

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

Conrad Carter

Interview conducted July 20, 1998

by

Joan Ash

SUMMARY

The interview begins with Dr. Conrad Carter stating his place and date of birth and addressing the question of why he chose medicine as a career. Having decided very early on to become a doctor, Carter matriculated at Reed College in 1942 as a chemistry major. Carter discusses the effect of World War II on his education, describing the shortened curriculum, Army draft procedures, and the unusual circumstance of being accepted into medical school as a college freshman. After 24 months at Reed, Carter began his medical education at the University of Oregon Medical School. He describes student life at UOMS in the 1940s and relates a few anecdotes about the social activities on campus and in Portland.

Carter goes on to explain his interest in neurology, noting that, in the forties, the UOMS curriculum was very neurologically oriented. He mentions the research interests and educational background of some of the faculty before going into greater detail about two particular doctors, Robert Dow and John Raaf. After an internship and one year of residency, Carter came back to Portland to temporarily take over Dow's practice. He talks about what it was like to be a neurology resident at Washington University in St. Louis after having spent a full year as a practicing neurologist.

After completing his residency, Carter returned to Portland and entered into private practice with Dow and Raaf. He left after three years to establish a solo practice, and he talks about that decision and discusses neurology and neurosurgery in Portland generally. He segues into a consideration of town-gown relations, and the competition between private practice physicians and UOMS faculty, both volunteer and paid. After a short digression about the general nature of medical education in the forties, Carter returns to the topic of competition, discussing the various Portland-area hospitals and the private practices of several UOMS faculty. He talks about the development of the neurology and neurosurgery departments at UOMS and the gradual change from volunteer to paid faculty on campus, going into great detail about Dr. Dow in particular. He describes the competition between the two neurology residencies in Portland and talks about the development of the Neurological Sciences Institute.

Carter then discusses his own decision to join the neurology faculty at UOMS. He talks about the selection of residents and describes the neurology residency program, including grand rounds. After two decades at UOMS, Carter decided to return to private practice, and he discusses the reasons behind that move as well as a later move to the Veterans Administration Hospital in Roseburg. After retiring from the VA, Carter rejoined the UOMS faculty, and he talks about how his experience in private practice has informed his teaching. He compares medical education today with the training he received in the 1940s, and returns again to the topic of volunteer versus paid faculty.

After a brief pause, the conversation resumes and Carter shares his impressions of a movement to unseat Dean David Baird in the 1950s, recounting in particular one episode involving Dr. John Brookhart. He speculates that some Portland doctors may have felt that Baird was not sufficiently sympathetic to the interests of private practitioners, or that the Portland Clinic had too much influence on the development of the medical school. Finally, Carter shares his own favorable opinion of Baird's tenure.

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Interview with Conrad Carter
Interviewed by Joan Ash
July 20, 1998
Site: BICC (Biomedical Information Communication Center)
Begin Tape 1, Side 1

ASH: It's July 20, 1998, and this is Joan Ash interviewing Dr. Conrad Carter in the BICC.

So as I said, the first question I would like to ask you is to go back to where you were born and brought up.

CARTER: I was born in Seattle, Washington in 1924, attended high school in Seattle and spent my first 18 years in Seattle. Then I took my undergraduate education in Portland, and I went on to Oregon Health Sciences University, which was the University of Oregon Medical School in those days.

ASH: Where did you do your undergraduate work?

CARTER: At Reed College in Portland, Oregon. Started in the fall of '42 and finished through the summer of '44. In those days there was a war going on; if you were not excused because of some physical disability, you were expected to attend a school 12 months a year. So I finished my undergraduate work in 24 months.

ASH: And what did you major in at Reed?

CARTER: I majored in chemistry. In those days to go to medical school you were really expected to major in chemistry or biology; sometimes physics majors would be considered, sometimes psychology majors.

ASH: At what point, then, had you decided to go into medicine?

