained education as a professional. Because, being immigrants, they emphasized security.

To make a long story short, I did all of my primary education in Portland, the Portland Public Schools. First on the Westside at what was then Failing School, which is now a government service center. And eventually on the eastside, which was just beginning to enlarge. An area called Laurelhurst. My brother didn't arrive until I was six years old, so I had quite a long spell by myself. As I say, the emphasis always was on education, on professional education particularly.

Interesting that the area that I was born in turned out to be right across the street from the old county hospital. And I remember as a child when they were expanding it, playing in a big pile of gravel in front of the hospital, looking for agates. The Marquam Hill area, eventually, of course, was the site of the new county hospital, where I was eventually to be as a student. Being in Portland I got an education in both music, took the violin, and eventually at Reed College, where I did four-year pre-med course, and then entered the medical school in 1935 and graduated in '39.

The classes in the medical school at that time were much different than they are now, of course. My class of sixty had only half a dozen women, which was thought to be

a kind of vague quorum for women, ten percent of the class. The attitude at that time was that women were, of course, supposed to be mothers and housewives. And so the worry was that if you "wasted your time," quotes unquotes, educating a woman in medicine, she would only eventually marry and have a household rather than becoming a professional who helped with the healthcare of the state. Of course that changed immensely.

I remember in my class, however, many of us came because we worked our way through, or had some scholarships, which were very readily available. But it was easier at that time, in a sense, because so many of the students worked in the summer. There were no classes through the summer. Classes stopped in June and picked up in September. A lot of our class were Asiatics. I'm talking about the period 1935 to '39. And that area of time, we all worked somewhere in the summer on non medical things. I was lucky enough to get a fellowship in the medical school and had a job raising mice colonies for people doing research. And even–

BLOOM: What about your early influences on you going to medical school?

LABBY: As I look back, I really feel I was influenced first by Mother and Dad being professionals. But after that, there was an intrusion when I was about sixteen, which would take us into the period in America of the Great Depression. I became under the influence of a rabbi who was a very modern kind of thinker, and I really used him as a role model for so many things. I wanted to be just like that. In fact, he befriended me and took me, actually, to, after Sunday school out to the golf course so I could caddy for him. And along came with him a very wealthy local merchant, Charles F. Berg, who had a large woman's store here in Portland.

The reason I bring it up is I was conflicted as to whether I wanted to go ahead and answer the call of being a rabbi, or possibly a doctor. Because I had to make a choice in my preparation at college. The result, however, was easily worked out because the rabbi, Rabbi Berkowitz was his name. He was the rabbi for the only reformed temple here in town for the Jewish community. He went to a national meeting, and came back looking very glum about the future security for rabbis, because synagogues were closing their doors. There were more unemployed rabbis running around. And he said I ought to think very seriously about whether this was appropriate for me. So I reached for medicine instead, and went pre-med through Reed College

One of the things that came out of that, of course, had to do with the fact that the young lady I was courting at the time had said more than once that she would never have married me if I'd become a rabbi. So it had a lot of plusses, aside from being a perfectly splendid opportunity. I loved being in medicine all these years.

To make a long story short, I graduated from the medical school after having been sustained pretty much by fellowships. I was the Noble Wiley Jones so-called fellow in pathology. And that deserves a comment because at the time, I was taught, even as an older freshman and then in my second year, how to do a post-mortem. Because we were doing many, many more post-mortems then than has been done since. So I would go out

and I knew how to bring in tissues from post-mortem. I didn't know what the pathology was, because I hadn't had pathology. So I was actually a kind of prosector who was doing post-mortems without much training except to know what tissues were important for review of my elders. And that's the way it worked. So for three years, my last three years in med school, perhaps a bit more, I was sustained mostly by fellowship.

And then something came along known as the National Reconstruction Administration, thanks to FDR, following the Depression. And some monies was available for students at that time in the colleges. And I took advantage of that. Somehow I made it through.

My first inclination in medical school was to enter a specialty that I never did get into. And that happened so often with medical students, attracted to many different disciplines that don't work out until something practical comes along. And what came along for me, since I had wanted to be either an orthopedic surgeon since I was under the sway very much of crippled children. There was an awful lot of osteomyelitis at that time, days before antibiotics. And the second one was ophthalmology, because I was terribly interested in cameras. And I took the first retinal pictures, actually, for the Department of Eye.

The other thing that happened in the course of having a sustained courtship with my wife, who happened to be the daughter of the chief of medicine, Dr. Lawrence Selling, he suggested that he could somehow manage to, my application for internship in internal medicine at Johns Hopkins University Medical School, Johns Hopkins Hospital, actually. And I hated to refuse that, because it was a great opportunity to not only get away from Portland for a period, but also to be in one of the finest, if you will, Ivy League medical schools.

So I accepted that and took my internship at Hopkins, and I've had no regrets. Because it put me in touch with a lot of very, very famous men. It interested me, though, at the time that I was actually interested in psychiatry because I was aware of my own sense of strong anxiety when under pressure. And I went to speak to the chief of psychiatry at Johns Hopkins at that time, who was a very famous man, Carl? Meyer, who established the field of what at that time was known as psychosomatic medicine. And as a result–

BLOOM: Adolf Meyer?

LABBY: Adolf Meyer.

BLOOM: Adolf Meyer. Well before, we'll come back to that. Let's go back and tell us a little bit about Dr. Selling and his influence on Portland and the school.

SIMEK: Before we get into that, too, Doctor, can you sort of corral your view to just to Joe? Because your eyes are wandering around the room, and we like to focus right on Joe if you can.

LABBY: Well, it's an effort.

BLOOM: You have to look at me. Okay, so tell us about Dr. Selling.

LABBY: Sure.

BLOOM: Just a little summary of his influences on medicine in Portland and on you.

LABBY: One of the great influences on my life was Dr. Lawrence Selling, who was chief of medicine. The medical school at that time actually had volunteer clinicians from downtown practice as the chiefs of every discipline in the medical school. Obstetrics, surgery. Very famous men, actually. And Dr. Selling was the head of medicine. And very influential in forming a true faculty. He had served in World War One, and came back to organize, help organize, the remarkable faculty we had.

Well Dr. Selling was one of the first internists, and also one of the first what he called, and what was called at that time, neuro-psychiatrists in Portland, because he had taken in his training special work in Germany in what they considered psychiatry at the time. Actually it turned out to have an immensely physiological basis, which is one of the approaches that made Germany so famous at the time. So for example, if you had an anxiety or a panic attack, the approach usually was to try and explain that we, the doctors, know why you are showing these symptoms. So it was all symptom explanation. And anxiety, for instance, was likened a lot to just the panic response following shock, the old cannon theory. Saying we know why you tremble, we know why your mouth is dry, we know why you feel insecure, and so on.

