OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

Dr. Daniel Labby

Interview conducted September 23 and 30, 1998

by

Linda Weimer

SUMMARY

Dr. Daniel H. Labby begins his interview with a brief biographical account before plunging in to a description of life as a medical student at the University of Oregon Medical School in the late 1930s. His postgraduate training was interrupted for a period of military service in World War II, and Dr. Labby talks about the medical error that kept him on American soil for the duration of that service.

Labby returned to Oregon in 1947 as a faculty member in the Department of Medicine at UOMS. He reminisces about several famous faculty members from that time, including his father-in-law Dr. Laurence Selling, Dr. Tom Joyce, Dr. Noble Wiley Jones, Dr. Hod Lewis, Dr. Edwin Osgood, and Dr. Olof Larsell. He notes that many early members of the all-volunteer UOMS faculty were also partners in the Portland Clinic. He talks about the development of a full-time, paid faculty, and ties the change to the construction of University Hospital South which brought an influx of new, paying patients to the Hill and fostered the growth of subspecialties among the clinicians.

Labby discusses trends in medical education after World War II, when veterans returning to Oregon highlighted a need for continuing medical education programs. He also notes that the war in Vietnam had its own impact on medical students, who were now more likely to question and challenge medical "authority." He touches briefly on the consolidation of the three schools into a University and its effect on the Medical School, and then switches gears to recount anecdotes about Dr. Charlie Dotter and Dean David Baird.

The second half of the interview focuses more narrowly on physician-patient relations, medical education, and medical ethics. Dr. Labby describes the evolution of the medical curriculum here at OHSU, from the 1950s through the present, as basic science information expanded and more clinical techniques were incorporated into the early years. He talks about the social implications of medical education, including topics such as abortion and research on human sexuality. His own interest in physician-patient relations led him to establish two early programs on medical ethics: CHIME (Council on Humanism in Medical Education) and a conference series on the sanctity of life, held at Reed College. He was also instrumental in the development of the OHSU Center for Ethics in Health Care and founded its Senior Clinician Seminars. He shares his opinion that the rise of women in medicine has led to a better understanding of patient rights and a renewed emphasis on physician-patient communication. Finally, Labby touches briefly on the role of the media in the conversation between society and a medical school, noting that while they don't always accurately report the facts, it is important to keep the dialogue going.

In conclusion, Labby addresses the issue of premedical education and its importance in forming well-rounded physicians. He talks about trends in medical education, both at OHSU and nationally, and the need for a balanced curriculum that is able to produce clinicians as well as researchers.

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Interview with Dr. Daniel Labby
Interviewed by Linda Weimer
September 23, 1998
Site: Dr. Labby's office
Begin Tape 1, Side 1

WEIMER: This an oral history interview with Dr. Daniel Labby. The date is September 23, and we are in his office in the Outpatient Clinic.

One of the questions we ask of all our interviewees is where they were born and raised. We'd just like to have a little bit of biographical information.

LABBY: Well, I was born in Portland—I'm a native—and on the other side of the Hill, actually, which is now Lair Hill. I was born in a house on September 1, 1914, and brought up here in Portland as a child and through my young adult life, and then eventually medical school after Reed College.

WEIMER: You went to Reed College here in town. What was your major?

LABBY: Biology.

WEIMER: What made you decide on that?

LABBY: Well, actually, chemistry and biology were requisites for medical school, so we had to pick up the scientific credentials. Reed College being a humanities kind of college, I took what I had to in the sciences to get in, and the rest was all humanities.

WEIMER: It sounds like you had known at an early age that you wanted to go into medicine.

LABBY: Well, Mother was a nurse, Dad was a dentist, although at one time he tried to become a medical student but didn't have enough money to manage. So I may have lived out some of their dreams, I don't know.

WEIMER: After graduating from Reed you went to the [University of Oregon] Medical School, and it was on the Hill at that time, Marquam Hill. What was medical school like?

LABBY: Well, it was very small. There were only sixty in my class, and only six women, because there was a kind of unspoken allotment of ten percent women. I'm glad that's changed. But of the six women, four actually completed medical school. One got married in her junior year, married to another doctor who was a resident at the time. But it was predominantly a male class.

WEIMER: I think we'll get back into women in medical school a little bit later. Tell me what a typical day was for a medical student. This would be in the later thirties, mid-thirties?

LABBY: Thirty-five is when we started, '35 to '39 was our class time.

Well, eight o'clock every day was a class, and a lot of the actual structure of the education was pretty much out of textbooks. In fact, we used an old textbook written by Sir William Osler, and we had to memorize the actual definitions of disease. For example, I remember once in my medical class the physician teaching asked me to define typhoid fever, and I had to define it in the words from Osler's textbook, and then he would call on others to fill in and flesh out whatever that was, and then he would add his experience. And that was the way it was done in the third year, actually. It was still pretty much a pedantic sort of thing. But the first two years were mostly things like chemistry, anatomy, physiology, pharmacology. And it was the old pharmacology. We had to learn to write prescriptions that had different elements in them. You didn't just put down the name of a medication. Like for a cough syrup, we had to learn what was the vehicle, what was the syrup that you added to the codeine. And so we wrote what they call polypharmacy, several different kinds of ingredients, and that's the way pharmacy, before it became much more physiological, was taught and practiced.

WEIMER: There were no standard generic drugs at that time?

LABBY: Well, we had the basics. We had opium and its derivatives, and we had aspirin, and we had a lot of herbals, an awful lot of herbals that we had to learn.

WEIMER: Obviously, antibiotics weren't there yet, they came later.

LABBY: They came at the time of our graduation, just in time for World War II.

WEIMER: This was also the time, in the thirties, of the Depression. How did that affect you?

LABBY: Well, as you'll see from the videotape I took of interviewing my classmates at our fiftieth reunion, we all worked. There was no school in summer, so—it was interesting that we had several very intelligent Asiatic students in our class, and they actually would go off to Alaska and work in the fish industry and make much more money than any of us who had more humdrum jobs. I was lucky I was employed on the campus in different laboratories and eventually was a fellow in pathology, and that helped me. I think I made at least $1.18 an hour, I think, if I recall correctly.

And after the Depression we had something called the National Recovery Administration, NRA, and so that reached out and touched a lot of the students, including myself, and I was employed to do several things like making a colony of mice for experimentation; working in the pathology laboratory helping with postmortems; and so on.

WEIMER: You graduated from school, and you went into an internship?

LABBY: I went to an internship at Hopkins in Baltimore in internal medicine.

WEIMER: How did you decide to go across the country for that?

LABBY: Well, it was an opportunity that was offered me, a chance to go from Portland to Baltimore, and I'd never been out of the city very much, so I wanted to have something a lot different and be exposed to different traditions in medicine. So I took my first year in internship in Johns Hopkins.

WEIMER: And from there?

LABBY: Well, from there I took a fellowship in New York City. And there was an old dictum in medicine at that time—we're talking about 1939, '40—that if you knew syphilis you knew medicine.

WEIMER: I've not heard of that.

LABBY: Well, that was Sir William Osler. Because we had so much syphilis around—there were no antibiotics—that it showed all kinds of medical complications. So I took a whole fellowship year in syphilology, as it was called, in New York City at the New York Hospital at Cornell. My class, however, was offered an opportunity to have commissions in the military, and I had one. So roughly three or four months before Pearl Harbor, my fellowship was interrupted and I had to report to Fort Lewis because of the gathering storm for World War II. So that was interrupted about August or September, and then Pearl Harbor was in December.

WEIMER: Were you a medical officer during your military service?

LABBY: Yeah. I was a captain. We were all captains at the start.

WEIMER: Did you see action or did you go abroad?

LABBY: No, I didn't get abroad. I managed to stay in the United States. Of course, I ended up at Walter Reed Hospital in Washington, D.C.

WEIMER: And how long were you in the medical corps?

LABBY: Well, I was in the medical corps until our whole medical corps—at least the infantry where I was a physician—broke down with hepatitis. It's a part of military history that we were supposed to be slated to go to the South Seas, South Pacific. They thought, and I think erroneously, there was yellow fever there, so our entire Third Division, where I was part of an infantry unit, were inoculated with yellow fever vaccine. The vaccine was contaminated, and we had a very high rate of hepatitis infection, including myself, because I

injected my battalion, and then myself, and so the result was we not only had a lot of deaths, but those of us who ended up quite ill were out of commission for a long time, myself included. I sat it out, finally, at Walter Reed Hospital when I became ill.