CARTER: I had always planned to go into medicine. There's no good reason why I did this [laughter]. I tended to admire our family doctor. We lived within a block of a pediatrician who practiced in his home, and I admired him. My mother for all practical purposes was Christian Scientist, so I was brought up in a home where doctors were more or less of suspicion, and surgery was considered a last resort, and often calling a doctor was a last resort. So I don't know where this really came from, other than the interest I seemed to develop in that area.

ASH: But you majored in a science so that you could go to medical school. It must have been pretty early on that you decided to go to medical school?

CARTER: Oh, yes. As I say, I remember my first year in high school writing themes in which we were asked to talk about what we planned to do when we left high school, and even then I

was quoting Robert Louis Stevenson from one of his essays about what it was to be a doctor. I think in those days the doctor was possibly placed in higher esteem [laughing] than they are at the present time.

ASH: So there were no other physicians in your family?

CARTER: None. None. I was the first one.

ASH: Then you were at Reed. What made you decide to go to this medical school?

CARTER: Well, one has to remember that the University of Washington did not have a medical school in those days, and so if you attended a school in Washington, you either went to a private medical school back East, or you went to the University of Oregon Medical School. I think maybe as high as 25 percent of the students in any class of the University of Oregon Medical School in those days were from the state of Washington. They did have an anatomy course at the University of Washington in which they used human cadavers, which they did not have at University of Oregon or Oregon State, and I think that may have been one reason why University of Washington graduates received the consideration that they did in coming to Oregon because they were always the best anatomy students.

ASH: What was your application to medical school—what did that involve?

CARTER: Well, that's an interesting story, also. I was admitted to medical school before I finished my freshman year in pre-med, which probably had never occurred before and never will occur again [laughing]. But you've got to remember, those were war years, and the armed forces were taking in able-bodied young men as fast as they could get them.

So there was this group of students in universities and colleges who were under the draft board, and the armed forces, I suspect, wanted to get to that group in a more efficient manner than through the draft boards. And so they came to the universities and colleges and recruited; so that many of us were recruited into the Army in a situation in which we were allowed to continue as civilians, but we actually were in the Army and at the disposal of the Army at their pleasure. The idea was that the Army wanted educated recruits, and so they would leave you to have your education but yet be available to them if they should want you. And they decided that they wanted us.

So even in our freshman year, students who were in this group, called the Enlisted Reserve Corps, would get their call to duty. As I remember, the sociology majors, and then the lit majors, and then the history majors, and then the psychology majors would get their calls, and then they started getting to the physics majors and the chemistry majors.

And the Dean of Men at Reed had some insight and was concerned and considerate enough to really take the premedical students that were there their freshman year—and there were about ten or twelve of us—into concern. So the story is he came up to the medical school and talked to the

admissions committee. He told them—and they probably already knew this—that with this war going on, we didn't know how long it was going to last, that all of the premedical students were going to be drafted, and they wouldn't have premedical students. The armed forces would assign students, or assign men out of the armed forces to the medical schools. The medical schools would have nothing to say about who's admitted, and that if they wanted to circumvent that, they should start admitting promising pre-med students right away.

Whoever he talked to, I assume it was the admissions board, the dean, whatever, evidently accepted this. And so the Dean of Men at Reed came back and said, "You guys get your applications in, and you get them in fast," which we did. And lo and behold, as I say, they went right down the list, and it finally came down to all pre-med students were drafted. Out they went, right out of college, except those admitted to medical school.

And I had been admitted one week—I was a freshman at Reed; I had been admitted to medical school one week before the draft notice came out that all pre-meds not admitted to medical school would go in [laughs]. And so there was this whole bunch of students, about eight to twelve of us, who were allowed to finish our premedical work as civilians. The Army discharged us as soon as they found out we were admitted to medical school. We were under the auspices of the draft board, the draft board received a report on us every month. And I could tell that this was happening because there would be one day every month where the professor, first thing in the class he would ask each one of us a question, and then the next class, the same thing happened. And I think they'd just write something down and send it to the draft board every month after asking us this one question, you know, because they thought it was a ritual they should go through for the draft board. Obviously we wouldn't have been there if we weren't keeping up with our work and doing what we were supposed to do, but...

