HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Gus Tanaka

Interview conducted June 12, 2001

by

Jim Kronenberg

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[Begin Track One.]

Exactly. Exactly.

Cause they're obsolete?

Yeah.

It's no different than what we see with cell phone technology.

Yes. Exactly. There's something different every day. And certainly, computer technology.

TANAKA: And I think the problem is that these advances are significant. We're asked to pay out a buck for every nickel's worth of gain. You know what I mean. And yet our social and economic planners won't admit to that reality. And blame physicians and hospitals and manufacturers for the inflation of medical care cost over and beyond the rate of inflation in the general economy. And compounded now especially, since our economy is shrinking at a phenomenal rate, and medical progress keeps going on.

SIMEK: Okay, this is rolling.

And Jim, if you'd start with a description of the event, the date, the time, the place, what this is for, and so forth? And introduce Dr. Tanaka. Then that would be a good head slate.

KRONENBERG: Okay. Great. It's June twelfth. We're interviewing Dr. Augustus M. Tanaka from Ontario, Oregon, here at the Oregon Medical Association. Gus, the first question I'd like to ask you is one that fascinates me. What have you eaten for breakfast every day for the last seventy years?

TANAKA: The last seventy years?

KRONENBERG: Yes. That's what you said. Do you remember that?

TANAKA: Yes. Generally some kind of cold cereal.

KRONENBERG: Cold cereal.

TANAKA: Yeah. Right. And it varies. Once in a while I'll have a fakey egg in interest of lowering my cholesterol. I don't eat the genuine stuff very much anymore. But it's usually always a bowl of cold cereal.

KRONENBERG: Fascinating. [laughter] I was hoping it was maybe bagels from your time in New York, something like that.

TANAKA: No.

KRONENBERG: Let's start out with when you were born. And where you were born.

TANAKA: Well, I was born in Portland, right here in town. August 3, 1923. Actually, I was born at home. My dad was a general practitioner in town. He had privileges, he had friends. But my mother was afraid to go to the hospital. So my father had to find a midwife, of all things. And I understand that I was born very uneventfully at home in Northeast Portland.

KRONENBERG: And did you have brothers and sisters?

TANAKA: Yes, I had one sister two years younger. She's since passed away. And I have a younger brother, four years younger than I, who's now living back in Portland. Ontario, I mean. And has suffered a major stroke. So we have him in an assisted care facility in Ontario.

KRONENBERG: And your father Ben was a physician here in Portland.

TANAKA: Yes.

KRONENBERG: How did he come to Portland?

TANAKA: Well he tells a long story. He was born in Hawaii, on the big island. Parents of plantation workers. When he was there, he was very young and he was sent back to Japan for a little education. At the age of about ten, for some reason, he was returned to his parents in Hawaii. Shortly thereafter, he was given the beating of his life because he was caught by the foreman trying to read during lunch break. And his job there was to try to work in the cane fields and the pineapple fields.

He needed an education and back in those days the Japanese laborers in Hawaii were pretty much like the slaves in the South. They were not slaves. Common laborers were recruited from Japan to work in the fields. My dad decided that he wanted an education, so would you believe it or not, at the age of about twelve he ran away from home, never saw his parents again, found his way into the Northwest. It was never clear in my mind whether he stowed away or found some legal way of getting over to the mainland. But he never saw his parents again.

He then went to, around the Spokane area, where he thought he had greater opportunity. There was a lady that took guardianship papers on him and enrolled him in school. At the age of twelve, he finally started his education. He self educated. He went

to the University of South Dakota, I believe, where he trained in engineering. But during the course of his schooling, he came down with appendicitis. He refused to go see a doctor because he had no money at that time. But he found a kindly physician who offered to take out his appendix but paid his hospital bills and made that promise that he would somehow repay him by doing some kindly thing for others.

At that time, he decided he was going to become a physician. When he finished his undergraduate education, he found a place, the old University of Oregon Medical School in Portland, where it took him about six or seven years to graduate, because he'd go to school for a year, lay off and work, make some money, and then return to school. And he was thirty years old by the time he graduated from medical school. So he's an old U of O grad. It's OHSU now. So he's really a homegrown product as far as medical training is concerned.

KRONENBERG: And your mother was–

SIMEK: Stop at this point and get a little water and– Ready, and take it away.

KRONENBERG: And your mother, was she from Oregon?

TANAKA: No, she was born in Japan. And when they were married, I think it was an arranged marriage. My mother was shipped over here. She knew no English whatever. And she was introduced to my father and they were married shortly thereafter. My father built a home in Northeast Portland.

At that time, there were such things as the, laws that prevented Japanese from owning property. They had to use certain subterfuges to get property. But my father, having been born in Hawaii, was considered a citizen at that time. Although he could not prove it subsequently when World War Two broke out, was able to buy property. However, the neighbors at that time, when they realized there was a Japanese building in their neighborhood, tried to circulate a petition to keep him from moving in. And my understanding was that he had to go to court to get permission to occupy his home that was built.

It was there that they finally moved in, and that's where I was born. Now because of the hostilities that had been generated at that time, my mother was quite fearful of going to a hospital where her life would be completely out of her hands, in the control of others. And she insisted on being born at home.

I don't want to speak ill of those neighbors, because once they moved in, and once I started in elementary school, got to know the kids, they became wonderful neighbors, and they still remain wonderful neighbors. As a matter of fact, from time to time I look up the kids that I grew up with. We have wonderful memories of those times. But back in those days, conditions were a little bit different politically, socially and economically. And under those circumstances, my mother just absolutely was too fearful to go to the hospital to have me.

Now subsequently, my brother and sister were both born in I think was the Portland Sanitarium.

KRONENBERG: Did you and your brother and sister speak Japanese or English as you grew up?

TANAKA: When I was growing up, I only spoke Japanese. Because prior to my enrolling in elementary school, I was kept pretty isolated. So when I started elementary school, it was as if I was born in Japan and I got off the boat and was tossed into the classroom there. I remember it was a very terrifying experience. But my parents, in spite of the fact that my mother hardly ever spoke English well, encouraged me to learn to speak English and learn it well. They thought that was the only way I could survive and compete in our society. I think I did a pretty good job of learning English.

KRONENBERG: So based on that experience, do you have views about the whole issue of multilingual education?

TANAKA: Do I have any feelings?

KRONENBERG: Yes.

TANAKA: Yes. I do not favor the type of bilingualism that is being promoted in the country right now. I sympathize with our efforts. But there's only one way to learn a language, and that's total immersion in that language. And I think that when they teach a language that's called a second language, that these people are not going to learn English as well as they might if they just worked a little harder at it and struggled. I think it's part of the rite of passage, so to speak. It's a tough way to go, but it's the only way to go in the long run.

KRONENBERG: So you went to grade school and public high school here in Portland.

TANAKA: Yes. I went to Grant High. It was Rose City Park Elementary School, which is still there. As a matter of fact, one of the interesting things is that one of the people I looked up was the (Shear?) family. They were neighbors of ours. They lived almost across the street. I read in the *Oregonian* that the (Shear?) Construction Company had a contract to redo the interior of Rose City Park Elementary School. And just about two years ago, I happened to see that in the paper. Looked them up and reestablished contact with a fellow by the name of Bill (Shear?) who lives not far from Lake Oswego who is still running the family. And we've had wonderful correspondence together. As a matter of fact, I try to look him up periodically when I come to Portland.

As I say, those times were rather hostile in the beginning, but it has matured into a warm relationship with my former neighbors. War and evacuation and so forth were

rather cool periods, but it's come full circle, and I think I still look forward to the fact that I have very good relationship with these former neighbors of mine.