WEIMER: That's a sad episode.

LABBY: Yeah, yeah it was, in the army, particularly, because it was a new disease. They didn't know what it was. And as luck would have it, the man who prepared the vaccine became a dear friend of mine later, Max Tyler, at the Rockefeller Institute, where I eventually ended up doing research. What they did—they apparently wanted to stabilize the vaccine, and they decided to put a small amount of serum, human serum, in the vaccine. Unhappily, they chose a man just coming down with hepatitis, so he contaminated hundreds of thousands of doses of vaccine.

WEIMER: Unbeknownst to anybody until…

LABBY: We didn't know what it was. It was a new disease.

WEIMER: Hepatitis was a new disease?

LABBY: Of that kind, viral hepatitis.

WEIMER: After the military, after Walter Reed, your recuperation, where did you go?

LABBY: I picked up my training. I went back to Cornell and became, eventually, chief resident. And then after that I went across the street in New York City to Rockefeller Institute and did two years, of course, in research liver disease.

WEIMER: [Laughing] A personal interest?

LABBY: Yes, of course. Then I came out here.

WEIMER: What brought you back to Oregon?

LABBY: Well, actually several things. One was my native land, and I didn't terribly care about big-city life in New York City. I was married and had two children, and my wife was a native of Portland. In fact, her father was the chief of Medicine [at UOMS], Dr. Selling. And so we came back and established ourselves here, and I was part-time at the Medical School because the Medical School had very little money for full-time faculty. So I was half-time in practice for a while and half-time at the Med School, and they paid me a small stipend just to do that. Then, after four years in practice downtown, I came up here full-time.

WEIMER: About what time was that, do you remember?

LABBY: Fifty-one.

WEIMER: And what was your main—were you in psychiatry?

LABBY: No, no, that came much later.

Just as an aside, I wanted to shift to psychiatry when I was at Hopkins, and I was interviewed by the chief, a very famous doctor, [Adolf] Meyer, and he offered me a residency, but then along came the Army, and so I had my war experience, and I lost my residency. So I picked up my medical training when I got out of the Army, and, as a result, came here actually sort of a second in command to Dr. Lewis, because by then my father-in-law, Dr. Laurence Selling, had given up the position full-time—not full-time, he was a volunteer. So Dr. Lewis and I were actually the Department of Medicine, along with only a few others at that time. We're talking about 1951, the early fifties.

WEIMER: When it was a much smaller place back then.

LABBY: Very much smaller.

WEIMER: Talking about Dr. Laurence Selling—and people have asked me to ask you about him—he is one of the notable personalities here on the Hill, but we don't have that much information about him. Could you tell me a little bit about him?

LABBY: Well, it's hard to tell a little bit.

WEIMER: Tell a lot, then [laughing].

LABBY: He was a very loyal volunteer chief of the Department of Medicine—as were so many other departments, you know, with chiefs. He and three others started the Portland Clinic, so they were all—all the four people who started the Portland Clinic were each chief of a division of the Medical School.

For example, the chief of Nose and Throat [Ralph Fenton] was one of the four who started, the chief of Medicine was Dr. Selling, the chief of Surgery was Dr. Joyce, and Noble Wiley Jones was also one of the four, and he was kind of second to Dr. Selling in running the department. And so the Portland Clinic really had control, almost, of all the things going on up here, as part-time people. Highly devoted. And Dr. Selling was what they called a neuropsychiatrist, but he was—in those days he was an internist with a specialty interest in neurology and, I guess, what then passed for psychiatry.

WEIMER: Was that usual at that time that there wasn't anyone full-time in psychiatry: it was more internist and then with a subspecialty?

LABBY: It really wasn't called psychiatry. For example, he was called a neuropsychiatrist, and it wasn't until many years later that Henry Dixon became—again as a volunteer, because he was in practice—he became head of Psychiatry. But even then

psychiatry was a much different profession and discipline than it is now, of course. It was mostly laying on of hands, and there was no thought of anything psychoanalytic in medical school at all.

WEIMER: What would you say were some of the accomplishments of Dr. Selling in his career?

LABBY: As far as the school is concerned?

WEIMER: Yes.

LABBY: Well, I think, for one thing, he was highly revered in the community, and he was a very inspiring teacher to the students. He was also somewhat feared—in a healthy way, I guess, because neurology was so utterly complicated. And he gave a series of brilliantly clear lectures, but they were so rich that it was very difficult for students to retain. As a result, there was as curious business that went on here in selling Dr. Selling's notes [laughter]. In fact, one of the come-ons to join a medical fraternity was that they had a complete set of his lectures.

WEIMER: [Laughing] I can see that.

LABBY: Like Cliffs Notes. He was a very dynamic, rather small man, a beautifully clear thinker, and he was renowned for his ability as a diagnostician in internal medicine.

WEIMER: You have these four physicians at the Portland Clinic, quite powerful up here. What were their relations with the Dean? That would be Dillehunt early on.

LABBY: Well, he was also from the Portland Clinic.

WEIMER: So was it sort of like a little old boys network a bit?

LABBY: I guess you could call it that. He was a very dear friend of my father-in-law, Dr. Selling. In fact, they were like brothers, very, very close. And Dr. Dillehunt, at the time in orthopedics, was a very close friend of Dr. Selling's. He was head of orthopedics, but he was not in the Clinic, he had his own practice. But they were all very close friends.

WEIMER: What would you say was Dr. Selling's vision for the Medical School?

LABBY: Well, he emphasized mostly the regard for the patient and the patient's dignity. He was terribly devoted. He would do house calls day or night, he was always available. He was really, I would say, the complete physician in many ways to people. He had very, very long-term relationships with patients. They stayed with him years and years and years. And on top of that, he was a very warm, empathic, accessible kind of person, and so he epitomized the doctor in ways that we unhappily have since lost. But he was always available and there when anybody needed him. And he worked very hard: he worked late at night, he

would make rounds, if he had to, in the hospital late, and so on.

WEIMER: Getting back to our four from the Portland Clinic, one of them also was Joyce?

LABBY: Dr. Joyce. He was the surgeon, yeah. He was internationally well known.

WEIMER: For his surgical abilities?

LABBY: Yes.

WEIMER: Did you have any personal dealings with him?

LABBY: Well, only as a student—but he was feared, because he was a very strict man when it came to making demands on the students. And one of the things that—you'll see a picture of it in my little album. He ran what was called the "bullpen." We all sat up in surgery in the gallery, and then he would call a student down to discuss the patient that was already present in terms of diagnosis and maybe treatment and physiology.

He was a very impressive looking man, ramrod back, shock of gray hair, and extremely intelligent.

But as a way of exemplifying some of his demands, on one of his examinations that he gave our class one of the questions was: How would you examine a donor for a blood transfusion? Which, of course, was used so much in surgery. And so we all answered to the best of our ability. Those students who did not say take a test for syphilis, a Wassermann test, he flunked, because he didn't want them to forget that very important—of course, he rescinded later—but he said, "It's so important, that I want you never to forget what you must do." So that was Dr. Joyce.

WEIMER: If I can picture this correctly, the bullpen, as you said, was in the surgical suite, and that's in the old Multnomah County Hospital?

LABBY: Correct.

WEIMER: And they would just bring a patient in there and they would just talk around about the patient?

LABBY: Sometimes they would not have a patient. He'd present a case or have a resident present a case, but always somebody was called down into the bullpen to become the pigeon. We all feared it, because he was extremely demanding.

WEIMER: I can imagine that would strike terror in a student.

LABBY: Yeah, it would.

WEIMER: Another person you mentioned was Noble Wiley Jones.

LABBY: He was less well known up here because he didn't put in quite as much time, but he was one of the early internists in Portland, as was Dr. Selling. But he did a kind of general internal medical practice.

And in those days we had a lot of what now seem almost ridiculously fanciful ideas about such things as infection and so on. For example, if you had arthritis or you had a lot of aches and pains, they talked about how somewhere in your body there is a focus of infection, and so we will take out all your teeth; we will cleanse your sinuses; we may even, in men, take out the prostate—because any focus of infection could be the cause of some of your aches and pains with arthritis.

