HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Laurel Case

Interview conducted June 12, 2001

by

Jim Kronenberg

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Date: June 12, 2001

[Begin Track One.]

SIMEK: Okay. We're rolling. And go ahead, Jim.

KRONENBERG: This is tape number one. Laurel G. Case, MD. Laurel, let's start out with the basics. When and where were you born?

CASE: [laughs] Okay. I was born in Little River, Kansas. It's a very small town, maybe five hundred people at the most. And it did have a small hospital. and that's where I was born, in that little hospital, in 1921.

KRONENBERG: And the date?

CASE: October twenty-fourth.

KRONENBERG: 1921.

CASE: That's right.

KRONENBERG: And what did your dad do for a living?

CASE: My father was a farmer.

KRONENBERG: He was.

CASE: He was a farmer. He had a farm about five miles from this town where I was born. And we lived on the farm and I lived there until oh, I guess it was 1936. And I went to eight grades of grade school in a little country school where the number of students in my whole school, the maximum number in the entire eighth grade, was nineteen one year. Most of the year, it was under eight. And we had a country schoolhouse and a teacher that the community hired. And I went all eight grades there.

KRONENBERG: One room?

CASE: One room. It had a basement under it. And it was also used as a community gathering place for the farmers and the people that lived there. So maybe every couple of months we'd have some kind of an evening supper, and everybody would join and visit and spend maybe a program, get a quartet to come and sing or something like that.

KRONENBERG: Did you have brothers and sisters?

CASE: I had one brother.

KRONENBERG: One brother.

CASE: He was two years older.

KRONENBERG: So you went to school there and you worked on the farm, I suppose.

CASE: That's right.

KRONENBERG: What kind of crops did your farm grow?

CASE: Well, it grew wheat, and some corn. And then there's lots of what they call Capricorn that we grew for feed for the cattle, cause we always, milk cows, and raised beef so that we could butcher every year, we butchered, had our own meat. And we had chickens, gathered the eggs and you know, typical farm life in those days.

KRONENBERG: And then where did you go to high school?

CASE: I started to high school at Little River, Kansas, at the same town where I was born in the hospital. And I went there, I started there as a freshman in let's see, what was it? Hmm, well, anyway, I graduated in 1940. So it had to be like '36, you might say. Four years. The only thing is that I didn't finish there because we had dust storms in Kansas. And we lived during that time when we had no rain for a number of years, and the wind would kick up dust storms from Oklahoma and bring them up to Kansas. It was sort of like dumping snow on top of a fence row. Only it was dust, all dust, instead of snow. And we had those for oh, about two years. We had no rain for two years. And so it was a little bit difficult.

And so my parents decided to move to Eastern Kansas, because they didn't have all these dust storms. They had good crops and fields and trees. We had flat, just flat Kansas soil, most of which ended up in our house during that period. [laughs] So it was not really a pleasant kind of life at that time. However, we did move when I was a sophomore or a junior, the middle of my junior year, we moved to Eastern Kansas. And I transferred to the high school at Osage City, Kansas, which is about fifty miles south of Topeka. And down there we had a river on our farm, and lots of trees, and no dust. [laughter] It was fun.

KRONENBERG: And did you start college immediately after high school?

CASE: Yes, yes. I started, I went to Hutchinson Junior College, which is one of the few junior colleges in that area at that time. And I lived at the YMCA and went through my first year there. And at the end of that year, I decided to transfer to another school, which is Baker University, which is in Eastern Kansas. I don't know if you've ever heard of Baker University or not, but it has been, it was one of the very old

universities. It was built in 1858, which incidentally is the year my grandfather was born. And so it was an old school. And so I went there. And probably the major reason I went there is because my wife to be lived in Hutchinson, where she was in junior college. And that's where I met her. And she was transferring to Baker University. And I followed her. Subsequently we found ourselves getting married.

KRONENBERG: You married during college?

CASE: Actually I was still in school, yes, but not there. Because that year when I finished Baker, at Baker the first year that I went there, then it was getting close to the draft board time. And I was just at the right age. And in the summer after my first year there, my cousin and I went to follow the harvest, because no one else up where we lived had much harvest. So we went down to a farmer's place in Southern Kansas, where they had good wheat crops, and worked for a while. Then I got called to the draft. So I had to stop that, and stop college. And to make a long story short, I was taken into the navy. The army wanted to get me signed up, but I'd decided at that point that I really wanted to do pre-med. So I wanted more training. And I really wasn't interested in being a foot soldier. And so I got the navy, I got into the navy, and went to corps school, so that I was a hospital corpsman. And that gave me some credentials to get started with.

Then I was, on that roll, I was transferred to the naval, the 42nd Navy Construction Battalion, which is a navy construction outfit. And they hauled me off to Dutch Harbor in the Aleutians, along with others who were in my unit. And I was a hospital corpsman then, so my job was to help take care of the people that were in our unit. So I had six months there.

And at that point, I had learned that there was going to be opportunities for serviceman to get into premed and go to school, back to school, under the auspices of the navy. So I put in an application for that, and I got it. And so that, after that six months, I was flown back to the United States and rode the train to Chicago, where I went back to the Great Lakes, where I'd taken my training in the first place.

And they decided to have me come there and wait until they had an opening for me to go into the med school. And after I'd been there for a few months, such an opening came about in the University of Cincinnati, Ohio. So I was transferred down there into the navy unit that was assigned there because they had lots of students in the school who were assigned there for engineering courses. And they also had a few that were interested in medicine, and that's what I wanted. So I actually went to the University of Dubuque. That's the, did I say Cincinnati?

KRONENBERG: Yes.

CASE: Well, that came later.

KRONENBERG: Okay.

CASE: I went to Dubuque first, and had my premed, finished my premed. Then they sent me to Cincinnati, where I went into the first year of medical school. And I had two years of my medical school there when the war ended. And at that point, I went back to Kansas University, because I wanted to be where it wouldn't cost me so much money. I had navy pay before, but I had to lose that, although I did get some help from the navy. So I took my rest of my medical school training at the University of Kansas. Graduated in 1949.

KRONENBERG: What made you decide to want to be a doctor? What factors were involved?

CASE: Well, I think, it's hard to know for sure whether what happened is the reason why I ended up going in medicine or not. But when I was in grade school, probably seven years old, my father had a heart attack out on his farm. And we had, the doctor, in fact, the doctor that delivered me was still practicing in that little town. And he came out to the house to see my dad. And it happened to be on the day, two days before Christmas. And he was in bed. And he came out and saw him and left, and left medicine for him. And he didn't get along very well.

And after maybe a few weeks in bed at home with my mother trying to take care of him, she called to see if the doctor would come out again and look at him, because she was worried about him. So he said to her, "Well, I trust that you will have the money to pay me for this." And she didn't. And he didn't come.