KRONENBERG: You graduate from high school in 1941. Is that correct? June of 1941?

TANAKA: I think that's right. Yeah, '41.

KRONENBERG: And at that point, this was before the war, of course.

TANAKA: Just before the war.

KRONENBERG: Right. And you were making plans to go to college.

TANAKA: Yes.

KRONENBERG: What way did you go, with regard to college?

TANAKA: Well, we decided for economic reasons it would be best if I stayed in town. And I applied to Reed College and I was accepted. The fall of '41 was when I started my freshman year at Reed College. Of course, we all know that in December of '41, Japan attacked Pearl Harbor, and that changed things quite a bit.

KRONENBERG: It certainly did. Let's talk about that a little bit. On December 7, 1941, life changed fairly fundamentally for the United States. And particularly for Japanese-American citizens. Let's talk a little bit about what happened to you and to your family over the ensuing four or five years.

TANAKA: Well, to start with, on the night of December seventh, my father was picked up by the FBI, and that's the last time we saw him for some time. In its vigilance, the FBI had identified people in the Japanese community that they felt were in positions of leadership, potential, perhaps potential enemies of the state and so forth. My father being one of the few Japanese who had a college education was looked upon as a community leader. And so he was the on the target to be picked up should something like a war occur. And by midnight, he was gone.

Now my mother, as I said, did not speak English well. I was the oldest son, kid, in the family. I was only eighteen at the time. So I could hardly provide mature adult leadership for the family. It was rather frightening period of time. But we went through the evacuation. The people at Reed College were very, very supportive. Helped me through this crisis situation. For some reason, Dr. Arthur Scott, who was the temporary president of Reed College at that time, called me in as early as February, or January of '42, to inform me that it looked as though there was going to be some kind of evacuation. I think he had some advance information at the time, unbeknownst to me. Dexter Keezer was the president of Reed College, and he had gone to Washington as a (dollar a year?) volunteer. I think he headed up the war power, manpower commission at that time. And

he was quite aware of the possibility that there was going to be an evacuation, which was ordered by President Roosevelt at that time. Sometime in the early spring, as I recall.

So I was being prepared for the possibility of having to leave Reed College at the time. And they prepared me. They were very, very supportive, very kindly, and they arranged for my transfer to Haverford College in Pennsylvania. There were several other colleges that were given to me as options. But Haverford College, being a Quaker college, dedicated, they were very pacifist oriented people. They were the conscientious objectors to the war. They were not disloyal to the American cause, but they had a moral objection to warfare. And I figured that perhaps this might be a better place for me to go to sort of hide out during the war years. And I transferred to Reed [he means Haverford] College.

While I was there, before I was there, the evacuation was ordered, and I had to go to the relocation center, first in North Portland, which was a converted stockyard. And from there, after a few years, we were sent to Minidoka Relocation Center, which is in central Idaho. It was from there that I was allowed to transfer out to go to Haverford College. Now let me just have something– [drinks]

While I was at Reed College, I was classified as an enemy, as an alien. So I had a 4C classification, which allowed me to continue with my education. But at the same time, I was unable to apply to medical school because all the medical schools were committed to providing physicians for the armed forces. So as I went through my undergraduate work, which was in premedical education, I was beginning to wonder what I was going to do with it because I was not allowed to even apply for an application form.

At that time, the government suddenly changed my draft classification to 1A, which was that of an able-bodied American. But before I could then send for my first application, I got my induction notice. So within a week, I was off to the war. I then spent two years in the army.

And surprisingly, after I completed my basic military service, I was sent to the University of Minnesota in an army specialized training program. And my job there was to learn how to speak Japanese. That program was then designed to provide a corps of military people in anticipation of staffing an army of occupation. In its foresight, the army was looking ahead to the clear possibility and the probability that we were going to win the war, and that we were going to occupy Japan. So I was part of that group of G.I.s that was assigned to learn something about Japan. And it was a wonderful two years, because I learned a lot of history. It was not like the military intelligence program that many Niseis, Japanese-Americans were assigned to for intelligence work, combat intelligence work. I was the only Nisei in this whole group designed to study Japanese and learn something about the politics of Japan and so forth.

When I got to Japan, curiously I had two jobs that I think were quite ironical. One was, in the morning, I was assigned to teaching English to American G.I.s who had not finished elementary school. And the second part of my assignment there was to serve

more or less like a propagandist for the American Army. Morale was very low in Japan. The G.I.s figured that the war was over. They saw no reason for not being allowed to go home to resume their personal lives. And my job was to explain to them why we had to fight the war, why we had to win the war, and having won the war, why we had to stay in Japan to preserve the peace. Why they would ask a Nisei to do this was a little bit obscure to me at the moment, at that time. But it was a good experience. It permitted me to, when I was discharged, I went back to Haverford College where I finished my undergraduate work. In the meantime was accepted at medical school in New York, and went on from there to finish.

Now there was a blessing in all this. By this time, my father, who had been interned from day one of the war, I was without any income. He did function as a physician in his internment camp. But he was being paid at the magnificent figure of twenty-one dollars a month. After World War One, the Geneva Convention established rules for the treatment of prisoners of war. And my father was under that program. And while he worked for a physician in this camp was given the mandatory payment of twenty-one dollars per month as per the Geneva Convention requirements. So he was pretty broke.

And when it came time for me to go to medical school, I had the G.I. Bill of Rights, having served two years plus in the army. And that's what really financed my college, my medical school education.

KRONENBERG: At what point in all this in your life did you make the decision that you wanted to be a doctor? Was it when you were a young man? Or a boy, or where?

TANAKA: Yeah. Somehow or other, my father and my mother kept talking to me to the point that I just assumed that my field was going to be in medicine. I never thought that I would do anything else but become a physician. And I suppose it was because of my father's work as a physician. I saw what medicine was about. My dad used to take me to his office periodically, and he'd take me on rounds at the Portland sanitarium and Good Samaritan Hospital, where he'd been on the staff. So I was exposed to some of that.

Now during the war, also, when I was at the North Portland assembly center, where the initial incarceration of Niseis took place, I was provided a job as a hospital aide in the little primitive hospital that they had there. So that gave me further exposure to hands on care of patients, although it was carrying bedpans and helping me make beds and so forth, it inspired me to want to become, stay in medicine, get into medicine.

KRONENBERG: Meanwhile your father, after he was released, did he come back to Portland to practice?

TANAKA: Yes. No. He returned to Portland, but feelings were still pretty hostile in Portland at that time. And he found that he was not likely to fare well in the first few years. In the meantime, there were a lot of people who had located in Eastern Oregon, a

little town called Ontario. At that time it was only about five thousand, where many of the Japanese, Japanese-Americans had settled to farm. And he had a number of personal friends there who persuaded him that he would be, could be used there. He was needed there. So he looked at that as an alternative.

One of the things he did, of course, was to see whether the medical community would welcome him. And he recalls telling me that he'd gone to talk to the mother superior of the Holy Rosary Hospital, which is run by the Dominican sisters. And she literally threw her arms open and welcomed him. Did everything she could to make him comfortably located in Ontario. Introduced him to the physicians there, of which there were maybe half a dozen at the time. And Dad decided this is where he's going to settle. So that's where he settled.

And after I graduated, I had to make some decisions, what I was going to do with my life. It turned out that my father was already reaching the twilight of his professional career. He was getting rather old. And he needed a little help. And I thought that maybe this is one way that I could pay back for all the help he gave me throughout my younger life. So I decided to join him in practice.

SIMEK: Why don't you take another sip of water there, please. Okay. Go on.

KRONENBERG: So you went to medical school in New York City?

TANAKA: Yeah. Well, it was in Brooklyn. It was the State University of New York, Downstate Medical Center in Brooklyn.

