HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

with

John A. Benson, Jr., M.D.

Interview conducted April 8, 2004

by

Joseph Bloom, M.D.

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Begin Tape 1, Side 1

BLOOM: ...2004. Joe Bloom, interviewer, and Dr. John Benson, John A. Benson, Jr., is the subject of the interview.

Let's start, John, with you telling us what you're doing now. What are your current - where are you living and what's your current activities?

BENSON: Well, last fall I left Portland, somewhat reluctantly, to go to Omaha and the University of Nebraska Medical Center, where my new wife became the dean of the college of nursing. I'd like to think because of her package that I was given, in fact, a paid job. Having volunteered in the dean's office for quite a few years before last fall, it was kind of interesting to be doing sort of the same things and in fact getting a salary. She's happy to point out that she gets more than I do.

So we live in Omaha, and she's been very successful in these first six months, and I'm enjoying it, too. It's a school on a positive trajectory; somewhat behind OHSU in its faculty size and NIH grants and scope of expertise, but on a positive trajectory.

BLOOM: What is your job there?

BENSON: I'm a professor of internal medicine. I haven't been seeing patients. I still feel reasonably inadequate in terms of clinical care because of the long spell in administrative work and the new knowledge and technology that's bypassed me in many ways. I'm on a search committee, work a little with the ethics people, and trying to develop a mentoring program. I do teach first-year students, which I enjoyed doing here at OHSU, and mostly sort of sizing up the place, working daily.

BLOOM: You were in Oregon for how many years?

BENSON: Since 1959.

BLOOM: You came in 1959, and you left just a few months ago. So, what are your initial comparisons of the two places? I mean, what is it like in Omaha and the University of Nebraska compared to what you experienced toward the end at OHSU, or even as OHSU developed?

BENSON: Well, currently, Nebraska is in some ways behind OHSU. It's a very good clinical center. The clinical teaching is excellent. For example, for six years running, now, the internal medicine residents, as first takers, have all passed the ABIM certifying exam, and that's a record few hospitals can boast.

The institution has merged with a private hospital, and that merger is incomplete and still somewhat contentious, because they speak of their respective partners, the university medical center or the hospital, and together they aren't as unified as I think OHSU is under its president.

It's way behind OHSU in terms of NIH grants, perhaps sixtieth rather than in the twenties, and it's like OHSU in Omaha away from the university itself, but the university in Lincoln, which is about as far away as Salem, does in many ways dominate the culture around the medical center as well, in that the president has to approve budgets, for example, is visible on the campus in Omaha, and so forth.

The medical center is gradually getting away from being purely clinical. It's gone through a town-gown kind of phenomenon with the merger with this hospital, something that I observed here in the fifties when I first came, and I think it's still struggling to make that merger work.

It's very well known internationally, actually, for transplantation, particularly liver, pancreas, small bowel transplants, and for lymphoma, for the lymphoproliferative hematologic diseases. Very good people in those areas, but in some areas - there are only two or three nephrologists, there are only two or three dermatologists in the department of medicine, for example. Very much less developed than at OHSU today.

BLOOM: So in the time you've been away, what's your perspective in kind of looking back at OHSU? Has your perspective changed any, or your - how do you visualize those years now?

BENSON: Well, I'm somewhat envious of the progress that has been made here at OHSU compared to Nebraska. On the other hand, the opportunity for growth and change is pretty exciting, and I'm sure it's attracted my wife and her career in nursing. And it's what the chancellor wants, as well, particularly growth in research. So I do miss that kind of contact. I miss the kind of unitary administration that I think prevails here, and chafe a bit at the fact that the two groups in Omaha still are struggling to live with each other.

BLOOM: How about your views of OHSU? Are they the same as the day you left, or have they changed in the time you've been away?

BENSON: Pretty much. I understand OHSU is having its problems with financial solvency, you might say, which many medical schools suffer from these days. It does seem a little aggravated since I left, and it's a lot more so than in Omaha. The state, for example, in Omaha, had to cut the university's budget, but by something like three hundred thousand dollars, instead of millions, as is true here. So that is a source of comfort in some ways. The university gets maybe 35 percent of its revenues from the state in Nebraska.

BLOOM: Let's go back to - you mentioned that you're seeing in Omaha now something you saw here in the fifties in the town-gown. So you came to Oregon in the fifties. What was it like then? And maybe take us through those years and the early development of OHSU in the time you were here.

BENSON: I think the seminal thing which occurred before I came was the construction of the University Hospital. And at the same time, Dean Baird was creating a full-time faculty in the clinical sciences. So I was the first full-time gastroenterologist, for example, and joined a department of, probably, fifteen people under Dr. Howard Lewis.

The people who had been teaching the clinical sciences were largely practitioners from downtown Portland. They'd teach in the morning, they'd operate with the residents in the morning, and then downtown continue their practices, often in multiple hospitals. A friend, George Long, who had run the gastroenterology division beforehand, would have patients in Vancouver, Providence, Emanuel, Good Samaritan, all at the same time, and was a consultant as well at the VA over in both Portland and Vancouver. At that time, Vancouver VA had a general medicine service.

Those folks who were displaced by full-time people like myself in other divisions and departments were pretty bitter at being displaced and losing a certain amount of esteem and were hard on the dean. The dean sort of holed up in his office and became depressed, it seemed to us, because of the competition that they felt we were providing with a state-supported, free hospital, so to speak, salaried physicians who didn't really have to earn their salaries, and the competition was presumably unfair. So that town-gown thing was hard on the dean and continued through well into the sixties.

By that time, more and more full-time faculty were coming in and departments were swelling in size and expertise, and it was also a time when NIH grants were easier to get and where support for research was more generous. And so it was a good growth period here, and the faculty took advantage of that to some extent.

The hospital need not have been seen, it seemed to me then and today, as such a threat in terms of competition, because most of our patients couldn't pay anything anyway. They often were the indigent. Some of the patients were the legislators and the state board of higher education members who the dean talked into being hospitalized at our place to get expert kinds of care, et cetera. But for the most part, the community patients preferred the amenities and the private care of the other hospitals in the city.

BLOOM: If we kind of approach this by decades, what did you do in the sixties, in that decade?

BENSON: Well, it was generating mostly a small group of gastroenterologists of keeping intact those downtown subspecialists in gastroenterology through such devices as a journal club, through having a combined medical-surgical conference with the surgeons and the radiologists.

At that time - Burt Dunphy had come the same year I did from Boston to chair surgery, and he and I knew each other from years gone by. He operated on my father, for example, when I was a fellow at the Brigham. We courted, really, these faculty members to keep them teaching and helping us, and they would do consultation rounds and work in the clinic. So it was consolidating that and setting up a curriculum for students.

Later in the sixties, there was - under Dick Sleeter, who ran what was then called the crippled children's division, the CDRC today, and Bill Krippaehne, a surgeon, general surgeon, there was a curriculum committee review and reform. One of the things that I was particularly interested in was introducing more pathophysiology and using clinicians as well as basic scientists in teaching second-year students with an integrated kind of curriculum, modeled to some extent on what Case Western University had done in Cleveland perhaps ten years earlier.

So it was a matter of doing that - we had an NIH grant and were studying, of all things, gastric freezing as a treatment for ulcers. It didn't work, it didn't help the dogs that we worked on, and it was abandoned very quickly as a result of research like this. And I was particularly interested in malabsorbtion syndromes.