And there was another doctor there in that same town, a newer doctor, and a younger. And so my mother called him and he came right out. Didn't even mention anything about the pay. And he made house calls after that until my dad was better. And he got well. He recovered completely. So everything turned out fine.

But I was just at a very impressioned age, at an age where I was very, very worried about my dad. Maybe six, seven years old. And somehow or other my mind took that in. I just couldn't believe that somebody would refuse to take care of a sick patient because they didn't have the money to pay for it. And that's when I started my heading toward medicine. And I never varied from it from that point on.

KRONENBERG: You graduated from Kansas?

CASE: Kansas University.

KRONENBERG: 1949?

CASE: 1949. Then I went to Bremerton, Washington, a navy internship. Had a year there. And that was in 1950. And then I went back to Kansas. And I went to Wichita, or first I went to, that's when I moved to Enterprise, where I told you about the flood. And I practiced there for three years. Then, lo and behold, the navy sent me a notice that I was, since I'd part of my training for medicine in the service, that I was going to have to

go back and pay back the navy for two years. And so I got a new intern out of KU to come down and take over my office. And he was just ready to go practice, so that worked out nicely for him. And we got in the car and moved down to Norman, Oklahoma, where the navy said they would assign me from there.

Well, within two months after I got there, Congress passed a new doctor draft law, which said that if you had at least seventeen months of active duty service before you took your training, that then you didn't have to do that. Well, I counted up my time and I had seventeen months and fifteen days of active duty. And I went right straight to the Office of the Navy there in Norman, Oklahoma, and wired him and said, I don't qualify for staying in the navy. They shipped me out. So I didn't know what to do, because I already had my home with another doctor living in it, my practice. And it hadn't been more than three months since I left, four months, so I didn't have anyplace to go practice, or even a home to live in.

So just, again, fortuitously, ran into a young surgeon there in Norman, Oklahoma, from Wichita, Kansas, who was just coming out of the service. Going home. And he found out what my predicament was. And he said "I work, I've got two general surgeons. He was a general surgeon who I worked for, and I'm just going back there." And he said, "They sometimes take in physicians just out of their internship." Which really wasn't too different from mine, since I was out practicing for two years, or three years. So he went home that weekend and talked to the two doctors. And they said, tell me to come on up and see them and we'll see what we can work out.

I ended up spending two years with them, along with another physician about my age. And worked as first assistant in all their surgeries, taking turns between the two surgeons so that every six months the two of us would switch. And after two years of that training, I felt pretty good about being able to go back to my practice. Only thing was at that point, I couldn't go back because he'd leased my practice, and he didn't want to leave. That's when I came to Medford.

KRONENBERG: Okay. Why Medford?

CASE: My wife has a brother. See she not only was a twin, but she had twin brothers. And one of them was Todd Tibbett, who still lives in Medford. And he was living there then, and so we talked about where to live. And of course we just got through all those dust storms, and decided that every time the wind came up we were going to have a dust storm. So we decided we didn't want to live in Kansas any longer. So we just packed up and came to Medford.

And we didn't go there initially with the idea of practicing there, but to look and see where we might practice. So we got there, and of course her brother lived there and they were anxious to have us come, and wanted me to stay there to practice. And talked to, took me around and introduced me to all the doctors that were there then, which not a lot of them are still there. Quite a few of them are gone now.

And so we drove up to Portland to, we stopped over at the OMA when Roscoe Miller was there. Remember Roscoe?

KRONENBERG: Oh, yes.

CASE: So we stopped and saw Roscoe, and got acquainted with him. And he was very interested in what we were going to do. I asked him if he knew about any small towns, because that's where I had figured I would probably go. And he didn't know of too many.

So at the end of that little conversation, we went back down to Medford. On the way down there, I stopped off at several different places, just to, and the first place I went in each of the places I stopped was the druggist, the local druggist. Because I knew the druggists back where I practiced and I thought that they would, if anybody knows what doctoring is like in this town, it will be the pharmacist. And that's how it turned out. So I won't say where, but one place I stopped, the pharmacist assured me that there really wasn't too much good stuff going on between doctors. They were separated. There's a group here and a group here and a group there. And he wasn't too highly recommending stopping there to practice.

So I went on. And by the time I got back to Medford, and Todd grabbed a hold of me and took me around to see a lot more doctors, there wasn't any contest from that point on.

KRONENBERG: So you started your practice in Medford in what year?

CASE: It would have been 1955.

KRONENBERG: 1955. Okay. And tell me a little bit about the medical community in Medford. Particularly in comparison to now. What kind of a hospital did you have? Things of that like.

CASE: Well in Medford we had, right now, almost downtown, there was a building that they had used as a hospital for quite a few years. And it was just a building. I mean, it really was, they had surgery in it, and they had a delivery room, and they had some beds. And I was able to get privileges there right away, and just started right in. And then that time we had Sacred Heart Hospital, which was up on the hill at Medford, out East Main and into the right, or south, up on the hill. And so those were the only two hospitals there. Well, there was an osteopathic hospital, I think, over at a neighboring town, but not right in Medford. And so that, those were the only hospitals there at that time.

KRONENBERG: Was there a hospital in Ashland at that time?

CASE: Yes, there was a hospital there, a very small hospital, not too much. But yes, there was one there. They were also on the staff at Medford, most all the doctors

down there. But none of the Grants Pass doctors. That was separated. They didn't get together.

KRONENBERG: About how many physicians were in the valley then, Laurel?

CASE: Thirty.

KRONENBERG: Thirty?

CASE: Maybe thirty-five.

KRONENBERG: Mostly general practitioners?

CASE: Well, there were a couple of OB, obstetricians. Most of them were general practitioners. There were several OBs and otolaryngology. Dr. Ingraham was in that. You probably remember Dr. Ingraham. And what was his name, the old doctor that was the ophthalmologist. I can't say his name anymore. Used to– too many years! [laughter] But they had, you know, a fairly broad group of people in different specialties. But no real cardiologists or highly trained surgeons. We had, Jim (Loose?) was there, so we had a neurosurgeon. And radiologists and lab people.

KRONENBERG: Did you have anesthesiologists for the operating room?

CASE: Oh, yes.

KRONENBERG: You did.

CASE: Yeah. We had both anesthesiologists and nurse anesthetists. So they both worked. Not always together, but sometimes together, depending on what the case was.

KRONENBERG: Now as a general practitioner in those days, both in Medford and in Kansas, the custom was that general practitioners did a fair amount of surgery.

CASE: Yes, that's right.

KRONENBERG: Was that the case with you?

CASE: Yes.

KRONENBERG: What kind of surgery did you do?

CASE: Well in Medford I did quite a bit of surgery, actually. I did tonsillectomies and I did appendectomies and gall bladders and hysterectomies. I would never touch a thyroid or a bowel obstruction. I didn't want any part of those surgeries. So I always got somebody to do it. At that point I didn't really have any problem getting privileges with my experience that I'd had in Wichita, two years, where these were two

very highly trained general surgeons that did all kinds of surgery. And I did, I had a lot of experience there, I really had a lot.