ASH: So this was like a little test?

CARTER: Right. This was like a little ritual test that they did every month to satisfy the draft board so the draft board would permit us to stay for another month. Because the draft board was under a lot of pressure to bring people into the armed forces, too. So this was something that happened at that time that will probably never happen again.

It's an interesting commentary on the times, that you could be admitted to medical school before you finished your freshman year of pre-med; and there were people that were very young as a consequence. I was 20 years old when I started medical school, and I wasn't the youngest person in the class. There obviously were 19-year-olds in the class that started medical school.

ASH: Now, how long did it take you to go through Reed?

CARTER: Twenty-four months, which was three years. Reed had a system there, and they still have it actually, where if a person would go to Reed for three years and do what needs to be done to stay there, then they are eligible to go to graduate school if they get into graduate school.

After two years of successful graduate school, Reed will give them a degree from Reed in lieu of the fourth year thesis-writing that is the usual rule that you have to follow to get a degree from Reed.

So after two years of medical school here, then Reed gave me a degree. [Laughter] Interesting situation. And they still do this with, oh, Cal Tech, MIT, medical schools, Columbia graduate schools. They'll get them get away without a thesis.

ASH: Were you living at home when you came up here to the medical school?

CARTER: No, of course not. When I was at Reed, I lived at Reed. But the students who were from Portland lived at home, most of them. But most of them didn't live in Portland. So there were a number of ways of dealing with this. One was the TKP house, which was a fraternity house, and it's still there. I don't know if it's a fraternity anymore; I doubt it because I've seen women come out of there, and I think, you know, it's probably kind of a boarding house for medical students. But there was the TKP house, there was quite a group who lived there, and then there was the AKK house, and I don't—now, I don't remember what these things stand for; of course they're Greek alphabet.

ASH: Alpha Kappa Kappa?

CARTER: Probably. They had a place, they had a big home, a renovated home, down in the area of the Multnomah Athletic Club. So there were two fraternities that housed students. Then the rest of us kind of lived around the hill. Married students lived in Marquam Manor in those days, that brick apartment house up there just beyond what's a 7-Eleven now. And the rest of us lived in kind of boarding houses. There are a number of homes up here that are renovated into rooms. Some of them contained bathrooms; some of them had a common bathroom down the hall. And we would eat in other places, where there were people on the hill who made their living just by providing two meals a day for medical students.

ASH: Where?

CARTER: Well, I'd have to go look and see what the street is. It was about three blocks up the hill. It was on a corner. And students lived upstairs, and there was a nice lady there who had been cooking for medical students for years, and that was the way she made a living. For a certain amount of money every month we would come in for breakfast, and eat our noon meal down here at the medical school and eat our evening meal up there. And then we would disperse to our rooms and study.

As I say, many students did that. There weren't many married students in those days, maybe five, six percent of the class. Those who were married either had families who were able to support them, or they were married to school teachers, registered nurses, ladies who could support the family until the husband was able to make a living on his own after finishing medical school.

So there wasn't much in the way of marital situations, maybe six, ten percent. And not many of them got married during medical school, until senior year, they started getting married.

ASH: So it was mostly financial?

CARTER: Yeah, it was mostly financial. Of course, we were just right out of the Depression, and we were pretty sensitive to the money situation and the obligations one had when one married and had a family and so forth. The husband was expected to support the wife, and until he could, he didn't get married.

ASH: I understand that a number of the medical students worked in the shipyards during the war? Did you know anybody who did that?

CARTER: Yeah. That's an interesting subject, also. There were at least one or two who would drive cabs on weekends. I heard a story, and I'm not sure that it's true, but it could have been: one student played in a jazz band in a nightclub, and the powers that be called him in and said that that isn't a proper thing for a medical student to do [laughing].