The other thing we did a lot were so-called circuit-riding courses for CME. A group of three or four of us would climb in a very tiny plane or a small bus of some kind and go off to the smaller cities in the state, and even over to Boise, and give an afternoon of CME teaching around medical-surgical gastrointestinal problems, largely directed at family physicians, at general practitioners. That was a very enjoyable thing. We would get fifteen people at one of these courses, but that was fifteen of the eighteen practitioners in three counties in areas like eastern Oregon, for example. One would meet good people trying very hard to produce good medical care in these outlying regions; Coos Bay, Ontario, Burns, John Day.

BLOOM: Who organized these circuit courses?

BENSON: Well, at that time, Bob Grover, who was I think called an associate hospital director, worked under Charles Holman, who was both an associate dean and director of the University Hospital, later dean of the medical school. Bob organized this sort of thing, getting grants from what was called in those days the Regional Medical Programs, federally funded programs to advance medical practice, I guess you'd say. He was succeeded by Charles Zerzan, who retired from the army, another gastroenterologist, and he often would drive us to Astoria or wherever, crossing the Coast Range in a snowstorm, to manage these. Later, it was Dutch Reinschmidt.

In 1970, I think, Dr. Reinschmidt came from Eugene and set up a more formal part of - I guess it was called a division, originally, along with the Oregon Medical Association funding, a division within the school of medicine, and later, as you know, became an associate dean and in charge of both CME and graduate medical education.

BLOOM: So that the link - do you know more about the link to OMA as this started, as this program started with Dr. Reinschmidt?

BENSON: I think he engineered a good bit of this. He was highly respected by the OMA as a very solid citizen, as a teacher, as a good doctor for the student health program at the University of Oregon in Eugene, and he also did things that were much - legitimized CME in various ways. For example, he did needs assessment. He found out what in fact the doctors in a given area needed, in their view, so that we wouldn't come down there with what we wanted to tell them, but rather what they wanted to hear. Then he also made sure that the evaluation system justified the expense and the quality of the presentations.

So he refined the system a great deal in the early seventies, and later became, I think, the chair of a committee in the national accrediting organization, the Accreditation Council for Continuing Medical Education, setting up standards that pretty much exist still today over such things, for example, as the influence of pharmaceutical firms on the selection of either speakers or curriculum.

BLOOM: Did you have any particular adventures on the circuit that you remember, anything that was - you mentioned a snowstorm. Did you have anything that was unusual or humorous?

BENSON: Well, you would meet underground in places in Pendleton that I guess were historically places where Chinese labor either lived or hid during the construction of the railroads earlier in the century. I can remember at Coos Bay the terrible motel, outside of which was a gigantic mountain of sawdust to be loaded on freighters to be carted off, I suppose, to paper mills, if not to Asia.

I particularly remember, though, not so many individuals. I remember Gus Tanaka in Ontario was very cordial and had us over to his home and fed us, and things like that. We were generally fêted by these local physicians. They were very pleased to have somebody come from the big city and treat them as though, you know, they were good doctors and deserved some help from the university. It was that sort of thing.

I remember a fellow named Ralph Hibbs from Medford. He had actually gone on the Bataan death march in the Philippines. First Corregidor, I guess it was, and then Bataan, escaping, but then being caught by the Japanese. He spent three or four years, I think, in a Japanese prison camp in Bataan and had stories to tell about this; lost, you know, half his body weight; saw a lot of his friends and others die from malnutrition, beriberi, and infections of various kinds. So there were characters like that that you had an opportunity to meet because you were in their own home.

BLOOM: Okay. Well, let's sort of...

??: Can I stop you for just one moment?

BLOOM: Sure.

BENSON: I did an interview like this for AOA, Joe, and it was done at the Harvard Pilgrim office for this practice plan, and they had the camera up in the ceiling, so I was always looking like this. No, I wasn't, I was looking - the difference was I was looking at you, and it looked as thought I was looking down all the time because the camera was fixed.

??: It's funny that the people who are making these things don't figure that out.

BENSON: I'm surprised, I must say.

BLOOM: Well, this is a health plan, running a camera.

??: Oh. Well, there you are.

BENSON: This was a little room for public relations, I guess, and it was a terrible mistake. It made me looked depressed the whole time through (laughs).

BLOOM: Well, we don't want to do that.

??: You look very good here, if I do say so myself.

BLOOM: He doesn't look depressed.

BENSON: It's great when a psychiatrist tells you that you don't look depressed (laughter).

BLOOM: So we've gone through the sixties a little bit. You spent time organizing a division and doing certain activities that you described, and you talked about the circuit. Anything else you want to say about that time before we head on into the seventies?

BENSON: One thing that happened to me I credit to Howard Lewis, the chair of medicine at the time. He, in essence, brought me here, and at the time, the very first year or two that I was here, he was both the president of the American College of Physicians and the chair of the American Board of Internal Medicine.

He had all kinds of stories to tell about that, because in those days it was just before jet aircraft served Portland, so there were a lot of long train rides, and going to places like New Orleans would take two or three days, just to give oral exams there.

But what he did was to put me, through his contact on ABIM, Board of Internal Medicine, on its subspecialty board of gastroenterology. I was thrown in as a very junior person, a year after I'd been certified myself in this subspecialty, with people like Joe Kirsner, from the University of Chicago, and Franz Inglefinger, from Boston University,

later editor of the *New England Journal*, and others of that ilk. It was a small board, maybe five people, examining people only orally for certification in gastroenterology.

I was kind of appalled at what I was seeing in terms of how uneven the process was. No two candidates had the same examiners or the same patients. They each had two patients and two different examiners, so it was hard to set a standard that was uniform across this. As the years went by, I became its chair and brought them to Portland.

In the meantime, we had hired Fred Smith to come from Cornell to run the VA section on gastroenterology, and we set up a practical examination with biopsies of livers and of the small bowel and of arteriograms of the circulation in the abdomen and certain x-rays and gave all of the candidates the same exam, just to set a pattern. This was an experiment - whether they passed or failed didn't count that year - but it set a prototype, it set a pattern, a template for continuing something like that in the future. Later on, the orals themselves were discontinued as being unreliable.

That also cast me into a crowd of national figures in gastroenterology, and in 1969 I became secretary-elect of the American Gastroenterological Association. I'm fond of saying that I've always been interested in marketing the University of Oregon Medical School, and on the stationery for both the board and the American Gastroenterological Association were the names of its members and where they were from. And I took some pride in the fact that you could write down University of Oregon Medical School and see it in Portland on the letterheads. Vain, I suppose, but I think it helped a little bit to call attention to the school and its growth.

That plus the new curriculum engineered by this committee in the late sixties were significant changes, and it was very gratifying to have a role, a partial role, really, in both of them, setting a more uniform standard.

The ABIM experience was fascinating in that this was a national standard-setting organization, as you know in psychiatry in your own work, and it set a standard uniform for all the trainees graduating from residencies and then fellowships. The board work further was interesting, because we decided the oral exam was too unreliable to continue. It also became logistically impossible to continue. We were having two hundred candidates. So in '72 and '73 we gave our last oral exams and started only doing national multiple-choice, primarily, exams. But those were highly standardized, very carefully put together, using both practitioners and academic types of specialists, and they were tested on recent diplomats of the board who were in practice to see whether or not they found the material realistic and representative of their practices.

So there were a lot of changes like that going on to standardize and in fact legitimize a national standard.

BLOOM: So when we start to come into the seventies, how would you describe your career in that decade?