KRONENBERG: And during that period of time, you were there until–

CASE: 1969. Late '69. Thanksgiving of 1969, when I arrived up here.

KRONENBERG: Is that when you had your family and raised your family?

CASE: Well, we started, we had our family started back in Kansas after I left Bremerton and went back to practice in Enterprise. So we had both boys then, but they were young. John started to school there. And Bob started to school in Medford. So his growing up period was almost all in Medford. Not as much as his memory, he doesn't remember too much about Kansas. John remembers some. And so, but it was mostly in Medford.

KRONENBERG: What do the boys do now?

CASE: Well, John owns and operates a classic chauffeur service here in Portland, and has had it for thirty years. and Bob went to Oregon State and got his degree in forestry and went to work for Weyerhaeuser in Springfield, and worked there for them when he graduated, he went to work for them. And he was there with them until just this last year, when he got an opportunity to get involved in a brokerage. So he now is a broker and what do they call them, financial advisor for, if I can think of the name of that place. It's one of the big ones, anyway, anyway, that doesn't matter. Anyway, he's working for them now, and is a broker and licensed and everything. Loves it.

KRONENBERG: So you've been in general practice in Kansas and Medford until 1969. And then something different in the way of a career came along. And as I've told you before, that was your first retirement. What happened then?

CASE: [laughs] Yeah. Well, what happened was that I was, the year previous to that, I was elected as president of the Oregon Academy of Family Physicians. And in that role, and also coming up here about a little later, as soon as I got up here, I went and took my boards, so that I passed them. Because I came up by invitation from the dean to start a Department of Family Medicine. That was the reason for my being hired.

KRONENBERG: That was here at Oregon Health Sciences University.

CASE: Here at the University of, Oregon Health Sciences University, that's right. And so the academy had been trying to work on the school for two or three years before that. And it happened I was president on that year. So I was the one that went up to the med school to talk to them about it. So the person that I talked to was Dean Holman. You probably remember Dean Holman quite well. I learned very quickly that he was really a gentleman and a fantastic person. And he jumped on the bandwagon with me just immediately. He just wanted, he really was anxious to do that.

So we went back to the academy and we developed a plan to meet with the faculty, you know, our academy, for the state to meet with the faculty, at least the executive faculty at a retreat down at the coast. So we went down to Salishan and all the executive faculty people came, and we had a weekend of discussion and I'd asked a physician from Florida who I had met through my work with the academy, the American Academy, and asked him to come out and be a keynote speaker. Because he already had some experience and training in family medicine. And so I asked him to come and talk with the executive faculty from the med school, which he did.

And I do think that helped quite a little bit because I think there were people on the faculty at that point who were very, really not very enthusiastic about having family medicine come into the med school. Because most of them were specialists, and they really weren't interested in giving away part of the money that they were getting to run their departments, and it obviously if there was another department coming, it was going to take more money, and somebody's going to suffer for that. That was the philosophy they had. Actually it turned out that probably that was less true than they thought. But at any rate, we did get the opportunity to start.

And so I had, during that period from the first five year that I was up there, I was busy, more or less, just generating interest in the part of the faculty and really getting the cooperation and also getting involved with the American academy because that was how I would learn myself how to be a good family physician, was to utilize the things that were already happening that I'd been involved in. So during that first five years, I was actually got an opportunity to be on the residency review committee for the family–

[End Track One. Begin Track Two.]

CASE: –practice people. So that I had a place to learn an awful lot more than I really knew about how to run a department. I knew how to run a family practice, but I didn't know how to run a medical school department. And I learned that those are two different things, and it takes a lot of effort and time and ingenuity and guts and all kinds of other kinds of things to get that sort of thing going in such a large institution.

KRONENBERG: How did you develop the confidence of the rest of the faculty? The surgeons and the ENTs and the orthopedists and the like? What was the task–

CASE: Slowly. [laughter]

KRONENBERG: How did you go about it?

CASE: Well, I depended a great deal on Dr. Holman. I mean, I used him as a confidante. And very quickly also I became acquainted with Dr. Roberts, M. Roberts Grover, who was the associate dean. And he had, and he was a champion of this. He went to bat for me on I don't know how many occasions that he went to bat for me, as did Dr. Holman. And I would say those two people almost unilaterally got me through the first

year. And from that point on, I had begun to make some more of my own associations with other people in the other departments.

And I had to go to every single department, so that one of the first things I did, though, early in that, was that I got the dean's approval to form a committee that he would appoint that would be representative of each department. That we would meet once a week, and I would be planning, based on the knowledge I was just gaining, partly out of the blue, and partly from my interactions with the board and in Kansas City, and the residency review committee in Chicago. So I was in constant contact with people like that, and I was also in contact with the feds, trying to get some money. And I finally did get, I guess the most I got from the federal government during that entire time was about $450,000, but I did get that, after quite a while. It didn't come very easy. But I did get some help in that from somebody up in Seattle, and the feds, working with the feds up there. So I had some help.

KRONENBERG: When did you start accepting residents for the family medicine program?

CASE: Okay, I'm trying to think. I think it was '72, late '72. Yeah. Yeah. And I had, that's kind of an interesting thing, too. Because one of the first people that I talked to about it was Bob, Robert, he was, I can't even say his name now. Well, that's crazy. Well anyway–

SIMEK: Why don't you take a little break for a second and take a drink of water.

CASE: Yeah. Yeah. Yeah, I could use a little drink of water. Is this my water?

KRONENBERG: Yep.

SIMEK: I wouldn't mind (?)

CASE: Okay. Yeah, I was getting a little dry mouth there.

SIMEK: Okay. (?), go ahead.

KRONENBERG: Laurel, when did you start accepting residents for your family medicine program? [pause] 1972, was it?

CASE: Yeah. '72. That's right. 1972. And Bob Hakala was at the time that this took place, Bob Hakala was already a resident here in urology. But he really was interested in family medicine. And so he came around to see me when he found out that I was here. And it ended up that he decided, and he talked with Bill Krippaehne because he really wasn't all that interested in going ahead with surgery. So he decided to become one of my residents. And it turns out he was my first resident. And then Hughes, Duffy Hughes, George Hughes from Salem, or from Eugene, was the second one. And he came in just out of his internship in the service, and came in. So those were the two people that

I started with. And they were at that point, they were both doing rotations on the various services. Because we didn't have a place to practice, we didn't have anything, except a lot of paper that we were writing on all the time. And so that's how it got started.

And then after that, we recruited. And once we started recruiting, and the world got out around the country, we had a huge number of applicants that came around every year. And we couldn't, there was no way we could have taken you know, any of them. But we started out with just the two. And then we had, let's see, two more. Four. And then the next time we made a change, I think we had maybe four. So we ended up with twelve before I left. And so we did pretty well, we thought, for that.