ASH: And he was getting paid to do that?

CARTER: He was getting paid to play in this jazz band, helping his way through school. And as I say, this is a rumor; I can't verify this. But it seemed to be pretty common knowledge that this person had been told that he'd better give it up because this wasn't the sort of thing that doctors did, or people who were to become doctors would do. Terrible kind of music and terrible kind of people; I guess that's what they thought, I don't know.

But there was one student who was a pharmacologist, and he worked on Saturday nights in an all-night pharmacy downtown on Broadway. And certainly, you know, the shipyards were going full blast in those days, and there were three shifts a day, and so a student could pick up money that way. Most of us weren't smart enough, really, to take that much time off from studying to be able to make a living that way, but there were those who filled in on weekends and things like that. So there were always jobs in the shipyards for students who wanted to make a little bit of extra money.

ASH: How did you get around? Did you have a car?

CARTER: Well, of course, remember during the war there were no vehicles constructed. Everything went into jeeps and tanks and so forth. So there were no new cars made, and it was almost impossible to buy a car. And nobody knew when they would start production again because nobody knew how long the war would last. So most of us did not have cars, and if we had a car it was the old family vehicle that was present when the war started, and the parents would permit the student to use the vehicle for a Saturday night date or something like that. But most of us did not have vehicles.

And we got around. There was a bus that came up on the hill, Marquam Hill bus, and right here where BICC stands was a place where you caught the bus. Transportation between cities, you know, was bus. The trains were filled with troops, and so you didn't get on the trains very often, and of course there wasn't airline transportation in those days except for a very elite few.

So we walked and we took the buses. Many a date that I had, I remember getting on a bus with my date, going downtown and watching a movie, and coming back up on the bus.

ASH: So what was social life like in medical school?

CARTER: Well, it depended upon, of course—one variable was whether you were married or not. If you weren't married, which was the majority of us, of course there was always the movie down on Broadway, so you'd take the bus downtown and watch a movie on the weekend.

The big bands would come out to Jantzen Beach. Everybody my age knows where Jantzen Beach was, but that's pretty much all gone. But in those days Jantzen Beach was kind of like a carnival or a state fair: roller coasters, Ferris wheels, et cetera.

They had a big pavilion out there, and big bands would come in like Glen Miller, Charlie Barnett, Duke Ellington, et cetera. So on big nights we'd go out there to the Jantzen Beach ballroom and see one of the big bands that were coming through, even during the war.

Otherwise, there were parties at the fraternity houses on weekends.

ASH: If you belonged to a fraternity?

CARTER: No, everybody was welcome to come to the fraternity houses. I spent many a Saturday night in the basement of the TKP house with a nickelodeon, dancing and enjoying a drink or two.

And that was the main social activity, really. Nobody had much money, in the first place, and in the second place there really isn't any place to spend it because everything was pretty well shut down during the war except for the nightclubs downtown, and they were much too expensive for us. So we made our own parties.

The County Hospital, of course, was the medical school hospital in those days. The fourth floor was the interns' and residents' quarters, and they had a common room up there; and so on Saturday nights those residents who were on call, their wives would come in, and the medical students who were working up there would get dates, and there would be a Victrola, 78 per minute records, and we'd go up there and dance on the fourth floor of the County Hospital. That was always the big time for the week for the residents, the interns and the medical students who happened to work over there.

The student nurses weren't supposed to be up there. On occasion it did happen.

ASH: If they were someone's date, was that all right?

CARTER: No, it wasn't all right. But you know, as I say, on occasion it did happen because who was going to tell? But in those days, you know, the nurses' homes had housemothers, and they checked you in and checked you out, and you had to be in by a certain time. The housemother never got wind of one of the students being up there, but it wasn't generally done.

ASH: This was when they were living in Emma Jones Hall?