Then, there were fads that they went through, and Dr. Jones was one of these people who promoted a lot of this. One had to do with the fact that one of the diseases called "undulant fever" was thought to be very prevalent here, because it basically is carried in the cattle in the area, and this is a big agrarian area. So we were testing everybody for undulant fever and treating them because they had arthritis again, possibly a very secret or rather cryptic form of undulant fever. So there were curious notions about infection in those days—before we had any antibiotics, remember. And he was a person who kept apace of a lot of these fads. They were not fads at the time; they were really beliefs. I could name several others, but that was essentially one of the things that he promoted. He was a very, very devoted physician. He was trying to give everybody the very best and the latest.

WEIMER: I understand that scholarship was endowed in his name? Or was it a lectureship?

LABBY: There was a fellowship, a Noble Wiley Jones fellowship in pathology, which I had for several—for two or three years, I think, and that paid enough to kind of help toward tuition.

WEIMER: Another one from those days, and I have seen a picture of him in your album, was William Fitch Allen, whom they called Pop Allen.

LABBY: He was really a tremendously absorbing character. He was the old-fashioned scientist who was completely devoted to his trade, and he had a special interest in the structure of the nervous system. And being a rather elderly man and a little bit getting into his ancient period, he was a person who we very lovingly would make fun of because of forgetfulness or some of his funny eccentricities. When he would, for example, lecture for class, he had very, very ancient diagrams that he would post that were already yellow with age. He also was a bit of a fussy old man, but totally devoted. In fact, there are a lot of stories about him. One that always warmed our hearts was, apparently at some faculty meeting they were talking about the fact that the buildings were not completely, comfortably heated, and they asked Dr. Allen to respond. He said, "Well, it was a little cold on Christmas." He was up

here taking care of his dogs, his experimental dogs. And he was, again, one of those people that would pedal a bicycle with his lunch in the basket, from his home every day, every day. He never missed, day or night. He was devoted to his experimental work.

WEIMER: There is another person that I've been asked to ask you about: Howard Lewis, whose nickname was Hod.

LABBY: Hod, yeah. Well, he was the chief of Medicine and a very distinguished man. He actually was a medical student here—he was completely inbred—and it took five years because he took a fellowship in anatomy in order to help his way through Medical School, I guess financially.

But he became an extremely astute diagnostician. Actually, he was trained in chemical engineering before he came to medical school, so his main forte in diagnosis was the physical diagnosis—with my brother-in-law, in fact, he wrote a physical diagnosis book. He had things down to differences in sound when you auscultated the chest, to the point where we had to learn all kinds of curious little differences in sound, which he gave names to. In those days you had more tuberculosis, for example, and much more lung disease, many more smokers, for example, a lot more infections, and so on, and so he had a rather elaborate system of detecting sounds through percussion and auscultation, particularly using the stethoscope, that helped you diagnose what was going on in the lungs, in contrast with people who just took x-rays, for example. Then, he was a very skilled diagnostician in feeling for things and evaluating patients' histories.

And eventually he became rather well known nationally and was finally President of the American College of Physicians, and a very revered man, a very revered man. He received many honorary recognitions from the American College and from medicine in general. I was his backup. When, for example, I was going to take my first sabbatical—I took three, a year apiece in Europe, and the first one I took in 1960—the year before, he had become President of the American College of Physicians, and so I delayed my own sabbatical year while I could backup a lot of his absences. So he became extremely well known by, I'd say, the cream of American medicine in internal medicine.

WEIMER: What would you say were his major accomplishments for the Medical School?

LABBY: Mostly organizing a medical department. We eventually were able to cover most of the main disciplines within Internal Medicine. For example, when I first came here there were only two other people in the department with me, and one was in the clinic and one was in physiology part-time. But since I'd had an experience in research in metabolism, I was at one time running the endocrinology clinic, the diabetes clinic, rheumatology clinic, nutrition, and diabetes itself, as well as working in gastrointestinal disease because I was interested in liver disease.

WEIMER: That's quite a workload.

LABBY: Well, you did what you could, you know, in twenty-four hours, but eventually we were to get people to take each department. Dr. Greer came in Endocrinology; I kept Diabetes, Dr. Bachman came in Rheumatology, and so on.

WEIMER: Of this era of the thirties and the early forties, we really don't have that much information. Are there any other notable personalities of that time that you'd like to talk about?

LABBY: Well, I guess most of them are in the album. I'd have to look at their names. We were not known during that time to be an institute known for its research, with one exception, and that is Dr. Edwin Osgood in hematology. He was world famous.

And eventually he was able to develop the technique, with the help of a medical student, of cell culture, so that he could grow different elements from the marrow artificially, and so he did an awful lot of work in physiology. He was an amazing man, probably one of the geniuses—true geniuses that we had on the Hill. A lot of interests. He was an accomplished geologist as well. Also a very strange man personally. He had a lot of funny mannerisms. But we always got the feeling that his head was so full of a number of things that you couldn't intrude too easily [laughter].

WEIMER: Could you just give me an example of one of the mannerisms that you would remember after so many years?

LABBY: Well, he wasn't always clear when he spoke because he always kept a kind of pipe in his mouth, and he kept chomping on it as he spoke, for one thing. And he always made you feel a little ill at ease. You knew that you were up against an enormous brain, and he didn't suffer fools gladly.

WEIMER: I remember one other name, Olof Larsell. He wrote the book *The Doctor in Oregon*.

LABBY: Right. Well, he was the chief of Anatomy, and he was a rather dour, sort of humorless person, although I understand on occasion he could lighten up. But since we were freshmen when we encountered him as chief of Anatomy, and since three times a year, I think it was, we had oral examinations with him, he was another kind of a terror for medical students, because he was a brilliant man when it came to anatomy, and he was terribly serious about anything. There was nothing very light around Olof Larsell.

WEIMER: It sounds like there were not that many women on campus, obviously on the faculty, but I do know that the librarian, Bertha Hallam, was here. Did you have any experience with her?

LABBY: Oh yeah. I was here when she came. She actually organized the library. We didn't have one that amounted to anything, but she organized it so we actually had not only a

physical space with the current magazines, but we had shelves full of back issues of the famous and the more important issues of magazines. And on top of that, she was a wonderfully cooperative person. If you wanted to look up something, she would do anything she could. She was only about four feet tall, a very tiny little woman, a bustle-y little woman, and she was totally devoted, absolutely totally devoted. And she was very good about helping the doctors downtown. They would call her up and say, "I need to look up something," and she would look it up and send it to them. She was really an extraordinarily cooperative and obliging person.

WEIMER: It's interesting to note that the service went to off the Hill, too, to physicians.

LABBY: Well, you see, we had what we've lost since; that is, we had a lot of physicians who were volunteering, and, as a result, we had to keep that so-called town and gown connection all the way through. We've lost a lot of it.

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

WEIMER: This is side two of our oral history with Dr. Labby.

We were just talking about Bertha Hallam, and you made a remark on the changes in the volunteer faculty. Could you give me a little bit of a history of that, because, as I understand it, it was mainly volunteers for a while, and then, of course, it has changed over the years.

LABBY: Well, in very simple words, I think the change occurred when we built the University Hospital South. The reason for that was because we were by then a fairly good-sized faculty, and we began to split off into subspecialties. And a lot of the volunteers that came up here and made rounds were gentlemen who had been in practice for some years, and, yet, the medical students who became interns and residents were full of a lot of new information that these doctors weren't given when they were medical students. There was a change of generation. And so they felt kind of out of the league. And so many that I talked to, because I came from practice up here, as I explained, said to me that they regret, but they don't really feel that they can continue because they don't feel they have much to offer. It took a little while for that to take place.

The reason I say that the University Hospital South had an effect was because we were now able to take private patients, and so there was then a developing town and gown problem. The doctors downtown said, "We're taxpayers, we built that hospital, and, yet, you're taking our patients away;" because we can admit patients to this hospital that they might be taking care of, you see, in private practice. Well, it lasted a short while, but at times it did get rather heated. On the other hand, they found that they could also refer patients to the hospital for specialty care of people up here who were doing research and had special interests. So it worked both ways. Now we have some volunteers, but it's certainly not like what it was in the past.

The other thing that happened was the doctors downtown felt they had to spend a lot more time in order to make a living, so they couldn't volunteer up here.

WEIMER: Well, for so many years, as I understand it, Multnomah County Hospital was your teaching hospital, although it was Multnomah County.

LABBY: Right.

WEIMER: What was the big push behind building our own teaching hospital?