KRONENBERG: When did your program become accredited?

CASE: In 1973.

KRONENBERG: 1973. Okay. That was an interesting new part of your life. Looking back on this teaching of physicians, there's a thread here. You have spent a lot of time in your career somehow teaching physicians, be they young or old or in between. And getting started this, I think there are a couple of issues. First of all, tell us a little bit more about the whole concept of a formalized education for family medicine. Where did that come about? And what happened to the old-time GP in the meantime?

CASE: Well I think the best way for me to approach that is to talk first a little bit about my experience at the American Academy of Family Physicians in Kansas City. Because I had a, well, I had a sabbatical, as you remember, for a year, later on. I'm starting a little bit advanced because what I was doing originally wasn't nearly as intense. I was too busy trying to just put the parts together here. And I knew that I needed to, at the same time, to be spending some time with others who were already doing this, you know, in other places. And there were lots of them that were already doing it.

And so I managed to get enough time that I could leave and go there for meeting for a weekend. And the more I did that, the more I got involved with them. So I had to, then when I come back here, I had to begin getting people on board that could help to get this thing going. And I think that what was the most encouraging to me was when I finally got my first report together to go to the residency review committee to get their approval to be a family practice residency, that's when I felt that things were really now taking hold, because we passed it without any problem at all. It just went right through, and that was really pleasing.

And then, the next step that came was that they collared me and asked if I would be on the residency review committee, because that was the major hurdle that every program had to go through was to be able to pass the test of the residency review committee. So I spent six years doing that. And during that time, Benny thinks I spent most of that time in our beach house that we had at that time, writing up reports. I spent every weekend when I was working on a committee meeting for the residency review committee, I'd have a stack of charts that high that I had.

And each member of that committee had the same charts and the same number. And we, and so we had a committee of seven people. Seven docs. And they were all family physicians who were either in charge of residency programs, or first in line, or whatever. You had to spend hours and hours and hours looking at those things and studying them before you ever went to a meeting. Because with seven or eight people sitting around this table, all have looked at the same charts. So you can't have, what do they call it, equinimitas for that many people. There are going to be differences of opinion. so I would say that an awful lot of the ultimate planning that went into what the question you just asked me took place in that committee. And it was a nationwide representation. So that's the thing I think I was really trying to get to when you asked that question.

Then I got the opportunity after that, when I went on my sabbatical, to do a research project where I took the, all the paperwork from all of the residencies across the country. And this was later now, a later time, several years. I had to go through all of those. And that was like four hundred programs, and create a representation of what all is good about each of these programs. And then set up criteria, and work with the board of the academy in developing the criteria. And then go through the process of studying all of the reports that came back in from the residency review committee who would have those people, have those charts, like I described, that I was working with.

So all that information came back into the academy was then turned over to me while I was on my sabbatical. And I had one of the personnel who worked there in the computer department who helped me in doing that. So at the end of that, I had 450 programs on a report that identified an awful lot of the characteristics of each and every one of those programs. So what we tried to do was we tried to collate that into a document that could be, that the other programs, all the programs would have some benefits, at least, of helping to develop these programs. So that's where an awful lot of my knowledge in it came from.

KRONENBERG: So your task was, in some ways, to build sort of a model?

CASE: Mm hmm.

KRONENBERG: A training program for family physicians?

CASE: Right.

KRONENBERG: Interesting.

CASE: Yeah.

KRONENBERG: And when did you leave the medical school?

CASE: Let's see. Wait a second now. '83? '84? '83, I think it was, '89, yeah. '83.

KRONENBERG: 1983. And why did you leave?

CASE: Well, at that point, we were having growing pains, for one thing. We were having difficulty keeping some faculty, and we had some faculty that we had difficulty getting rid of. [laughs] I shouldn't say that in a situation like this. Why don't you wipe that out? I shouldn't have said that. But it's true.

KRONENBERG: [laughs] Okay. Well, so long as it's true.

CASE: Ask that question again. I'll start over. [laughter]

KRONENBERG: All right. Well, after such a long time as chairman of this new department, and all the challenges that were involved, why did you leave?

CASE: You know, that's a really hard question to answer. Let me try. For one thing, I was really getting tired. And I guess another thing is that we were, we had so many problems at this point in terms of the university, and problems with getting money from the state that it just got kind of overbearing for me. It just got very tough. And I just decided that I'd been there quite a while, longer than most people would have stayed with any department chair. Most department chairs didn't hang around more than five years during that period of time. Most of them were gone, and here I was fifteen years. And I got tired. And I decided that if I could find somebody that would come and take it over, or that they could, but I just felt that I had done so much already that I needed to, I needed to get back and smell the roses a little bit, see what's going on in the world.

KRONENBERG: So now we come to your second retirement in your career.

CASE: Yeah. Right.

KRONENBERG: And after you retired from medical school, what did you do with your retirement, then?

CASE: At one of the meetings that the OMA had over at Salishan, Bob Dernedde collared me and said something about– well, I should preface that with something else that happened just before that. And that was, due to the fact that I was working with the department in trying to set up a program that would help to identify problem physicians, and to do something about that, that I thought I could spend some time doing that. So I got some funds. I got some funds from the, not the board, but the offshoot of the board. You know what I'm talking about.

KRONENBERG: Oh, yeah. The Foundation for Medical Excellence. Yes.

CASE: Foundation for Medical Excellence, yes.

KRONENBERG: Foundation of Medical Excellence. And so I got–

SIMEK: Would you start that again so you can use (the title?)

CASE: Oh, yes. Oh, sure. Okay. At that point, I checked with the Foundation for Medical Excellence to find out if they had any funds that I could use in developing a program, and then explained to them what the program was. And after we had quite a bit of discussion about it, they, the board, decided to give me five thousand dollars for starters. Mostly that was intended for travel because I had, in order to do this, I was working in hand with a lot of people in other programs around the country in addition to the AMA. And so through all my other time in Kansas City and Chicago and so forth, I had gotten acquainted with a lot of people around the country who were interested in the same things. And not just about family practice, but in terms of the quality of care, and relating to the question that you really just asked me, which had to do with the quality of the care, too.

So as a result of all of that together, I talked with the board. I started working on a plan, and the board was very supportive. So I spent–

KRONENBERG: This was the Board of Medical Examiners?

CASE: Board of Medical Examiners here. And that was while I was still at the med school. I came back to the med school after I finished my tour with the, Bob (Barry's).

KRONENBERG: Oh, OMPRO?