BLOOM: So he practiced this method in Portland?

LABBY: Yes. It was mostly explanation to give reassurance that we understand why you're showing these. But it did not get at any of the reasons why you are a person who is subject to, say, anxiety or panic.

His position in the entire Northwest was really quite special. He trained in medicine, actually, at Johns Hopkins, having been graduated from Yale. And came out to Portland and practiced immediately this brand of medicine. He became known as a diagnostician, and he was particularly good at locating neurological lesions. Because of his intense study of neuro-anatomy and neuro-function.

So he and three others who were eventually to form the Portland Clinic: Dr. Kistner, in ears, nose and throat; Dr. Joyce, who was worldwide in his fame as a surgeon, who gave demonstration surgeries all over the place; and the fourth one was Dr. Noble Wiley Jones who kind of a well advanced GP who had the strange idea that, along with others, that the cause of a great deal of disease, particularly rheumatism, was due to what they call focal infection. So a lot of medicine at that time, talking about the 1930s and

‘40s, was based on the fact that if you had rheumatism, or if you had some sort of unexplainable disorder, they would either pull out all your teeth, clean out your sinuses, remove the prostate for men, and try to give you injections of sterile solutions, to make sure your blood was not quotes unquotes “infected.” So he was a major influence, not only in the area, helping to actually establish certain societies. North Pacific Society of Internal Medicine, which I think he established about 1927, along with others, so that people in the Northwest who were practicing internal medicine would know each other from Washington, California, British Columbia, and eventually Idaho.

BLOOM: So he assisted you in your internship, getting your internship at Hopkins.

LABBY: Right.

BLOOM: Why don’t you tell us a little bit about that, and what happened after your internship?

LABBY: The internship at Hopkins was a fascinating one, and it was built on the basis of the old William Osler tradition, that you gave yourself entirely to medicine. For example, at Hopkins, as well as Harvard, I understand, and others, you were on duty twenty-four hours, and you were on duty seven days a week. And you lived in the hospital, and you were not married. Because if you were, you could not get these appointments. And if you got married on the sly, you lost your appointment. It was said that at Hopkins, at least, that if you wanted to get married, and you asked the permission of the director of the hospital, he was never known to give it. And those people who were caught, and some were, actually did lose their positions.

The medicine at Hopkins, as I say, was under the influence of Sir William Osler. And it interested me because Dr. Selling had also interned there many years before, around 1908. And he told many stories about famous people. For example, one that comes to mind was about William (Rengdon?), the great German X-ray specialist, who brought his X-rays to demonstrate at the Hopkins. And William Osler at the time was actually the chief of medicine. And my father-in-law, Dr. Selling, as he eventually became, said that he asked Sir William Osler what he thought about the future of the X-ray in medicine, and he said it was a passing fad. And we all took great courage in that, because we knew the great man at times could be wrong.

BLOOM: You had mentioned, I had cut you off earlier. You had mentioned that you went to see Adolf Meyer and you had an interest in psychiatry. Eventually you’re going to be going into psychiatry. So tell us about that encounter with Dr. Meyer.

LABBY: Well I got interested in psychiatry when I was taking care of patients on the wards of Hopkins because so many of them, in addition to having physical illnesses, were also quite disturbed and not understanding some of their very conflicting problems. So I had decided perhaps I ought to look into psychiatry. This was about 1939. So I got an appointment to talk to Dr. Adolf Meyer, the very austere but somewhat kindly man

who interviewed me. Sitting alongside him was his secretary, a man taking shorthand, my words and his. Later he told me, "We always record everything the master says." So I don't know if he got my words, but he certainly got Meyers'.

Meyers appointed me, actually, as a resident in, it turned out to be about 1940, early '40s. So I knew that I would be leaving internal medicine as I was being trained the first year at Hopkins, and eventually becoming a psychiatrist. However, when the time came, he suggested that perhaps I ought to do some research between my internship, and that was the mode then, between my internship and my residency. So I took, believe it or not, an entire year of training, as Osler had said it, in syphilis. Because Osler said that if you knew syphilis, you knew medicine. And I believed him, of course. I believed everything older people told me.

So I went up to New York Hospital at Cornell, and in the course of that fellowship, 1940, having a reserve appointment as a lieutenant in the medical corps. World War Two was about to break. And so I was hauled off my fellowship and had to report to Fort Lewis, Washington. And of course I was in in August, before the December Pearl Harbor period. At Pearl Harbor time, I was at Fort Lewis. And we were all hauled up in the woods because they were afraid the Japanese were going to bomb Fort Lewis. So I was in the army for quite a while.

BLOOM: Did you serve through the whole war?

LABBY: No, because what happened was, we were trained eventually up in the Puget Sound area in landing craft, they idea being we were going to go over to the South Pacific, and do the landings that eventually became so important in taking part of that territory. What happened was, somebody got the idea, and it's never been traced down as far as I know, that there was yellow fever in the South Pacific, which is not true. At least it's minimal if it's there at all.

So they decided to give us all shots for yellow fever. In the course of which I gave the thousand men in my battalion and myself the shot for yellow fever with yellow fever vaccine. It turned out, however, that the yellow fever vaccine, and I knew this, for very good reasons I'll come to in a moment, was contaminated with what turned out to be infectious hepatitis. They didn't know that at the time because that was a new disease, yet to be discovered and named. However, after about a three to six weeks incubation period, we all started coming down with jaundice. So we were kept in hospitals in Southern California which we had been moved to, Fort Ord, in order to overcome this.

By a strange coincidence, many years go by and I found myself doing research in the Rockefeller Institute in New York. And one of my companions at lunch was a young man who had designed that actual vaccine. And I asked him how it got contaminated. And he shook his head and told me that what happened was, he decided that vaccine, as he made it, required stabilization by human serum. Which is the mode, as I understand it, in making vaccines. And he picked on a person who, unbeknownst to anybody, was in the incubation period of hepatitis. So over a hundred and twenty thousand people were

inoculated in the army with this contaminated vaccine. His name was Max Tyler, and we became very good friends.

BLOOM: So you never did go to the South Pacific? You were ill for, how ill were you?