KRONENBERG: Then when you graduated in those days, you took an internship as opposed to going right into specialty training. Is that right?

TANAKA: Yes. I did take an internship in straight surgery, rather than a rotating internship.

KRONENBERG: Where was that?

TANAKA: That was in King's County Hospital, which was part of the medical school system that I went to. Essentially stayed in the same place for my residence.

KRONENBERG: A couple of things happened during your internship that are probably worthy of note, both personal and in terms of your health.

TANAKA: Well, I did come down with tuberculosis effusion, which took me out for about a year. I was tubercular negative when I started my internship. But I woke up one night about six months into my internship with a severe chest pain. And we think that was due to the fact that I was rotating through three months of neurosurgery where in Brooklyn I was taking care of drunks and literally derelicts off the street who probably had a lot of high incidence of tuberculosis. And as I sewed up their split heads and took

care of them, they spit on me, vomited on me. Probably the source of my infection. So they made me take six months off completely, then they put me on light duty for six months before I returned to complete my one-year internship.

I gave it a lot of thought because I knew that my surgical residency was going to be very demanding physically. After talking to my attending, who took good care of me, he felt that I should be able to get through it all right. It turned out he was probably right. I went through a complete career and I'm still alive. My TB has never shown up again.

But I think the most heroic thing was my wife. During my period of convalescence, I met her. And she knew about my TB and all that. But she decided she would be willing to marry me anyway. That's pretty bold, I think. Don't you think? [laughs]

KRONENBERG: Well, I think she made a good decision. You certainly did. And during your time in your training, you had your family, if I'm, before you went on to Ontario.

TANAKA: Yes. I had, all three kids were born at King's County Hospital. A daughter, a son and a daughter.

KRONENBERG: And they are? Their names?

TANAKA: I beg your pardon?

KRONENBERG: Their names?

TANAKA: One is Maya. She's now married, living in Lake Oswego. My son John, who's an associate professor at Oregon State University and currently is in La Grande, assigned to the Agriculture Research Station where he's doing research, doing some teaching at Eastern Oregon University. And I have a daughter, Susan, who's married and living in Southern California. And we have five grandchildren, one boy and three wonderful granddaughters.

KRONENBERG: Wonderful.

TANAKA: And all doing honors work in their respective schools. And we're very proud of them.

KRONENBERG: Of course, they have a really smart grandmother.

TANAKA: Yeah, they do.

KRONENBERG: Yes. [laughs]

TANAKA: Speaking of that, looking back on it, in our generation, it was sort of accepted that fathers went out to work and mothers stayed home and raised the kids. And Teddi and I have talked about this, that really our kids were raised like by a single mother. Teddi says, “Well–

[End Track One. Begin Track Two.]

TANAKA: –yeah, that’s right. But I always knew that you were around someplace, and that made a whole lot of difference.”

KRONENBERG: As to your formal residency in surgery, where did you take your residency?

TANAKA: At King’s County Hospital.

KRONENBERG: You stayed there for your whole–

TANAKA: For the whole thing, yes.

KRONENBERG: So at the end, your decision had pretty much been made to go to Ontario with your family and join your dad in his practice? Is that correct?

TANAKA: Yes. And it was also made easy by the fact that Teddi came from that community. She actually grew up in Eastern Oregon. She was not part of the evacuation picture. Her father actually had settled there way before the war. He homesteaded some ground out there and started from scratch and farmed throughout the war. They had about eight kids altogether. So it was like going home to her. My going to Ontario was not like returning home, although my parents were there. But I had never lived there before that.

KRONENBERG: So you joined your father in his practice in 1958. Is that–

TANAKA: Yes, that’s right.

KRONENBERG: What was the medical community like in Ontario when you started, Gus? Were you the only trained surgeon there?

TANAKA: No. As a matter of fact, there was a surgeon, there were two surgeons. One was Dr. Charles Palmer, who happened to be on the Board of Medical Examiners at that time, and in fact signed my license when I applied for my license. He had brought in a young associate who was going to be his heir to his practice, Dr. Lester Scott. And he was boarded in surgery. So for a small town, we had three general surgeons. Myself and those two other gentlemen.

Actually, Ontario was rather blessed for a rural community. Dr. Charles Palmer had three other associates. One was in OB/Gyn, another was in internal medicine, and a fourth one was in ENT. For a small rural community with only, the town itself had only about five thousand people. The county had about between anywhere from twenty to

twenty-five thousand, the second largest county in the state, area wise. Across the river in Idaho, there was a larger population that Ontario served medically. So actually it was a fairly active area.

Now the Ontario clinic was probably the core area of medical facility in the western Treasure Valley, which is the Boise area. But it was rather primitive, even, nevertheless. I remember being shocked when I finished my residency and returned to Ontario, how primitive the operating room was. There was no air conditioning. The summers were hot in Eastern Oregon. I remember there was a nun who circulated, swatting flies while we operated, because the flies would get in through the open windows. We had only open drop ether, instead of endotracheal anesthesia, which made, for me, performing surgery, quite a challenge. Because I didn't get the relaxation I took for granted when I was in training.

Medicine was very primitive in many, many ways. But the people were very dedicated. The nuns, to their credit, did everything possible to try to encourage innovation. They tried to provide as much equipment as possible to keep up with the times. But I think it's largely to people like Dr. Charles Palmer, back in those days, and the dedication of the nuns that made Ontario the medical center for that end of the socioeconomic area which is centered around Boise, Idaho.

KRONENBERG: In your recollection at that time, were things different in other parts of Eastern Oregon? Towns like Baker City and La Grande, (?)

TANAKA: Well, they were all dominated entirely by general practitioners. Back in those days, all the people in general practice did a little bit of everything. So there was some surgery being performed, babies being delivered, heart attacks being treated by people who, by current standards, would certainly not be specialists in any way. But they provided service that was otherwise unavailable. Certainly different from Portland, and it was very different from Boise, Idaho, which was the referral center for those of us who lived in Eastern Oregon.

KRONENBERG: You did a little general practice yourself, though. You just didn't limit yourself to surgery.

TANAKA: Yes. We had no choice. We had to take our turn in the emergency room. It was a matter of considerable shock and terror to me to have to go to the emergency room, to respond to a call from the emergency room, a six month old baby having febrile convulsions. Something totally foreign to me as a surgeon. So I had some associates and friends in the department that I could call on to help me in those circumstances.

The fact that we had nothing like emergency room physicians back in those days made it very difficult for us to track people from the specialties for that reason. One of the reasons that I felt that I could handle the kind of practice that I had in Ontario was the fact that I was trained by a man who did everything possible to keep physicians from

becoming pure technicians within their field. He wanted us to never give up the fact that we were physicians first, surgeons second. And that approach to medical care I think helped me handle the multiplicity of problems that we saw from time to time.

About fifteen years into my practice, the concept of having physicians dedicated to emergency room medicine came about. And the sisters then arranged to have, hire physicians from as far away as San Jose, California, to fly into Ontario to staff the emergency room. And all of a sudden, this changed things. When people from the various specialties would come look at Ontario, they were attracted to the notion that they would not have to cover the emergency room and provide services to people with work outside their own specialty. That's what spooked most of the people, looking at a place like Ontario, which otherwise looked rather attractive to them.

The thing that made Ontario so attractive to most of the people who came to Ontario to practice was the fact that it was a great place to hunt and fish. And so many of the physicians that first came to Ontario were those people who really liked that kind of recreational opportunity there.

KRONENBERG: So when you recruited emergency physicians for your emergency room department at Holy Rosary, I'm assuming that you began to have an influx of physicians. And like many other parts of the state, many more, a wider variety of specialties.