LABBY: Well, because we wanted to have more beds, and, secondly, we wanted them to be teaching beds and we wanted to equip a modern hospital. Multnomah County was really from the 1920s, as I recall. In fact, when I was a student, the chief of the hospital was a retired army officer. So when this hospital came available, we had research space, we had people with special interests, and people from all over the state could refer up here, and so it was an enormous opportunity. And, then, the expansion of the Veterans Hospital at the same time, with connections to the Medical School, made a lot of that possible for us.

WEIMER: Was there a community reaction with the new Veterans being located up here?

LABBY: Well, it had been here many years, and so it was kind of accepted. The reaction occurred when they were going to make the so-called new Veterans, the expansion.

WEIMER: So that would be later in the eighties?

LABBY: Something like that. Almost fifteen years ago, twenty years ago.

WEIMER: What was the difference in the patients or type of patients that you received, from indigent-care patients at Multnomah County to fees-for-service patients at the teaching hospital, the new Medical School hospital?

LABBY: Well, we had no control of admissions to the county hospital because you took whoever, and the result was that the wards were very often filled with strokes, heart failure patients, and so on, and it was the more common kind of case. But with the interest in research and the specialty development that coordinated with the building of University Hospital South, they gave the permission for admission of any patient to the resident of each service. So a doctor downtown, if he had a case of special interest he wanted studied, would call the resident, and the resident on that service would say yes or no.

We had some difficulties because they'd say, you know, "Well, I've seen this patient who has a stroke but a very interesting heart condition," from, say, southern Oregon and they wanted him shipped up here, but we got the feeling they were just kind of dumping the patient. So we trained our residents, hopefully, to be very astute so that the new research

hospital, teaching hospital, wouldn't be filled with the sort of thing that was at County.

WEIMER: And at that time, because the University Hospital South was built, I believe, around '56, you still had Multnomah County Hospital continuing under Multnomah County for at least, I believe, twenty years.

LABBY: Yes, that's right.

WEIMER: So you had the two types of patients.

LABBY: Right.

WEIMER: After the war it's my understanding that prepaid insurance came into the foreground. How did that change medical practice?

LABBY: Well, a lot more people were getting medical care that couldn't afford it before, so it became, I'd say, really almost a renaissance. We began to see a lot more people asking for medical care that before would hold off. So it had several advantages: one is people were coming in a little earlier in their distress and not waiting until something would go away; the second thing is we were having an immense increase in volume of patients, so we needed the two hospitals; and, then, thirdly, with the veterans—of course, it was then not too many years after World War II—we still had people who were alive and needed medical care as they aged going to the Veterans. So we really had three enormous opportunities of populations of patients for care and for education and for research, and it was ideal.

WEIMER: After the war, was there a different type of medical student? You had the GI Bill and more people could afford graduate education. How did that change?

LABBY: Well, what happened was, increasing opportunity to study patients meant we could increase the size of our classes. So, like when I graduated in '39, there were only sixty-some in the class. Slowly, by some kind of per capitation arrangement, we began to get up to 120, almost double that. It's since fallen back.

But the other thing that happened, of course, was that we were finding we could have more women in the class, and none of this nonsense about a ten percent allotment that we had in the past. At some time—I don't know about now—we had almost a third, occasionally, I think, close to a half of the class of were women, which increased the attraction for me, anyway, in teaching, because they brought such a different dimension to care than the men would ever have thought of, and it was a pleasure.

I had two things that really made me terribly excited. One was the fact that as a result of World War II, and then Vietnam, particularly Vietnam, we had a kind of student coming to the Medical School who needed proof of everything. He didn't trust the glorious professors just to say what things were; they wanted to know why you think that way or what's the evidence. They were very critical. And it was exciting. You know, that was the period of

"Don't trust anybody over thirty," and the result was the students picked up on it, particularly after Vietnam.

The second thing that happened that excited me, of course, was that when you get men and women together in a small group to teach, the difference in the approach to caring for people, I think, was an education to the men students; and it certainly made it a lot easier for those of us who were interested in the kind of care that we tried to promote: intimacy with the patient, patient-doctor relationship, and so on.

Coming along, though, with that was a very strong, as I'm sure you're aware, technical development so that an awful lot of technical things were available, and technique took over the care of the patient to the point now where, as I see it, it's beginning to affect the humane approach. We're seeing more patients, we have less time with each one. There are an enormous number of things we can do, so we *do* more than we listen, in many ways.

WEIMER: Do you think it's more that you order the tests and you look at the results and you go from there, rather than a doctor using his intuition and actually talking and observing the patient?

LABBY: Well, that's part of it. For example, we used to have something called CPC, clinical pathological conferences, where a doctor was presented with a case as an unknown, and he stood up and discussed it in front of the students and the faculty, and he was supposed to say what he felt about the case. Then the pathologist—it usually was a fatal case—would give us the results of the autopsy. Now, diagnosis is very much less often a mystery because we have scans, and there's no cranny or corner of the body that's sacrosanct. We can put a catheter anywhere, and we can visualize the inside of the body like we never could before. So I don't know whether—of course, I'm not in internal medicine now. I've been in psychiatry over twenty years. I guess it is not the same game that it used to be.

WEIMER: We have talked a little bit about changes in clinical practice, fee for service and growth of the full-time clinical faculty, and that continued, obviously, after the University Hospital South.

LABBY: Oh yes. We had more money; a lot more research money was available. One of the problems that came out of that was, if you hire somebody with research money, can you ask them also to teach? Because the money says, you know, you're supposed to do research. So that was an issue, but I think it's been worked out now.

The other big involvement, of course, was the development of sub-subspecialties, so that, for example—what occurs to mind right away is that we had somebody in hematology studying blood disease whose real interest was in the physiology of coagulation of blood, and he was a specialist in coagulation pathology, and so on. There are a lot of ultimate kinds of developments in medicine like that, and it's true in all the specialties now. We have people who are more interested, for example, in the biochemistry of medicine than they are in the

clinical. So as I always said, you need all kinds of horses in the barn, and we have all kinds of sub-subspecialties.

WEIMER: When did the rise of specialties, just the specialties, develop?

LABBY: Well, actually, it was not too long after World War II when more money became available, especially from NIH. One of the first things that happened was that the general internist could no longer keep up because there were people who were getting into the subspecialties in cardiology, pulmonary disease, gastroenterology. For example, in my own field, at the time, of liver disease, I was interested in clinical liver disease, but the liver is a masterful metabolic organ, so people were interested in physiology and all kinds of things about the liver, but they were still, in a sense, bench workers and not bedside people. So there's always been a curious kind of dichotomy. There are people who can handle it. We even have Ph.D./M.D.s, of course, who do both and do it very well, but they're not too common.

WEIMER: And, then, we just talked about the sub-subspecialties; about what era did that come?

LABBY: Well, as we became more specialized, the subspecialties split off.

WEIMER: Developed alongside of it?

LABBY: Yeah, alongside of it.

WEIMER: Becoming a university. You had been a medical school for decades, and in the seventies you actually became your own university. What type of changes did you see then?

LABBY: Well, it was mostly, as far as I can tell, at the financial level, especially now that we're even a public corporation. As I recall, we used to get about fourteen percent of our budget from the Legislature, so we were a bit hand-in-glove to what we could do. I'll give you an extreme example: when Charles Holman was our dean. Now, he was completely inbred. He was a medical student here, took all his training here, and he followed, I guess, after Dean Baird left. He was very much a status quo sort of person, but he was very respectful of our support from the Legislature. Well, when I started to get interested in psychiatry, of all things I was interested in some of the [effects of] age problems and human sexuality, and that disturbed him because he was ultraconservative, and he was worried about having that kind of a, for heaven's sakes, interest in the Medical School [laughter] if he had to go to the Legislature, who were pretty conservative themselves. How would they feel if they were, for example, for heaven's sakes, supporting the idea of abortion.

And there was even a development that I was part of with another man in transsexuals and sex-change operations, and he really had trouble with that because he had to go to the Legislature and tell them what we were doing up here and then ask for money, and he

worried about whether that would sit well with them. That's a rather extreme example, but it says at that time we were very much hand-in-glove and didn't want to lose it. Eventually, of course, it split off and we became, ourselves, independent.

One little sidelight that I think not too many people know about, when Dr. Selling was playing golf many years ago with Dr. Joyce and, I think, somebody who was high up in the echelon of the Legislature or the Board of Education of the state, they were talking about making this medical school part of the University of Oregon, when it was the University of Oregon School of Medicine; and I think—as Dad told it to me, I think that was accomplished during the golf game.