BENSON: A very big change, because, one, I traveled a lot for these two organizations. I became the secretary, and then very soon thereafter got in the chain that led to presidency of the AGA in 1977-78.

And on the board, my elected term ended in 1975. I was on its executive committee at the time, and we were the search committee to create a new president or to secure a new president. We had revised the bylaws, had added some six subspecialties to the original four, and had begun to look for suitable president candidates for this position newly created by these bylaws revisions.

They were done, by the way, with the help of a Philadelphia lawyer, and I got to know a little more about good they really are and how vast their firms are in terms of getting support and data and information and standards from other sources.

The long and short of it was, we tried to get Jack Meyers, then the chair of medicine at Pittsburgh - he had come out of the Duke - Emory and Eugene Stead's school of young faculty - but he was more interested in developing computer-based medical records and even examination of patients and turned us down. So we turned to Bud Relman, Arnold Relman, who was then the chair, I think, of medicine at Pennsylvania, noted nephrologist, and he turned us down because the *New England Journal* wanted him to succeed Franz Inglefinger as its editor.

At that point, Sol Farber, who was chair of medicine at NYU, turned to me and said, "Would you be interested in being a candidate?" That blew me away as an opportunity. He gave me about two or three weeks to talk to my...

[End of Tape 1, Side 1/Tape 1, Side 2]

BENSON: ...over and talked to Dr. Lewis, and the long and short of it was I became a candidate and was appointed in '75 to be the first president, so-called, succeeding a very able executive secretary, who had come from Hopkins and had, with this board, expanded board and the new bylaws, set up the position that I took. So I became much more oriented around national figures.

I had been seeing patients throughout my career, private patients, but only on Friday afternoons in my office. And they were complicated cases. Usually it would come in with, you know, several pounds of x-rays and past records, and they were difficult, usually unsuccessfully treated patients. I'd see two of them, maybe - It was very luxurious - and probably charged them twenty-five dollars for this consultation. It took me about three hours each.

I felt that - and then there were some in the hospital that needed inpatient care. But I felt, when I took particularly the board job and they let me continue to live in Portland - I had two young children still in school - that I would be away too much to justify having private patients. And so I redistributed them amongst their doctors and Cliff Melnyk, who had joined me on the faculty, and Ron Katon and others, and there

was one who decided I could not discharge him. In fact, his wife decided that. He was a cardiologist with sclerosing cholangitis, a disease that lends itself to liver transplantation. So I would come home from wherever my travels were and see him in his office.

Finally, about 1980, '81, it came to a recommendation for a liver transplantation. That was fascinating, because the closest center that did them was Dallas, and it was still under the general auspices of the Tom Starzl program at Pittsburgh and conducted at Dallas by one of his trainees, a surgeon named Klintmalm, a Swedish guy. And so this doctor was - I don't mention his name because of the current HIPPA sort of reservations we undergo. But this doctor was worked up in Pittsburgh and then lined up for Dallas and finally had a very successful transplant and was followed up by others after a short time and still is active in cardiology at St. Vincent.

BLOOM: Well, let's - before we get to the board years, the early years in the seventies, what was the medical school like and what was medical practice in Oregon like in those earlier years of '70 to '75?

BENSON: The hospital changed in another way some time in, I think, the mid-sixties, I guess. The - his name was Clark, the Multnomah County Council commissioner named Clark, decided that the budget for the county hospital, Multnomah Hospital, was too high - it was $2 million a year - and so would the university, in essence, buy it, which I think they did for one dollar.

We had long trained residents and students at the county hospital, even before the University Hospital was built, and it was a source for patient care as well as training. It became a University Hospital - what should I call it - branch or unit. That continued, though, to pretty much take an indigent-care group, and it was very hard to, again, attract patients. Medicare had come in in the mid-sixties. It made it possible for most patients in the elderly group to have private care, and we lost a lot of private patients to the Medicare hospitalization of people in the downtown hospitals, it seemed to me, for that reason. So we were scrambling still to try and get patients, paying patients, insured patients. More and more that was happening, there were more admissions.

Another thing that happened in the early seventies was the creation of the department of family medicine, at first under a practicing generalist named Laurel Case, a nonacademic-trained kind of physician, and they had hospital privileges. It sometimes seemed unreasonable, to me at least, that some of the critical care that they were undertaking in the inpatients they had hospitalized was under their supervision; for example, bleeding esophageal varices - it's a very complicated complication of terminal liver disease - and so there were some struggles over how that would be handled.

The surgeons were succeeding, I think, more and more in getting patients and being reimbursed through insurance, so that was improving. By then, Dr. Baird had retired and Dr. Holman had become dean, and early in the seventies, the - I'm not quite sure who generated this, Joe. Perhaps the university thought, Well, maybe we should amalgamate things under a single university heading, separate more from Eugene and

develop a precedent at the University of Oregon Medical School, the University of Oregon Dental School, and the University of Oregon Nursing School. The nursing school, in the sixties, had become independent, had been under the dean of the school of medicine.

For that, a national search was created and a person named Lewis Bluemle, a nephrologist from the University of Pennsylvania, was appointed to be the first president. He was a marvelous fellow who - visionary. He was a stranger to Oregon ways, to kind of the Oregon culture, and a lot of people found it hard to accept him, I think. But he did espouse the curricular change, tried to develop more research, more grants, and more full-time faculty. That didn't last too very long, because he was attracted back to Philadelphia and became president of Jefferson Medical College and its much larger operation in Philadelphia.

BLOOM: When you say he was a stranger to Oregon ways and culture, what do you mean?

BENSON: Well, I think he, as any person new to a city must do, was cautious and was careful and was discreet about telling people how it should be and how it could be better, and so forth. On the other hand, he wanted to make it grow, he wanted to do much more with the hospital's amenities and filling out the beds with paying patients, and things like that, which met some resistance. And he, at the same time, was limited in the budget that he could wield, because the state still provided the major support for faculty. I always, for example, until the time I took the board job, was on hard state dollars; very comfortable for somebody who came from Harvard where you earned every dime that you made through research and seeing patients. So he had this burden of trying to distribute money to reward people for getting grants and bringing in clinical revenues.

BLOOM: But do you see something like an Oregon culture?

BENSON: I think it's conservative. It's a little leery of change, or it was; maybe it still is. I see some of that in Nebraska today, and it reminds me of those days in Oregon.

You were dependent upon a legislature that - many of whom came from small towns, who earned less money than you did as a physician - saw us as privileged professionals. And the legislature, on the other hand, had to be cajoled and teased into giving us more and more money to run the whole operation. That took tact and skill. Dr. Bluemle had a good deal of that. I think they were a little more used to the down-home, one-on-one visits from Dean Baird and Charles Holman and their roots in Oregon; Baird from Baker and I guess Holman from here abouts. So Bluemle was an easterner. He was suspect.

In some ways, I think he was rescued by Jefferson into a superior job, actually, which he did beautifully, and that institution grew like crazy, and they built a multimillion dollar Bluemle Research Building for about eighty million dollars from charity.

BLOOM: So he went off to Jefferson and soon after that you went to the boards, but there was a little bit of time there. Who came after Dr. Bluemle?