CARTER: Yeah, there were student nurses in Emma Jones Hall, and then there was another hall [Katherine Hall] where the Crippled Children's Hospital is now, the Shriners Hospital. There was one floor for nurses there, student nurses.

And student nurses, as I remember, were obligated to live in the nurses' home, at least x number of years. In fact, they weren't allowed to marry. And they had housemothers who checked them in and checked them out. There were student nurses who on occasion imbibed too much, and they were pushed in through a window so they wouldn't have to go by the housemother [laughing], things like that. Those were rare occasions, but they did happen.

ASH: Were you ever present when a nursing student had to go around the rules like that?

CARTER: No, I never was. But I heard about it. No, I always brought my dates in in a manner that was acceptable to the housemother. [Laughter] But it did happen. I forget how the girls got around checking that girl in, but they did it some way or another.

ASH: Maybe help from another student?

CARTER: Well, I'm sure that they had to sign them in some way without the housemother realizing that they hadn't been inspected on the way in.

ASH: So as I said, I wanted to talk to you a little bit about the people you knew when you were a medical student. Were there any faculty who were particularly influential in your decision about what you would become, a neurologist?

CARTER: Oh, I don't think so. I just kind of fell into neurology through the back door. I really didn't have any inclination towards being in neurology when I was in medical school. In fact, Dr. Dow was the only neurologist in the state of Oregon at that time.

Do you want me to go into that?

ASH: Well, let's stick with medical school for now.

CARTER: Okay. In medical school, you've got to realize at that time it was very neurologically oriented, because Professor Allen was really doing brain research on dogs, and Dr. Larsell was world renowned in respect to his knowledge of the cerebellum. So the two highest faculty in the Anatomy Department were interested in the nervous system, and so obviously that was emphasized in that year of anatomy we had the first year.

Dr. Youmans in physiology was somewhat of a neurophysiologist himself. And Dr. Selling, Laurence Selling, who was the chairman of the Department of Medicine and professor, was for all practical purposes a neurologist. He had trained in Europe, Munich or Vienna I believe, in neurology after his internal medicine. So he was practicing at the Portland Clinic at the time, but he did mainly neurology.

He was an excellent neurologist and very knowledgeable, and he taught what we called the "flunk-out course." I forget if it was junior or senior year he had a semester course in neurology, lectured one hour three times a week, and it was well known that you did well on that examination—and there were one or two exams and that's all there were—or you were in bad shape as far as staying in school.

And so we learned our neurology. He would come to class—there were no slides in those days, no movies, no visual images. He just walked back and forth, out of his mind, and gave us these well-organized lectures.

ASH: Blackboard, did he have a blackboard?

CARTER: No blackboard. There was a blackboard there, but he didn't use it.

ASH: This is Dr. Selling?

CARTER: Dr. Selling. He just stood up and lectured. You know, the blackboard was too time-consuming. He didn't have time; there was too much material to cover [laughs]. I guess that's why he didn't use the blackboard. So he would come in and walk back and forth, and all of this information would come out, and of course we would be writing as fast as we could. But fortunately we had a former court reporter in our class, and he—and I don't know who it was, but he talked to Dr. Selling asking if we couldn't have the lectures recorded by this court reporter.

Dr. Selling was very helpful to that, and so this court reporter would go over to Dr. Selling's home, to his library, it occurred in the evening, of course, and Dr. Selling would give the lecture. And he would go around and pull books out and look at things and then go on with the lecture, and pull books out and look at things and go on with the lecture. So we had in print, for a small amount of money, all of his lectures, which we could add to, of course, what we got out of the verbal lecture—so that we were in a much better situation and probably learned a heck of a lot more than other classes in neurology. He had a certain set amount of material he wanted to cover. When the time of the lecture was completed, he would even head down the hall still lecturing.