WEIMER: Oh really?

LABBY: Yeah, I think so. There was something about them meeting on the golf course and deciding it would be neat if we were a university [laughter]. And that goes back probably to the post-World War I period, I'd say the late twenties, early thirties.

WEIMER: Becoming a university brought in the era of the President. Bluemle was the first, in '74. How did that change operations up here?

LABBY: I don't know that it changed a lot at the level of just the development of the place, except I have a feeling that when we went with our hat in hand to the sources of money we had a lot more prestige as part of a university. So that was a period when a lot more research monies were coming in, and even some monies for teaching, and then eventually, of course, for the expansion of the building, because to be a true university, why, we had to have a lot of different services as well as research opportunities to offer. And eventually, I guess, we became the biggest budget in the entire state, and I think that's still true, as a matter of fact. I think we have the biggest payroll in the state of Oregon.

WEIMER: I wouldn't be surprised. There are quite a few employees up here.

How did the average doctor on the faculty relate to the President, or did he? Because you still had a Dean for the Medical School.

LABBY: Well, we had to get used to what is a president? But it finally became clear that we had nursing and dentistry as well as medicine. The one concern I think we had at the time, and I'm reflecting what my fellow people on the faculty said, was, is the administrative tail going to wag the medical dog? Are we going to get top heavy? Because we used to have a Dean and a Dean's Office, and then we got the idea that maybe it's okay if we have a PR department, and that was administration. That and payroll and the physical plant. And now, talk about subspecialties [laughter].

WEIMER: True, true.

At that same time the School of Nursing became a school rather than just a

department. How was that perceived, that change?

LABBY: Well, I don't think that there was an awful lot of overlap. I think we saw it as three different units, you know, dentistry, nursing, and medicine, and I don't recall any particular difficulty about it. I don't think so. One thing that was always true was that the nurses and the doctors kind of kept their own shop. There wasn't an awful lot of cooperation, except maybe at the administrative level. But even still I think there's some curious kind of, oh, social distinction among the three, even though myself and others have taught in Nursing School and in Dentistry just because they wanted to have that influence. But it's never very rich, at least as far as I can tell. I'm not in a position right now to know that because I've been retired, you know. So they tell me.

WEIMER: You're still here.

LABBY: I'm still here, fifty years later [laughter].

WEIMER: We have talked about research and the growth of it, and it sounds like it's ebbed and flowed, research dollars. Can you give some reasons for that?

LABBY: Well, I'm not in a good position to know that. I think the Dean would know more about that than I, certainly.

I think we've had some outstanding people in research. Dr. Dotter comes to mind. I actually had him as an intern at Cornell. I brought him out here.

WEIMER: Oh, I didn't know that. Now, tell me about—I know they call him Charlie, and always with a chuckle. Charlie Dotter.

LABBY: Yeah, that's right.

WEIMER: Tell me about him.

LABBY: Well, when I was chief resident at Cornell in New York City, a medical student by the name of Charlie Dotter was coming through. He wanted to do a kind of an externship as a student, and I had the utmost respect for his ability. A lot of energy. He was kind of hyper, as you may understand.

I do remember that he always had a pocket full of colored pencils. He was a very good draftsman; he could draw beautifully. And one little episode: when he was an extern and I was the chief, I was making rounds one day on a patient that he had admitted to Cornell, the New York Hospital, and he hadn't written any progress notes. The patient had come in with a very bad eye infection and was quite ill, but was getting better. And so I said to Charlie, I said, "You know, on the acutely ill patients you ought to have a daily progress note." I said, "Let me see what you can do with it." Well, the next day on rounds, what he had done, he'd taken his colored pencils, and he postdated it and went clear back to the—and he drew the eye, and

he made it look inflamed and then less inflamed and less inflamed, right up to the present. And I remember this page with a bunch of eyes on it staring back at you [laughter]. And that was Charlie Dotter. He eventually went into radiology. He liked graphic things. And, of course, he was a major contributor to angiography. The father of it, really.

And one day when Dr. Lewis and I were talking about getting some bright young man to take over radiology, I said, "Well, I'm going East. I'll drop in and see if I can find Charlie." So I had this wonderful experience. I went back to where I was a resident at New York Hospital and walked into the radiology department, and there was Charlie looking at some x-rays on the view box. His back was to me, and I walked in the room, and I said, "Charlie, how would you like to go to Oregon?" And without turning around he said, "Dan, I'd love to go Oregon." He recognized my voice. So he came out here, he and Pam, his wife, who was a surgical nurse, and established themselves. The rest is history.

WEIMER: To put it on the record, could you give me some of his major accomplishments? We even have the Dotter Institute named after him.

LABBY: Yes. Well, he picked up the idea of catheterizing blood vessels from a man by the name of René [Courtonne?] at Bellevue Hospital in New York, and he eventually applied it in a way that developed what we call roto-rooting; that is, if somebody had a plugged vessel, he could run a catheter down there with a sharp endpoint, and he could rout it out. So having done that for some rather wealthy people, he accumulated a fair amount of money. So he pursued his research, and eventually he was able to do the, at that time, impossible: he was able to put catheters in the heart, and then, eventually, even in the coronary arteries themselves.

And there was one stunning experience we all had here in grand rounds in 8B-60, where Charlie was doing grand rounds that morning at eight o'clock for the Department of Medicine, and he was talking about what you could realize if you could get a catheter in the heart and what the graphs would look like. Well, he brought in, with his assistant, a rather large—standing about six-feet tall—cathode oscillograph, which is like a TV screen with these graphs on it. And he said, "I've been standing and talking to you for about twenty minutes, and all this time I have had a catheter in my heart," whereupon he rolled up his sleeve, and here was the end of the catheter. And he said, "I'll now show you what a normal heart reading looks like. So he went and he plugged himself in to the machine, and we were all kind of gasping, you know. There's a man standing there with a catheter in his—and he moved it around among the chambers of the heart as he stood there, and he explained what the graphs represented.

WEIMER: I can imagine that was an amazing moment.

LABBY: I would use "startling."

WEIMER: Charlie Dotter sounds like a little bit of an actor, dramatic.

LABBY: Oh, well, yeah, he was very flamboyant. On top of that, he was extremely intelligent, had a very broad intelligence. Everything interested him. He was a mountain climber, he drew and painted beautifully, and so on. He was an amazing man.

WEIMER: You have been here at the Medical School for quite a few years, and I'd like to ask, how has the organizational culture changed—from when there were just a few people to, maybe, this is the largest employer in the state of Oregon, or at least for the public sector?

LABBY: Well, we had to get used to, although slowly, the immense overlay of administration. I'm glad we still have a Dean. But I guess modern merchandising being what it is and competitive markets being what they are, I have no trouble justifying what's been going on. I think it's been very healthy.

I had a hard time getting used to the fact that a high percent of research money does go to administration of that money, though, because you'd think it would all go to research. But the question is, are we top heavy with administration? I don't know enough about it to criticize it, it's just that it's been overwhelming for me to realize how much administration there has to be. Also, you know, the modern-day medical world being what it is, we even have a department with legal counsel now, and that's necessary.

WEIMER: I would like give equal time to Dean David Baird. We talked just briefly about Dillehunt, and, of course, you gave me your observations about Dean Holman. Tell me about Dean Baird. He was here from the forties through the sixties?

LABBY: I think he held the deanship longer than any other dean of a medical school in the country.

WEIMER: I didn't know that.

LABBY: Yeah, I think so, by many years, in fact. He was a very quiet, totally devoted, totally honest man. He was rather a recluse. It wasn't easy to get to him. And when you did finally get an appointment, you very often listened more than were able to talk to him. I don't mean that as a criticism, because eventually he was always your champion. There's no doubt about that. He was, as I say, a very close friend of my father's, and they worked together a lot, but his honesty and his scrupulous devotion to this school is undoubted.

WEIMER: There have people who have said he was a visionary and people who said that he wasn't, that he was too ingrown a little bit, because he was from Oregon. How do you see him?

LABBY: Well, at the time when we were building and we were increasing there was no doubt about his vision, and he knew how to go to important people to get financial help for a lot of things. He did stay in office a long time, and I think in general American medicine marched on, and I think he felt that. Eventually, I guess he had health problems that made

some decisions for him. But his devotion and his warmth and his championship were never doubted.