LABBY: Well, we had several deaths, actually, as you might expect. I came down with it and I was sick, I would guess, for about two or three months. So that when my unit was eventually moved to Virginia to take over the North African campaign and go up the boot of Italy, I missed that, because I had a recurrence of the jaundice. Very fortuitously, in a sense, I suppose, and they put me on inactive duty. Which meant I had to stay in uniform, and I had to be tested every few months.

BLOOM: Did you go back for your residency in psychiatry?

LABBY: No. actually by then, several years had passed, considering the war service. What happened was that I picked up my internship and eventually residency at the Cornell New York Hospital in Manhattan, where I stayed until I became chief resident, actually, in 1945, I believe it was, 1946.

BLOOM: So you trained, you were internist, chief resident, at New York Hospital.

LABBY: Yeah.

BLOOM: What brought you back to Oregon? You came back soon after that.

LABBY: Actually, no. I had a, over a two-year period across the street at the Rockefeller Institute. And since I had a kind of unusual interest in hepatitis, I was doing research in liver disease for two years. And I came back to Portland in ’48. We had two children by then. I had been married in 1940. So I wanted to come back and at least my wife kind of half insisted that I come back, because it looked like Oregon was the better place to raise children than New York City.

So I came back here and was half time at the medical school, because there wasn’t enough money at that time, it had to be about 1948, for full time. There were only about four or five full time people in the medical school. Dr. Osgood. Herb Griswold in cardiology from physiology, Hans Haney. And eventually Dr. Howard Lewis, who took over when Dr. Selling gave up the post in his sixties.

BLOOM: You were half time. And the other half time?

LABBY: I was practicing internal medicine downtown with one of the people who was a volunteer at the med school for about four years. about three years, actually. In 1951, they had enough money to employ me full time at the med school. And I became Dr. Howard Lewis’ second hand, and his assistant at that time.

BLOOM: So you came to the medical school in internal medicine. And how long did you work with, tell us a little bit about that period of time, working with Dr. Lewis. And then what happened?

LABBY: Well, it was a fascinating time, because there weren't too many of us full time. There wasn't enough money. There were only, I'd say, about half a dozen of us, perhaps, all together. Maybe six, seven, eight people. And if we ever wanted to get together as a faculty, all we had to do was wait, because we'd all meet in the lunch room and talk about what was necessary for the teaching. The approach was completely different than it became, of course. For example, we gave seventy lectures – and I gave most of them, frankly – in internal medicine to the junior class. In addition, since we had no specialists in certain areas, I became a specialist because of my interest in metabolism. And rheumatology, diabetes, endocrinology and gastrointestinology, gastrointestinal work. Because of my interest in the liver.

Eventually, I was to be able to hire people to do all that work. But it was much like an old fashioned jazz combo, where you play the saxophone for a while, then pick up the clarinet or the trumpet, and play whatever is necessary. But eventually I was able with Dr. Lewis to hire people like Monty Greer in endocrinology, and Dan Bachman in rheumatology. I got somebody to help me in diabetes and metabolism. And then John Benson came along in gastroenterology. So that began to offset the need for a lot of volunteers from downtown Portland to run these special disciplines in medicine.

And the medical school then began to grow, both in sort of its setting in the national group of medical schools, and also in research. We began to get our first research dollars, because these people we appointed were also research people in all these disciplines.

BLOOM: So how many years did you work in internal medicine? And then what led to your switching careers?

LABBY: Actually, I stayed in internal medicine from– well, I graduated in '39 in internal medicine. And the medical school, I was 1948 in internal medicine, full time in '51. And then about the late '50s, early '60s, middle '60s, I presume, I began to have feelings that my old interest in psychiatry was beginning to awaken itself as I was handling more and more patients with physical disease.

And one rather critical experience, we had a visiting professor that made rounds with me. And at the end he said, "You seem to be more interested in the person than in their disease." And I thought that was a kind of message that I hadn't really appreciated. So I thought about it seriously and took my first sabbatical to think about these things and have a prospective look at what I was doing in Oregon. And we went through actually, thanks to Chester Jones, a professor of gastroenterology at Harvard, to Europe. I asked him one night at dinner, when he was a visiting professor here with Dr. Lewis, where he

would go if he knew of my interests, which he did, in internal medicine and liver disease. He said, "I would go with Jules Stahl in Strasbourg, France."

And I remember saying, "I've really never heard of him."

And he said, "Well, that's not his fault. He publishes." And as a result, that changed all of our lives. Because we were to end up eventually in Strasbourg for over a year.

In the meantime, Dr. Lewis became president of the American College of Physicians, and asked me to delay my going abroad for a year. And in doing so, the professor with whom I was to work, Dr. Stahl in France, I asked him to send over his daughter to members of our family. And then we would bring her back. And that turned out, it had lots of consequences. Because she became practically a member of our family, and still is, many years later. And is sending her daughters to live with us and my relatives.

So in 1960, we had our first sabbatical. And after a period of doing French medicine and taking care of French patients, which is a story in itself, and teaching, actually, in France, I had a chance to have a long prospective look at what was going on for me in Portland. And as a result of that, I realized I really thought I ought to get off internal medicine and into psychiatry in a more formal way.

So I interviewed George Saslow, who was known for seducing people from internal medicine into psychiatry. And I attended a lot of his teaching sessions, and learned his method of interview. And he and I had a good collaboration at that time. And eventually, when some of the other people were filling out some of the positions in psychiatry, I came to them and asked them what they would do if they were in my position of retraining. So to make a long story short, I ended up going first to Harold (Leaf?) in Philadelphia and training for the medical school there for almost a year, particularly in his interest, which was relationship work. He was very close to the Pennsylvania marriage counsel, I believe. And so I trained in marital counseling.

And from that, I went over to London and took for a year after that in the Tavistock Institute in London, which was analytically orientated. I wanted to see what sort of progress they had. That was 1960. 1970, excuse me. And in 1970, that was 1960, or 1970 I took another year at the Tavistock. So I had a year between Dr. Saslow and Harold Lief in America, then two years in England for my psychiatric thing.

BLOOM: Did you move, then, to the psychiatry department?

LABBY: I moved, actually, before that. I moved about the late '60s, early '70s. And David, I can't remember the name of the professor who was chief of medicine. He did a wonderful thing. I'd had him as an intern when I was in medicine. He became chief of medicine following Dr. Selling's withdrawal, in fact, following Dr. Lewis' withdrawal. And he did a most amazing thing, which you probably would never do nowadays. He

took out of his own departmental budget my own support and put it in psychiatry for me, for which I've been eternally grateful. And as a result, I've had that kind of help ever since, during my own career in psychiatry.

BLOOM: So tell us now about how your career in psychiatry blossomed after you transferred to the department.