CASE: OMPRO, yeah. Finished my term with OMPRO. Then I went back up to med school with the idea that I was going to use that, they gave me an office so that I could work on planning, and then I had made some, kept in touch with some of the people on a national basis who were working on similar type things. So during that period, maybe six months, I attended several meetings that the people that I had contacted before were all going to meet and talk about these plans. So I had discussion with people all over the country. Once they went to Colorado Springs for a meeting, or they had a meeting there anyway. We always piggybacked on a meeting that already existed, is what we tried to do. And that made it less expensive, and it made it more easy for more people to get there. Because this is something that a lot of people were interested in. So that was a springboard, then, for my coming up, coming down here, you see. Because it was right in that period of time when I realized that there wasn't much that the family practice department was going to be able to do to help me, because they had too many problems of their own. And I could be there and have a little space, but only when it was convenient, you see.

And so that's when I called you or maybe, I don't remember if I talked to Bob or you first about this, to see if there might be some other way to go about this. And Bob urged me to call you and make an appointment and come talk to you. And I did. And that's what started that whole period of time.

KRONENBERG: That was in 1991.

CASE: Actually, ’90.

KRONENBERG: ’90? Excuse me. I thought it was 1991.

CASE: No.

KRONENBERG: Okay. That was in 1991. So you came here and you set up an operation. What was the goal of the program, from your perspective?

CASE: Well, from my perspective, the goal was to try to develop a plan, a way of responding to needs that physicians, and we particularly were interested at that time in family physicians who were struggling to get their practices going and who were trying to do this under the auspices of the family practice insignia, and so forth. And I felt after meeting with all of these national groups and meetings, that I saw all of them had the same problems in mine. That no one knew what to do.

I mean, they had a big meeting down in San Francisco that I attended that was part of the big educational meeting that the AMA always has. And out of that meeting came a whole host of things that people didn’t know how to go about. And that’s what led me in the direction that I went of trying to develop methodology of tracking family practice, particularly family practice people, that’s what I started out with. But it ended up going way beyond that. And to figure out ways to help keep them in practice, keep them going, when they were having problems, when the board had problems with them and when they weren’t performing well, and in hospital staffs, and so forth. So that was really, I felt that no one was doing anything about that. And they weren’t. Just very little that was being done.

So that’s really what the goal was, was to get going on a program that would actually end up doing what I think it did. Subsequently.

KRONENBERG: Let’s go back to your first work, when you were practicing. One of the things that always fascinates me when I’m talking with senior physicians such as yourself, and it’s always a different story. I’d like to hear your story. Can you describe for me what it was like to be a physician before Salk vaccine was available? And then when it became available, what happened? How did the medical community respond?

CASE: Well I guess my first, would you include penicillin in that?

KRONENBERG: No, we’ll get to penicillin. We’ll do penicillin.

CASE: Okay. I didn’t know if you wanted to combine these things or not.

KRONENBERG: Let's talk about the polio epidemic and the response and how physicians responded. Was this, when Salk became available, was this in Kansas or here in Medford?

CASE: No, that happened when I was in Medford.

KRONENBERG: Okay. Let's talk about it.

CASE: Because in Kansas, we didn't, I don't remember having anything like that in the time I was practicing. Well, yes. When, we had a very active staff of physicians in both hospitals there. And they were all very, very eager to help each other. This is really one of the best places to practice medicine in that period of time. And I've talked to like Bill (Mayer?), the surgeon down there. You probably know Bill real well. Bill (Mayer?), one of the times I was talking to him just recently, he was telling me how much he appreciated the fact that way back when we were all getting going here in Medford, the camaraderie that was there, and how it's still there, it really was something that they all had a feel for. And I really felt that that was, that was the best group of physicians that I'd ever worked with. And I still feel that way. And you know, they're really, really close right now. Anybody I see there that was there when I was there.

For example, just a few weeks ago I was at church one Sunday morning here in Portland. And there was a fellow sitting in front of me that I didn't recognize. And he turned around and he saw me and he said, "Well, Laurel Case!" He knew me from back there, and I hadn't seen him in years. And we had a big visit. Those are the kind of things that give you the warm fuzzy feelings that you have. [laughter]

KRONENBERG: Okay, getting back to the polio epidemic that you and certainly even as a child, I remember, was there a lot of polio in Jackson County in those days?

CASE: Well, I don't know. I don't recall that there was a lot of polio there. There was some. But no, I didn't feel that that was a big deal there. But there was enough of it around that people didn't want any more of it. And when they found something that everyone felt would do the job, boy, the physicians just turned to, our practices just waited. And I can still see us in that big huge basement room of the school. And people all over just, you know, everybody had a job to do. And it was just really a fantastic thing. And I know other people felt the same way at that time.

KRONENBERG: How long did it take you to immunize the community?

CASE: Oh, boy. That's a good question. It's very difficult to answer that question after this long a period of time. But I would guess that it would be like four days.

KRONENBERG: Amazing.

CASE: That's the closest guess I could make.

KRONENBERG: Looking back over your career, now and into your retirement, an awful lot's happened, of course, in medicine. Not just socially and economically, but also in terms of the science. What would you say, as a former practicing physician and educator and the like in your career, at least in your career, have been among the most important developments, clinically? In terms of drugs and procedures and knowledge. What would you think have been the most important, and why?

CASE: Well, I'll say that the very first one that I came along and believed was fantastic was penicillin. Even when I was in medical school, they were talking about it, but it wasn't being used yet. But by the time I got into my little country practice in Enterprise, Kansas, it was available. And it was something that was highly reliable. And all of us were just really pleased to see. It was one of those things that looked like it was going to be for good. And I think it was. So I would say penicillin is definitely a very strong one.

I would say the second one in that sequence in terms of time, and perhaps in terms of value, maybe that's not the right term, but I think that's close, close enough. And that is the steroids. I think steroids at that point became extremely important because, you know, there were a lot of things being used that people–

[End Track Two. Begin Track Three.]

CASE: –got allergic to, and steroids became a real lifesaver for some of those.

KRONENBERG: What diseases in those days would they be particularly applicable to?

CASE: Well, one thing was, you give them penicillin, which was one of the best ones. But there were a fair number of people that showed some pretty serious allergic reactions to penicillin. And the steroids became a real strong, of course, we always had adrenaline, even before that. But sometimes they didn't have it, or didn't have it available or something. But at any rate, it had less side effects than the adrenaline. But I think that was probably one of the very strong ones.

And, let's see. What else?

SIMEK: Shall we take advantage of the opportunity to change tapes?

KRONENBERG: Yeah, we need a break.

CASE: Yeah.

[End Track Three. Begin Track Four.]

SIMEK: Ready, we're rolling, and go ahead.

KRONENBERG: Laurel, you've been a physician for fifty years. Describe how medicine has changed, and how the physicians that you've worked with and that you see now have changed over that period of time. What's different?

CASE: Well, you know, I'll start at this end of it and work back. Because I believe that the changes in the last, say, ten years, I mean, even since I came down here, when I first came here to work. And I think that the concept of care, patient care, has just changed a great deal. I think that most of the physicians that I knew that long ago, ten years ago, were still taking care of their patients in the same manner that I did before. You know, as far as I could tell, they were still maintaining the same standards of how they treated their patients, how they managed them, and so forth.