WEIMER: Talking about looking outward and being too homegrown, too many Oregon people at the Medical School: when did that change, that there were more people coming from outside?

LABBY: You know, that's pretty recent, because for a while we were appointing people who we had trained for important positions. The Department of Medicine appointment was a good example of that. I had George Porter as an intern; he eventually became chief of the Department. I also had Dave Bristow, the previous one, as a resident. All I can say is that I'm so sorry to lose Dr. Bristow. He was a love of a man. He did an amazing thing for me. When I shifted in my interest toward psychiatry from medicine, he made it possible by just giving the money in medicine to psychiatry for me. You can't do that anymore. But he just took the money, as I understand it, and gave it to Dr. Saslow, and I shifted to psychiatry and trained. George Porter became kind of inbred, but he'd had a rather broad experience in research in kidney disease, and so on, so there was a worry that we were going to become too incestuous, there's no doubt about it, and that's beginning to break down now. It's very unusual to find that kind of, you might say, familial appointment anymore. That broke down, I'd say, probably about twenty years ago, fifteen, twenty years ago.

WEIMER: Well, we're almost to the end of our tape. I have one last question. You've had a long career here and back East, but what is the accomplishment you're the most proud of?

LABBY: Well, I like the fact that I was given an opportunity to teach, I think, because I felt that was probably my métier, and I guess I'm happiest with students and patients. I had opportunities to become a chief or more administrative, and I realized that would intrude. And I think my greatest satisfactions have come from what I could do with students and patients.

I always thought the ideal situation, the ideal ultimate unit, is a student with a patient and myself in a room, quietly, with the door closed. And I like the fact that now in our curriculum there's room for small-group teaching, which is the best we can do, but it's more the tutorial and getting away from formalized lecture work that I like very much. Either that or at the bedside.

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

WEIMER: We're on tape two—we ran out of tape—and I'm going to let Dr. Labby proceed.

LABBY: Well, what I was going to tell you was that—I think I indicated that when I came here in 1948, this being my fiftieth year, there wasn't enough money to have me full-

time, so I was part-time. Well, finally, in ’50-‘51, I guess, Dean Baird said they could take me on full-time, and so when I met him in his office and he offered me the job, he told me how much he would pay me, and I said, “Well, gee, Dave,” I said, “I made much more than that the first three months I was in practice, and, here, you’re offering me that for a year” [laughter]. And he didn’t change his face expression at all. He said, “Well, you must realize you’re entering a sacrificial profession.” You want to teach, and so you’re going to have to sacrifice money. I can’t imagine hiring anybody nowadays and talking like that. We’re talking about 1951.

WEIMER: I guess I have one more question, and this because of your story about the change in medicine over the years from when you started out in the thirties. How have you seen the basic changes in medicine over the last five decades, and what is your vision of medicine in the future?

LABBY: Well, I guess, like old people, of which I am one now, it looks to me like the great loss is the personal contact in the relationships that patients used to have with their doctors and the emphasis on service rather than intimate connection with a caretaker, somebody who cares about you. It’s easy to care *for* somebody, but to care *about* somebody, I think that’s most difficult under the present circumstances of having to see so many patients in so limited a time.

For example, one of the physicians that was a student of mine—or an intern, I guess he was—has become my physician, and so I can take a little more time with him, and it’s a real luxury, whereas he’s limited as to how much time he can give any patient, including me, and I don’t like that. I’d rather have somebody interested in who I am, not just what bothers me, you know, and that’s one of the things that I think is being lost.

On balance, it’s probably a plus in the sense that there’s better medical care, we can do more things; but underneath it all I worry about patients, what they really want. I remember Shana Alexander, the famous journalist, once said about her doctor, “I just want a doctor that will listen to me and answer my questions and be honest.” And she found that very difficult. That’s what I think is being lost. But, as I say, on balance we may live longer because the care technically is better. But I have so many people that call me up and say, “You’ve been here a while. Who can I see that will really listen? You know, who listens?” We don’t have time to listen.

One of the things about psychiatry that I’m very fond of is you have to understand your patients. And, by definition, we can take almost an hour with each patient.

WEIMER: That seems like a luxury nowadays.

LABBY: It is. Unhappily, we have to charge for it, too. It’s an hour of our time. But I like the idea of understanding who it is who sits before me, and I like the idea that they feel someone understands them. But that’s just something that has to go by the board, I guess.

WEIMER: Well, I want to thank you for taking the time and sharing these memories about the Medical School.

LABBY: Sure. My pleasure.

WEIMER: Thank you.

[End of Tape 2, Side 2]

Interview with Dr. Daniel Labby
Interviewed by Linda Weimer
September 30, 1998 [Interview 2]
Site: Dr. Labby's office
Begin Tape 3, Side 1

WEIMER: This is our second oral history interview with Dr. Daniel Labby. The date is September 30, and we are in his office in the Outpatient Clinic. Dr. Labby was kind enough to call me back, and we were going to discuss further a couple of areas, lines of thought, one of which is curriculum.

Just before our interview you mentioned briefly that curriculum had to change right after World War II to educate the physicians returning from the war. Shall we start there?

LABBY: Sure. There were only a few of us who were full-time faculty. In fact, I was only part-time in 1948. But in '51, by then we had developed a rather rich—broadly covering a lot of medical subjects—a very critical reeducation attempt for returning physicians who had spent so many years fighting the war. This went on for several years, and it was very successful, and, as a result, it had a lot to do with so many in the community of physicians with the Medical School, and there were many expressions of gratitude because of this. It also enabled us to get a little more funding so that we eventually could even have a better and broader faculty. And the School then, I think, enjoyed, and even flourished under the arrangements, very cordial arrangements, between the community and the Medical School.

The result was that we eventually were able, as I mentioned previously in our interview, to build the University Hospital South, and from then on, of course, it was almost a spiral. More national funds were available for research. We were, therefore, able to have more faculty who were doing research and teaching, and even to increase the physical building that we were able to put on the campus. So, I think it is a good thing not to forget that the School and the community are an integral part of each other.

And although we've had some losses, we've had enormous gains because of this. Some of the loss has been because it's hard for a practicing physician to keep pace with what's going on in the research area. But, on the other hand, the research areas have provided great opportunity for some kind of super-consultations for medical practitioners in the community to take advantage of.

WEIMER: You were a student in the thirties, and, as I understand it, the emphasis in medical education has changed through the years, like anatomy was considered *the* subject, and now I don't know if it's biochemistry or genetics. How has it changed? How have you seen it change since you were a student in the thirties to present day?

LABBY: Well, there has been a reduction, unhappily, in some of the time given to the basic sciences in the curriculum. On the other hand, there has been more emphasis on keeping current with new developments in the fields of biochemistry, pharmacology, physiology.

The other thing that's happened, of course, is that from a curricular standpoint we've been able to have students begin to see patients earlier in their curricular experience: witness the fact that we even have, occasionally, physiologists and pharmacologists and biochemists along with clinicians doing some kind of team teaching, so that as the student learns the physiology of a disease he will see an actual patient with the disease.

Alongside that, though, I'm even more impressed by the fact that they begin personally to have contact one-on-one with patients as they learn physical diagnosis, how to take a history and so forth, so that the old boredom that they complained of, of sitting through hours and hours and hours of lectures of relatively dry anatomy and so on have been reduced, and the focus has been toward getting centered early with the patient.

We even have a new—at least for several years now—a way of exposing the students to the basic clinical principles of taking care of patients, where practitioners are actually the teachers that try to integrate what the student is seeing at any time in the Medical School with his future experience in the office.

WEIMER: Can you tell me if there are power struggles between basic sciences, hands-on patient care, lab time? And who determines how all that works out?

LABBY: I don't have as good a reading on that as I might have many years ago. I don't think there is so much competition as there used to be, possibly because of the rise of a very special kind of doctor. We have Ph.D./M.D.s now, who come out of research into clinical medicine, and some who do both. Also, there are now special areas physically, buildings like the Vollum and so on, where we have people who do only research. And so their monies are no competition for monies to do clinical work.

If it does exist I'm not too aware of it, but I rather think it's less than it used to be because everybody has his own special bailiwick. Perhaps that's an exaggeration, but I think it's better than it has been.

WEIMER: I've read in some of the transcripts that a department head would be arguing for more hours in the curriculum, like Psychiatry would want more than Biochemistry or Anatomy. Have there been standards through the years, or how does that work?