LABBY: Well, actually–

BLOOM: What your interests were and–

LABBY: My interests actually lay, first, trying to revive my old interests when I'd spoken to Dr. Meyer, (Karl?) Meyer, about psychosomatic medicine. I thought if I were an internist becoming a psychiatrist, it was a natural. But I found myself more and more drawn to relationship work, thanks to my work first with Dr. Lief in Philadelphia, and eventually (?) Tavistock for two years. So I had the field of relationship work and marital work pretty much to myself in psychiatry, and did a lot of my teaching and a lot of my presentations were around that kind of clinical exposure and experience. And it's been a very good field. I stayed with it formally actually through two or three chiefs of psychiatry. And I formally retired, at least from the standpoint of my fiduciary support, in 1985. But I've stayed on part time doing the same kind of work until more recently.

About 1972, I became interested in one more layer of the practice of medicine. That had to do with ethics. And it came to pass because the students brought to me all kinds of problems that they were dissatisfied with. They didn't like the sorts of decisions some of the clinicians were making on the ward about the more humane and the more ethical issues around such things as end of life, telling people bad news, and so on. And this group was a group of what I'd call very good citizens, as students. And so we began taking on the issues periodically in our group work having to do with ethics.

As a result, they decided they wanted to have their own club, and so they formed something called CHIME. It was an acronym for the Council on Humanism in Medical Education. And they came to me only as a kind of advisor as to good speakers. And they met about once a month with the whole student body, from freshman on up, with people who would talk about issues of personal ethics as well as, you might say, community ethics. And it had a long life. I think it may still be in some form still around. But since 1989, we've had our own center under Susan Tolle, the Council on Humanism.

BLOOM: We'll get to that in a minute. Tell me a little bit about how you saw the field of psychiatry in your area of relationships and marriage and family psychiatry. How did you see that progress from the time you started in it, say, to the time you stopped doing that actively?

LABBY: Well, it looked like the issues of bioethics were, they were deserving of development at the medical school. And it comes out of the fact that medicine was, I think, from my point of view, was developing very heavy technologically. So that slowly,

slowly, and this was even a contemporary complaint, patients were beginning to feel that they weren't having the same kind of doctor/patient relationship that they had enjoyed. That the doctors were more interested in what they could do to them, rather than what they were doing in a sense less for them, but understanding who they were. That's about as much as I can concentrate on.

I remember very much being aware of it when one of my favorite students, who was an extremely intelligent young woman, came back to me very excited because she'd just managed to do a lumbar puncture. And I was startled because I thought she was much more interested in another kind of medicine than being manipulated or even invasive in the way she approached patients. So we had a long talk about it. And as a result, apparently one of the better students in the 1980s, Susan Tolle, decided she would like to put her efforts into a different approach entirely, which was to talk about some of the guidelines that doctors should use in understanding their patients, and in a compassionate way taking care of many of the needs that are just as important, if not more so, when they become ill.

BLOOM: But for you, you're saying a very interesting thing. That the roots of ethics, the formation of an ethics program, the roots of that program come back to relationship issues and to relationship psychology or psychiatry.

LABBY: That's true, but I have to take a little excursion to the side. I wasn't as aware of it until something I think in the nature of being aware of what patients go through as a person when they become ill. That's an old one in medicine, of course. It isn't the disease the person has, it's the person who has the disease.

So along with a few other right thinking people, I approached Reed College. I was on their board at the time. I'm talking about 1968, I think. And I said I wanted to do something about what view the medical profession still has with regards to how precious life is. I put it on very almost sentimental terms. And so to make a long story short, we eventually, with the help of monies from the Kaiser Foundation, put on what turned out to be an immensely successful three-day seminar on something called the sanctity of life. In fact, it led to a book I wrote having to do with the summarization of some of those discussions. And with the help of the Reed faculty, we managed to reach out worldwide to some very famous people all over the globe to come and be speakers. And they did. And we had three days of remarkable, remarkable discussion. So much so that two years later we had a second one with the same sort of thing.

I was pleased that recently one of the textbooks in bioethics give that seminar in my own (?) I guess credit for starting the interest in bioethics, actually.

BLOOM: What were the issues that were discussed in that first seminar?

LABBY: They had to do with the approach of different kinds of scientists. They had to do a lot with things like euthanasia, how precious is life. They had to do with a sociologist from Chicago who was remarkably articulate. They had to do with a

technologist from Princeton. They had to do with a cell biologist who was a Nobel Prize winner from London. And so that kind of a board of participants, we couldn't lose. They were marvelously articulate personalities. So much so that Kaiser had no trouble coming up with the need for a second one. And we went over much the same thing with people who are by now, at that time, we're talking about 1949 or so, '50, perhaps, talking about issues that were much more being part of a national conversation in America. About ethical issues guiding people in whom we entrust our life, and so on.

BLOOM: So I can readily see how you moved into the area of ethics. And tell us about the evolution of the Ethics Center, and your role in the Ethics Center.

LABBY: Well, 1989, Susan Tolle came back from working with an ethicist in Chicago, and established the chair. And since I had expressed an interest and had some activities behind it, she asked me to come alongside and ride rifle with her, which I did. I said that one of the things that I regretted, it now being 1989, and I was on a semi-retirement program myself, as that all the remarkable knowledge and experience and, if you will, wisdom, that doctors have after practicing medicine for fifty or more years, goes to waste when the retire. They play golf or go fishing or whatever. And something ought to be done to capture that loss of manpower. And she said, "Well, what would you suggest?"

So we got together with two or three people that I knew of my age and who were in similar circumstances, and talked about it. And we gave our first seminar in 1989. And I think we had three people who came and attended, which is a little discouraging. But we kept going until now, of course, it's a given thing. We just gave our twenty-seventh.

BLOOM: And could you describe what you're talking about a little?

LABBY: Well, I knew an awful lot of people, because there was a time when I was part of the medical community, a practice in Portland. So I got them to help me assemble people of like thinking. And I got feedback from them as the best way to go. I remember one surgeon, as a matter of fact, in Portland, who retired. When I asked him if he enjoyed the session, he said, "Well, gosh, at last I have something important to participate in, instead of feeling like I was off to the side."

So it slowly grew until now some of our sessions, including one a couple of years ago I remember on ethical issues around the end of life, we had over a hundred people attend. And one just last week having to do with the position of alternative medicine in the medical curriculum, we had over fifty people.

BLOOM: What's the name of these seminars?