And now it seems different. It seems now like that when you read things all the time in the paper about the problems that they have in the managed care arena, particularly that, I think is one of the major concerns that bothers me is that there's this, it just seems like that in the mechanism that is known as medical care, patient care, whatever, probably patient care is a better term to use, is much different than it has been in the past. And the difference seems to be, to me, that there's a whole lot more emphasis in the structure, in the structure of the practice of medicine. There's a whole lot more emphasis on the whether it's appropriate, and the cost. And physicians, I'm sure that physicians get into problems that they really shouldn't be getting into because of that. Because they miss things. Because they're so focused on dotting all the "i's" and crossing all the "t's" so that they can get their pay, that it's easy to forget something that you really shouldn't forget. It's easy to not do everything that should have been done, or do more than needs to be done.

And those are things that I see as changes that I don't think we saw very much when I first started practicing. I feel that those days we were all really scared to death not to be more cognizant of what the problems were, and to really put the patient first, and not try to second guess everything that takes place in the mechanism of the community, or the mechanism of the, say, the community of the medical care complex. There's much more emphasis now on whether or not the medical care industry is really caring for the patient. Much more emphasis on the questioning of that, whether they're caring for the patient as they should. And you see it in the newspapers, it's all over. You can't miss it. And they talk about whether or not the patients are really getting the proper care. And you know, that bothers me a great deal.

KRONENBERG: Do you think, what are some of the factors that you think are contributing to that, to this change that you perceive?

CASE: Well, I think that the "healthcare industry," quote unquote, if you will, has seemed to come around to a complete change in how they think and how they operate. And it seems to me that the pay system, the pay system, how paying takes place, is one of the major problems. And patients get shortchanged. I'm quite sure they get

shortchanged more than they should, and I think more than they used to. That's my perception.

KRONENBERG: Is it the people? Is it the way they're educated, do you think?

CASE: I don't know. It's hard to know exactly what the reason is, but I think that the insurance industry is one of the big question marks in my mind. That it seems to me that the insurance industry has become a much more active player in this arena than it used to be. So I think that's probably one of the big factors.

And the docs, I think the docs are really pushed in a corner an awful lot of times. I don't think they consciously want to provide poor care for patients, but I think that they have so many different things going on, regulations that form regulatory mechanisms on them, that it's difficult for them to really use their own head and decide what's best on that basis, as opposed to what the insurance company says, and so forth.

KRONENBERG: Some people say that part of the problem is the resources that are available now that you didn't have in the '50s and the '60s, that technology can do so many things that it couldn't do that physicians are less reliant on their own skills and knowledge, and tend to substitute technology for what they know. How do you respond to that? Do you think that that's an issue?

CASE: Well, I think that's part of an even larger setup. And I think that the focus that I would place to try to pull that together is on the research that's been taking place, and all the changes in things that people are even now able to do in healthcare that were never even thought of a number of years ago. This Drucker, or whatever his name is, locally is getting quite famous now for having some success in some of the gene work. And I think the more that comes along, the more a lot of people begin to try to think well, that's great. How are they going to use it on me? [laughs] And it's an unknown, still, really, except that there are some things happening that you can't really argue with. You just have to recognize that things are changing. There's going to be some changes.

And I can talk here now about the changes that have taken place, which are all bad. But I see changes coming down the road that are all good, an awful lot of them.

KRONENBERG: For example?

CASE: Well, the ability to, let's see, I'm having a block on that.

KRONENBERG: Okay. Let's back off and try something else. When you became a physician, I suspect that probably something over 90 percent of your new colleagues were males. Today, when we go to the medical school here in Portland, we see not only half of the medical students are females, but we also see that many senior faculty are females.

CASE: That's right. That's right.

KRONENBERG: That's been an enormous change. What role do you think that this has played in terms of the provision of quality healthcare in this country?

CASE: Well, I can look back at my freshman year in medical school. There were four girls in our class, and we had a large class. So that's where we were then, which is a lot different from where it is now, you're absolutely right. As far as I can tell, I have no reason to believe that changing that mix has done anything to hurt medicine, the value of medicine or the effect of medicine. I think it's probably better. I don't think that probably there's been that much of a major change in the quality of care given that I would look at as being because of change in that mix. I don't think so. I think if so, it may be the other way. I think it depends on the field you're in, and an awful lot of where you're at and where you're practicing, and so forth. So I don't really think that that is a major factor.

KRONENBERG: Except around wars in the last century, physicians tend to go to high school, to college, then to medical school, complete whatever specialty training they're going to take. And they were in practice often before they were thirty.

CASE: Yeah.

KRONENBERG: Now if you look at medical students, not just here but across the country, you find many medical students in their forties and even in their fifties. And it will be interesting to see what that amounts to over time. What do you think it means?

CASE: I'm not sure I've given that a lot of thought, that question.

KRONENBERG: Okay.

CASE: Hmm. I would have trouble coming up with something that I have any confidence in. [laughs]

KRONENBERG: Okay. That's fine. We've talked a little bit about the economics of medicine, and the role of insurance. When you started in practice, there wasn't any Medicare, there wasn't any Medicaid. Presumably doctors took their share of patients who didn't have any money. To a certain degree, that still goes on. Certainly the advent of widely available health insurance either through the government or through private sources has had enormous, an enormous effect on how healthcare is delivered as you've alluded to. Comment on what you've seen during your career in that regard.

CASE: Okay. Well I can say that the first year that I went into practice in the little town of Enterprise, that it was sometime late in that year when I had my very first insurance company bill. Or not, paperwork for them, where they were going to pay a bill. And I can remember how much that affected me, and thinking about it, wondering about it. Because it was the first one I'd had. And I was amazed.

And now in later years, like when I was practicing in Medford, that was a big part of what you collected. Blue Cross and Blue Shield, for example, were the big ones in those days. And it's just grown from there. So other than, I don't know how I can answer the question. I see that as a definite change that took place over a period of years. And I don't know what it, whether it has any real meaning for the future or not.

KRONENBERG: Speaking of the future, what do you see for the future in the way of, you name it. Additional technology that can be applied, changes in education, changes in how healthcare is paid for. What, as a retired physician and a recipient of healthcare, what do you see changing in the future?

CASE: Well, I think there's evidence already that while it's a very slow moving project, that the gene therapy and so forth is going to, I see that as something that's really going to change an awful lot of things. I don't know how fast that's going to come, but I really believe that what I've seen of the literature as far as developments that are already in progress, and I think some that are just bubbling under the surface, that are going to be, just all of a sudden, they're going to explode one of these days. And I think it's going to just completely change the whole practice of medicine.

Now that's going to take time. It isn't going to happen overnight, I'm not saying that. But I really do believe that once they start tapping into that resource, they're going to have it bubbling up all over. Somebody's finding something out here, and that translates into something somebody else is thinking about. And pretty soon you've got all kinds of things cropping up that are going to really help medicine, help people's health (?). I think that's, I think that's definitely not very far off.