BENSON: Well, he - I left before he did, and he - so did Dave Bristow, who was then chair of medicine. He had succeeded Howard Lewis - David, a cardiologist - and he decided to take a sabbatical year and then leave. He found himself, as the chair of medicine, largely spending his days in committees, and he didn't much like that kind of career. At the same time, the cardiologist - I'm blocking for his name. Don Kassebaum. Don Kassebaum had set up critical care units, was the electrocardiographic expert, and he was becoming a hospital director, hospital administrator. So all of a sudden, three of us who had been in a small kitchen cabinet of Bristow's were leaving, and Bluemle thought we were all jumping ship on him. He didn't know what he was going to do about that. That was kind of gratifying to hear, but I think it did influence him in some ways to think about going elsewhere.

So there was a period of a couple of years, I think, when there were a number of acting presidents and acting chairs of medicine, including Dick Jones as a president; the chair of biochemistry, Bob Koler; and George Porter, perhaps - I'm trying to think if there are others who were acting chairs of medicine. And searches were difficult, because there was instability of leadership, it was felt, and not a whole lot of money for creating packages to bring people to the institution. So there was a period in there of at least two years when these two positions were led by acting or interim physicians in acting positions.

Finally, George Porter was talked into taking the chair of medicine, with certain provisos that suited him pretty well, and they hired Leonard Laster to come to be the president of the university itself. He had been dean at - first he was the head of internal - I guess that's what they call it - gastroenterology at the NIH, and then was the dean for a time at Downstate in the State University of New York in Brooklyn and there was having a hard time, perhaps too strong a personality for the faculty there, and looked for a change, and he took the job, after a national search, here as the president.

There's a history there of, again, another easterner, a fairly egocentric guy, some very good ideas, some rather despotic behavior, it seemed to me from the outside. I was then an observer from my office downtown in the American Board of Internal Medicine.

He did not get along well with senior leaders in the faculty, the chairs of surgery and biochemistry among them. On the other hand, he did create two good things. He - what should I say? He went after the community in various ways, and particularly seeking friends who might contribute money to development of the university. He met with them, he became members of boards of companies down there, and gradually created a foundation, or energized a foundation, for the support of the university and brought in the moneyed people in the city and created friends among them.

He, in particular, befriended the person who had made his fortune with Tektronix, and that person donated some $25 million, which was a huge amount at the time, for the

creation of research. Dr. Laster, beset with budgetary restrictions - in '81-82, the state was in a financial recession, the state budget was restricted - determined that these moneys should not be used to bail out foundering departments or to make up for the state budgetary restrictions and instead plowed it into what he'd like to call the jewel in the crown. I'm blocking for the name.

BLOOM: The Vollum.

BENSON: The Vollum, that's right, the Vollum Institute for Biomedical Research. Plowing all the money into its development created a gem of a building, architecturally attractive, and attracted a very prominent biochemist from Eugene, internationally known, a leader, to be its head. Unfortunately, that person developed cancer of the pancreas and died within three or four years or less, and another search brought in Dick Goodman, from Tufts, who has continued its very good work.

BLOOM: Let's - excuse me. Why don't you finish.

BENSON: Well, I would say that I'd credit Dr. Laster with the vision to create that Vollum Institute and use all the money for that and for attracting some of the moneyed people in Portland into being supportive through a foundation. He basically became less and less attractive to the faculty, and it was harder and harder on him and his wife, and he took a similar job at the University of Massachusetts.

BLOOM: Okay. We'll come back to the time after that in a little bit, but let's go back to the period between when you came in 1959 and you took the job at the internal medicine board in 1975. If you could tell me, during that period, very important period, of development of the medical school as it has come to be now, who - if you could name five people who were the most influential, and tell me a story about each one. Who would be your five people in that time period?

BENSON: On the faculty?

BLOOM: On the faculty.

BENSON: Well, certainly Howard Lewis, chair of medicine.

BLOOM: Tell me a story about each of them that you remember.

BENSON: Well, Hod was enamored of army discipline, had been in the army in World War II, chief of medicine at a major hospital in New Jersey, and had great interest in physical examination. He and Dr. Selling's son, Phillip, taught physical diagnosis to second-year medical students. He had the reputation for hearing things in the lungs that anticipated what x-rays would show. He was uncanny in his skill. The problem was, he expected all of us to be as good, and he was a little unhappy that we couldn't measure up to that standard.

I remember one time when he was hospitalized and had some abdominal surgery, and I was asked to see him afterward because he had trouble getting his gut going again. I went in to examine him, and I felt his pulse, and he took my hand and said, "No, it's here, John." You know, the most rudimentary of examination procedure, taking the pulse, which any good nurse knew how to do, he would correct me.

He also had the reputation of proper dress; white, clean uniforms, and so forth. You may remember there's an auditorium in University Hospital called 8-B-60. Fairly gradual elevated tiers, and chairs without any barrier in front of them. One of the anathema for Howard Lewis were white socks, and anybody wearing white socks would be asked to leave the room, if you did it twice, but certainly not to come back again with which socks and display them so to him up in front of the auditorium or the class.

BLOOM: How long had you been a physician when Dr. Lewis told you where to feel for the pulse?

BENSON: Probably twenty years, something of that order (laughs).

BLOOM: Okay, that's Dr. Lewis.

BENSON: George Saslow.

BLOOM: What's a story about George Saslow?

BENSON: George was another transplant from the NGH, a few years ahead of me, along with Joe Matarazzo. A very physiologically-oriented psychiatrist. I think his Ph.D. was in physiology at Rochester.

He dramatically changed what went on in psychiatry. We had cold water bathrooms and isolation rooms, and things like that, that had been built into this University Hospital at the behest of prior private clinician psychiatrists, which he revamped. He had a lot more group therapy, a lot more therapy, and was a very practical fellow.

From my point of view, he taught us how to be educators. We would have Thursday noon lunchtime sessions with Howard Lewis, with Joe Matarazzo, with Walter Lobitz, the chair of now the department of dermatology, and others. Roy Swank, now the chair of the department of neurology - those had been sections within the department of medicine in '59 - and others; Dan Labby, whom I'll come back to. We would read sequentially through books, *Teaching and Learning in Medical School* by George Miller, who was a renowned professor then at Rochester, and other books by educators, people from Harvard, et cetera.

BLOOM: Did Dr. Saslow have trouble with white socks also?

BENSON: No, he was much more liberal than that. He had a sense of humor, too.

But he would lead us through the chapter-by-chapter reading of these texts. What that taught me a lot was, one, have objectives for what you're trying to do in teaching; two, have some formal evaluation system; three, make students be active learners rather than passive recipients of lectures; try and find out what they needed. Some of the basics of education which led to a good deal of the changes that I mentioned earlier and the curriculum later in the sixties.

BLOOM: Do you have any story that illustrated Dr. Saslow's personality or idiosyncrasies, if he had any?

BENSON: No. I remember his struggles with psoriasis, his medical problem, and he - but he was, with his wife, a very cultured guy. He was interested in the liberal arts, they were loyal attenders of the Chamber Music Society concerts each summer at Reed and Catlin Gable, and things like that, the opera. As an example for many of us, he showed us that there was much more to being a physician and a faculty person than coming in to work every day.

BLOOM: How about number three?

BENSON: Well, Dan Labby was one of the first people I met. As a matter of fact, he and Dr. Lewis met me at the plane at the airport in the summer of 1958. I was pretty impressed that two professors drove out to meet this instructor of medicine from Harvard. He and Hod took me to dinner at what was called Hill Villa, now the Charthouse up here overlooking the city, and I'll never forget that evening, looking at the sunset on Mount Hood and the sailboats on the Willamette River. It was a pretty captivating introduction to Portland in August, a very pleasant month, as you know.