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

CARTER: One reason why there is a tendency towards the specialty of neurology among the students at Oregon is the fact that there is one very renowned neurologist who came out of a class of—oh, maybe '42, '41, '40—Milton Shy, who ended up Chairman of the Department, professor of neurology at Columbia University. He's deceased now, but revered by the entire subsequent generation of neurologists. Unfortunately Oregon had never recognized him.

ASH: How is his name spelled?

CARTER: S-h-y. Milton Shy. He grew up in St. Helens, Oregon, and went to University of Oregon in Eugene. Then he finished here, and when he got out of the service he took a neurology residency at Montreal Neurological Institute and wrote some papers there that published some information that really opened up the field of myopathies, diseases of muscles.

He went on from there to be the first head of neurology at the National Institutes of Health. He then went to the Chair at the University of Pennsylvania Medical School, and from there to Columbia. A young fellow who grew up in St. Helens. And we've never recognized him.

ASH: I guess because he didn't stay here?

CARTER: He never came back, as far as I know, and nobody really realized, I don't think, other than just a few of us, Dr. Dow and myself, that he was a native.

ASH: Well, at what point in medical school did you decide that you definitely wanted to become a neurologist?

CARTER: Well, as I say, I kind of fell into it. In my internship at Good Samaritan Hospital, Dr. Raaf—who was probably at that time the only neurosurgeon between Seattle and San Francisco—Dr. Raaf practiced at Good Sam, and he had a ward full of neurosurgical patients. And he was in practice with Dr. Dow, who was the only board certified neurologist in Portland at that time. Dr. Selling was still alive then, and then there was another neurologist named Richard Carter who was practicing.

But Dow and Raaf were the specialists in neurology and neurosurgery, and neurosurgical patients came from all over, and of course neurology patients came from all over, also; and they had this ward, and so every intern rotated through neurology and neurosurgery. We all scrubbed on craniotomies, and it was pretty exciting.

They would have grand rounds on Sunday morning, actually, and go over all the patients, and students who were interested in neurology at Oregon up here would come down on Sunday mornings just for those rounds. A fellow you may have heard of, Rosenbaum, who went on to an illustrious career in neurology at Washington University Medical School in St. Louis, I remember was one of the students who used to go down. So that was kind of exciting.

But I decided I wanted to be psychiatrist, so I went back to Denver to the University of Colorado for a year of psychiatry and decided against that. And about that time it was decided that any doctor who had not had at least 24 months of active duty during World War II should go into the armed forces, and the Korean War was going on.

So, as I say, I came back to Portland not knowing exactly what I was going to do. I enlisted in the Air Force, assuming that I would be picked up soon. Had nothing to do. Dr. Dow said he needed somebody to work up his patients, and so I went into his office, and he paid me enough so that it was worth our while, while we were waiting to go into the service, to work for him. And I worked up neurology patients and presented them to him.

ASH: And this was after you had had an internship?

CARTER: After an internship and one year of psychiatry residency. You've got to realize that in those years residencies didn't pay very much, so a lot of doctors after they finished their internship would go into practice and save up their money until they could take a residency and support their family.

ASH: Had you already decided that you wanted to go into neurology?

CARTER: No. No, I just took this as a way of making a living until I had to go in the armed forces. And it ended up that they didn't take me for about twelve months. So I had a whole year of neurology; really, a preceptorship, is what it boiled down to. And as a consequence, when I went in the armed forces I was the only person on the base who knew any neurology, and I did the neurology on the base besides the psychiatry.

During that time Dr. Dow had written to me saying that he was planning to go to Italy for a year and write a book on the cerebellum with a famous professor over there, and he needed somebody to take his practice. And this was pretty awesome to me, taking his practice. I didn't have anything else to do when I got out of the armed forces, and I realized that in my neurology residency I could use my one year of psychiatry residency as part of my training to be board eligible. So about that time I decided I should go into neurology [laughs].