TANAKA: Yes. Yes. Yes. It made all the difference in the world. Because up till then, let's say an obstetrician would like to settle. But they did not like the idea that they would have to take care of a heart attack patient, or a kid with fever, a trauma case, someone with broken limbs and so forth. But once they knew that someone else would take care of those kinds of things and then assign them to others as the case demanded, they felt more comfortable and the town looked far more attractive to them as a place to practice.

KRONENBERG: How large is the medical community now, Gus?

TANAKA: I can't give you accurate numbers. But the number of physicians on the active staff, I understand, is somewhere on the order of about thirty-five or forty. And that is a far cry from the half dozen or so that were in practice there just a few years ago, relatively speaking. The town itself has only grown, has doubled. It's now officially at about ten thousand instead of the five thousand. At the last census, the county has increased to all of about thirty-one thousand, which is hardly a neighborhood in Portland. [laughs] But we have several counties on the Idaho side that look at Ontario as the place to get medical care. So actually, we have a draw area of about fifty to sixty thousand .

KRONENBERG: Are there other hospitals and medical communities in Malheur County?

TANAKA: No. There used to be one in Nyssa, but it folded because it just could not compete in the economy of the complex medical care that's needed now.

KRONENBERG: So to put this in perspective from Ontario, the next concentration of doctors to the north would be Baker City. Is that correct?

TANAKA: Yes, sir.

KRONENBERG: Then to the east, it would–

TANAKA: It would be Caldwell, Idaho, which is about forty miles away.

KRONENBERG: And then Boise.

TANAKA: And Boise. And Nampa.

KRONENBERG: And a long, long way to the south. Probably Salt Lake City to the south.

TANAKA: Salt Lake City. Salt Lake City is about the same distance from Ontario that Ontario is, that Portland is in the opposite direction. There's a fairly large Mormon, or LDS population there that look to Salt Lake City as a Mecca for medical care as well as for the spiritual needs. So some of the referrals go in that direction. But Portland and Seattle are still looked upon as the primary referral areas, distant referral areas.

Of course, Boise itself is a referral area for us. And we have a very close relationship. We have helicopter flight service to evacuate patients and so forth.

KRONENBERG: When you look in the Ontario telephone book, there are a fair number of parties with Japanese surnames. There's also a fair number of people with surnames that are associated with another large, very influential ethnic group in your area.

TANAKA: Are you referring to the Basque?

KRONENBERG: Yes. Tell us a little about the Basque and their influence on your community and on that part of the country.

TANAKA: Well, the Basques are just remarkable people. They're hard working. They have a tremendous reputation for integrity, honesty. I don't know how they are, how they stack up in terms of numbers, but it's a group that has a certain cohesiveness and yet they don't isolate themselves. They are very involved in community affairs. They are good employers of people in the community. Probably the most outstanding person in Ontario is Tony Yturri, who was an attorney. He served as chairman of the Highway Commission. He was a state senator of tremendous reputation and respect. We have a

Basque gentleman who is head of US Bancorp, who was born and grew up in Jordan Valley, which is a small cow town in the southern part of Malheur County. They have a tremendous reputation and enjoy the respect of the entire community.

KRONENBERG: Now the primary economic driver in your county is agriculture.

TANAKA: Is agriculture, yes. Yeah. Yeah.

KRONENBERG: What do you grow over there?

TANAKA: Well, right now they're growing potatoes, onions. It's a great cattle country. I'm sure that there are more heads of cattle than there are people in the country. Right now it is, however, undergoing a great deal of economic hardship because of the low prices of agricultural products. During the last census I think it developed that Malheur County has the lowest per capita income of all the counties in the state of Oregon. But it's not a county that's, it's not in Appalachia, by any means. So to keep it in perspective, it's a nice place to live. It's not full of extremely wealthy people. We do have a fairly high percentage of people who are on public assistance. But it is still a thriving community, and one which people there take a great deal of pride in.

KRONENBERG: One of the sources of pride in Ontario is your hospital. It's truly an outstanding hospital for a small town.

TANAKA: Well, we think it is. And it's going through growing pains. One of the reasons it has grown is that it has merged with Catholic Hospital Initiatives, which is the large corporate body. Has access to funds that the Holy Rosary Hospital in itself would not have been able to afford the various advances. That's the plus side.

The minus side is that control of policy decisions comes from someplace else. Which makes the physicians less than happy. And I think forms, creates some sense of frustration on the part of the hospital administration sometimes because they serve two masters. Their corporate masters currently in Denver, Colorado, and the masters in town.

SIMEK: Let's pause here for just a moment.

KRONENBERG: Good idea. [pause] Gus, thinking back on your medical career, really, I guess, from the time that you graduated from medical school up until you retired, which I believe was in 1993, thinking about that, what piece of knowledge or equipment or drug or other medical armamentarium that you didn't have at that time, by the time you ended your career, you wish you'd have had?

TANAKA: There are a number of things that happened. I imagine if I really dwelt on it, I could come up with a variety of things. But some of the more striking things that come to mind are when I was in medical school, for instance, someone would come in with congestive heart failure, we had a rather simple way of taking care of things. I

remember we used to call it the cardiac cocktail. We'd give them quick acting, a short acting digitalis preparation, a diuretic and (alenoplin?), which was to help relieve their breathing pressures, stick them in an oxygen tent and pray.

Now they have so many things that are available, drugs that were not even dreamt of back in those days that it makes the care as different as night and day. I think probably pharmacy, the fact that drugs now based on dealing with certain characteristics of a person's physiology has made such a tremendous advance that medical practice now is entirely different from what it was, even from the time that I was a medical student. I was only about, less than, about fifty years ago. I'm just amazed that the amount of change that's come about.

For my part, as a surgeon, I think if there's any one single thing that made surgery so much easier for me was advances in anesthesiology. Now one is that when I first attended, I started practicing at Holy Rosary Hospital, we had a sister who could only give open drop ether. Now that's pretty primitive. I don't think the modern anesthesia resident even knows how to give open drop ether anymore. It's relegated to the museums and history books. But now, the kinds of things that are done, taken for granted, the fact that they can open chests, do (?) surgery and so forth, represents not so much, it does represent advances in surgical techniques and surgical technology, but advances in anesthesia I think that made all that possible to begin with. I feel that if there's any one single thing that has helped me as a surgeon, it was advances in anesthesiology.

Now a few years before I retired, laparoscopic surgery came on the scene. And microsurgery came on the scene. I didn't get involved in microsurgery so much. But one of the challenges I wanted to undertake was at my advanced age, could I learn something entirely new, entirely different? And with laparoscopic surgery making a very dramatic entry into the field of surgery, I went to Seattle, to the University of Washington, took a course in laparoscopic cholecystectomy, learned the technique, even though I knew that within two or three years I was headed for retirement. And mastered the technique. And the last year that I practiced, I think I did about fifty lap cholis, and in my own mind I thought that was a bit of an accomplishment, because the old mind hadn't fossilized entirely to the point where I couldn't learn something entirely new, something that was entirely foreign to my previous training and experience.

Now since then, even in the few years, that technology has advanced so much that it makes what I learned back in '91, '92, look pretty primitive by comparison. The major advances in all medicine, I'm thinking in such fields as ophthalmology and so forth has been so dramatically striking that it's appalling. To use the term of, that the kids use, it was awesome. Okay? [laughs]

KRONENBERG: Some people think that the period that you were active up till now, perhaps medicine's become too technically oriented. What's your take on that? How do you feel about that?