LABBY: Well, they're named after me, but they're essentially senior clinician conferences. And we're up to twenty-seven, and we've given two a year, spring and fall. And interesting in their evolution. We started out talking about difficult cases, because I figured doctors love to talk about patients and cases. And then that went on for quite a

while. And then we slowly shifted from just talking about cases to how do we evaluate the behavior of certain scientists who are doing some spectacular things, like gene therapy, or transplantation therapy. Or some invasive or manipulative work, projecting some kinds of new technology.

And then slowly we took on some of the bigger issues like what happens in doctors' behavior. For example, they make mistakes. How do they pick up the ashes? They also sometimes don't tell the truth. They also have patients who don't always agree with what they suggest. So what we're emphasizing, of course, is patient autonomy. Their right to have a vote in what happens to them.

And on top of that, we more recently got into something less than scientific. Although medicine isn't terribly scientific, at least as we say, the medicine we practice is based on evidence that things are good. But however it turned out, some of these things that go on now don't even have any experience except for experience. Like Oriental medicine, or nutritional kinds of medicines, and chiropractic, and so on. So we've gone from case discussions to suggestions of things that even have community ethical overtones.

We've talked a little bit about how to protect the community from aging people who still want to drive. Is that ethical to allow them to, and so on.

BLOOM: How do you choose the topics?

LABBY: I do. Just by keeping current on what I think is, at the moment, controversial. Sometimes I get tips from the newspapers. Sometimes I get tips from just talking to people at lunch about what's (invested?). And we've never really faltered. It's interesting to me. I never thought it would grow to this point. But as I say, we've done twenty-seven in the last fourteen years. And they still, we get complaints that they'd like it every month instead of twice a year.

BLOOM: Sure. Good. Now as you look back at this evolution of your interest in ethics, where do you see the, what do you see as the future issues here for doctors? As you see the changes from your first Reed seminar to now, what do you think the future is going to hold for us in this area?

LABBY: Well, I don't need a crystal ball, because I want to believe so firmly in what I'm thinking. I hope it turns out to be right, but I may not be around for it. There seems to be a swing back, particularly as a result of a lot of the complaints about the success or lack of it of HMOs. What I see is, you might say, the devolution rather than the evolution, of the doctor/patient relationship. And that's come out in our last several seminars so strongly. Patients want to be understood. And they want the doctor who is responsible for their health, and even their life, to know them as a person as well as, of course, take care of them, whatever disorder they have.

And what's happened, I think, because of the invasion and the intrusion happily, in a sense, of this amazing technology, is that we're getting a kind of service, but we're not getting a kind of attention. In other words, this is a crude comparison, but it's almost like doctors in the main are running service stations. I'm sure there are marvelous exceptions. But I have to report what I feel is coming on.

And now I think patients are beginning to complain. They don't have enough time with their doctors to talk about what's important. And on top of that, the doctors are rushed and are not giving the kind of service because they're prescribing a great deal, and rather quickly. And so there's an intrusion into the doctor/patient relationship from considerations of taking care but not really understanding, and patients are not being cared for in a personal sense as much as they would like to be. I think I was lucky to be able to in psychiatry have almost an hour with a patient. Because that's the bread and butter of psychiatry. But in the more technical aspects of medicine, in internal medicine surgery particularly and so on, that just isn't happening quite the way you should.

BLOOM: But you said you didn't need a crystal ball because you had a fervent belief. So what's the belief?

LABBY: The belief is that the patients are going to be revolting, and want a better kind of care. And I already see that. I already see that happening. And maybe I'm being starry eyed about it, I rather think I am. But I would hate to think that that isn't going to happen. Because I think the care of a much different kind has to be restored to the profession. And I think the business, that intrusion, has been devastating in this respect.

BLOOM: In looking at your career, you've started in one field, you've switched to another field. And you've been, a common theme through your whole life has been as an educator, a teacher.

LABBY: Sure.

BLOOM: Going from seventy lectures a year to somewhat less than that, but still you've been a teacher all your life, and you still are. So what do you see about the evolution of medical education, the fields of psychiatry and internal medicine? How do you see these areas in your crystal ball?

LABBY: Well, I go back to the fact that regardless of what the discipline in medicine is, it all ends up with a doctor and a patient in a room by themselves. And what happens there is critical. Or in the hospital, with a patient in bed. Even that has been a bridge. You know, patients don't stay very long in the hospital. But as far as each of those, and I can't sort them out separately, I'd like to feel that we have been able, at least at the medical school here, to put more and more of the compassionate kinds of care as a dimension of any kind of teaching that we do. That it still remains the major thrust of the doctor, whether he's a urologist, a neurologist, an internist or whatever he is, a surgeon, that he still takes care of the person who's ill, and not just the disorder.

I know for a fact that in some areas where the technology has been so extraordinary, some of the patients during referral have been told by their referring physicians, "Don't expect Dr. So and So to do more than take care of you, take care of your problem, because he doesn't talk much to patients. He likes to do the technology an awful lot." And I have a feeling that maybe an awful lot of that is going to have to go before patients are satisfied. How that's managed, I don't know whether a national program that somehow allows doctors more time than they presently have.

BLOOM: Why do you see it as so important? Why do you see the doctor/patient relationship as so important for the patient?

LABBY: Because they come to be cared for. And they may be intruded upon, they may be actually invaded by certain technologies. But they'd like the doctor somehow to say something like, "Well, Mrs. Smith, I know what it must mean to you to lose a breast because of cancer. But on the other hand, I'm aware of the fact that you may have feelings about losing a breast, and I'd like to know what those are." And so on. Talking about the other dimension of what, in this instance, it means to lose a breast. And hence have an intrusion on your sense of femininity and so on.

And so in some instances we've trained surgeons, for example, to have the husband alongside. And so they can talk about what it means, each to each, to put up with this kind of illness. And that kind of thing, I think if it's more and more pushed, a better understanding between doctor and patient can't help but come out of it.

BLOOM: I want to go back for a minute. I think you were giving credit to the chief of medicine who transferred your salary. Was that David Bristow?

LABBY: That's right. That's the name.

BLOOM: David Bristow. Say a few words about David Bristow.

LABBY: Well, I first knew David as a resident in the veterans' hospital. And he turned out to be, for my sake, a very compassionate, very understanding, soft spoken quite an appealing, congenial person. And I always liked him a lot. We liked each other. So I wasn't surprised when he became chief of medicine. And he took on, actually, the name chair, which is named after Dr. Selling the chair in medicine. In fact, I cheered him on. And he turned out to be a real ally, because he knew me from way back. Very soft spoken person who was very accessible as a person.