Dan also was relinquishing, one by one, various full-time activities here. He had been responsible for bringing Monte Greer to replace him in endocrinology, he brought me in gastroenterology and liver disease, which he had studied at Rockefeller and elsewhere, and while I was here, actually, in Strasbourg. He also showed me a good place to live in the Southwest that was easy travel over the hill to get to work, and a pleasant environment, and introduced me to people, like his father, the senior Lawrence Selling, and others. Always a friend, horticulturally impressive, would bring flowering witch hazel to work in January, with its lovely odors.

He gradually relinquished these activities and changed his own career from first studying in Strasbourg on alcohol effects on the liver and then in a center in New York, also on alcoholism, and he got into treating alcoholics and other substance abuse. Then, another sabbatical or another time trained himself in family counseling and with his wife did that for a time and gradually became a member of the department of psychiatry and no longer really did anything in medicine, I would guess from maybe the mid-sixties on, in terms of attending or teaching medicine to medical students.

BLOOM: Dr. Labby told us in one of these interviews that the reason he went to the airport to meet you was that he was giving all the lectures to the medical students and recruiting you would divide the lectures at least in half.

BENSON: I think that was a secondary gain, if not primary one, for him.

BLOOM: So did you get the assignment immediately to start lecturing the medical students?

BENSON: Absolutely. You know, you learn so much that first year when you're having to prepare lectures, to be able to teach what you think residents and medical students need in any specialty. It was pretty difficult for me, really, to know exactly how to proceed. I'd given some at Harvard, but not many, mostly to residents. Trying to select what would be appropriate for, in this case, mostly third-year medical students and then be up to date to give them something current that was useful was a big learning experience for me, particularly in that first year.

BLOOM: Okay, number four.

??: Let's pause here. We have to change tape.

[tape stopped]

BLOOM: So we're up to number four. Who would you name as four?

BENSON: I thought I'd use Charlie Dotter as one of these five. He is interesting to me in one way. I roomed in medical school with a fellow who married one of Charlie Dotter's neighbors in Cambridge, Massachusetts, when she was a girl and he was a boy, and she characterized him then as crazy. He was at the time I came here he was the chair of radiology.

BLOOM: He was here already?

BENSON: Yes. I don't know where he had trained, where he had come from, but he was here.

[End of Tape 1, Side 2/Begin Tape 2, Side 1]

BENSON: ...starting the treatment of arterial disease with catheters and pulling balloons through them, and so forth. He's seen as the father of angioplasty.

I can remember a couple of things. One was *Life* magazine had a picture of him. As you know, often in radiology suites they have a red light. Well, they took the picture of Charlie there. Honest to Pete, he looked like the devil incarnate. It was black and red only, and this wild-eyed face that he had with his enthusiasm.

He once did a demonstration at medicine grand rounds - every Tuesday morning at eight we had medicine grand rounds in 8-B-60 - and he came in to talk about this, and, low and behold, he took off his white coat and bared his arm, and there was a catheter which he had inserted in, and he then proceeded to demonstrate, with I think a portable fluoroscopic machine, how he could put contrast into that and outline, in this case, the aorta, I think it was, and maybe the arteries of the legs.

BLOOM: What was the reaction to that?

BENSON: We were all sort of aghast at seeing that he had this and that in fact he did it to himself, self-experimentation. He would try things like that. He set up a team after this, too, which has gone on to make this place really famous for the development of catheters and so forth.

One of the assets for me personally was he brought Joseph Resch over from Czechoslovakia. Joe had pretty much escaped from the Soviet invasion or influence on Prague; a well-known angiographer in Europe at the time. And he came over here, because he had to, by himself, leaving his wife and some kids there.

Joseph was another breath of fresh air. He would always come to GI conferences and show these magnificent arteriograms that could demonstrate, for example, a pancreatic cancer or certain liver diseases or tumors of the colon and (unclear). And he also had developed a technique for liver biopsy with a catheter and measuring portal blood pressure with a catheter, et cetera. Joseph taught me a huge amount, and all the gastroenterology fellows and faculty, with his skills, and I always credited Charlie Dotter with that.

BLOOM: Do you have a fifth person?

BENSON: I'd like to give credit to George Long as a very loyal friend. George Long was a practicing gastroenterologist in Portland. He practiced with a fellow named Fitzgibbons, who was the dean of gastroenterology in this city, and a couple of others, and all of a sudden, about 1958, Dr. Fitzgibbons died and one of his partners developed tuberculosis, so all of a sudden he was down to two people, and he dearly wanted somebody full time to come and relieve him as the head of the gastroenterology division.

At the same time, he remained loyal. He would come to clinic. He always was at our GI conferences Tuesday afternoons, which we set up, as I indicated earlier. We had Journal Club every month, and we would go to his home, as well as our own, for gathering the faculty for Journal Club. So the town-gown thing just did not exist in digestive diseases.

He was a very skillful clinician. He did do x-rays in his own office, which antagonized a lot of the radiologists. They didn't think he was trained or competent. He had an untrained assistant who did a lot of the barium studies, for example, and I can remember having one myself, at his behest, where he tried to prove that you had some

regurgitation or reflux back up from your stomach into the esophagus. He'd put on a tilt table practically standing on your head, pushing on your abdomen to make sure that you did have reflux, and, of course, normal people did under those circumstances. And so I think his diagnosis of hiatal hernia, or whatever, was a little suspect.

But he was a very gracious guy and would have us out to his summer home on Wauna Lake in the Cascade Range on the Washington side, and was a friend to the very end. Even while I was working for the board he would come up to my office and visit with me. I don't think I could have done it without his support and help, and his modeling for others in the town. So it wasn't just Fred Smith and myself and later fellows like Cliff Melnyk and Katon and Emmett Keeffe and others, but this team of people from the practicing community. He knew his gastroenterology and was a willing teacher and a good friend.

BLOOM: Well, let's go back to your early - or, start with your early years now. Tell us a little bit about where you were born and raised and kind of take us through that.

BENSON: Well, I'm a Connecticut Yankee by birth and went to college - I went to a prep school in my hometown, because they didn't charge tuition because I lived there and because I could trace some lineage from the founders of this so-called Loomis School, the Loomis family, and then to Wesleyan University in Middletown, Connecticut.

That was a marvelous experience, particularly because I got to work, as an honor student, with a fellow named Edward Schneider. Dr. Schneider was the chair of physiology, and I took my honors work under his preceptorship. He was known at the time as the father of aviation medicine. He did a lot of work in the mountains of Peru with high altitude sickness and the oxygenation of the blood under those circumstances. I always credit him with a letter of recommendation to Harvard Medical School that facilitated my entry there; in fact, even a scholarship to Harvard. So Wesleyan was a great experience, a small college, and one that exposed me to some very good faculty.

I also learned at Wesleyan, purposefully after the prep school experience, that I should do more than just take premed courses; in fact, had a minor, if you will, in English. I'm sure the liberal arts, as a result of that experience, and the languages I learned in those two places conditioned me to think that that is important for a physician. In admitting medical students, I'm always interested to know, for example, their background in college and their interests beyond biochemistry, for example.

Harvard was an experience basically during World War II. We were not permitted - we were deferred. We were given deferment by the draft boards, even in my hometown, because I was pointed toward medicine, and they wouldn't let you get out of that. That was some sop to conscience, because you saw your friends going off to dreadful experiences and being killed, and - but I was in the navy as a V-12 student during medical school, which was marvelous in that, one, it protected us from all that danger in the war, but it also paid for tuition, books, room, and board and, basically, books. So for three of the four years of medical school I basically had a free ride.