TANAKA: Well, yes. I think that the advances in technology has perhaps depersonalized the relationship between the doctor and the patient. Medical care is so fragmented that a person with any major illness does not have a doctor anymore, they have a team of doctors. And the patient oftentimes has a hard time deciding who is their principal physician anymore. Doctors come and go, they take care of their own little niche in the care of the patient. Unfortunately sometimes there's a falling off, a coordination of those efforts, that I think sometimes occurs to the disadvantage of the patient. Although overall it's an improvement. But I think that it has helped depersonalize the relationship between the physician and the patient.

Now the increase in technology, I think, has changed some of the aspects of the interpersonal relationship. I think there's less hands on encounters. Doctors tend to rely on laboratory tests, various sophisticated examination procedures, rather than hands on type of care. And unfortunately, I feel that sometimes it's made hands on care a little bit redundant compared to the importance of the more sophisticated techniques that are being made available.

It's also increased the cost of care tremendously. And one of my concerns is that the people who plan medical care and financing of medical care do not make enough recognition of that fact. And complain about the increasing cost, blame it all on physician greed, for instance, as a cause for the crisis of medical care financing in this country.

KRONENBERG: What do you miss most about medicine, now that you're retired?

TANAKA: I don't miss a thing. When I was looking at retirement, one of the things that threw Teddi into a panic was, what is he going to do? And I had to face that possibility, too, that I would be bored to death and I would just sort of wither up and die without something to keep me occupied. So in preparation for this, I resolved that when I got out of medicine, I was going to get out 100 percent.

I made one effort to try to not to waste my medical library at home. I tried to make a donation to a charitable medical organization, such as a foreign mission. They made such terrible demands on me that they wound up packed in certain packages, packed and sent to them in a certain [glitch], I got disgusted. I called one of my nephews who had a pickup and loaded seven pickups full of books, journals and so forth and took it to the city dump. Incidentally, they closed the city dump two days afterwards. I don't know if there's any connection or not. [laughter] But now the city of Ontario takes their waste, solid waste, to the state of Idaho, where they do the disposal. Just a little bit of trivia.

KRONENBERG: You were not only active in surgery and in your community, you were also very active in the wider medical scene here in Oregon. I know that for a fact. Tell us a little bit about how you became active and involved in the Oregon Medical Association. You were president. What year was that?

TANAKA: ’71-’72, I believe.

KRONENBERG: How did that happen? It’s a long way from the Oregon Medical Association and Ontario.

TANAKA: I really don’t know how it really happened. Somebody was a very convincing talker. Because I had a great deal of reservations about committing myself to serving as president of the state association, living 370 miles away. My involvement, personal involvement, meant driving at that time as long as nine or ten hours. Because that was before the freeway was completed. It required a lot of flying out of Boise to Portland, and so forth.

How I really first got involved in OMA was, two things happened. When I first started practicing here, I had no idea about charges. So I used the model of the fee scale of the Oregon Physician Service, which was the precursor of Oregon Blue Shield. And I used that as a basis to determine my fee profile, not realizing then that the OPS fee schedule was deemed disgustingly low by most physicians in the state. So that was number one.

Number two, when I got started, the Oregon public welfare was in terrible financial shape. And in the first year of my practice, the state asked the physicians to voluntarily accept a fee schedule which was half of that which the welfare department was paying for the services. Well here I was, starting my practice, thoroughly in debt, and I was asked by the authorities to give rather a heavy dose of charitable care. And I was having a heck of a time paying my bills at that time. And I wrote to the OMA complaining about the inequity of providing care for the indigent. And that got me started working on the committee that was a liaison with the welfare department. And from then on, it just kind of, someone convinced me that I should represent Eastern Oregon. I was persuaded to run as a delegate from Malheur County. That got me involved in the House of Delegates. And from then on, one thing added to another. I was involved in more of the political aspects. Somehow or another I got on the OMPAC board and gradually, before I knew it, I was serving as president of the state medical association.

KRONENBERG: And that’s a one year job. It isn’t like you just sort of quit then. What else did you do outside of your own community, with your profession?

TANAKA: Well, one, going through the presidency of the OMA got me involved as an alternate delegate to the AMA. So for a few years, I continued in that role. Before long, someone asked me if I’d be willing to serve on the Board of Medical Examiners.

KRONENBERG: And what does the Board of Medical Examiners do, Gus?

TANAKA: Well, it’s a state organization, the state board that licenses physicians and disciplines physicians when they develop errant ways of behavior. I was reappointed so that I served a total of eight years on the Board of Medical Examiners. And I thought I was really through with everything. And then before long I was asked to serve on

OMPRO, Oregon Medical Professional Review Organization. And I was on that for seven years until I had to slow down for a coronary bypass surgery in 1991. And that's when I really decided it was time to think about quitting.

KRONENBERG: So you've had a pretty full life as a physician. Pretty interesting life. Let me ask you a question, and I anticipate it may not be any one person. Thinking about your entire life, tell us about some of the people that were most influential in your own life–

[End Track Two. Begin Track Three.]

KRONENBERG: –and your direction. People who you really admire.

TANAKA: Well, it's hard to say. There are so many people who really impacted my life. I guess I'd have to start off with my father as number one. And we've already talked about him in many ways. But I think that he gave me the inspiration one, in several ways. One, that there was no way through life but to work hard. And two, that you had to maintain your dignity and your integrity, without which you are nothing. You could be the brightest person in the world, but unless you could gain the confidence of people through honesty, through integrity and sincerity, that no one would ever believe you or take you seriously.

And one of the other factors was that my father kept saying, "It isn't enough that you work hard and pay your taxes. You have to serve your community, also." So I imagine if any one person gave me a sense of direction in life and purpose in living, it had to be my father.

Now, beyond that, a number of people, I think, have had a great deal of influence on my life. I mentioned Dr. Arthur Scott at Reed College. That was a time when war broke out and my father was gone, we were really cast adrift. He would call me into his office and just settle me down, because I was ready to walk away and just give up. My performance at Reed really fell off. I could not concentrate to study and so forth, but he kept encouraging me to do the best I can. And I think the college was extremely generous in not just flunking me outright. Because I don't think my productivity as a freshman college student at Reed was anywhere near the standard that they would have demanded of–

Then made arrangements for me to go to Haverford College. He knew the chairman of the chemistry department there. And I think it was largely through personal requests and so forth that I was accepted there at Haverford College. Now Haverford, incidentally, both are small liberal arts colleges. Haverford was a college for men only at that time. Both colleges had the distinction of producing more Rhodes Scholars per capita enrollment than any other schools in the country. Of course, I wasn't anywhere near a Rhodes Scholar, but that's just a measure of the level of the academic excellence that these schools demanded. Politically, Reed College was as liberal as could be. Haverford was a conservative institution. So as different as night and day. But these are the ironies

of life that I had to go through, that I had to reconcile with my own mind, was rather interesting.

There are people who I recall as being very, very, impressed me with my life. One was in high school. There was a classmate of mine by the name of Bill Sigardson. He was just a remarkable guy. He was president of the student body. He was the star football player. The brightest kid in my class, and so forth. Unfortunately, after the war he went on to Stanford, and he was good enough to be accepted to Stanford either on an athletic scholarship or an academic one. When the war broke out, he volunteered into the army, I think he became a Marine officer, went through the South Pacific. And by the time– and he surprisingly survived it all. But came back a broken individual. I never made contact with him. The rumor is that he was really just all broken up. He never amounted to anything, and died an early death.

But during the war, when the war broke out, there were a number of kids in my class who just really bullied me. And took every opportunity to quote "accidentally" knock me over or injure me, because I was a rather puny kid. When I started Grant High, I only weighed ninety pounds. And by the time I was a senior at Grant High, I weighed all of about 120 pounds and was rather sickly and frail. But Bill saw some of this abuse and he was strong enough to get away with it. But he just knocked heads with these guys and told them to lay off, that I was an American, that I was not responsible for what happened at Pearl Harbor, and was really my protector during my senior year in high school. The war hadn't started then, but feelings were already developing pretty strongly. And Bill was one of those people.