I remember when he went into cardiology. And one time I wanted to have a certain cardiological test done. He took the time after the test was done to explain everything to me, and ask me how I felt about his being my resident, former resident, he being my former resident, taking care of me now.

And I said, "Well, after all, it's a real pleasure." And I also have chosen one of my former residents to be my personal physician. That makes it somehow possible to have that dimension I was talking about, a person to person.

BLOOM: Is that a person you would identify?

LABBY: Sure. Lynn Goldberg. We had a marvelous triumph as staff, which I was, and he was resident, in a cardiac case many years ago. He and I believed one thing, and the cardiologist who did all the manipulating, including catheterization and so on, measuring all the dynamics, they came up with one diagnosis. And he and I, just listening to the heart and looking at X-rays and so on, came up with another. And it turned out that he and I were right, and the technologists were wrong. So we've been stuck together ever since. And I like that dimension of care. It means a lot.

BLOOM: If you look back over the last, say, twenty, thirty years, forty years, in the medical school, just name a few people who you felt were remarkable teachers, educators, physicians. Who comes to mind?

LABBY: Well, many of them that come to mind, I didn't appreciate at the time, because I was a student. And that's a lot different than looking back in retrograde fashion. But we had some very devoted people in all of the basic scientists, particularly. For example, Olaf Larsell, a name that only people well of an age would remember, was a totally dedicated medical historian, and has written a book about the history of medicine in Oregon. Totally devoted to anatomy. And that was in anatomy.

And in physiology and pharmacology, particularly in physiology, a man by the name of Dr. (Bergett?) came along, and he was succeeded by a remarkable fellow, William (Humans?), who became a professor of physiology at Wisconsin. I think those were outstanding people at the time.

On the clinical side, we had Dr. Thomas Joyce, who was an internationally recognized physician. And he ran a method of teaching that kept us all absolutely on edge and frightened that we would be called down in the bull pen, as we called it, in the OR, to be given some kind of a quiz right in the OR on surgical pathology and surgical anatomy. And he was an outstanding man. Remarkable personality.

My own father-in-law, Dr. Selling, was an amazing lecturer. He would lecture by closing his eyes and walking up and down, without reference to any notes, he would lecture on neuro-anatomy, because he knew the brain in and out so very vividly. Those two.

And then of course the real stellar giant in physical diagnosis was Howard Lewis, who was brought up as an engineer at Oregon State. And because of that, he was interested in, of all things, the different kinds of sounds that the breath makes when you inhale and exhale as you listen over parts of the chest. And he was internationally known

and wrote a book about some of his understandings of this. That was before we had anything more than just X-rays.

In fact, I once gave an examination for certification in internal medicine with him. He was my co-examiner, or I, his. And of all things, the candidate from California had a case of emphysema. And we put the X-rays up on the view box, and Dr. Lewis asked him what he saw. And he said, "Well, it looks like a very clear lung."

And he said, "Well, what does that mean to you?"

He said, "Well, I don't know. I really don't know. It could be possibly something like emphysema."

He said, "Well, if you were to listen to that chest, what would you hear?"

He said, "Well, in our clinic, we don't listen to the chest anymore. We just take X-rays." So naturally, of course, Dr. Lewis flunked him. Because that was really a sin to think that you didn't examine the chest anymore. So those were some of the outstanding people.

BLOOM: Now how about in this area of the–

[End Track One. Begin Track Two.]

BLOOM: –complete physician, the physician who's concerned with dealing with, taking care of the patient, as you said. How about some of the younger physicians? You mentioned Dr. Tolle, you mentioned Dr. Goldberg.

LABBY: Yeah.

BLOOM: Who do you identify as carrying on this tradition now?

LABBY: Well I don't have that much contact of course with the residents anymore. I don't do hospital medicine. But I do see more and more of the, I'd say, actually the curriculum given over to that aspect of caring for patients. For example, Dr. Tolle and others on her staff, myself included, have tried to teach both the entering medical students and the residents something about caring for patients in that regard. And one of the things that's come out of it is they like to be examined in pairs. For example, when the authorization for power of attorney was designed by the department, we had them interview a patient and present this pamphlet, power of attorney, to older patients. And then had the patient actually criticize the way the intern or resident did it. And then we'd have another resident sitting alongside listening to this, and then they would change. That's just one little sort of model that we have.

And the other is, of course we have now called introduction to residency for the seniors, where we talk a lot about not only the legal protections that you need as you

begin to take care of people and sign your name to put your efforts on the chart. But also, whether or not they have considerations of talking to relatives, husbands, wives, families. And these are all models. Sometimes we use actual actors who act this out. So there's a whole new dimension, I think, that's on top of the curriculum now.

And then there's another big course for the freshmen, the introduction to medicine, having to do with the clinical basis of medicine. And a lot of those sessions, which meet weekly, actually have to do with some of these other values that we're trying to promote.

BLOOM: Try to get integrated, principles of clinical medicine.

LABBY: That's it. Yeah.

SIMEK: Let's take a pause here. We have to change tape. And then we'll take a break, (?) restroom, besides me.

BLOOM: Okay. Let's think about what else we want to cover, too.

[End Track Two. Begin Track Three.]

LABBY: [coughs] Excuse me. I'm getting a little rough in the throat.

SIMEK: Okay, we're set.

BLOOM: Could you tell me the name of the chairman of medicine who transferred your salary to psychiatry?

LABBY: Yeah, that was Dr. David Bristow.

BLOOM: And how did you first meet him?

LABBY: I met him, actually, as a resident in the internal medicine at the veterans' hospital, and we became immediately good friends as well, and remain so. I was always attracted to David because he worked very hard, as everyone probably knows, at jogging and running. And it was really a loss to know that he finally died of cancer. In otherwise perfect physical shape.

BLOOM: Were you his attending? Or what was your role?

LABBY: I was his attending at Veterans' Hospital when he was in training.

BLOOM: Good. Now I want to go back to the early days, when you talked a little bit about the Osler Method of training. Could you tell us a little more about what that involved?

LABBY: Well, William Osler, the Canadian, who eventually became Sir William Osler, won the Nobel Prize as a doctor in literature, of all things, because he wrote some beautiful, beautiful treatises having to do with the care and the training of doctors, as well as other things. He dominated a lot of the training post World War One, for the training of doctors. As a matter of fact, he made it a kind of dedication to be a doctor. You felt the call, feeling a dimension of medicine, I think, has possibly been lost, though not maybe entirely. But the idea in detail, as it was worked out in some of the so-called Ivy League medical schools: Harvard, Columbia, Cornell, Duke, and others, was that you were devoted as a doctor to the care of the patient. And he's the one who talked a great deal about the care of the patient is also the care of the person who is ill.