We went to medical school nine months, after nine months, after nine months, so we did the four years in thirty-six months without appreciable vacations, and there was some suspicion we were deficient, because the quality of the students entering medicine might have been compromised by the fact that people were going into the military and the war. It turned out that in my class were two Nobel laureates in their careers, which I always thought refuted that fear that we were somehow a substandard group.

We did not have women in our class. They had been admitted to Harvard earlier on, then stopped, and then, when we were third-year students, seven women were admitted to the first-year class, and those doughty women hold together even today, insisting that they produce clinical care and they aren't just getting trained and not having it used. It wasn't wasted education. I didn't have a whole lot of contact with them, because I was off in some thirteen hospitals doing clinical clerkships and they were taking the basic science courses at the courses.

We lived in the dorm right on campus. It was on the corner of Longwood Avenue and Avenue Louis Pasteur, and in the center of that "T" was a little island with a statue of a guy named Tugo, Victor Tugo, T-u-g-o, and we used to complain that we only could fight the battle of Tugo Circle.

Navy students had a lot easier time of it. We had officer-like uniforms, white shirts and black ties, and the army guys were in the fuzzy olive drab uniforms that were not so special. We had caps with visors; they had the usual small army cap. And they used to have to march in the morning and go through certain exercises that we were freed from.

Another advantage was that there weren't many men around, as you might imagine, and so young men in uniforms, particularly if they looked like officers, were invited out to dinner, to parties, to dances and things like that by the ladies of Boston.

I think I got a fine education. It was a great sendoff in a career. I always thought that I got credit for being smarter than I am, simply because I went to Harvard. On the other hand, there were people in - particularly a fellow, a surgeon here, who would kid me about this: "You knew about this; you're from Harvard, aren't you, Dr. Benson?" And rub it in publicly. Claude - I'm blocking for the surgeon's name. That may not sound right.

But in any case, I then applied for internship, and I decided to take a straight internship going - a job offered to me at Hartford Hospital, then a very good rotating internship, and back home, and applied to Case Western, to Cornell, to Columbia, and to Rochester. We didn't have a matching program then, and Rochester turned me down, Case Western admitted me, and then they give you a week or two to decide yes or no, and you didn't know what was going to happen in New York, so you took the best deal you could, and I went to Cleveland. I'll never know whether I was admitted to Columbia or Cornell, but, in any case, I went to Cleveland.

That internship lasted fifteen months, because it started April 1, and they got it back to a July 1-July 1 system during that year. Some of my junior interns coming back from the war were colonels in the army. I was a very youthful looking guy, and it was hard for me to find myself teaching these fellows, who insisted that they should do the scut work, insisted that they didn't know what I had learned because they'd been out of it in the service for a time, et cetera. I remember one junior intern who became chair of neurology at Duke in a short time after his residency.

Then I went into the navy. We had to pay back...

BLOOM: What year is this?

BENSON: This would have been '47. We were deferred, of course, during the war, and went into the navy. I was sent to Charleston, South Carolina, to the navy hospital, which, again, protected me from being alone on some ship in the middle of the ocean, trying to figure out whether I could do an appendectomy. I had had a straight medicine internship. I delivered two babies as a student. Most of my class had only been able to deliver one; another wartime phenomenon. There weren't so many pregnancies. So I was protected by going to this hospital.

I learned a lot there from the fact that people from other schools were very well trained. There were a dozen of us lieutenant JGs in this group that came in in July of'47: two from Rochester, there was one from Vermont, there were a couple from Penn, a couple from Cornell, one from Columbia, one from Virginia. But, importantly, there were two from the Medical College of South Carolina in Charleston, and those two guys knew more than the rest of us combined. They were very able to - they knew how to do everything. They could do an appendectomy, they could deliver babies, they knew how to take care of babies, they knew how to write orders for milk of magnesia; knew how to write orders for antibiotics and digitoxin. They were excellent doctors. They happened to be number one and number two in their class at the Medical College, and one learned very soon that good people from any medical school were good.

That was very helpful to me, coming to Oregon, by the way. Having gone back after my training to Harvard, I'd come from the kind of students that they were able to attract to an unknown, in some ways, and the good students at the top of the class here were also very good.

After the navy, '49, I went to the Brigham, had a residency year with George Thorne, whom I had known as a medical student, and then a couple of years - the residency was one you kind of made up to bring back people from the service, and it was a little unusual. I had about three months in a TB hospital near Worcester, Massachusetts, a VA hospital. At that time, streptomycin was just barely coming into therapy. It was the first antibiotic useful for TB, and so I saw a lot of surgery, thoracoplasties and pneumoperitoneum, and things like that that seldom are used today, very destructive kinds of surgery to rest the lung.

BLOOM: Did you have any experiences in the polio epidemic?

BENSON: That followed, basically, Joe. I went from the Brigham to the Mass General. I had a fellowship in gastroenterology at the Brigham, and then thought I'd be happier at the General and moved down there for two years, and in, it must have been, '52 or '53 there was a polio epidemic, and this was before Salk or Sabin had produced their vaccines. We had two floors of cases in iron lungs; in rocking beds, where the bed tilted back and forth so that the abdominal viscera would push the diaphragm up when the head was down, and that would cause the lungs to be cleared of air, and then you'd tilt the patient the other way and the lungs would fill. So it was an assist for weak respiratory muscles.

All of us were assigned to two-hour shifts throughout the twenty-four hours, tending those patients. I was probably a gastroenterology fellow, maybe junior faculty. I think I was a fellow then. And patients died, patients didn't make it. It was scary. We were not so fearful of ourselves, of catching polio, because these patients already had the acute illness and were subject to motor paralysis, basically some of it bulbar paralysis, so they couldn't breathe properly or swallow properly. So we weren't trying to escape the epidemic for personal safety, and I'm glad that was the case. There was never any doubt that you would do this. It was the thing to be done.

That lasted for quite a few months in one long spring.

BLOOM: Were these mostly children?

BENSON: There were quite a few adults. I think probably the majority were adults in that particular experience.

BLOOM: So they assigned physicians from all over the hospital to have these two-hour shifts?

BENSON: Yes, whether you were in training or on the staff. Thank goodness the polio vaccine came along later.

One other epidemic experience I had was a personal one. When I was an intern in Cleveland, around Christmastime I got influenza, the serious influenza. We were tired because of hours; we worked every other night, we had to work every Sunday morning, go on rounds with the chief. I got influenza, and the sort of assistant to the chair of medicine - he was kind of the straw boss, because the chair was usually in Washington with the National Research Council at that time - this was right after the war - listening to my lungs, thought he heard some rales and decided I should get penicillin, which in those days was aqueous, and you got a shot in the buttocks every three hours. So he prescribed that and I started on it.

Later, the x-ray showed in fact I did have pneumonia and grew Staphylococcus out of my sputum and blood. So he anticipated what killed people in the epidemics of

1917 and '18 in the pandemic - it was considered an epidemic then - and I thank my lucky stars that he was so careful with the physical exam, and I was cured, basically. I went back to work probably mid-late-January.

BLOOM: In the interest of time I want to cover two things quickly, and then I want to explore one other area with you.

So you were a resident - you went to the General, and why don't you get us from there to Oregon.