And another fellow that had a strong influence on my life is my–

SIMEK: Excuse me. Can I get you to hold that?

KRONENBERG: If you could lick the corner of your mouth here a little bit. There you go.

TANAKA: I dry off, I foam at the mouth very easily, and it cakes. [laughter]

[End Track Three. Begin Track Four.]

KRONENBERG: Gus, I asked you a question regarding those who had major influence on your lives. And you mentioned, among others, your dad. And when you practiced together I understand that, as I recall, the arrangement back in the early days was there was basically the Ontario Clinic, which was one group, and the Tanaka Clinic, which you and your dad established when you came in 1958.

TANAKA: Yes.

KRONENBERG: And there were some other individual practitioners. But basically that was the medical community. Is that right?

TANAKA: Yes, when we first started, yes.

KRONENBERG: Right. Okay.

TANAKA: Another one we joined from the beginning was Dr. Jim Flanagan, who was an internist who left the Ontario Clinic because he wanted to practice more on his own. The business arrangement in our group was entirely different. We shared expenses, we were supportive of each other, we were associates. But we kept our own books and we brought in our own income based on our own individual efforts. The Ontario Clinic was more like it was a pool and they salaried each other out from the revenues. And Dr. Flanagan wanted to be more of his own man in that arrangement, and was happier joining us.

KRONENBERG: You and Dr. Ben actually owned the office, the physical facility.

TANAKA: Yes we did. Yes. Yes.

KRONENBERG: Where was that?

TANAKA: Where was it?

KRONENBERG: Yes.

TANAKA: It was directly across the street from the hospital. Yes.

KRONENBERG: And how long did that arrangement continue with Dr. Ben?

TANAKA: Well, while he was alive and in practice. Yes.

KRONENBERG: Right. And when did he retire?

TANAKA: It was back around 1983, '84, or thereabouts. But for years he just made a physical appearance there. His practice was down to zero, zilch. He saw a few of his old cronies. He sensed if they had anything really seriously wrong, he referred (?) to Joe Flanagan or myself.

KRONENBERG: Was your relationship with the other surgeons in town a friendly one? Or was there some sense of competition?

TANAKA: Well, there's always a sense of competition when you're in competition with each other. But I think one of the nice things about Ontario was that at the professional level, there was a great deal of collegial relationship which we were supportive of each other. One of the things that we never did was speak ill of each other in public. And one of the things I give credit to the whole town was the fact that when I

was involved in all these other activities that took me out of town, they covered my practice. It made it possible for me to do this. They could have eaten me up if they really wanted to. And I think it's really to their credit that I was able to do the kinds of things I did for medicine and for the community. I think in the long run they sensed that what I was doing was for their benefit as well. And it was part of their way of supporting me.

KRONENBERG: Has that attitude changed, that collegial kind of relationship?

TANAKA: Yes, I think–

KRONENBERG: Not just in your community, let's not pick on Ontario.

TANAKA: Yeah, well, unfortunately I think there has been a lot of loss of collegiality. Individual physicians are more interested in what they're doing. They are not particularly interested in the broader aspects of medicine. When I was on the medical staff, everyone attended journal club. Everyone attended the staff meetings. Our scientific presentations, of necessity, were given by people within our community. And the people who presented papers and reports and so forth, presented material that was germane to their particular field of interest. But everyone attended, and everyone listened.

Now there's a tendency of these people well, it's a medical paper, and I'm an orthopedist, I'm not interested. So attendance is not very good. I think it's rather unfortunate that people take such a narrow, progressively narrow view of that whole field of medicine. Because I think that physicians are richer for knowing a little bit more about what other people are doing in the field, besides what they are doing, the area of their own field of interest and expertise. I think there's too much self centeredness within the profession now that they don't see the larger challenges of medicine. That there are several things that guided me and several others like my associate, Dorin Daniels. We felt that as physicians, if we didn't all hang together, we were all going to hang separately. And that guided some of our behavior, that we had to learn to get along with each other, to understand each other and have an interest and concern for each other. Even though in the practice areas we're oftentimes competitors, we have things in common that we have to struggle for together.

The other thing that we developed was the concept that if we had a physician who had some kind of professional problem, it was far more valuable for that individual and for the community if someone of maturity would have a chance to talk with him rather than just to spread rumors about him. So we felt that this was a rather constructive way of looking at our fellow physicians. And I think that the community itself benefited considerably with that type of approach to each other.

KRONENBERG: Since the advent of Medicare, which was part of your experience in the mid-'60s, the way that healthcare in this country, regardless of location, big city, small town, has really changed fundamentally. And you had the perspective of having seen that evolution or devolution, depending on your point of view. Tell me a

little bit about your experience and attitude with first Medicare and then the development of the Medicaid program even up until today with managed care.

TANAKA: That's a tall order. [laughs]

KRONENBERG: Give it a try. Give it a try.

TANAKA: Well, there was no question that some form of medical financing through public effort or group effort had to be undertaken because of the increasing cost of medical care. I rather thought that the Medicare program as it finally evolved was in my mind a second choice. I thought the Kerr-Mills Bill, which was based mostly on the, based on need rather than an across the board system of providing coverage was conceptually a better way of dealing with it. But so be it, social security and the Medicare program as it exists now is the law of the land. And I think we have come to not only live with it, I think we've now reached the point where the nation is dependent on a continuation of some sort of medical coverage program.

For myself, like I told you earlier, one of the things that I think is a failing in medical training, at least of my generation, was the total failure to provide some practical aspect of practicing medicine, the business side of medicine. When I started my practice, I had no idea what my fee schedule would be. I relied on the Blue Cross/Blue Shield model, which in retrospect was probably scaled down much lower than what most physicians could happily live with. Now I made a living, but I did so by working long hours and seeing a lot of patients and committing myself 100 percent to patient care.

Now when Medicare came in, Wilbur Cohen, who was the first secretary in charge of setting up the program begged the physicians not to factor up their fee profile but to present it to the government as is. And in my desire to be a law abiding citizen, I submitted my fee schedule, which turned out to be ridiculously low in retrospect.

I'll tell you how low it was. I remember being visited by the field representative for Eastern Oregon from OPS who called on me and asked me if there wasn't some way that I could raise my fees so it would be more in keeping with the spread in Eastern Oregon. Well, one of the things he suggested was I use things which I thought was philosophically wrong. And in retrospect, what he was telling me to do was to unbundle my services. Which got bad publicity because physicians were doing this with a vengeance at some point along the evolution of medical care financing. I felt that if I were to do a procedure that everything was covered by one fee. And he showed me how I could charge for this aspect of the care, that aspect of the care. And bill on their separate, I would get to that and totally threw him out of the office. [laughs]

Well, when Wilbur Cohen then asked us to submit our fees. And he said if there are certain inequities that might appear in the future, come to us and we'll make the adjustments. Well, after about eight or nine years of this, I decided well maybe it's time for me to let them know that maybe my fee pattern was a little bit on the low side. I got a nice letter from HEW that said, "Doctor, have your accountant give us a documented

statement showing how you're losing money practicing medicine, and we'll adjust your fee schedule." Well, I wasn't losing money, I just wasn't making it as perhaps as well as I might have, considering the effort I was putting in. So I threw the thing away in a wastepaper basket and continued practicing medicine as I always had.

Do I have any regrets about all this? No. I made a good living. We're not fabulously wealthy, but we're not poor, either, by any means. And my watching our dollars, we'll survive. Provided we don't live so long that we outlive our retirement.

