

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

Nelson R. Niles, M.D.

Interview conducted September 29, 1998

by

Linda Weimer

SUMMARY

Dr. Nelson “Sam” Niles has been a faculty member at OHSU for over forty years. In this interview, he talks about his early medical training, his military service, and his tenure at the university.

Dr. Niles participated in the Army Specialized Training Program while receiving his medical education at Cornell University Medical College in New York. He talks about his experiences as a uniformed student, and about the accelerated training for medical students during the war years. He moves on to discuss his postgraduate training in pathology, and talks a little bit about the development of pathology as a specialty.

Dr. Niles came to what was then the University of Oregon Medical School in 1951 as a resident in pathology, eager to work with two “giants,” Drs. Warren Clair Hunter and Edwin Osgood. He reminisces about both of those men, and their contributions to the school. He also talks about the development of the Department of Pathology and the main work of that department: autopsies that were performed for various local hospitals and the county coroner. In discussing the relationship between the department and other medical professionals in Oregon, he touches on the town-gown tensions that were so prevalent in the 1950s and 1960s.

Dr. Niles also shares his memories of Dr. Charlie Dotter. He talks about the now infamous episode in which Dr. Dotter catheterized himself during a presentation to demonstrate the safety of the angiography procedures he had developed. Dr. Niles also talks about Dr. Dotter’s later years, his declining health, and his death in 1985.

Dr. Niles briefly touches on his work as a member of the Faculty Senate before commenting on some of the changes he has seen here at OHSU in the course of his forty years as a faculty member. He talks about changes in the curriculum and laments the loss of laboratory time for medical students. He also talks about research at OHSU, noting that the lack of an organized research program in the early years of the school in no way discouraged individuals from pursuing research related to their own teaching and clinical work. Finally, he talks about the rise of technology in medical education, and the challenges that face women and minorities in medicine.

TABLE OF CONTENTS

Biographical Information	1
Medical School in Uniform, World War II	1
Training in Pathology	3
Coming to UOMS	5
Dr. Hunter and the Pathology Department	5
Dr. Edwin Osgood	6
Senior Skits	7
Autopsies and Other Department Work	8
Town-Gown Relations	10
Dr. Charlie Dotter	11
UOHSC Faculty Senate	14
Curriculum Changes	15
Research at UOMS	16
Laboratory Work in Medical Education	17
Rise of Technology	20
Women and Minorities in Medicine	20
Index	23

Interview with Nelson R. Niles, M.D.
Interviewed by Linda Weimer
September 29, 1998
Site: History of Medicine Room
Begin Tape 1, Side 1

WEIMER: This is an oral history interview with Dr. Nelson R. Niles, but I understand everybody calls him Sam as his first name. The date is September 29, 1998. We are in the History of Medicine Room, and my name is Linda Weimer.

We've been starting out all our oral history interviews with a little information on early biography. So I'd like to ask you where you were born and raised.

NILES: I was born in Southampton, New York, and raised in New York City and some parts of New England and Long Island. And I never got much west of the Hudson River until the Army put me at Fort Lewis, Washington in 1949.

WEIMER: But you had gone to college before the military?

NILES: Yeah, I went to Princeton University beginning in 1942, June 1942, and that was the accelerated schedule, and it was really accelerated; I got equivalent of two years of college in a year and a quarter, about. Started in Cornell Medical School with an Army uniform in January 1944, graduated from Cornell in, I think, April '47; and an internship and residency, then in the Army in '49 at Fort Lewis.

WEIMER: I know that the Medical School here at University of Oregon had a condensed program, four years into three because of the war. Was that also true of Cornell?

NILES: Yes. I mean, theoretically they weren't condensed, they were accelerated. But in academia, those definitions are pretty loose, and I think some things were left out. In medical school, I know we had some old retread professors who had retired and came back, and that was especially true in the anatomy department, but I thought the anatomy course that I got at Cornell was excellent because of this old retread. He was a gentleman of the old school and very formal. He wore spats. At least, that's my memory; it may be mythical. And it was an excellent course. I think anatomy has always been my favorite subject because of that, even though I didn't quite always understand that at the time.

WEIMER: Did you wear uniforms?

NILES: Oh yeah, we wore Army uniforms. I really was extremely lucky because the Army gave me a uniform, and Cornell was in New York City, still is, and it was not good to be a male in New York City unless you had a uniform on in the early days, or any days of the

war. So I was one of those so-called heroes, and all the heroes in school then wore this peculiar patch that I think was supposed to be Aladdin's lamp, and it was blue and yellow, and we called it the flaming bedpan [laughter], and everybody in the Army knew what that meant, but most of the civilians didn't.

WEIMER: And what was the official designation for that?

NILES: Army Specialized Training Program, or ASTP. Meant you were going to school.

WEIMER: What was the feeling in New York—I mean, was the patriotism, the war fever, so great?

NILES: Oh, yeah, it really was high. There was a lot of concern. For those who are not old to remember, I think, you know, this country was extremely lucky that the Japanese bombed Pearl Harbor and overnight they made America a very patriotic, all-for-one-goal nation. Whereas before, there had been a great deal of resistance to the idea of war and armament and supplying or helping to supply Britain or other countries in trouble.

WEIMER: Yes, because the war had been going on in Europe before we ever got involved.

NILES: Yes, you bet.

WEIMER: What was the understanding of the medical students? Were they going to go immediately into the Army?

NILES: Well, the medical students were in the Army, and all we did was salute and take orders. But it was really a cakewalk because we only had to do Army work for about one hour a week, and we got marched up and down this little parade ground by this veteran of the North African campaign, a lieutenant who was a very tough guy, and he didn't too much approve of all these students getting away with all this stuff [laughs], and it was only because there was a colonel over him that was quite benign and tolerant of all these things.

I meant to go on and tell you that the Army not only gave us uniforms and food and room and board and just everything you could want. It took over our nurses' dormitory to give it to these ASTP and Navy students, too. The only thing they didn't supply was laundry. My mother lived in New York City, and so I was able to take my laundry home whenever I wanted to and give it to her, and she had a helper, a maid who did most of that stuff.

And I can remember one night in, I don't know, I guess it was '44, the war was still hot and heavy then, and it was doubtful, you know, which way it was going to go. And so I was crossing Third Avenue under the old elevated train one dark rainy night, and this huge bag on my shoulder. And there was a bar on the corner of the street I was crossing, and a few people stepped out of the bar and said, "Oh, there's one of our boys. He's shippin' out

tonight. Come on, kid, we'll give you a big deal, you know, we'll show you the town," and I said, "No, no, no, it's all right," you know. I really had some difficulty getting away from them, but was able to escape [laughter].