LABBY: Well, actually, the way they work it, as I understand it—and I've spent many years on the curriculum committee in the past—but at present those committees are made up of representatives from different departments; so I'd like to think in some democratic way it's somehow made possible for the students to have what they call a reasonable blend. Yes, there were some people who were so, as a matter of fact, terribly in love with their own subject. I remember, for example, a pathologist who wanted twenty lectures on cancer of the cervix

[laughter], which is ridiculous in terms of total curricular time.

The other major shift, though, has been, we do less lecturing and much more, you might say, tutorial work. And, then, a lot of the stated stuff is on carousel tapes so students can sit any time, day or night—they're open twenty-four hours—and can take on the basics without the professor interfering. And if they have questions, the professor is available.

WEIMER: Talking about availability of professors—and I know the Medical School class size has increased—how has the teacher-student relationship changed?

LABBY: I think right now, except for the people who are strictly basic science, there is much more contact. Students have counselors, and, on top of that, as I said, they see a lot of practitioners and some of the full-time teachers in the institution from the very first day of their first year.

The new curricular effort, called "The Principles of Clinical Medicine," has been extremely successful because it covers a broad variety of topics, including even the sociology of medicine and some of the political things as well, and these are very often taught by practitioners, as well, who volunteer.

WEIMER: Medical education, as well as the medical profession, has social implications. I believe it was in the early seventies, and before—there's always been the controversy of whether or not to teach doctors about abortion practices. Let's discuss that for a while.

LABBY: Well, I'm glad you brought it up, because that turned out to be a terribly tempestuous time for us. Being a state institution, the question arose whether or not we should be allowed, if you will—or would it be politic for us; that's better, probably—to do abortions. But it was a fact of life, and, of course, we had the so-called sexual revolution coming along in that era, late sixties, early seventies, and there was, as a result of this, an enormous interest in personal freedoms.

It brought to the fore one very important issue having to do with curricular planning in general, and that is, how well does an institution like a medical school respond to society's needs? And the needs of society at the time, of course, were to, in a sense, get the students, if you will, as future doctors, much more comfortable with some of these very tender issues, particularly the one of abortion, and even the freedoms around sexual behaviors.

At that time we started—I actually did, I guess—an elective called "Problems of Human Sexuality," and it turned out, after a period of time, to be an overflow audience. And I like to say now that it's actually part of the regular curriculum, and I taught it for almost thirty years myself. It's now continuing into the senior year. It included not only some of the ethical issues about personal freedoms and all the issues around sexual freedoms, but it had a lot to do with talking about not just the problem of abortion, but even the treatment for people who were having sexual difficulties. And when I shifted in the seventies to psychiatry, it was one of my major interests, along with marital therapies.

So as a result of that, and the sensitivities that arose, especially in view of the national conversation that was going on about freedoms at that time, somewhat tinctured by influence from the Vietnam War, we had a much different kind of student coming in. They were very questioning, they were challenging professors on some of the things that we were teaching, and we had to show due cause. What is the evidence for whatever.

As a result of that, though, I had a rather critical experience that I think is worth reporting. I happened to have a tutorial group of about, I'd guess, eight or ten students in this office who were terribly interested in the social implications of medical care: such things as confidentiality, the patient's right to the truth, also the problems of patient's rights. In fact, we were thinking—and have since had people on our administrative staff who are patient advocates. So we decided among the almost dozen of us, I guess, myself included, to start something that would end in a monthly sort of lecture-discussion on some ethical topic, bioethical, if you will.

And, as a result, the group that was put together formed something called CHIME. It was actually an acronym for the Council on Humanism in Medical Education. They met once a month. I was kind of the faculty adviser. They chose their own topics, with some help from me and the speakers, and it continued for many, many years under relatively good supervision by the students. And as each class graduated, a person from the class beneath would be chosen to take on the responsibility. About that time a lot of ethical issues were coming to the fore, especially with regard to insurance coverage, meaning confidentiality, which is still a hot issue, and, on top of that, issues of how much doctors actually could afford to tell patients when they had serious illness.

Dr. Saslow, in psychiatry, started a course called "The Psychological Basis of Clinical Practice," in which we talked about death and dying issues, issues of confidentiality and so on. It wasn't until 1989, however, that Dr. Tolle came and started, along with help from myself and others, the Center for Ethics in Health Care, which has, of course, been a burgeoning thing in the past ten—almost ten years; and she's achieved, along with her staff, of which I'm proud to be a member, national prominence.

At that time also I was able to start a couple of conferences at Reed College in the late sixties, early seventies on sanctity of life, in which we had rather notable international figures come and talk, that have since received a fair amount of notice.

So I think those issues having to do with our ability now to talk about sexual issues with patients as a result of curricular change, and the new developments in bioethics, particularly as it culminates now in discussions about death with dignity, and so on, have been very major developments in curricular attempts to meet societal needs.

WEIMER: When we talked last time you mentioned that there was a quota for ten percent women students, and, of course, that has changed. How do you think the introduction of women has changed the curriculum, if it has?

LABBY: Well, I like to think it has. For one thing, you make me think of one experience I had when I was supposed to talk, of all things, about menopause to, I think, the junior class in medicine. And I remember standing up and saying, "This is the first time in my teaching career here at the Med School where I rather wish I was a woman." I was of an age to have had a menopause, if I was [laughter]. And everybody laughed, especially because the girls sitting in the front row saw me blushing, and it was cause for a lot of merriment.

Well, anyhow, at that time, beginning maybe in the middle seventies—I'm not too sure of my time on this one—certainly since, we've had an amazing increase in the number of women students, as has been noted many times. The important changes that have taken place: first of all, the women are extremely articulate in small-group teaching, and in my previous experience, when we had fewer women, they would sit almost humbly and not respond. But now they speak up, and sometimes they challenge—very often they would challenge the men students about certain issues.

The second thing is, they have a much different approach to caring for the patient. For example, if I am to talk about—to the students—do you feel comfortable touching a patient? The women don't have much problem with it, whether it's male or female. The men are not too sure because it might be misinterpreted, sexual harassment being the issue now so much. So that's one thing, the important influence on caring.

And, of course, the feminine point of view that men very often don't think about. I'll give you a good example. Not too long ago I was with a group, and we were talking about nurses and doctors taking care of patients on the wards, having to do with the patient who is terminally ill. When the patient is almost close to death, the men very often—there are marvelous exceptions, of course—but the men medical students or the men interns and residents very often will begin to stick to protocol. They want to make sure everything's on the chart, they want to make sure that hospital policy is followed. And they will talk to the patients' families, but very often the families will prefer to talk to the nurses. And in conferences where I've had residents and nurses together, the nurses very often will make sure that the patient is cared for, comforted; that the family is managed; and the issues having to do with the feeling state around the loss of a person to death are managed much, much more skillfully than with the men. The men will very often stick to, you might say, to protocol, and only secondarily to the other. Now, there are exceptions.

And as a matter of fact, one of the big, new curricular efforts has been—thanks to the center for bioethics, actually, and some of its staff—talking to the staff about how you talk to patients and families about feeling issues and social issues and familial issues, if you will, and personal issues.

I'll give you a few examples. We have an actual teaching tape, and we teach the students how to present, for example, the secret that a patient may have held that they're homosexual. Another issue that sometimes comes up is how patients feel about managing chronic illness or fatal illness. Very often the students are not too articulate, and the staff particularly so. Even when we have them assign power of attorney for health care they very often have to search for the language. So we have a series of volunteers that come and act like they are patients. They are

very often women—not exclusively so, but very often women—who act as if they have serious cancer. And then at the end, after they've talked to the resident, they'll give them feedback as to how felt with the resident's responses. So all that new effort to try to make the students and the house staff more articulate has been paying off in very, very good ways.

WEIMER: It sounds like it's been, like many things in life, a slow development.

LABBY: Extremely, yeah. But thank goodness it's here now.

WEIMER: Getting back to the early seventies when, I believe it was, Roe versus Wade was upheld by the Supreme Court, a woman's right to abortion. How did the Medical School handle that? I mean, now all of a sudden you have to teach abortion procedures.

LABBY: Well, I think you'd probably get more critical information out of the OB/GYN people; but one of the things that I learned personally is how very little men in general know about the experience of being pregnant, unfortunately, when you don't want to be, what the impact of that experience is on a woman. And thanks to what I've had to do in psychiatry, my patients have taught me a great deal about the female point of view in regard to, certainly, abortion and other things as well.