So I came back to Portland, and I took care of his practice, which of course I really didn't have the background to do, except that I was working under the auspices of Dr. Raaf and another person in the office by the name of Wilbur Larson, and I worked very closely with them so that I was able to give the patients, I think, good service because I had good coverage and asked questions and shared my problems with the rest of them. And the patients were well served.

A lot of this was working up Dr. Raaf's patients. He had patients coming in from all over, and I would spend my evenings between, oh, after dinner until 9 or 10 o'clock at night working up his patients that were admitted to the hospital that day. And then I would get there first thing in the

morning, and I would present these to Dr. Raaf. He would come in first thing before he did his surgery and go over these patients with me. And Dr. Dow went to Italy and wrote his book [laughs].

So it was during that time that I said, “Well, I’ve had all this experience, let’s go into neurology.” And I had the residency in St. Louis at Washington University. It was recommended to me, and it was probably the closest one there was going East. There was one in Minnesota, one in Wisconsin, one in Iowa and there was one in Missouri, and that was the closest there was. From the West on there really was no neurology residency, except that UCLA had started their first year in 1954 when I started my residency.

But I went back to St. Louis and spent two years there, which with my one year of psychiatry was adequate to be board eligible, and I came back to Portland and went into practice with Dr. Dow and Dr. Raaf.

ASH: What did it feel like being a neurology resident when you had actually been a practicing neurologist for a year?

CARTER: Well, of course it was very helpful. You’ve got to realize, here again, that the Eastern residencies, Johns Hopkins, Yale, Harvard, Columbia University, Vanderbilt, Washington University in St. Louis, were very elitist, and they gathered the cream of the crop, so to speak. So I was a very unusual person because all the rest of the residents there were from Harvard, Yale, et cetera. And I guess the reason I had been appointed was that I did have so much experience.

In fact, they had a pyramid system. They would start out with, oh, maybe sixteen internal medical residents. At the end of the second year, there would be eight. At the end of the third year, there would be one. So you had one chance out of sixteen of surviving three years of residency in internal medicine at Washington University, and those who dropped out at the end of the first or second year had to go someplace else. It was a pyramid system. They were very competitive with each other, and this is the way it was at those schools back there. There wasn’t such a thing as signing up for three years of residency. You were measured very carefully, and only one survived.

Fortunately, in neurology they didn’t have that. They only had one neurology resident at one time. So I was the neurology resident for—what they had was a private service and a house service. The house service were indigent patients who didn’t have to pay a cent, and they were entirely cared for by what they called the house staff, which were the residents, interns and medical students. The medical students did the lab work in a little lab across the hall.

There were 24 patients to a ward. There were curtains between beds. There was the African-American ward and the non-African-American ward. And there were the female wards and the male wards. This was the house service, and as I say, it was very elitist. The faculty member on rotation would be number one in charge. Number two in charge would be the senior resident, which was the one of the sixteen that survived into the third year, and then would be the medical resident, and then would be the first-year intern, and then would be the medical students.

On rounds, the professor only talked to the third-year resident, and the whole entourage would be grouped around, but the professor talked to the third-year senior resident. He would turn around and tell the group what was going on [laughing].

ASH: Like an interpreter.

CARTER: Like an interpreter. And of course the third-year resident was good. He was professorial material, and he was expected to go on to some type of appointment at some medical school if not at Washington University.

And of course they expected the senior resident in any specialty to be as good if not better than the faculty as far as clinical things were concerned, and you didn't survive unless you were. Fortunately I had this head start, so I was right on top of things, and it worked out very well. I knew how to keep—I had worked with a neurosurgeon, so I knew a neurosurgical condition when I saw one; and so often the neurologist would get into trouble because they would have a neurosurgical condition and they would wait too long before they got the consult. And I was right on top of this, and so the neurosurgeons loved me because I got them in time, and in those days it was important because we didn't have the imaging studies that we have now, and so we couldn't tell things that are going on in the head; we had to use our experience, we had to use our examination skill.