WEIMER: Here at University of Oregon Medical School, we actually had some Japanese-American students that were immediately interned.

NILES: Oh, yes.

WEIMER: Did anything like that happen at Cornell?

NILES: No, of course, I only got to Cornell after the war had started. It was January '44, so I don't know what happened at the beginning of the war.

WEIMER: We may have had more of a Japanese population on the west coast than the east.

NILES: Sure, oh yes.

WEIMER: I was just curious on that. What made you decide to go to medical school?

NILES: Well, my father, I think, was a leading image for me, and he died about, oh, in 1941, and I really liked the idea of it. Also, I think I wasn't really too eager to start picking up a gun and learning how to do that [laughs]. It was a little bit of escapism, maybe more than a little bit of escapism. But medicine was, really looked like interesting stuff. When I got into biology and that continued to turn me on.

WEIMER: After graduation at Cornell, what happened?

NILES: Well, I went to a little hospital in New Britain, Connecticut for a rotating internship. I decided then—well, as in medical school, my internship was sort of the same. Every subject that I got acquainted with was something that I decided, "I'm going to do this, I'm going to become a specialist," or this thing and that. So I got a heavy dose of surgery because of luck in the rotation system, and I decided, "Yeah, I think I'll be a surgeon." And then I said, "Gee, you know, before I get too deep into surgery, I think I better know more about what I'm taking out of people and identify it." So I thought what I really was short on was pathology.

So I went back to Cornell for a year in pathology, and that was good; but it was so kind of highbrow, experimental pathology, and we did, of course, some general pathology in a hospital, too, but I kind of wanted a little more low-key kind of thing. And I thought at the time that the Army would be a good place for me to do that.

You see, I'd gotten out of the Army. We were all discharged shortly after the war was over, and that was summer of 1946, the war being over in '45, and then there was nobody in

the Army because everybody was out of it. But they began to get a little nervous about this because the world was still in sort of an uproar, and so there were all kinds of pleas, and I thought, “Well, yeah, maybe the Army would be good for me to see the world,” or something like that, you know, and so I joined voluntarily. And that was just a year before the Korean War broke, and I got in and I was at Madigan Hospital for two years there.

Madigan Hospital was one of the eight or so Army hospitals—they’re called Army General Hospitals in the U.S.—and they had all the services that were required, but they were kind of short on pathology.

Pathology was not a thoroughly recognized and, I think, accepted specialty like surgery and the others, and in fact the colonel that I worked under mainly was really a self-made man. He was really, I think, my main teacher and hero of my life. He graduated from medical school some time in 1915 or ’16, and a few months later he was in the Army. I mean, he got about a half of an internship, and then he was in the Army because America was getting into, or had gotten into the war.

So he was over there in France and he got shot up, and he had all kinds of wounds from a shelling; and eventually after about ten years, he lost a kidney because of a continuing infection due to the wound, and by this time he was emaciated and it looked like he was going to die, really wasted, hadn’t been able to work for some time. But, remarkable man. They finally diagnosed that he had a kidney that needed to be removed because of the chronic infection, took that out, and said “Well, now, what are we going to do with this wreck? He can’t work a full day,” you know. “Oh well, let him be a pathologist, they don’t work anyway” [laughter], you know, and so he became really a laboratory guy.

He knew enough about mechanics and mechanical things so that he became expert in fixing all the instruments that were in the lab, and when I got there, this was in ’49, he was the guy who would fix everything that went out in the laboratory, the centrifuge and all the little instruments. I mean, he really knew how the things worked.

Besides which, during that time, he pretty much had taught himself a great deal of basic pathology. He didn’t know a lot of the fine points, but he really understood the basics very well, and I thought of him as a great teacher. One day I had done an autopsy, and my conclusions were sort of hazy and incomplete, and so he wanted to know what I was putting down and what—and I was convinced that this was a cancer of the lung, I think, and with this man. And I said, “Well, colonel, it’s just the way it seems to me. It’s just got to be, it ought to be that.”

So he said, “Son, ‘ought to’ ain’t ‘is’” [laughter], and I thought, “Boy, can’t do better than that.” So, you know, that’s a real good lesson that has been important to me.

So I got out of the Army in ’51. The only places in the Northwest that had medical schools were the University of Washington—and their school was very new then; I think they graduated their first class shortly after I got out—and this school, which had a long history.

And there were two giants down here named Hunter and Osgood who were well known. And a pathologist up there in Fort Lewis, a civilian pathologist who we consulted with, told me this was a good place to come to and I should take my residency here and sign on with those two. And I did, and I learned all about Hunter and Osgood and what characters they were. [Laughs] Shall I go on?

WEIMER: Yes, I'd like to hear about them. Let's do Hunter first because his name is mentioned, but most of the people here now really don't know...

NILES: Well, Warren Clair Hunter I think graduated from here in the class of '24. His picture's in the hall there along with Osgood, the same year. I think they were the first two recipients of the AOA degree, you know, honorary degree, and Hunter became a pathologist. You must remember in those days pathology was not really a recognized specialty; it was just, you know, throw tissues in the ash can and forget it. Who cares about a diagnosis?

In fact, to digress a minute, when I was here in '52 or '53 or '54, something like that, one of the residents that I'd come to know went down to a certain town, a well-known town in another part of the state that I won't mention [laughs], and so he wanted to be the pathologist. They didn't have pathologists. There weren't any pathologists except in Portland and Salem and Eugene—maybe that was about it. Maybe one or two others someplace. And all the tissues that people wanted to send in for diagnosis were cut by surgeons or interns or whoever, and they'd bundle them up and send them in the mail, no less; and so Dr. Hunter had this huge mail-order practice.

But there was obviously an opening and a growing need for pathologists in different hospitals. This fellow, friend of mine, was interviewing for a job down there, and he was meeting with resistance because obviously he was going to be cutting into the territory of some of the old-timers. And one of the old surgeons there that hadn't looked through a microscope in a long time, I think, said, "Son, we don't need a pathologist here. I do all the pathology." Oh, yeah [laughter].

So what was I saying? Anyway, Hunter got his first job in pathology because the Pathology Department—I mean, it was an academic subject that had to be taught in medical school, but practice was something else. He got a job as a secretary in the department, typing up reports, and then he began to get to look at what he was typing up, and that was the beginning, I think, of the five-year student program.