Now as far as the way medical care costs have been challenges have been solved such as managed care, such things as all these prepayment plans and so forth, I have some misgivings about it. I think that capitation takes a certain, it takes certain proper incentives to providing good care out of the picture in some instances. I don't think the solution of medical care financing has been anywhere close to being solved in the United States.

SIMEK: Would you take another sip of water there please, Doctor?

KRONENBERG: Okay.

TANAKA: I know I haven't come close to responding to that overwhelming question that you–

KRONENBERG: Big question. Let's ask it another way. In terms of Medicare and Medicaid, particularly Medicare, which is probably of much more interest to you these days than it was–

TANAKA: As a recipient now? [laughs] Yeah.

KRONENBERG: –twenty-five or thirty years ago. In your experience, do you believe overall that the existence of the Medicare program has been beneficial to the elderly? That is, to the people that it was designed to serve? Do you think it's on balance, recognizing it's had a huge influence on the rest of financing of healthcare in this country, do you think the Medicare program is a success?

TANAKA: I think it's been largely successful. I think at least in our generation and the generation ahead of me, we're extremely proud people. People who, if they couldn't afford it, just did without. And I think that to the extent that the medical care was made available to these people, and made it easier for these people to seek medical care, I think has been a benefit to them. I think that in some ways it has led to some maybe overutilization, some abuse. I think that the programs that aim to sort of lean hard on the doctors not to take advantage of that kind of thing has had a moderating influence in that direction. So overall, I think that the policy makers have been trying to strike a balance between providing the care in a way that will be beneficial to the country.

But I say, I think it's far from being solved because I think that some of the fundamental facts have been either ignored or have been pushed aside.

KRONENBERG: Nearly everybody talks about the good old days. And you and I can engage in that kind of conversation with more comfort all the time, because as a matter of fact, the good days were a long time ago.

TANAKA: Yes.

KRONENBERG: In terms of what you know now that you didn't know when you started your career in medicine, that is, when you graduated from medical school, recognizing that your perspective may be different than someone who's twenty-five or thirty years old, what would you like to impart to a young physician who's, say, graduating from medical school this month? What can you tell him about your experience, or her, that would be helpful? In terms of developing their career, making them a good physician.

TANAKA: Well I think it still goes back to the basic fundamentals. One is that the patient comes first. And that anything you do, anything you plan, the patient's welfare must be kept foremost in mind. Regardless of the system of care that is being developed or being forced upon the profession and so forth. That the physician must always be the patient's advocate.

Number two, I think that by conscientiously trying to do the right thing, the correct thing for the patient, that he's less apt to create harm and mischief to that patient and to the system. You know, as we get into a system that's governed by rules and regulations, one can get into technical violations of things which makes people, individuals, look bad. But there are certain fundamental rights and wrongs that I think one cannot lose sight of. And I think that if you adhere to those kind of basic guiding principles, most physicians will do well and be a service to the public.

KRONENBERG: In your career, is there more, in your opinion, would be a better way to put it, is there more to being a physician than just providing good medical care? To being a good physician. Does a physician have a larger role?

TANAKA: Well, I think he does. He's a member of society, first of all. He has to conduct himself as an individual who can inspire respect from the public as a citizen. His role in society should extend beyond medicine itself and involvement in community affairs and so forth. And that kind of service has to come from the individual's own sphere of interests. Not everyone is going to be interested in serving on school boards or particular service club and so forth. But by setting an example for living I think in itself serves as a guiding light for society itself. I think physicians, in spite of the fact that there's been a lot of doctor bashing by the press and politicians and so forth, still is looked upon as some sort of a model by which people can be expected to try to emulate in small ways. I think that just providing care alone in isolation of everything else is wrong.

We had a president whose conduct in office was a little bit sometimes deviant from public expectations. And there are people who say, "Well who cares, as long as he serves as, does a good job as a president. His private life is his own matter." I really don't believe that. I think every citizen has a certain responsibility to conduct himself in a matter that would be a credit to the community. And I think physicians in his role has that kind of responsibility as well.

KRONENBERG: Would you encourage your grandchildren to become physicians?

TANAKA: I at one time, I got to the point where I was so discouraged by the way medicine is going that I found it very difficult to recommend medicine as a career to anyone. But I realize that that's a rather selfish point of view, because society needs physicians no matter what. And it needs good physicians. It needs dedicated physicians. So in my mind it became wrong to even say anything that might discourage a qualified or potentially qualified individual from seeking a career in medicine.

Having said that, I think that if a person wants to go into medicine, he'd better be darn sure that that's what he wants to do. Because it's a hard road to follow. It's very demanding in terms of not only financing that education and training, but it requires a great deal of dedication to decide that's how you want to spend your life. I don't think that the field of medicine is certainly not free of stress. I think it's one of the most stressful occupations one can undertake. Although while I was going through my career in medicine, I did not view it as being stressful. It's only after about two years after I retired that I realized how much of a stress it was. But I don't regret it, and I'm not resentful of the fact that it was there, because it was a challenge that I thought was very gratifying.

Therefore, if any of my kids or grandkids had any desire to look into medicine as a possible career, I would encourage it. But only to the extent that they feel a strong commitment to the more positive aspects of wanting to go into the field. And I think that to me, the poorest excuse for going into medicine would be the prospect is it going to make a lot of money.

KRONENBERG: If you had it to do over, would you?

TANAKA: Yes I would. I had no other, any other desires in life. I think I would still have come out with the same desire to go into medicine. It's been a great life for me. I found a great deal of satisfaction in being a physician and serving my community and serving medicine and so forth.

KRONENBERG: I'm done.

SIMEK: Thank you very much.

Hang on. Couple more.

TANAKA: Okay.

SIMEK: Okay, we're rolling, Jim.

KRONENBERG: Gus, when you graduated from medical school, there were very few women in medicine. Now they constitute about half of a typical graduating class. How has this gender shift affected medicine? And in your opinion and experience, how will it affect medicine in the future?

TANAKA: I can only say that I think it's only great that women have entered the field of medicine. One is because an insight and perspective in the field, they bring talents and vision to the field that men alone could not provide by any means. I do have some concerns that from the standpoint of productivity that women cannot devote as much time to their field as women have traditionally. But that's changing, also, in the sense that men don't feel all that committed to providing 100 percent of their lives to medicine. In a way, I'm envious, in a way, that this has come about. But on the other hand, I do feel that the public's investment in physicians' education, and certainly I think it would be a myth to think that any guy that went through medical school financed his own education alone. There's a tremendous amount of public support, both by taxation and donation in support of medical schools and such efforts that physician is pretty darn egotistical if he thinks that he did it, it's all his own effort, by any means.

But so I think society has a certain right to expect a certain amount of return from their investment. And when physicians put out less than their full time, full effort in their work, they're letting down on the expectation of, society's expectation. But I think it's also not unreasonable to think that every individual, no matter how dedicated they might be, to demand a certain amount of time for himself and his family, which unfortunately I felt in retrospect that I didn't give my kids nearly as much time as I think that they deserved.

Now you hear that kids don't turn out well because parents have not dedicated their best efforts to the development of the kids. And I feel that my kids have grown up quite well. All I can say is that I have to give all that credit to Teddi, who was more than just a mother. She was a part time father, too, even though I was there physically.

KRONENBERG: There's an old saw that we hear in the medical community that medical knowledge fundamentally doubled in the first half of the twentieth century, and then it doubled again in the next twenty years, and then it doubled again in the next five years, and now medical knowledge is doubling almost exponentially. As a physician, do you ever get the feeling that maybe this whole thing is becoming too complex for ordinary human beings to stay on top of?