BENSON: A resident at the Brigham, a fellow in gastroenterology at the Brigham, along with Howard Spiro, who became a household name in gastroenterology, still at Yale, and then went down to the Mass General as a fellow with Dr. Chester Jones, and did that for two years.

He was probably my leading mentor in gastroenterology. He treated me like a son, I saw his patients for him in the evenings. He was a good physiologist, he did a lot of the lectures at Harvard, so I knew him as a teacher from several years back.

He had a group called the Jones Boys of young faculty who many of them had been in wartime experiences and had come back, and had a very active private practice with a lot of serious patients with ulcerative colitis and liver disease and that sort of thing, cancer. And he was the sort of fellow who would say, "I only had to tell a patient, 'I don't know,' three times today." He was a feisty maniac, as he often called himself, but he also was generous with admitting, to his patients in particular, that he didn't know something.

He also taught me, "Why did you get that test? What are you going to do differently because you ordered that test? Supposing it's high? Supposing it's low?" which usually meant you shouldn't do the test, and, therefore, save the money or save the patient whatever trauma there might be. That was in the days, too, before we had these multichemistries where you get twenty tests with one needle-stick.

He thought I needed, if I was going into academic medicine, another research experience without any clinical medicine. I had done some research and some work in the clinical research center, which was called Ward 4 at the Mass General, in the old Bullfinch Building, kind of in the vanguard of CRCs, and mostly metabolic work on patients with malabsorption. So he sent me off to the Mayo Foundation with a fellow named Jesse Bollman, a physician-Ph.D., who worked in the medical sciences building and didn't see patients.

I spent a very happy year there. I didn't like Minnesota's winters much, did a lot of work basically on rats and collecting lymph from liver and intestines with microsurgery taught to me by a fellow who helped Dr. Bollman, a fellow who also had taught us how to square dance. He was a square dance - along with his wife - caller, and I came away from the Mayo Clinic with a whole bunch of square dance records, actually, which I never really used much after that.

But it was a successful year. I published two or three papers, spoke at the national meeting of the American Gastroenterological Association, actually for the first time at a national meeting, and roomed in Atlantic City, where the meetings were at that time, with Philip Lee. He was a fellow, so-called - a resident, basically - in medicine at the Mayo Clinic at the time. They had a six-month period of research in their assignments, and he was assigned to another fellow, Charles Code, a physiologist at the same medical sciences building, and his office was next to mine, and so we became fast friends.

Phil later, as you know, became assistant secretary for health under Lyndon Johnson and set up an institute for health services research at the University of California San Francisco, where he is now. But in any case, we roomed together in Atlantic City and practiced our talks together in our bedroom there.

Atlantic City was another experience, because you were on a steel pier in this enormous blacked out auditorium, talking to three thousand people whom you couldn't see, and you were all by yourself up there, showing slides - not even little Kodachromes, they were glass slides in those days, certainly now PowerPoint and computerized delivery.

It was fun for other reasons. We all ate breakfast at the YWCA, which had a cafeteria, and you'd stand in line with people like William Castle, who got a Nobel Prize for liver extract and pernicious anemia, and Maxwell Finland, both at the Boston City, whom I knew from my training, getting breakfast at the YWCA. So many, many fond stories about that experience.

BLOOM: So why didn't you stay in Boston?

BENSON: It was what I thought I'd do forever. We had lived in suburbs on the west side of Boston, practiced at the MGH, taught residents and fellows, did a little lecturing for medical students, and - but my salary was zero. I had grants from - I had a fellowship from the public health service and grants from the NIH and saw Chester Jones' patients in the evening, making his second-day call on them. We would sit down and we'd go over each one together about 5:30, and he would tell me what he wanted the next day, and I'd make rounds. But that meant that - and I would get ten dollars for that experience, which was a lot of money for a person on soft money at the time, but it meant I wouldn't get home in the evening until nine o'clock. We had two little boys at home - lived in West Newton - and got home about nine o'clock, and it was all soft money.

In fact, Dr. Jones thought I ought to meet Dr. Lewis. They were colleagues and officers, successive presidents, of the American College of Physicians. Lewis had heard me talk to a college meeting in Boston and was interested in me, and Jones thought I ought to go see him. He said, "Well, I'll pay for the trip. I have this foundation." The foundation turned out to be his checkbook, but it was his money that brought me to Oregon in '58 to see the job.

BLOOM: And that was the Hill Villa trip?

BENSON: That was that...

[End of Tape 2, Side 1/Begin Tape 2, Side 2]

BENSON: He was a marvelous mentor, and his support for the Jones Boys was absolute. We were the chosen few. He was hard on us when we were dumb. He expected us to be very good. He was a marvelous - probably the most important mentor I have ever had.

BLOOM: Let's stop for a second.

[tape stopped]

BLOOM: John, tell me about your work with the Foundation for Medical Excellence, what the foundation is, just briefly, and then I want to discuss one facet of the work with you.

BENSON: The Foundation for Medical Excellence is an offshoot of the licensing board. Back in the early eighties, John Uwelling and Ralph Crawshaw, the practicing psychiatrist activist in Portland, had faced a number of doctors who got into trouble with self-abuse or over-prescription of narcotics, and there were a bunch of suicides late in the seventies which got everybody's attention. One of the thoughts that these two had was for the licensing board to have educational programs about the use of narcotics and the risks, and so forth. It was Crawshaw's idea that that could be done best by a separate organization, namely, a foundation, so this spinoff from the licensing board began. Dr. Crawshaw was one of the earliest of its board members; John Uwelling, who had been, I guess, the secretary or director of the licensing board, gradually withdrew from that to run the foundation.

My interest came - and exposure to it came in the nineties, after - in the mid-nineties, because of my interest in communication, doctor-patient communication. That was an important facet of clinical competence that we felt, in the ABIM, to be a significant criterion for certification in internal medicine, that is, the demonstration of good communicative skills, humanistic qualities, professional attitudes among them, and here was this Northwest center for doctor-patient communication, a center bred out of the foundation, Uwelling's foundation. I was pleased to see this happening and was invited to join its so-called advisory board and was particularly impressed by the work of people like Wendy Levinson. Dr. Levinson was a very skilled general internist in teaching communication.

This was important for another reason. This was an era of managed care in which efficiency, productivity, and measures of that kind to improve the bottom line were critical. It meant, as well, that visits with a - follow-up visits, in particular, with a physician were shortened to, say, ten minutes or so, and that put a lot of pressure on physicians to communicate, to listen to the patient, to find out really what the patient needed, to instruct the patient as well as to examine them in these very short intervals, and devices to do that, various strategies, Wendy Levinson and others were skilled at.

They put on courses here and, ultimately, around the Pacific Northwest, from Medford to Vancouver, B.C., over to Boise, to enhance these skills.

This foundation broadened its interest beyond courses on communication and narcotics to controlling pain, for example, and, ultimately, to get into what's wrong with the health care system today, and maybe reform.

BLOOM: Okay. We'll come to that in a second. On the communication agenda, did you focus at all on doctor-patient relationship in that? How did you see communication in the doctor-patient relationship?

BENSON: Well, one was to give the patient more autonomy, more say in decision making. Patients were learning a lot from television and the media about medicine, they were much better informed, perhaps sometimes misinformed, but came into offices with more information themselves and a greater desire to enter into decision making. That was hard on a profession of solo practitioners that had long seen themselves as do-as-I-say-not-as-I do or autonomous themselves, people who dictated what you should do in terms of diets and pills and weight loss and having an operation, et cetera. So with a more informed patient and with much pressure to communicate quickly, there had to be some changes in behavior, and I think the doctor-patient relationship suffered a bit during this era.