Ever since then and continuously, I think, for all these years, the Path. Department here has had a program whereby individual students are selected at the end of the sophomore year and asked if they wanted to spend an extra year in school doing pathology. We used to sort of spread that extra term, extra year out over the next three years, but now it's concentrated into one year. Anyway, the students graduate one year later, and they get an experience much like the residents do in doing all the anatomic pathology. They don't do any clinical path, but they do surgical pathology and autopsies. And they do very well. We've often felt that the students—I mean, generally, it's the pick of the class. We can have the real

pick of the class. So the students are excellent, and often have far outshined the residents they compete with.

WEIMER: Quite a compliment.

NILES: Quite a compliment, yes. And I guess over the years about half of them have subsequently gone into pathology as a specialty, and some have made some big names, I think, although I can't remember any right offhand. And the other half do other things: ophthalmology, general surgery—you know, whatever—family practice.

WEIMER: So that all started with Dr. Hunter?

NILES: Well, yeah, I would say so. Dr. Hunter first was a secretary, and he just stayed on doing the thing for all those years.

WEIMER: How about Edwin Osgood?

NILES: Osgood, E.E.O. Well, E.E.O became—I don't know how, I don't know his real history as well—but he was really a character that everybody got to know. His specialty seemed to be hematology, but he was a broad thinker and a great laboratory man. I'd say he was the basis, the chief of the whole subject of clinical pathology.

I mean, pathology has really always had anatomic on the one hand, and clinical, which means blood-banking and microbiology and blood chemistry and—et cetera, several other things, radiation, nuclear medicine, as part of it. But in the early days, I think pathology meant to a lot of people just anatomic stuff. In fact, at Cornell when I was there, the division of clinical pathology was very small, and it was not a big unit, and I think that was the way it was throughout much of the country for a long time. Gradually, you know, clinical pathology has grown a great deal since then. So it's now about an equal, or even greater, part.

So anyway, Osgood became a laboratory man, I don't know how or why. And hematology was his real concentration, and he ran an excellent Division of Hematology which—when I came here, Bob Koler and Arthur Seaman were his associates. Arthur Seaman recently died, I see by the paper, and Koler is still around here. Koler, I think, graduated from school either the same year or a year ahead of me.

Osgood, I think, was probably this school's really greatest product, individual human product, because his contributions to the field of medicine were really pretty good stuff. He developed some ideas about the nature of neoplasms and the difference between healing and neoplasia, which is fascinating. And he developed a system of nomenclature of the series of different blood cells which led to a better understanding of them throughout, and that was adopted internationally, I think. There was a famous Rome conference of which he was the leader of and developed that system.

He wrote many, many articles on many different subjects. Oh, also, for some time

before I came here, this would be in the '30s, maybe '40s as well, he taught. He was, I guess, one of the main teachers in general medicine, and he taught physical diagnosis and diagnosis by history, too, which was part of physical diagnosis, really, which was a huge subject. Now that's kind of amalgamated into other fields, but it remains, if you consider it by itself, a huge subject, very important. And he was great about that, and he had a lot of humor in it, and he was really someone the students remember well. And he taught, of course, laboratory medicine which nobody knew anything about [laughs]; he was the only one who did, anyway.

And he was such a funny character. He was sort of slow and seemed to mumble and bumble. He smoked these pipes which were foul-smelling things, you know, and you could sort of trail him around the institution—in the elevator, “Oh yeah, he's been here,” you know [laughter]. They weren't so bad when he got them going somehow, but they left this trail like a bad taste.

I just recently learned from a friend of mine, who's a dentist and knew him, and finally figured out one day that what Osgood was doing: he'd be mumbling all the time, just riding along in an elevator or a car, or anyway when other people were just sitting there, he was doing this funny thing with his mouth. And what this dentist figured out was that he was taking his denture and rolling it over in his mouth, and you would hear this click-clack if you would listen closely.

Anyway, what else?

WEIMER: Well, there were some other notable people at that time, even in administration. We had Dean David Baird. Tell me your impressions of him.

NILES: Well, he was a very benign and quiet sort of a dean, I think, and of course he was sick off and on for a couple of years. I don't remember what the illness was, and I didn't get to know him very well.

I remember in one of the old class shows—the seniors at graduation would have these dinners they'd put on every year, and they'd work up skits, and since then, because they were so male-oriented and raunchy, they have passed out of practice because, I guess, the females complained that they were a little too sexist—which they were—and had to be cleaned up, and so they were. But I think it's regrettable. It's not that I'm against women, but... [laughs] Anyway, they had all these skits, and they printed even a little program, and they'd take off on all the individuals like Hod Lewis. Howard P. Lewis was “Dr. Pod Louise,” lues being another name for syphilis. And I remember there was a fellow named Abe Oyamada in the pathology department, and they called him “Abie All You Wanta,” and there were many others. Dr. Phoul Smelling. I just can't bring them up at the moment.

Oh, and Baird—they had these skits, and people would walk on and off and take speaking parts, of course. But they had this guy come on with a plant, and he'd just walk across the stage, and then he'd come on later with a kind of a bigger plant. I think this was a

take-off on an old Broadway show, “Hellzapoppin’,” where the plant got progressively bigger, and in the end as you walked out, there was a guy sitting in a tree out in the lobby [laughter]. But this guy was labeled the head gardener, D.W. Baird or whatever his initials were.

WEIMER: David W. E. Baird.

NILES: D.W.E. Baird. But that’s because he had so much interest in gardening, and the students really never saw him, so he didn’t mean much to the students, as deans don’t, I guess. He was a quiet sort of a guy.

WEIMER: You briefly mentioned Howard Lewis, who other people have talked about. Could you give me your impressions of him?

NILES: I thought he was an excellent person. When I came, he and Dan Labby constituted all of the full-time Department of Medicine. That was it. Of course, those were the days when volunteer faculty came out of private practice to lecture and help in the clinics and so forth, and the school owed a tremendous debt to those people.

But Hod Lewis and Dan Labby did all the full-time stuff. And Hod, I know, had been a five-year student in the Anatomy Department, similar to pathology; and he knew his anatomy very well, but he also knew a lot of other stuff very well, and he was really a great person to demonstrate physical diagnosis. He could, before a class and with no previous exposure to this patient—the patient would have been selected by a resident or some other person who was responsible so that he would have something that Hod could demonstrate to the class, if he *found* it. Well, he found more than they expected him to find usually, and he was so great about that.