TANAKA: Well I think you're right in many ways. There's too much knowledge there for any one brain to absorb or to apply reliably. And I think to offset that, we do have computers and other technological methods of making sure that it's there and

readily available to the benefit of the patient [doctor?] and his patient. I think that in a way it's rather unfortunate that new knowledge is already halfway obsolete before it really gets well established in society. But isn't that true of every field now, whether it's in electronics or whether it's in computer technology or automobiles or airplanes? I think that that knowledge is exploding in such a rapid rate in all fields that it's a challenge for the people in all the different fields to be on top of things.

KRONENBERG: One way the profession has responded is clearly by further specialization and sub-specialization. One also wonders just how far you can go with sub-specialization, where you have physicians whose knowledge becomes so specialized, it's almost not relevant to a primary care physician or to most patients. Do you have a concern about that?

TANAKA: Yes, I have a genuine concern about that, that oftentimes the right hand doesn't know what the left hand is doing. And the worst of it is that sometimes the people who are involved don't seem to care. I think that realization of what the other people, people who are taking care of the other aspects of a particular problem, must learn to maintain contact with each other so that there is some coordination in effort. I've seen examples where different consultants pursuing a patient's problem go their separate ways in the care of a patient. And each not knowing what the other is doing, which I think can be a hazardous situation for the patient's welfare. There still has to be somebody coordinating the effort. And whether it's the role of a general internist or a family practitioner or whatever, I don't have the answer to it. Because those people themselves have to have an inherent appreciation of what these people are doing.

[End Track Four. Begin Track Five.]

TANAKA: And when it gets so technologically complex that they can't comprehend this, then they can't assume a coordinating role in an effective manner. It is a danger. I don't know how they're going to address that situation. But I recognize that as a potential hazard for the profession in the future.

KRONENBERG: Thinking of hazards and challenges, Gus, from your perspective after a long and very productive career, give us an idea of some of the challenges that you see in the near and long term for your profession, and for the science of medicine.

TANAKA: Well, the science of medicine is so complex now that you kind of have to look at specific examples. I think one of the evolving fields which I think is just going to turn things upside down and inside out is the field of (say?) genetics. It will have implications in all fields, including surgery and everything. Because so much information is starting to flow that's going to turn a lot of the conventional knowledge of say the last fifty years completely around. I think they're going to be approaching things from an entirely different perspective. It's almost frightening to realize that some of this stuff is just going to evolve, that the material that we think is part of the working armamentarium of the physician is going to wind up in the history books rather than part of the current

armamentarium. But that’s progress. And I think we’re just going to have to accept that and go on. And I think it will represent progress.

And in doing so, I think that someone has to keep an eye on the basic fundamentals of why it’s there in the first place, and to give a direction and a sense of value so that we don’t just go half cocked in some crazy direction and lose sight of the ultimate aim of all this.

KRONENBERG: So there may be some ethical imperatives that have to be taken into consideration in view of the increasingly complex and scientifically order of medicine that we see.

TANAKA: Oh, I think clearly. And I think this is where the medical ethicists and people of that type come into the picture. But I think that sometimes these people also in their own zeal for specialization lose contact that they’re dealing with medical issues, but they don’t know medicine. And they start coming up with certain conclusions which I think sometimes are not consistent with reality. And someone’s got to bring their feet back down to earth and down to the ground where we have to take a look at it. Put the proper valuations of these things.

SIMEK: Another drink of water, Doctor.

Jim?

KRONENBERG: Yeah.

SIMEK: Oh, Jim, I think you’ve probably already addressed some of these, to what extent they’re valuable–

KRONENBERG: There’s one good one here. Really good one. Gus, you and I talked about this earlier. I heard a piece on the news coming to work this morning where actually a local physician here in Portland announced with a great deal of confidence that with his laser he could in effect sew up a lacerated liver. Which for a general surgeon is fundamentally impossible.

TANAKA: Yeah, it’s revolutionary thought.

KRONENBERG: And furthermore, that he thought he could adequately train somebody without any medical training to do that in a matter of a few minutes, maybe two or three minutes. The procedure would take two or three minutes. Spend a minute with us, first of all, to educate us just exactly why sewing up a lacerated liver is a big deal. And second of all, give me an idea of your speculation of this kind of technology, particularly in terms of your own field. Surgery where we’re talking about trauma and the role of the golden hour and all that sort of thing.

TANAKA: Well, one, a badly lacerated liver is a surgical challenge. One of the things which makes repairing badly damaged livers is it has no body. So you throw sutures into the liver substance, try to sew it up, and the suture material just literally cuts through. So you don't accomplish a whole hell of a lot. Matter of fact, you may make bad things worse.

A number of techniques have been developed over the years to cope with this. And they have been incremental improvements over the years so that compared to the colonial days, for instance, a great deal of improvements have occurred. Now I don't know anything about this laser approach that has been, that has been touted. Number one, I think that there may be some value to what this gentleman has said, but number one, I think that before such glowing reports be released in the newspaper, that there should be some quiet demonstration of the effectiveness of the procedure, and generally accepted by other responsible people of the medical community before these glowing reports be released.

No, I'm not criticizing an individual for releasing such material to the press at this point. Maybe he has the data to support these kinds of claims and all that. But offhand, I think that there's been too much tendency within the research community to try to grab credit for a lot of things prematurely. It raises hopes. It has a tendency to try to improve the image of that individual. To me it's a little bit akin to advertising before the fact, so to speak. I think that in the rush to gain recognition, the rush to capitalize and profit by advances in procedures, I think sometimes motivates some people to lay claims that seem to be ahead of itself.

Now without knowing anything more about this report that you're referring to, it may be totally unfair observation. But I'm speaking generically about the rush to publish, the rush to lay claims to certain advances. And I think it raises many false hopes that oftentimes will create a demand for such services ahead of its time. So that it throws the whole medical economic aspects of this off kilter, and thereby creates some problems as well.

KRONENBERG: On the other hand, as a practicing surgeon and now retired for a few years, in the last twenty years, many of the things in your own field, nuclear medicine, lasers, laparoscopic procedures, radiation technology and the like that we thought were science fiction have become the truth. And it's likely that that will continue as the science continues. Do you see a time when in your particular specialty, surgery where cold steel through an incision, sew-'em-up surgery will ever go away?

TANAKA: I don't think it will ever go away completely. I think that enough modifications will occur so that so-called traditional way of making the ten-inch gash through the abdominal wall may be less of an occurrence. But I think there will be times when those techniques will have to be utilized. I've already heard where the younger surgeons sometimes are at a total loss to explore the common (duct?) when the situation is that the laparoscopic approach seems inadequate or inappropriate and the skills aren't there to do these kinds of things. It's a little bit like esophagoscopy, endoscopy,

bronchoscopy. Back in the old days when there was a rigid brass tube that the EMT people and the thoracic surgeons used to pass down with a great deal of ease and extract foreign bodies and so forth. Now that they use these flexible scopes, when the time comes to insert a rigid scope, the skills aren't there. And the patients, a small percentage of patients, thereby suffer from the lack of that skill.

I think that in our advances we'll be giving up some technologies which under certain circumstances will be sorely missed. But if you think about the totality of medical care needs in the community, I think perhaps society will be further ahead by it than will be the losers. But I think one of the realities of medical care is that we're never going to reach a point of 100 percent certitude and perfect outcomes. And the sooner we realize that, I think the more humble we will be, and we can proceed from that point on.

Super.

KRONENBERG: That was great.

TANAKA: Okay. [laughs]

KRONENBERG: You did a super job.

TANAKA: Well, I don't know how super it is, but–

[End Interview.]