Technology was another problem. Radiology, imaging of various kinds, a lot of new immunologic tests, radioimmunoassays, had made diagnosis much more accurate and less speculative, particularly for internists, so tests tended to replace talk and learning from the patient what was needed. Therapy became better and more specific. I've seen the emergence of antibiotics and chemotherapy and all of the psychotropic drugs during my career from nothing. These - and generations of them at that. These therapies made the doctor, one, more sure of what the diagnosis was and what should be done about it, and, to some extent, put a barrier between the doctor and the patient. The doctor wanted to get these things done, the patient wanted to tell a little bit more about lifestyle and personal problems they may be having. So it was important to have communication skills, it seemed to me.

BLOOM: You saw that as a bridge in helping reestablish doctor-patient relationships?

BENSON: Yes, precisely. I think it's happened, too, particularly - if I can attribute it to anything, to people like George Saslow and his course and George Miller, people like those in the foundation that saw the value of this communication center, and to people like informed patients who wanted their say. And I think it worked out.

There was another influence on this, and that is the increasing number of women in medical school, and, again, particularly in internal medicine. Basically, about half of residents in internal medicine became women. In psychiatry, in pediatrics, pathology, and some other specialties, that had happened long before. Women were more sensitive, were more willing to listen, had a better liaison, it seemed to us, with patients, and have a

kind of natural nurturing personality. I found that a fairly strong influence. And I think among medical students now, as they practice interviewing on each other, for example, the women teach the men a good deal, and the men coming into a third-year clerkship in medicine or family medicine, or surgery or whatever, are much more sensitive as communicators.

BLOOM: Let's finish by - you were starting to talk about the foundation getting into the area of health care delivery, so could you tell me what you and what the foundation has done in this area?

BENSON: It started, I think, Joe, with the so-called leadership forum, these breakfast meetings that brought together maybe three dozen or so invited people from both the business aspects of medicine and practice and the university to talk about health care as a general subject. To some extent, outside speakers were brought in. The foundation also brought in lecturers, a Crawshaw lecturer, established the Kitzhaber lecturer, and these - and David Lawrence, who was long the leading CEO, really, of Kaiser Permanente, a physician public health fellow. These lecturers would bring in medical economics, health care services, health care delivery problems, financing, the economy of health care, and so forth, and we were thrust into a good deal of interest and learning about health care and, of course, the need for health care reform.

Out of that derived a project called the Oregon Health Care Assessment Project in which these same characters, pretty much, a smaller group, developed, with the support of the foundation and its board, a successive number of meetings and two publications on health care reform. The approach was first to look at the problems. One fellow wrote up a business about how we should segment health care into various forms of delivery. I gave a talk, along with Peter Kohler, on self-interest and the growing, rampant interest in people and their own hides rather than in the patients, and so forth. There were various talks like that.

This ultimately ended up with the development of values that we thought ought to undergird health care reform, and there were five of those, the first being choice for the patient, and then principles under them, these values, to undergird any solution there might be in the reform of health care. We all thought that no one was happy, that it was a dysfunctional system. People have characterized it as almost at a perfect storm in health care. These values and principles were designed to be the bulwark for any specific health care reform that might be undertaken. The problem was to implement, to figure out strategies, in fact, to do it.

A very generous and bright businessman named Steven Gregg, generous in funding and really a brilliant mind - had come out of managed care and hospital administration - attempted to set up a model in McMinnville and talked Blue Cross, which was the major insurer there, the physicians and the one hospital into considering some sort of a program where they taxed each other to produce care for a safety net, to provide a safety net to uninsured people who may or may not be covered by the Oregon Health Plan and the Medicaid plan ten years in place.

The long and short of it was the implementation has been the problem. People are finding it very difficult to actually try and set up something like that. For example, where every provider, whether insurer, the physician, the hospital would chip in through some voluntary taxation to support care. Another feature of it was charity care, in which physicians would be asked to volunteer time, and you had a big Hispanic population out there, and even a special clinic. This sold for some of the folks in McMinnville, but, apparently, not quite enough.

BLOOM: What would you - just in the last minute or so that we have left, what would you like to see in the health care system?

BENSON: Well, I'd like to see some universal insurance coverage. I don't mean by that a federal, single-payer Canadian kind of system, but, rather, one that uses the current resources, incorporates Medicare, Medicaid, the children's health insurance program the states run, incorporates the managed care kinds of programs, in particular the close-panel health maintenance organizations, into segmented care; that you'd have one group that everybody would be in, there would be a safety net for those who had never had insurance and didn't care to buy it offering basic effective care - and those are hard to define, those two words - and to have a second group that might wish to relinquish choice to an agency like Kaiser Permanente that had its own rules and its own doctors, and you took their medications, whatever they decided; and then a third group that would buy whatever they wanted. They were able to afford insurance, even cash-on-the-line care, and buy whatever quality of care they wished.

I'd like to see that accomplished by some sort of taxation system. Tax credits, the taxation, of course, that supports Medicare and Medicaid already, and some sort of taxation, again, of the providers, such as the Oregon Health Assessment Project wished. It takes a lot of definition as to what "basic" is, what would you provide? I don't think it would provide cosmetic surgery or a lot of fancy drugs. It would provide a lot of - it would stress prevention in hopes that that would reduces costs ultimately. It would take people out of going for their primary care in emergency rooms, but rather make sure they go to a clinic. That would be cheaper.

I think there's plenty of money in the system; I think we waste it. It's what, 1.3 trillion, or something, dollars a year a couple of years ago, half of which is provided by governments, about a third by employers. I'd get all of those resources into some sort of universal coverage. That has not been well handled, because politically it's hard to do something that sweeping. That change is hard on doctors.

We've suffered through incremental change ever since Medicare and Medicaid came in in the sixties, little tidbits, most recently the drug benefits for Medicare patients, to me kind of a fraud, frankly, and not an overarching solution. It's a piece of it.

BLOOM: And why the fraud?

BENSON: Well, one, it isn't going to really cover much, maybe six hundred dollars. A lot of it isn't going into effect until 2006, et cetera. Many of these patients that can't afford medication will have medication bills of two thousand dollars a month. That isn't sufficient. The cost of medical care continues to rise, particularly for hospital and pharmaceutical costs, and those need some sort of stabilization.

The fear is, of course, that it'll be an imposition by Big Brother of something none of us like or are apt to like. But it's hard for me to see forty-five million uninsured, maybe eighty million underinsured, an equal number of people who aren't insured part of the year for health care, and to me that's almost immoral as a culture, as a society, particularly when we're spending so much more - if we spend fifty-nine hundred dollars a month per person in this country a year and Canada can get better results in terms of quality and value for thirty-eight hundred dollars per person per year, we're making some terrible mistakes in terms of waste and duplication and profit, profit often for shareholders rather than profit that might be shared by nonprofit organizations for better services.

BLOOM: Well, we're at the end of our time. Is there anything else you'd want to add?

BENSON: No. I appreciate the opportunity. I'm particularly grateful to Matt and the OHSU and OMA for supporting these historical interviews and anecdotes. I'm sure I'll think of things afterward that I should have said, and I appreciate very much your willingness to do the asking. Thank you, John.

??: May we invite you to come back after you've thought of those things?

BLOOM: Well, we could do another two hours.

??: Easily.

BENSON: Thank you for your forbearance inviting me out.

[End of interview]