We used to have a weekly pathology conference where we would demonstrate all the autopsies.

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

WEIMER: This is tape one, side two of our interview with Dr. Niles.

NILES: I was talking about Howard Lewis. When I first came here in 1951, the year ’51-52, one of the main functions of the Pathology Department, not the only one in practice, was to perform autopsies. And for the County Hospital, which was the only one here then, we did 451, I think, autopsies in that one year. We never afterwards reached such a high number. But Hod had the idea, which in retrospect, I think, was a very good idea, that every patient who dies in hospital or dies after having been in hospital and gone home with some disease or other, should be autopsied. And the job got to be kind of onerous for us because we were also doing autopsies for the Multnomah County coroner, and everybody who was found dead or fell over after mowing his lawn, or found in an alleyway under very suspicious circumstances, like a knife in the chest [laughs], would need to be autopsied, and it fell upon

us to do them.

Of course, the staff, which consisted of five people, including Dr. Hunter, were usually the ones who caught the heavy stuff, the significant criminal cases, but there were a lot of other cases that were much more routine or low-grade; and I think we did something like another five hundred cases for the coroner. Of course, in those days, too, Dr. Hunter and [Vinton D.] Sneed and a couple of others did the pathology for Physicians and Surgeons Hospital, the Portland Adventist Hospital, and a hospital in Oregon City, too, so they covered a wide area. So there were another hundred or so autopsies from there.

Anyway, as residents, we did the autopsies for Multnomah County Hospital and the coroner, and, you know, it was a thousand or eight hundred cases we did in a year. And we were traveling to do these because all the autopsies were done in the funeral homes, and the material we'd bring back here to demonstrate what was found to whoever was our staff person on that. Not an ideal situation, but at least we looked and it was pretty good for a long time. It was a custom in the Northwest generally to do autopsies after embalming, after they'd been in funeral homes. Gradually that was broken down and overcome.

Lost the train there.

WEIMER: Well, we were talking originally about Howard Lewis, but I'm curious about the autopsies you did for the other hospitals that you mentioned, like Portland Adventist.

NILES: Yes. I meant to say about Howard Lewis: we had a weekly conference with all of the medicine residents and Howard Lewis [would be] sitting in the front row. And the chief medical resident would see that the case was verbally presented by one of his residents and that they would tell the clinical story, and then Hod would go into points of fine discussion. "Why did you do that?" and "What do you think is the significance of this?" and so forth, and pretty well work out a diagnosis.

After he got through, we would demonstrate the pathology and then there would be more discussion and so forth, and I think that's a great idea which has now passed; and the medicine people, I think, are interested only in getting a report. They don't want to spend the time to come to see most of the cases. They get a verbal report which, in my mind, is not enough. But then, I'm of the old school.

WEIMER: You consider it more like a loss of a teaching and a learning opportunity?

NILES: Yes, I do. You see, in those days generally throughout the country in the '50s and through the '60s, it was considered by any hospital that regarded itself as a teaching hospital at all (and Good Samaritan, for instance, does even though they were not a medical school) but a lot of places would say, "Well, what is our autopsy percentage?" and the autopsy percentage was the single figure that gave the most credence, the most importance as to the value or worth of the hospital's program, and anything below fifty percent was not so

good.

We always had one in the '60s, and at every one of these weekly conferences, Hod would ask his resident what the score was for the week. And he would say, "Well, that brings us up to (or down to) 73 or so percent for the year," and if it fell a little, he would say, "Oh, you have to do something about that." He would really lean on the residents to do that.

And they also gave a prize to the intern who had the highest number of autopsies at the end of the year—highest percentage or highest number, I don't know. And in the Path. Department, as I say, we felt overburdened by these and said, "I wish I could give a prize to the one who got the lowest percentage" [laughter].

But since then, I've said, "Gee, we should be doing all that we can, and we should be having more rapport with clinical departments for these." It's too bad that the custom is for the clinicians now, I would say, to think only of answers to the questions that they can think of. And as we used to do in the school clinical-pathological conference held over here in the auditorium every Friday morning, it was a demonstration for fourth year students and a good course, as it was in a lot of other medical schools. It has been a national change, and it's just too bad.

WEIMER: Going back to my earlier question, just because I'm curious, the school was doing the autopsies for some of the other hospitals as you mentioned, the Adventist...

NILES: Well, that was because of contracts that Dr. Hunter and others had with those hospitals. You see, there were not many pathologists here in the Northwest.

WEIMER: So do you think it was more of a matter of scarcity of pathologists or an opportunity to make some money up here if you could?

NILES: Well, we never made significant money doing autopsies. Pathology earned most from private clinical laboratories and, next, from surgical pathology. But a few pathologists, mainly under Dr. Hunter, did the majority of the work and earned most of the money. I mean, Dr. Hunter and two or three others: Clarence Hodges in Urology, and Dr. Weeks and his successor Dr. Kenneth Swan. These were the envy of the medical community, including the State Medical Society.

Swan, whom I see all the time, I think he and Hunter and these others were brought to task by the Oregon Medical Society or some others because of, really, jealousy and "incursions into our practice" and so forth, because they were setting up these big clinical programs and doing their private practice here while they were also paid salaries by the Medical School. Here, as in most other places, there was early on the development of the idea that faculty could be paid by their private practice. Anyway, it was a point of serious and sometimes bitter contention.

WEIMER: One of our themes is town-gown contention, and perhaps we can explore

that a little bit based upon volunteer faculty coming up, and then being told not to come up because we were having more of a full-time faculty?

NILES: Well, there was some real contention including in the field of pathology. We used to rely on friends from the VA [Veterans Administration] and from several other local hospitals to help us with our teaching programs. And they did, for the most part, very graciously. We were most grateful for a long time to Jeff Minckler; but there were many others. Too bad this custom has ceased.

WEIMER: When you came up in the '50s—and you've already mentioned Multnomah County Hospital, our main teaching hospital up here, but then of course in 1956, we got our own teaching hospital, the Medical School Hospital. Were you involved in the politics behind that at all?

NILES: No, certainly not. As a resident, I didn't get invited to discuss serious matters like that [laughter]. But you do remind me that I think 1956 was the year that Charlie Dotter came. And he'd graduated from Cornell Med., and so I'd known him before he came here; and he was another famous individual who you could say is in part, at least, an Oregon product and made many great contributions which you probably know about.