And he specified in this devotion and dedication that you did not marry until you were established. Because otherwise, you would be so diverted that you couldn't take proper care of your patients. And my own father-in-law, Dr. Selling, who was chief of medicine, held off on allowing his daughter to marry me because of that I was in training. I was a medical student and I was a resident and I did research and so on, well until we had been together over five years.

We had some amusing sorts of encounters about this. He said, "Well, you can't really afford to take care of Margaret, can you?"

And I said, "Well, you've been maintaining her and you've been taking care of your daughter all these years. I don't know why that couldn't continue." Which he thought was a laugh. But painfully so.

So finally, when I became an assistant in research at the Rockefeller Institute in New York, it was okay, and we went ahead and got married.

BLOOM: So you married after your internship year.

LABBY: Oh, well after. We married in '40, and I graduated in '39.

BLOOM: Okay. Let me ask you a few questions. Looking back on your career, changes in psychiatry, how you see psychiatry. You've had a unique niche in psychiatry, so to speak. And how do you see psychiatry evolve or devolve as a profession over the years? And then I'd like you to do the same in internal medicine. Let's start with psychiatry.

LABBY: Well as a student, and as, I suppose, a place to start, we were exposed to psychiatry in a rather superficial way. For example, some of you may remember the hospital, Morningside Hospital, in Portland, that had had a contractor take care of the insane from Alaska out on the east side. And our exposure to psychiatry was to go as a group and see the patients in the wards of what then was euphemistically called an insane asylum, as was the hospital in Salem, state hospital. We had no, were given no theory as to why all this took place. But we were given by one of the people who was practicing psychiatry in Portland, we were given some notion as to how to take care of them. We

had none of the psychoactive drugs then; all we had were sedatives. And most of the care consisted of either hospitalizing people, or incarcerating them if they were terribly troubled, in these mental hospitals. Or somehow keeping them in close touch with physicians if they had life problems. But the latter was not really emphasized. People didn't go to a psychiatrist like they do now, as walking wounded, having just life problems.

So the major, I think, change came, actually at our medical school with Dr. George Saslow, who came with a much different approach having to do with understanding people through their reports of their behaviors and problems and conflicts. And then eventually the use of psychoactive drugs which of course is absolutely cataclysmic in changing the general approach in psychiatry. Now psychiatry is split up into so many domains and so many different sects that in the course of teaching, at least in my now approach, I think what I prefer to do, taking a kind of conceptual look at it is to say, "We will show you different sorts of role models for taking care of people. But each person must devise his own or her own. Because taking care requires such highly personal sorts of stipulations about how you feel about the people you take care of."

When medical students say, well, what kind of a person do you have to be to be a psychiatrist, I always start with saying, "You have to like people." Because the psychiatry discipline as I've seen it is one of the most demanding. Even comparing it certainly to my experience in internal medicine.

BLOOM: Demanding in what way?

LABBY: That you be available. Not just day and night, but you be available to take care of whatever the patient brings. That you be on top of trying to push them into understanding why they behave the way they do, if you can get to that point.

BLOOM: What about–

SIMEK: Remember, Doctor, if you would, to focus on Joe here. Your eyes are wandering quite a bit.

LABBY: Sorry.

SIMEK: Thank you.

BLOOM: What about changes in internal medicine and how you see that today?

LABBY: Well, I'm not in it so much as of course I used to be. I actually left it about thirty years ago. I've had thirty, thirty-five years in both disciplines. I guess the thing I referred to earlier, having to do with technology, is the thing I see taking over an awful lot. An internist being a kind of now generalist, they have less time than they really need, I think, so often, to take care of people the way I was trained to. They, for example, have all the aids they need technologically to take care of a lot of things. And they have

an awful lot of medications now, a wide variety. And of course they're certainly the subject of a lot of merchandising by the pharmaceutical industry to this extent. So I see the overuse now, if you will, of medication. And I see the extreme use of technology. You know, things like the implants to control heartbeat and so on, and some of the things that have to do with taking care of dysfunctions of gastroentologically. And a lot of visual material now is available in the form of doing scopes in different parts of the body. Stomach and any of the accessible organs and so on.

BLOOM: With all the advance in technology, do you see the Ethics Center and the fact that some of the physicians you mentioned are internists. That this is an internist move back toward the kind of care you were talking about, of being more concerned with the person?

LABBY: Well internists, like all doctors, vary in how much time they will give to that sort of thing. Lynn Goldberg, when I first went to see him after not seeing him for some years, because I was away, said, "Well, I'm supposed to give eleven minutes to an interview like this. But since you're my old staff man, I'll give you two units: twenty-two minutes." Though we've joked about that over the years, and he gives me, of course, whatever time is required within reason. But it still reflects underneath it the notion that they would like more time. But they're obligated to see a lot more patients.

And as you know, some of the people in Portland at some of the clinics, I know of several, some of the doctors decided they could not practice that way. And they were let go because they could not justify the income that they were expected to earn in order to sustain their part of the overall expenses of the clinic.

BLOOM: I have just two other areas that I'm going to ask you some questions about. One is, do you have any advice for patients who are looking to find a physician? How should a patient find a physician like the physicians you're talking about?

LABBY: I'm glad you brought it up because I do get called, not infrequently, about "I'm new to this city," or, "I don't like the man who's taking care of me. Do you have somebody that would be–" and these are the words, – "a good match for me?"

And I say, "Well, what do you mean by a good match?"

"Well, I'd like a physician that will listen and answer my questions."

And I said, "Well, I'm with you there. But can you ask the questions that you need answered?" Because it works both ways.

As a matter of fact, one of my friends in New York wrote a book on just this business of how to use your physician. And it has to do a lot with not being frightened, or worried about how little time he has. Make sure you don't leave the office until you've had your questions asked. Answered. But make sure you know what to ask.

BLOOM: So you're looking at a patient who's educated, also, in relating to a doctor. Just as a doctor would relate to a patient.

LABBY: So often, I'm sure others have this experience, patients will say, "Well, I'm going to see my doctor next week. What do you think I ought to ask?" They do need educating, that's true. But then there's an awful lot to say about how well educated patients now are, thanks to the media. Newspapers and television and radio, they get an awful lot of understanding of what they have and what they can do if they see a doctor. But there's timidity, and there's uncertainty.

BLOOM: How do you answer them when they ask you, "What do you think I ought to ask?"