KRONENBERG: You see, it's not fair to talk about in your lifetime or mine, but do you see a cure for example, for cancer?

CASE: Well, you know, it's always difficult for me even to respond to that question, because there are so many different kinds of cancer, and there are so many different causes that can affect that. But I definitely see a change that's going to take place in how cancer is treated. And I think that the prevention of cancer is now already being, is already on the move. I think I have seen enough of my own acquaintances around this many years that I've lived, who I think are already benefiting from that. And I really believe that it's going to grow, and grow rapidly.

KRONENBERG: How about AIDS?

CASE: That's a tough one. That's a tough one.

KRONENBERG: From a practicing physician's perspective, what blocks the breakthrough with HIV and AIDS? Such a terrible disease in many parts of the world.

CASE: Sure.

KRONENBERG: From your perspective, what needs to be done to begin to address it?

CASE: That's a tough one. I'm not, of course, I'm not as up on the literature in that area. It does seem like, that AIDS has, for a long time, AIDS was, in terms of popularity of what people were thinking, it was coming up pretty fast. But now it seems to me that in this country it doesn't compare to what it is, say, in Africa, in terms of the severity and in terms of the onset of it and so forth. And the related problems that perhaps cause it a great deal. So I think that by the fact that AIDS in the United States has already improved in terms of the incidence of it and the problems that it brings about, I think that that has the chance of becoming a definite breakthrough. And over time, I think that's going to be handled.

The only problem is that for that to be handled in countries like Africa, and there are others, I'm sure, there's going to have to be a lot of other things changed before that happens. And I don't know exactly how that's going to happen. I sure hope it does.

KRONENBERG: It's fair to say that the patients that your successors see today in their offices are a good deal more sophisticated about medical care than they were in 1950 or 1960, or even 1995. They have access to the Internet, things of that nature. And one that we're all familiar with, because we see it every day, another way they become more sophisticated or perhaps more demanding, is the advent of advertising of prescription medications in the media, particularly on television. What does the more sophisticated and more demanding patient do to the patient/physician relationship, in the traditional sense that you're used to? Is this good? Is it bad? What do you think?

CASE: Well, I think it's some of each, honestly. I see a number of types of patients, and groups of patients, who particularly in terms of cancer, cancer of the breast, for example, I see people taking some really bizarre routes to try to prevent that in ways that I don't think there's any evidence to give you a very strong feeling that it's going to really help. Some of those things that, there are a lot of things that may be helping already. I think particularly breast cancer that there are some people working on some things that aren't very scientific, but still seem to be affecting in a good way the incidence. So it makes you kind of wonder what to think. Because we've been trained, some of these things haven't been tested to the extent that we all think they should be. And yet, it seems like maybe the incidence of breast cancer is getting less. And why is that? I'm not sure we know.

KRONENBERG: But you think it might be attributable to the patients who are more aware?

CASE: Yeah, I think that probably is true.

KRONENBERG: We talk a lot today in medicine about technology and its role, whether it be drug therapy or new diagnostic equipment. And in your experience again as a medical practitioner and now a medical consumer, do you have any concern regarding

the use of technology becoming so pervasive that it gets in the way of perhaps other parts of medicine that are as effective in treating and dealing with human disease?

CASE: Could you be more specific?

KRONENBERG: Sure. Sure. Is there too much technology? Not enough? Does technology sometimes get in the way of providing good medical care?

CASE: You know, I don't know that I can give you an answer to that. I think it's possible, that latter part of the question, that it could give in the way. I do know of some people who've had breast cancer, for example, and who have not gone along with the treatment that was prescribed and was thought to be the best. And I know that some of those people have lived quite a while since then. So who knows? It's one of those things which I think–

I think one of the things that bothers me the most is in terms of the notification of people, particularly what we see on TV when somebody is advertising their drug or whatever it is that they're recommending, and really no one has tested it. That really bothers me. And I think a lot of that's happening. So from that standpoint, I think we've gone too far in the advertising field in trying to hold up certain things as being really valuable, when there's really no evidence to prove that.

And the point is, no one studies that, you see? They study, on the other side of it, they study it to prove that it's good. But no one studies it to prove that it isn't good.

KRONENBERG: When you started practice in 1950, in comparison to now, now that you're retired as a practitioner and an educator of family physicians, and a doctor for many, many years, how does the community perceive you and other doctors in comparison to, say, 1950? Are you seen in a different way? Are you viewed in a different manner than you were fifty or forty years ago?

CASE: That's a difficult question. For one thing, to try to characterize how I feel I'm treated, for example, in that context. It's hard for me even to think what I would try, what kind of questions I'd try to ask to decide that. I don't feel like I'm treated any different than I've ever been treated. But then I'm not doing things that I many years ago have done. I'm not a practicing physician any longer. So I don't think that I would come across to other people in the same manner that I would have a number of years ago. Maybe that's not really what you're asking, but that's how I feel about that. I think it's pretty difficult for anyone to answer that kind of question. Maybe I'm missing something, I don't know.

KRONENBERG: Just put on your thinking cap for a minute. Tell me what you think that a family practitioner, as you know and understand it, might be doing and be able to do, say, in 2050? What will be different?

CASE: Well, I have on occasion fantasized a little bit about that question.

KRONENBERG: Fantasized.

CASE: And that would be the best I could do, would be to try to fantasize.

KRONENBERG: Good.

CASE: It seems to me that there's going to be a major change in the pharmaceutical industry. Where else can they go, you know? There's so many things. And then with science searching for other things, there's going to be some major changes in the area. Some things won't ever be used, they'll be gone. And I'm sure that that's something that you could project, almost, you could predict. Because there have already been many major changes. There are things that were used fifty or forty years ago, or forty years ago, quite frequently by doctors that are not used at all anymore. And that, we don't know how far that's going to go. But I feel that there definitely are going to be major changes in that area. It seems to me that when I look at what's happening in the gene world, it seems to me that there are going to be changes that in the future, not too distant future, that will cause many of the things that we have had, to be out of synch. Gone. No good anymore. I think that's a very real possibility.

KRONENBERG: Will, obviously medicine will be more sophisticated as technology increases.

CASE: Right.

KRONENBERG: But will the practitioner be different, do you think? Will they be more technical–

[End Track Four. Begin Track Five.]

KRONENBERG: (?) education, the educational process changed, have you given thought about what might be in store in that regard?

CASE: Well, I think the family physician concept that we've come up with is going to change. I don't think there's any doubt about that. Because they have become a good deal more sophisticated than they are, I'm sure. On the other hand, the amount of change that's taken place in the physicians who are not family physicians, changes that are taking place, I think we have to stop and realize that we no longer have just a surgeon. We have many, many, many types of surgeons, and that keeps growing. The numbers of kinds of surgeons that you have keeps growing as all these other things change. So I think that the family physician is going to be different, too. I think there are going to be some of the other, the other than the sophisticated scientific things are going to change the way family physicians are going to function. I don't think they're going to be doing the technical stuff that they do now. I think that will change in due course.