WEIMER: Well, some people have talked about Charlie Dotter, usually with a little chuckle, but you were a resident at the time he came, or...?

NILES: No, I think I'd come on the staff by then.

WEIMER: Give me your impressions of the man.

NILES: Well, a lot of people say, "Well, he's crazy; I mean, he's a manic individual." I never saw him too depressed; he was certainly a live wire.

I don't know if you want all this material on tape, but I'll give it to you anyway and you can cut out what is wrong, but he was so active in so many ways, and he scientifically produced a great amount of material and wrote all kinds of papers.

He'd gotten interested in angiography before he came here, and he was pushing it, and people were saying, "You can't do that. You can't put wires into people down into their hearts and sense what's going on, and take pictures, inject material and get radiographs. It's impossible." And he proved not so, and it was a great contribution to not only the study of congenital heart disease, which grew a great deal in the '50s and '60s, but of coronary artery disease, angiography.

And to demonstrate, you know, that this was really a safe procedure and guys shouldn't be so afraid about things, he did some demonstrations and took on some cases that people could say, "Well, you're just crazy, you can't get away with that stuff. It's going to fall down on you."

He set it up one day for a conference, being invited by Hod Lewis' medicine department, to put on a show at their weekly Tuesday morning, or whatever it was, meeting in 8B60. So the room was even then pretty well equipped for movies and slides of all sorts and x-ray demonstrations and so forth. So Charlie talked about this idea of putting the wires into people and you could record the pulse, take an EKG, record pressures, take chemistries, take blood samples for oxygen and other measurements, and take movies—that may not be the proper term. In effect they showed the contrast agent, “dye,” going through the blood vessels to see what the problems were.

So he showed some pictures of these things and demonstrated some movies and so forth, and then he had an EKG going along over here, blip, blip, blip, you know, just like you see on soap operas today, and another one showing stuff flowing through the heart or certain vessels. And then he said, “And you know, this is really not hurting anybody at all. It feels fine. This is being taken from me, and here's the wire in my arm, and the sensor is up here in my right atrium, and it's recording my EKG there,” as it was.

WEIMER: He had already had that all set up?

NILES: He had it all set up. I don't remember whether he made the final hook-up surreptitiously there in the middle of the program, but he had the catheter in his heart all the time. People just fell out of their chairs. It was a seminal event. I don't remember the year, but I guess it was early '60s probably.

And he did another thing. This was before the idea of doing anything serious in a surgical or any manipulative way about coronary artery disease; and, as you know, the problem is obstruction, which may be at any particular point throughout all these arteries. So he developed a system of putting a catheter in and doing some dilation internally. And the system is still in use, and it has been changed and developed a lot since then. The proper term now is angioplasty. And it was just regarded as something that was too risky to do with anyone who had coronary artery disease because you could kill somebody, and people are killed and have been killed so, but the number of patients who've been saved by it is more significant.

And it led me into experiments, studies on post-mortem cases where I did similar things by injecting the arteries of patients who had died of cardiovascular and of other diseases.

But Charlie said, “Well, if you surgeons and interns won't refer to me any patients that I can work on because you're afraid I'll kill them, at least let me study those people whose legs you are going to amputate because of the same disease (atherosclerosis), and give me a try at it. You're going take the leg off anyway. Let me do what I can do beforehand and see if I can help them.” And certainly he saved a number of people and a number of people's legs, and that was important in giving him more credibility. Eventually, people got to really rely on it.

He was a good teacher, too, and he was an important part of this clinical-pathological conference which I mentioned before.

But he got himself into a problem. I mean, this is a character flaw, I guess you could say. He was an avid mountain climber, and he probably had climbed all the mountains of any significance west of the Mississippi. I guess there aren't all that many outside of the Rockies. But that's a lot anyway, and a few in Canada. And I don't know where else. And he'd decide he was going to go and do it, and he'd pile his wife, maybe, and a friend or two who was going to go with him, and a couple of dogs, he always like to take dogs, and they'd drive for a thousand miles, and he'd drive nonstop and then climb this mountain, and drive back.

And being interested in imaging, he was a very good photographer, and he had a number of photographs of strange things on mountain tops, like a view from above looking down on a mountain peak to show a round top there, and one of his dogs just sitting there, and you'd say, "How the devil did the dog get there?" [laughter] Things like that.

But then, let's see, he died about '88 or so. I guess I'm not sure. Before that, he began to feel that he wasn't able to climb as well as he should, and he must have been having some fatigue or aging or perhaps real symptoms of disease, felt his heart was going out. So he had a coronary angiography, which was then a well-accepted procedure, done on him, and he said, "Well, it look's like I ought to get that fixed up," and I think Al Starr did the operation, an endarterectomy or bypass. And so after the operation he healed and he started climbing mountains again. But he still thought, "I need another operation."

And he just—I think he refused to admit that he was aging. You know, I have the same tendency today, only my problem is my knee, and I feel I ought to be able to do more with it than I should. We are all subject to such beliefs. But anyway, he wanted to get another operation, and he hunted all over the country; and Al Starr wouldn't take him on, and Stanford was where he thought he could get it done, but nobody there would touch him. He found some fellow in—perhaps Milwaukee, Wisconsin, I'm not sure, who did the operation, but he never really made a good recovery from that.

He damn near didn't get off the operating table, and he had all sorts of complications, and he was a terrible patient from then on. You know how bad doctors are at being patients. Well, he was a prime example of that, and I think he had something, some clot dissolver, streptokinase or something similar to that, smuggled into the hospital, and he injected it into his own arm, his own vein, to give himself a dose of that, but it went outside the vein instead, and he had a big problem, maybe was in danger of losing the arm. And you know, he died after a year or so of being bedridden, of various complications from that. And that was really, I mean, that's killing yourself, you know. He wouldn't admit that he was aging, I think.

WEIMER: He sounded bigger than life, though, in many ways.

NILES: He certainly was.

WEIMER: In the '70s, we became a university. The Nursing School, the Dental School and the Medical School consolidated. What were your impressions of that consolidation?

NILES: Well, I wasn't bothered with the administrative problems and that didn't really change anything for me. [Laughing] I'm sorry, I...

WEIMER: That's okay. We have a series of themes, and obviously some people have more experience in one than another. I wanted to ask if you were on the Faculty Senate Committee at all?

NILES: Yes, and I was on the committee that was elected, I think we were elected—there were twelve of us—to write a constitution for the faculty, and I guess that was an OHSU, or what were they?—UOHSC or whatever it was called first.