LABBY: "What would you like to know?"

And they say, "Well, I don't know what I'd like to know." So we get into a conversation about how to explore that. Yeah. Yeah. I'm really amazed, because some patients will call me up. Friends, actually, not patients.

I'm thinking of a woman who called me up last month and said, "You know, I sprained my thumb and it's in a cast and it's beginning to hurt. And I think my thumb is swelling a little bit."

So in the course of seeing her, I said, "Well, call up your physician and have him take care of it. It shouldn't be that way."

She said, "Well, I don't want to disturb him about something. Shouldn't I just stick it out?"

I said, "Well, no. I'd rather you stuck your thumb out and made him change the cast." So people somehow are intimidated, some of them, about what they might ask of their physician.

BLOOM: Okay. One more area. And I'm not asking this to embarrass you. I do know a little bit about your life. One of the very important topics in medicine are medical marriages. Now you've been married now for sixty-

LABBY: Three. Sixty-three years.

BLOOM: Years. Your wife is the daughter of this physician and the wife of a physician. Tell us a little about your wife.

LABBY: My wife?

BLOOM: Your wife. Your wife's name.

LABBY: Well Margaret unhappily has been not only the daughter of a physician, but the sister of two other physicians, and the wife of a physician. And our son and his wife are physicians. So she's never known anything but a medical marriage. As a matter of fact, we for a, were touring the state, talking about that topic, called medical marriages. Just because there were so many people that had hesitancy about should I marry a person that I may not see very often.

And I was surprised that an awful lot of wives, we'll stay with them, would not really understand the kinds of priorities that doctors had. For example, in doing this actually professionally, and I had my share of medical marriages to do in therapy, they complained a great deal about their husbands being quite independent, having to go back to the hospital at critical moments. Until I explained that a doctor is always welcome wherever he goes into the hospital. They're delighted to see him. And some of my friends told me if they're bored at a dinner party they'll leave and go to the hospital. Because who would say that it wasn't a legitimate excuse.

I had one woman, I remember, who was married to a doctor. She said, "He takes off. He's an obstetrician, so he has to take off an awful lot of the time. And I'm getting a little resentful, because he can't be a father."

I said, "Well, have you ever gone with him to the hospital to see how things are done?"

She said, "Well, I've delivered a child."

I said, "No, I'd like you to observe your husband delivering someone else's child." And she was amazed at what he went in. the preparation for his arrival, the setting up of the OR, the delivery and so on. And so one of the ways of managing, get the wife of a medical marriage to participate somehow, if she can, conditions allow it, in what her husband does.

BLOOM: So are you saying that you and Margaret went around the state? Or just you did?

LABBY: Yeah. Yeah. Both of us did, periodically.

BLOOM: And you gave seminars on medical–

LABBY: We did that. Not around the state so much as in the medical area, in this regional area. And then we established some years ago a group for students who were in relationships or married. And we had one rather revealing experience among many. There was a group that we met with once a month, or I think possibly more often, at five o'clock. And we'd have tea and cookies and talk. And in one of the groups, there was a nurse who was married to a medical student. Which happens often enough.

And all of a sudden one day she turned to Margaret and myself and said, "Well, Dr. and Mrs. Labby, what did you think would happen to your relationship if you had children?"

And I looked at Margaret and she looked at me and we both said the same thing. "Did we have a relationship?" That was a new word. Now but not new at all. A buzz word. So we had to emphasize a lot about intrusions into the life of the medical marriage with the arrival of children, and what that meant, when there's already an intrusion with an over busy physician who has no real schedule but is on call. It was a very popular thing to do, as a matter of fact, and it still is, I understand. We're not doing it anymore. Just being role models.

BLOOM: And Margaret is trained person?

LABBY: Yes, she's a, Margaret was, in addition to having been an English teacher for many years, she retrained. Which happened to all the members of our family by second careers. She retrained in social work. So we did our thing as much as we could, yeah.

BLOOM: So last question: with Margaret being the wife of a doctor, the daughter of a doctor, the mother of a doctor and the sister of doctors, what would she say about the practice of, profession of medicine?

LABBY: Well, she is pretty much sold on the notion that anybody can go through medical school, probably the least educated, starting at base. I rather think she's, in a sense, admiring of the physician. I like to think so, anyway. I don't see how she could be otherwise. But she's also very skeptical. And in the course of bringing up all our three children, instead of listening to my medical advice periodically, she'd rather put the kids in the bathtub and give them aspirin than anything else. So keeping up with sense of humor in spite of all of the intrusions and invasions, I think, is a real catch word, I think, for a successful medical marriage.

BLOOM: Good. Thank you. Anything else?

SIMEK: I'd like you to tackle the one question about a few words of advice to new physicians.

BLOOM: Oh, okay. I forgot. One more.

LABBY: Really? Anything left? My god.

BLOOM: I asked you about advice for patients. How about advice for new physicians, young physicians? What would you like to tell them?

LABBY: Well, I guess I can only reiterate what I said earlier bout taking care in a holistic way as much as you can. The other force that I hadn't mentioned is this

breaking down into specialties. So often friends of ours will say, “I just came out of some modest surgery at the hospital, and I’ve had five or six different doctors take care of me.

And I said, “I’ll bet you don’t know who was in charge.”

They said, “I really don’t. I thought my own physician was in charge, but he turned me over to the hospital staff.” So there is a fractioning, fractionation that goes on, and a crumbling down, really, of who’s really taking care of me and really understands what I’m gong through? Because a series of people who come to the bedside and say, “I’m your anesthetist.” “I’m your physiotherapist. I’m going to make sure you get out of bed, or turned in bed every hour.” And so on and so on. And then a lot of physicians don’t stay long. “I’m the person who did this test and so I just wanted to tell you it’s okay.” And then they leave without telling you what the test meant.

BLOOM: So the advice is?

LABBY: Make sure somebody’s in charge. And if you are a person who uses a lot of referral, make sure that you remain in charge and are at a final common path for all the questions.

It happened, actually, my brother had a serious accident. Actually a head injury form an automobile accident. I was called. I was out of town. Came in and found six doctors in the room. And I walked in and I said, “Who’s in charge?” And nobody knew. But there was a neurologist, a trauma surgeon, etcetera, etcetera, all in the room. And everybody was doing a little bit. But nobody knew the whole.

SIMEK: Marvelous. I’m going to stop.

BLOOM: Thank you very much.

LABBY: Yeah. Okay. Where do I send my bill? [laughter]

BLOOM: You can send it to me.

LABBY: We never talked about money, did we?

[End Interview.]