KRONENBERG: You've mentioned that in your career you've seen technologies and drugs and procedures go away, never to return, presumably, because either it was found that they didn't work or something more effective came along. Can you give us some examples of that? For example, in 1955, how you would have treated an acute attack of asthma as compared to what they would do now.

CASE: Well I think in 1955, I think there would be less change. I think if I go back to when I first started practice, which was, '55, '50, '52 is when I first started back there. At that point, I think that I would have, there were some things that came right after that, like penicillin, for example. When I first started practice, penicillin was being used mostly in the development stage. It wasn't just everybody used penicillin. And so at that particular point, I think that from that point, it didn't take long for that to change, because it was effective. It worked. And I think that's the thing that is the real answer, is that if you find things that are going to do the job, then that becomes, if you go to that as opposed to something else that doesn't work so well. And so it's going to change. I don't think there's any doubt about that. I'm not sure that, I don't know that I can be any more specific than that.

KRONENBERG: When you started your practice in the early '50s, you provided, for example, you provided treatment to people with congestive heart failure. Everybody in your specialty does that and a good many other specialties do, too. Certainly that's an area where things have changed. How did you manage a patient with congestive heart failure at the beginning of your practice in comparison to how they're managed now?

CASE: Well, I still used digitalis. And that was common. You frequently saw people like that who had a lot of edema, both in the chest and elsewhere. So you used a lot of, you know, to mobilize the urine. I can't think of the name of it.

KRONENBERG: Oh, yeah. Diuretics.

CASE: Yeah. Used that heavily, and I used insulin. Or, I'm sorry, I didn't mean insulin. I'm blocking it out. Diuretics were the major thing.

KRONENBERG: Major, sort of the treatment of choice. And of course, digitalis. I (didn't?) think about that. Digitalis was very highly used at that time, and usually got pretty good results with just that. There wasn't a whole lot more you could do at that time.

CASE: You've seen, while you were in Medford, which for probably sixty years has been, for its area, a pretty sophisticated medical community for the size of the population.

KRONENBERG: Yes. You began to see the advent of a lot more specialists in your community, and all around you in much smaller towns. What effect did that have on the quality of care overall in the community? And as medicine has become more specialized, do you see the advent and the use of specialists over time becoming more

important? Less emphasis? Will there be more emphasis on primary care in the future? How do you see that spinning out in terms of the physician, the whole issue of physician workforce? Do you see the composition of the physician workforce, not just in Oregon, but nationally, changing over time?

CASE: Well, I think it's changing some, but I don't see that as a great change is going to take place. [pause]

KRONENBERG: That's a pretty one.

CASE: Yeah. I like it. Really like it.

KRONENBERG: Okay, looking it all over, your long career in medicine, if one of your grandkids came and said, "What do you think about me becoming a doctor," what would be your response and why.

CASE: Well, my response, I think I can tell you exactly what my response would be. That from my stand, I would say to them, from my standpoint, nothing would make me happier than to see you do that. But I would want, I would hope that you would give it great thought. Think about what you're saying, and find out, really find out what you need to know in order to make that decision. It's not a question of having to know all there is to know about practicing medicine at this point. It's a question of finding out what you need to know in order to decide whether or not you want to do this or not, or should do this or not. So I would try to turn that into a problem solving process for them.

KRONENBERG: But you wouldn't say, "Oh, no."

CASE: Oh, no. No way.

KRONENBERG: But you wouldn't say, "Oh, yes."

CASE: Well, you know, I wouldn't say "Oh, yes," but not because I have any reason to say that I haven't enjoyed being a physician, or haven't been glad that I did. It would be because I don't want them to jump into something that they haven't thoroughly studied and looked at, to make a good decision about whether that's the thing for them to do or not. That would be the reasoning that I would use for that.

KRONENBERG: Okay. You've enjoyed being a physician, and you're glad you are one.

CASE: Yes.

KRONENBERG: Looking back, if you had it to do over again, is there anything you'd change?

CASE: Oh, I'm sure there are things I'd change. I don't think there's any doubt about that. If you're asking what would I change–

KRONENBERG: Yeah.

CASE: That's a different question, and I'd have to give some thought to that.

KRONENBERG: Okay.

CASE: But I'm sure that I would change some things. I know I would. As a matter of fact, I think I did. [laughs]

KRONENBERG: Give me an example.

CASE: I shouldn't have said that, either. [laughter]

KRONENBERG: Okay. I'm done.

SIMEK: Okay. One more question.

KRONENBERG: Sure.

SIMEK: Any moments stand out in your career? Most rewarding, most gratifying?

CASE: Oh, yeah. That's a good one.

KRONENBERG: Ready?

CASE: Yeah. Well, not quite, just a second. Let me think just a minute. Yeah. Okay.

KRONENBERG: In your career, is there any moment, any special moment, any special time or event that particularly stands out that you're especially proud of?

CASE: Yes. Two years ago, when I went back to my reunion of my medical school graduation class, I was just pleased as could be to see the large turnout of the students that I was with. Out of a total of ninety-three in our class, there were sixty-three at that meeting. Fiftieth class reunion.

KRONENBERG: Good heavens.

CASE: And that was a real highlight of my life. Because I for the first time saw many, many, many of my good friends with that many people. And most of them came to

the conference and the banquet and so forth. And we just had a great time. And that was my fiftieth class reunion.

KRONENBERG: So the lesson is, be a doctor from Kansas if you want to live a long time.

CASE: [laughs] Well that's a good, that would be a good one. That would be a good one.

SIMEK: Well, conversely, how about the most terror producing moment? Like when you worked up at the medical school?

CASE: No, that wasn't. [laughs] Oh, boy. I guess that the, you know, that's a pretty strong word, and I don't think I–

SIMEK: Maybe that's not the right word.

CASE: I don't think I remember a time where I had literally terror.

SIMEK: The saddest–

CASE: Pardon?

SIMEK: The saddest, the worst, the most disappointing.

CASE: Oh, oh, okay. Well, I would say–

SIMEK: Tell Jim.

KRONENBERG: Tell me.

CASE: Yes.

KRONENBERG: What was maybe the low point of your career?

CASE: Hmm. That would be hard. I don't think I've had a low point in my career. I can't remember having had a low point in my career.

KRONENBERG: Any moments of stark terror? [laughter]

CASE: Well, sure, there have been times when I really wasn't sure what to do. And when you aren't sure what to do, you yell to somebody to come and help. That's what you do. That wasn't very often, but it happens.

KRONENBERG: Great.

SIMEK: Thank you so much.

CASE: You're welcome.

[End Interview.]