WEIMER: Right, our first university name [University of Oregon Health Sciences Center].

NILES: Dick Jones was the committee chairman, I think, and Jim Metcalfe was the alternate or vice-chairman, and we took a year or so to write this document, which may be an important step in our history. The democratic principles then established seem to be natural now—and not very crucial.

WEIMER: What was the purpose of it when you first started? I mean, what made you decide you needed to have a constitution?

NILES: Well, there was a lot of concern then about representation—I mean, as with most institutions or organizations, there were the “ins” and the “outs,” and some people have control of what's going on and how things are done. As an institution grows, I think it is inevitable that representation becomes problematic.

I remember Dr. Hunter was up there on the third floor of what is now Baird Hall, where the Pathology Department used to be, and Dean Baird was just two floors down, you know. And Hunter would get pretty steamed up about something, and he'd want to go down and talk to Dean Baird and say, “You can't have that program, you can't change the curriculum like that,” and so forth. And Baird sometimes would—I'm sure he was beneficent and listened well, but some people regarded that there were a few who were more inside than others, such as Hunter, were.

Ed West was the chairman of the Biochemistry Department, and he was a benign old guy who seemed to have, or at least in Hunter's mind anyway, he had Baird's ear. And Hod Lewis, of course, had his ear on the clinical side, and Hunter was frustrated by this, and he'd try to get through but felt that often he couldn't.

Mary Goss was the Dean's secretary, and Hunter called her "the harridan at the gates." [Laughing] He just couldn't get through her. Then there was also, and possibly more, contention by people who were even more out of it, the lesser faculty who wanted a raise and couldn't get it or a promotion or some other thing. And so there's always politics.

I think it was natural that there had to be at some time, some sort of a system of government developed. Maybe it's got a little too formal now. I'm not a Republican by calling; my father used to be, but I am certainly not, but even so, I think we still have too much government in some areas, and that includes in institutions here, as well as in the general government. You need protection, but you don't need all these damn rules [laughter].

WEIMER: Could you just give me an example of an area where there would be too many rules, too much government here at the University?

NILES: I guess control of the publications, which blends into control of events, announcements, appointments, buildings, etc. I think it may really have been better and more democratic before. The curriculum probably is my main area of concern and always has been, and maybe there's a little too tight a control. I do wish there were more emphasis on pathology. But I'm sure the surgeons say, "Well, for crying out loud, a surgeon needs more surgery training."

WEIMER: You brought up curriculum and how that is a concern of yours. What were the curriculum changes through the years?

NILES: Well, knowledge has increased so much that it's natural that people, particularly young people who are enthusiastic about every new thing will say, "Gee, I've got to bring this into the curriculum." We keep adding and adding and adding more stuff, and the students are overloaded with the fancy details but need more basics. I think it's perennial. This has always existed. I felt it as a medical student at my time, that they were overfilling us with what the faculty wanted to do, and if they'd just keep it simple, I could get it a lot better.

But in the last forty years, gee, look at the growth that's occurred and the number of ideas and inventions and whatever, and so when you add all that up, somebody has to come along and say, "No, we've got to stick with basic theory and stuff," and as the science has increased, the number of names of diseases, not necessarily of diseases themselves, has increased, and the number of little entities, you know. And some people are really splitters and like to tell you about every little thing that's along the line, and then there are, in opposition to them, the lumpers who say, "Our basic problem is this."

To digress back to Osgood for a minute, I think one of the real contributions that he made that was important was saying, "It's easy for anyone to identify a certain condition, a disease, anything whether relatively biological or not, if it's a typical example, if it fulfills all the criteria. But it's the examples on the edges that are a little shaded here and challenge us as to whether this is a manifestation of a real, say, cancer, or just something that happens to kill you because of some other reason, but it's not really a cancer. But it's at the edges, the areas

where the overlap occurs that confusion and problems arise.”

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

WEIMER: We are on tape two, side one of the oral history interview with Dr. Niles, and we were talking about the curriculum changes, actually. And my question is when the University consolidated, there was actually talk of consolidating the curriculum: that the person who taught whatever subject in the School of Medicine would do it at the School of Dentistry and the School of Nursing. Did that come about, or what were the power struggles there?

NILES: Well, for the last several years after I retired, I took up with the Dental School Department of Pathology, and that was because they were really short of pathologists. They've lost faculty in that department seriously in the last few years. I don't know how long it's been going on; I guess for fifteen or twenty years maybe. The courses in pathology have a lot of lectures by members of the Medical School faculty department and there are other faculty in other Medical School departments that do a lot of teaching for the Dental School, too.

But I think the basic departments are entirely separate, and people in those departments would regard it as, you know, an abrogation or invasion of their rights if the departments were fused. I'm not so sure it would be at all. I think it could be a very good idea if here, as in some other schools, that they combined anatomy departments, for instance, and physiology, pharmacology, pathology departments, I think, and have one department do the teaching for both schools.

I know that there has been at least one fellow in the Dental School Path. Department who used to teach a segment of anatomic pathology, among other things, and I thought he was really way out of date and they should have replaced that long ago, and a few others probably as well.

So I guess that covers everything I can think of on that subject.

WEIMER: There is another area of interest that we have, and that's research. Some people have said that University of Oregon Medical School was a latecomer to the research field. Other people say, “Well, no, in certain areas, we've been doing research all along.” Tell me about the research here on campus.

NILES: Well, yes, I thought that when I first came here in Hunter's time, which lasted up until 1962, I think, we couldn't say we were doing much research at all. It was only individual research—but, I mean, individual research looking at the material that came across one's desk in the course of the daily practice. But I don't think that should be put down in any way because guys like Hunter really became expert. He was the world's leading surgical pathologist, I think, and he was able to write up, identify, and be leading speakers, in many diseases because of that very broad experience he had.

And I neglected to mention that Dr. Hunter and his predecessor as chairman, Frank Menne, were both very prolific writers. Menne was the senior editor of the most prestigious pathology journal, the American Journal of Pathology. And Hunter was accustomed to hunting down and understanding everything that came across his microscope. His important contributions are many. This, we tend to forget, is an important type of research. It is not to be overlooked.

But then, in '62, we had a succession of new chairmen, and certainly research came in and was developed in a much more basic way, on the pre-planned, funded basis of grants, and I think Ben Siegel was one of those who was hired as a pure research type, a virologist.

I didn't feel, myself, that I wanted more of basic research. I guess I'm maybe too much of the old school. I'm pretty conservative.