WEIMER: There has certainly been an evolutionary change in how we deal with the social implications of life and health and death, and you brought up the fact that we now have a bioethics center here. We've talked about how the curriculum has changed, but how has the school as an institution dealt with the community during these changes?

LABBY: Well, I think you can probably say better than I, but I like the fact that we have an administration that has backed us up, with the media, at least, through public relations. I also am terribly pleased that we have a legal department so that if something comes up that might be of general public interest, we at least can be protected.

One of the things I wish would happen more often would be that the media would more carefully research some of these subjects. I was thinking, for example, a couple of weeks ago—perhaps more by now—there was an article in the *Oregonian* saying that we didn't teach our students about death with dignity.

WEIMER: Oh, I remember that.

LABBY: Well, nothing could be further from the truth. We actually teach them a great deal about it, and they spontaneously bring these things up anyway because they read. That reporter was terribly misinformed.

WEIMER: I think that's one of the complications of working with the press sometimes.

LABBY: It is, but I'm glad that the press at least is interested in what we teach.

WEIMER: We talked about research briefly last time we were together, and it's one of the themes in our oral history project; and we were talking about the institution as a sense of place. How does research and education and the taking care of patients—what is the struggle, if there is a struggle, between the three missions of the institution?

LABBY: Well, it's not easy to generalize. It's terribly individual. I do know this, that some of our staff are very much aware of certain research directions, so that being a, you might say, teaching medical center we have very complicated cases referred to us. And I'd like to think that our clinicians, who attend meetings around the campus so much, will refer to the research people for backup help; and that happens not infrequently, when necessary.

More and more diagnoses, for example, just to be intellectual about it, are being made at, you might say, the cellular level. We used to settle for what you could feel and hear, and so on, in physical diagnosis, but now we're way down to the units that are cellular rather than gross. And the backup we've had from such things as, well, the scans; the biochemists who have interests that are related to clinical diseases; and on top of that, the very special tests that can now be made in our general laboratories—all that has been a great help, as a matter of fact.

WEIMER: How do you see the struggle—and this is not necessarily with the medical students but in medicine generally—the struggle between pure research and the clinical application of research?

LABBY: Well, of course, people begin to have their own little bailiwicks, and there are people who do pure research that don't have much clinical contact. I don't know how rich a bridge there is between pure research and bedside, for example, but there are, I think, enough people who are doing, you might say, the transitional sorts of work—whereas at one time they said to me, "You have one foot under a laboratory bench and one under a bed." I think that person is still around, not in great numbers. But I know, for example, my own physician is doing research—well, I've known him since he was an intern—and yet he's able, in a, you might say, schizophrenic way, he's able to be both, and talk about his research as he examines me as his patient [laughter].

WEIMER: I don't think there are too many of them around, but it's nice to know that there are some.

Well, we started this interview to add a few lines of thought and development. Do you have anything else that you would like to add?

LABBY: Well, you know, it's funny, but I still am concerned about the premedical training of medical students. I'm not as in touch with it as I perhaps used to be so richly, but I do hear from those who are that students don't know how to write and they are not often terribly articulate. There is an easy kind of routineness to fall into when you're a medical student. They hear the patterns of how you present a case on rounds, and so almost every case begins to sound like every other case.

And I guess I would wish they had broader backgrounds. Now, there are some changes going on, because medical students apply for medical school in such numbers that now we can pick off the more broadly educated, and even the more broadly experienced, so that our students, I think, in general are becoming a little older as they enter. They have more life experience: they didn't start at the age of five and all of a sudden at the age of twenty or twenty-one they're in medical school having never been anywhere but in college. We have some Ph.D.s, we have people who are applying from a broad variety of disciplines from the humanities, even from things like music and art, as well as sociology and psychology; and all of that makes for very good, well-rounded physicians. And I wish that would increase as much as possible.

One of the problems, of course, is the increasing cost of a medical student's education, and so people try to hurry it up if they can. On the other hand, because of that they sometimes delay so they get a little more broadly based before they hit medical school. But we have some students now that come in in their early forties, men and women.

WEIMER: I think that's nice.

LABBY: Well, I think all those things are for broadly-based physician experience, and it makes you a fuller person. Those are the things that concern me most of all, I think, right now, that we continue to broadly educate our physicians. It used to be that the doctor was the most broadly-educated person in any community, he had the longest education. We then began to worry, well, he had the longest training, but did he ever have the longest education? There's a difference.

WEIMER: Definitely.

LABBY: Those are the main concerns, I think, because I think people want to be treated and cared for in a way that it takes a broadly-based person to be interested in.

Those are the main thoughts I had.

WEIMER: Well, I have enjoyed this very much. I think we have included a few very worthwhile topics that needed to be discussed, and I want to thank you again for your time.

LABBY: Sure.

One little last thought that occurred to me: Family Practice has a program where medical students, I think in their third or fourth year, are farmed out to doctors all over the state for a so-called "hands-on" experience. Well, beginning in the mid-seventies, as I recall, I got together with the chief of the Department of Family Practice and said that one of the things that we could do would be to get doctors, who are very busy practitioners, to hire medical students to do their histories and even the preliminary physical and even possibly get paid for it. Well, that's still ongoing, except they don't get paid. But we used to send people all over the state.

And in some instances, the medical students made such a hit with the doctors that they

eventually ended up going back and joining the practice. In one case there were a couple of marriages, I guess, that came out of it, with the daughters of the doctors. So I was glad to see that program ongoing. I think that's been a very good development.

WEIMER: I think I have one more question. We had been talking about Oregon Health Sciences University, and it's the only medical school here, so it has a regional base. But do you see a correlation between what Oregon is doing and national trends? Is it nationally driven, or is some of this regionally driven?

LABBY: I think both. I think it has to be both. I think we are well appreciated nationally, for our research particularly. I'm glad you brought it up. The thing I've been so grateful for is that we've always been a blend.

[End of Tape 3, Side 1/Begin Tape 3, Side 2]

WEIMER: This is side two of our interview with Dr. Labby. Go ahead.

LABBY: When they started the medical school at the University of Washington in Seattle, it had a very heavy emphasis on research; and at that time it was in direct contrast to us, because we were much more heavily invested in teaching doctors to be doctors, the clinical side. Slowly we've become a mixture, and I think the mixture is still healthy. I still think we do very well training physicians clinically, and we still have now, thanks to new buildings and monies, of course, a very good blend of research as well to back that up. But I think that's been the most successful sort of thing in all the medical schools in the country, to have that blend.

But I think—as a matter of fact, wasn't it—not last year, or was it last year, that we were voted by *Time* magazine one of the best places in the country? I think we were number one.

WEIMER: Was it in family practice? I'm not sure in what category.

LABBY: It had to do with the general, I think, turning out of physicians. And that said to me, at least, that that part of it is still respected.

WEIMER: Recognized.

LABBY: Recognized as well, right. It's a complicated issue, this turning out a doctor. A very difficult enterprise.

WEIMER: Courtesy of these interviews, I am realizing that it's much more than just learning a few medical subjects.

LABBY: Oh, gosh, yes. Well, when you get down to the point of caring for a patient so that patient trusts you enough to tell you what you need to know to take care of them, that takes a lifetime, almost, to be able to radiate that. But there are ways of making it possible for you to slowly get your patients to feel that you're a person they can talk to. The worry is, will there be

time enough to talk [laughter]?

WEIMER: And we mentioned briefly last time about the incursion of health insurance, and then, of course, we've got the HMOs.

Talking about HMOs and ethical issues: it's been in the paper lately where some HMOs would forbid a doctor to discuss all possibilities of treatment because some of them were not covered in the maintenance plan. How big of a problem is that here?

LABBY: You know, I'm not in that end of it anymore. I can suggest you talk to my son, who is, because he has to deal with it every day. But as far as I know, it's been one of the greatest protests, and even among doctors who are trying to set up competing programs, so that is no longer an issue. A so-called gag rule, where you can't tell a patient their options, out of personal interest: you're going to get more money if you don't. There are all kinds of people becoming doctors [laughter] , and I guess that will always be with us.

WEIMER: Well, I want to thank you.

LABBY: Sure. My pleasure.

WEIMER: This is the end of our interview.

[End of interview]

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