WEIMER: Well, there's a classic struggle in research, at least I have heard of, and even Senator Hatfield mentioned it once, between the pure research or basic research and the clinical aspects of research.

NILES: Oh, I think you need both. I think you just have to have both, but it's kind of like the curriculum, you know. You get overloaded, this and this and this in there, and somebody's got to make some decisions about what is important to us. And I don't think it's too important to have a firm set of rules of what's admissible and what is not. I think any way that you want to build it or restrict it that fits your particular program, that's okay.

WEIMER: You've been here almost forty years—or a little over forty?

NILES: Yeah, forty plus.

WEIMER: And I know the organizational culture has changed here, from a fairly small school when you were first here to 8,000 plus now. How have you seen those changes?

NILES: Well, the first thing that comes to mind is the number of students in a class. When I first came, I was—well, I guess after a couple of years, not my first year—but I was sharing the teaching load for the basic pathology course with Dr. Hunter. And what we did was he would lecture for one term, and I would lecture for the other term, give all the lectures, and that was three times a week, I think.

I really enjoyed it at the time because there was something like 68 or 72 maximum in the class, and I was very young then, too; because of my lucky (if it was) acceleration through medical school, many of the students were older than I was, teaching them. So I was a contemporary talking to these guys, and it was very enjoyable to me to be with them.

The number of students was important. And then we added on to get up to about 80 some and then 90 some, and then in the '80s, I think, it went up to 105 or 115, and with each

one of these changes, you began to have less and less feeling of knowing the students. I couldn't remember so many names and so I couldn't communicate with them. Of course, age was working into it, too, so I don't know what's more important.

But I do think that small classrooms are better. And incidentally, as a continuation on that theme, one of the real changes that I think is happening and is a bad one is that we're losing laboratory experience for students in most of the basic sciences.

I can tell you that Ralph Tanz, in what was the Pharmacology Department then, used to give a cat lab each year, with living animals, and get them hooked up with sensors all over, and there would be four or five drugs that the students would have to identify by the reactions of the cat to them, and it meant that the students had to know something about how to put a needle in a vein and tie it off and use various equipment. And although I as a student didn't like those things myself, I realize that it's a very important way to learn, and they don't have much of that anymore now, I think.

Also, anatomy labs are not taught by anatomy professionals. They're taught by more surgeons and clinicians of different sorts who have time to get in, whereas the Anatomy Department consists of researchers who have less interest in teaching anatomy. Now, that's a big mistake, I think. The Anatomy Department should be responsible for doing anatomy teaching.

I told you I loved anatomy as a subject, and I can really tell you how important it was to have that guy right there with me. One of the things he did—this was at Cornell—we had a semi-circular or quarter of a circular-shaped room, and there was a blackboard and a series of maps—this was before the days of projection of slides, it was prehistory—and he could draw down a map of the arteries of the abdomen or something like that, and point at it.

But he would walk up and down between these two doors, and from the doors there was a steep series of steps on either side which would lead up to the seats. There were 84 students in that class and 84 seats and, you know, we were tight. And the prof, this old geezer, walked up and down with this long bamboo pole, a pointer, and he would point out things and here and there.

I remember one fellow came in late. He was always in a hurry. This guy was a little disorganized, and he busted through and he knocked the pole almost out of his hand as he was going, and he rushed up the stairs and got his seat there, and the prof calmly took the pole again and went right back in stride, didn't miss a step, and I thought [laughing], "That's class."

This professor's system of questioning was special. He'd say, "Now, tell me what's the course of the common femoral artery," and he'd call out a name and he would get an answer and discuss it. And then he'd call out the next name in the alphabet and the next name and the next, and so you knew when you were coming up. But then he'd jump around a little bit and he'd maybe take off in the alphabet from the same position just to keep you on

your toes. And when he would point that bamboo pole at you and say, “Now, can you tell me the name of this?” and that pole was right here it seemed like.

WEIMER: Oh, this long pole.

NILES: And, I mean, that’s involvement. Now, dry lecturing doesn’t have that, you know. And in the same way, laboratories have to involve students, I think, in doing things, and it has to go on for long enough so that they can achieve some success in it if they fail the first time; and I think it’s very sad that that’s being lost. I believe that we may well find in a number of years that we have produced a generation of doctors who don’t know a lot of very important basic anatomy and other subjects that they should know. They will do this because they will think they can always rely on others for the information.

WEIMER: What do you think are the major reasons why the lab time is being lost from present-day education?

NILES: Because there’s so much influence of money, the need for money. I think administrations have become rather shortsighted and too much money-oriented, and not only administrations, but everybody, the whole society is money-oriented. But it’s run by bosses, CEOs [laughter], including deans and presidents, and they can get more money for the institution by hiring some hotshot out of wherever he is with a great new idea and money from NIH [National Institutes of Health] or whoever, who will come and put fifteen percent of that money into the institution. And when they hire the guy, they say, “Well, you’ll probably have to do a little teaching; you don’t mind doing it?” “Oh, sure, I can, love to talk about my stuff.”

But these guys who come in today may be very good teachers about their field of research and they may lack scope. They just like to talk about their stuff, and they’re not broad enough, as goes along with a super-specialization, you know. You’ve got left eyeball people and right nostril men and so forth. Need a little breadth, I think.

WEIMER: Basically, what we’ve been talking about is the art of teaching.

NILES: Yes.

WEIMER: Give me your impressions of, or tell me what the optimum teacher would be.

NILES: Well, there would be several different types. I think it requires a community, not individuals so much; but the individuals have to be characters. I think a character who’s got some real honest character to him is very important. I think firstly he should be interested in relating to students, and in a social way as well as just in class. If you can get to know students personally as much as possible, it’s better.

We have a lot of that in the clinical end of things now in that students get to know

residents. I don't know how well they get to know staff people. There's a hierarchy there. Students may not get up beyond the residents very much and deal with the staff. I have a feeling there's a little unnecessary stratification. You're bringing out all my cynical complaints [laughter].

WEIMER: I didn't mean to do that. Shall we give fair play to what is good?

NILES: What is good? Well, I think *some* automation is good, the advent of some automated materials and teaching by computer, and there's a lot of available computerized stuff that could be used maybe—stuff that might replace some teachers who don't have enough scope.

I think the BICC [Biomedical Information Communication Center] is a great idea, and there are people over there like Jim Williams who would love to be able to develop, with faculty, teaching programs that faculty want to develop. But I don't think the idea of faculty working on teaching programs has caught on as much as it could have or should have. There's been some, that's true, but I think there's a lot more that could be done; and I would encourage faculty to get into that more.

WEIMER: Talking about computer-based training, that brings up the idea of technology. How has technology changed the medical community?

NILES: Well, we've got all these visual things like computers. I think they've got in the Dental School now, but I haven't seen it, some system whereby individual faculty can load all their photographs onto a program, you know, and then it'll be there, and then when they lecture or give a lab, I guess, they could say, "Oh, yeah, I forgot about that. Let me show you this other one, too," and they push a button and there it is, and that is a gimmick, but it's a good one.

But it may not really replace actually seeing the real thing in a dissecting laboratory, too. On the other hand, you've got so much more material available that way, that it has a super advantage to it.

WEIMER: I've enjoyed this, our interview. I need to ask, to give you fair play, if there's anything that you would like to add, if you think of something that we haven't talked about because I think we've hit most of our themes.

The one thing we did not talk about was minorities and women on campus. If you've got a few thoughts about that, we can talk about that.

NILES: No, I think I don't have any points that bother me about that. And I see the number of women in classes keeps going up and up, and I hope it won't become, you know, greater than ninety percent, but... [laughs].

WEIMER: It goes the opposite way.

NILES: Yeah, but I think, you know, whoever's qualified deserves to be there. Sometimes I guess it seemed to me that some women—and I think this is less true of men, but maybe not—some women have taken on the idea of going to medical school as a challenge: they want to show that they can do it, and they do it and they practice, and then they go back to their family or whatever they were doing before, and I think that's a waste of an education. But by the same token, guys do it, too, I think, but I don't think they do as much.

As far as minorities go, it often seems too bad that we don't see more people of various colors here. We know the purported reason for it—I guess it's the real reason: that they're not qualified, and the basic education that they need isn't there.

I run this little premed class for Portland State students, and I've had a couple of blacks in that, and two of them have been, I think, very good students who have tried hard to get into medical school by writing letters and contacting people, and they've both been turned down repeatedly. And you know, when you get to know a student—our class is only about ten people, or ten to fifteen, which allows me to get to know them pretty well—and, by the way, that's an important thing. I think many of our lectures and classes are too big.

I went to Princeton University, and sometime well before I got there, Woodrow Wilson had developed the idea of the seminars, and that to me was a really important part of our education. We had lectures, yes, but we also had these seminars where you were encouraged to get into the fray. And these were only small groups of students, not more than ten or eleven.

Well, the same thing could and should be done here, but it would require a lot more discipline by the faculty. And maybe because things are changing all the time in science and medicine and curriculum and everything, it may not be possible to do that, as it was in an undergraduate school.

But anyway, we sometimes get too close to individual students because you are in a small group with them, you know, and you get to know them over a time like that, and you say? "Gee, this guy, he may not have the language quite right, but he's sure got the stuff." And other people don't see it that way.

WEIMER: I think I would like to ask one last question to finish the interview, and that is what are you most proud of in your career?

NILES: Gee, I don't know. I guess relationships with several individual students, memorable characters. And I've really enjoyed some guys that go way back, unusual persons, reprobates some of them [laughs], guys like Charlie Dotter. I'm proud I've been able to semi-compete, I mean, to be alive in this institution which is developing so rapidly and has all these smart ideas coming out.

I've given up the idea of trying to learn everything in my field, I gave that up long ago, but there's more and more coming along now that I just don't really try to keep up with. And I'm not so proud of that, but at least, I recognize necessity.

That's not much of an answer to your question. I'm sorry.

WEIMER: No, it sounds like you're a true teacher at heart because you remember the individual relationships.

NILES: OK.

WEIMER: Well, I want to thank you very much for sharing your time with me, and also the memories.

NILES: Good time to quit because I'm getting a little hoarse [laughs].

[End of Interview]

INDEX

A

angioplasty, 12
Army Specialized Training Program, 1-2
autopsy, 8-10

B

Baird, David W.E., 7-8, 14-15
BICC (Biomedical Information Communication Center), 20

C

Cornell University Medical College, 1, 3, 6, 18-19

D

Dept. of Anatomy, 18
Dept. of Medicine, 8
Dept. of Pathology, 5-6, 8-10, 17
 funding, 10, 17
Division of Hematology, 6
Dotter, Charles, 11-13

E

education, medical, 18-20, 21

G

Good Samaritan Hospital, 9
Goss, Mary, 14-15

H

Hodges, Clarence V., 10
Hunter, Warren Clair, 5-6, 9, 10, 14-15, 16-17

J

Jones, Richard T. (Dick), 14

K

Koler, Robert, 6

L

Labby, Daniel H., 8
Lewis, Howard (Hod), 7, 8, 9, 14

M

Madigan Army Medical Center (U.S.), 4
Menne, Frank R., 17
Metcalf, James (Jim), 14
Minckler, Jeff, 11
minorities, in medicine, 21
Multnomah County Hospital, 8

N

Niles, Nelson R.,
 biographical information, 1, 2, 3
 career, 21-22
 education, 1, 3-4
 internship, 3
 military service, 1-3, 3-4

O

Oregon Health Sciences University,
 administration, 15
 curriculum, 15
Oregon State Medical Society, 10
Osgood, Edwin, 5, 6-7, 15
Oyamada, Abe, 7

P

pathology, 4, 5, 6, 10
Physicians & Surgeons Hospital, 9
Portland Adventist Hospital, 9
Portland State University, 21
Princeton University, 1, 21

S

School of Dentistry, 16
Seaman, Arthur J., 6
Siegel, Benjamin V., 17
Sneeden, Vinton D., 9
Starr, Albert, 13
Swan, Kenneth, 10

INDEX

T

Tanz, Ralph D., 18
technology, information, 20
technology, medical, 20

U

university consolidation, 14, 16
University of Oregon Health Sciences Center
administration, 15
curriculum, 15-16
Faculty Senate, 14-15
University of Oregon Medical School,
administration, 14-15
curriculum, 9-10, 15, 18
enrollment, 17-18
faculty, volunteer, 10-11
research, 6, 11-12, 16-17
student activities, 7-8
students, 5-6
town-gown relationships, 10-11
University of Washington Medical School, 4

V

Veterans Administration Hospital, 11

W

Weeks, John E., 10
West, E. S. (Edward Staunton), 14
Williams, Jim, 20
Wilson, Woodrow, 21
women, in medicine, 20-21
World War II, 1-3