So I got along very well just because I had such a head start, and it was my job to be the consultant to the internist and to the whole doggone hospital; even on the private service I was the neurology consultant. And the internal medical residents, interns, would rotate through this neurology service, which was my service.

ASH: Were you working with neurology faculty there? Were there any outstanding neurology faculty?

CARTER: That's an interesting note. The chairman of the department was really a Ph.D. He had little or no clinical experience. And there actually were no exceptional full-time neurologists on the faculty. They were all private. These private neurologists would rotate on the service, and they were good. They were excellent clinicians. They were excellent. And they would spend their time. Although there was one neurologist, who was an excellent clinician, he'd make his rounds—well, he'd make rounds when he was rotating at the usual time in the morning as he was supposed to, but he used to make his own private rounds, oh, after seven o'clock at night. And after the day was over I would wait for him and make rounds with him on his private patients because I learned so much.

As I say, these were private doctors, and they weren't paid to do this work at the hospital. But, you see, it was a combined private hospital and house service hospital, so anybody who admitted their private patients to this hospital was expected to be of faculty caliber and expected to teach, and they did. They took a great deal of pride in their teaching and a great deal of pride in the quality of the output of their residents. It worked very well at that level.

The faculty were mainly researchers in neurology—well, all of the faculty, even in internal medicine and surgery, had their little research business going on and were expected to publish. Neurology at Washington U was mainly neurophysiology. They were just beginning to develop nerve conduction studies and EMG, electromyography; the electroencephalography was the only electroencephalogram in the city of St. Louis, or in the state of Missouri. All the electroencephalograms came through our department. Every night I would take home six EEGs, and I would write out the report after I got home, and then I would bring it back in the morning and go over them with the professor.

And you know, a lot was expected of you. I had one week vacation in 24 months.

ASH: You were married by this time?

CARTER: I was married, [laughing] I had two children. We had a little house on the outskirts of town; it was 40 minutes from the hospital to the house, 40 minutes back. I would get home about 10 o'clock at night, and up in the morning and back. And of course we had Saturday morning rounds, so I usually didn't finish up until late in the afternoon Saturday. There were Sunday morning rounds. So every day I was in that hospital, besides being on call. And that was 24 months, and that was what was expected of you. Nobody complained, and this was part of your life.

ASH: And then you came back to Portland from there?

CARTER: Came back to Portland and went into practice with Dr. Dow and Dr. Raaf and Dr. Larson. And I spent three years doing that, at which time I decided to go into private practice by myself, feeling a need for independence.

ASH: And why was that?

CARTER: It probably wasn't entirely rational. I think it was a feeling that I wanted to have more control of my life. And you know, it wasn't rational because I had less control of my life: I was responsible 24 hours a day to my practice, and I had nobody to cover for me if I wanted to not be available.

So from that standpoint, it wasn't a good decision, in retrospect, although it was a maturing decision that placed me in a position where I needed to think about the economic aspects of the practice of medicine. I had to think about developing a friendly office that was conducive to both patients and referring sources, goodwill. So from that standpoint, it was something that was very maturing.

ASH: Where was your office?

CARTER: Well, originally my office was kitty-corner from Dr. Dow and Dr. Raaf, in the Medical Arts Building. From there I moved within a few weeks, actually, to an office down the street—and by golly, it was on Taylor, but I forget the name of the building.

ASH: Were there any hard feelings on their part that you did this?

CARTER: Oh, I think so. I think so. I left, you know, a hiatus there that they had to cover for because I was doing a lot of work, and so I think that they probably resented it, although this was never expressed forcibly and they were very good about permitting me to make copies of patients that I had seen that I was seeing in private practice. But I'm sure that life wasn't any easier for them, and I can understand. And also, I can understand that they felt as if they had been very supportive of me over those developing years, which they were. On the other hand, I felt that I had worked very hard for them, too. So it's one of those things that it's hard to tell which side was right.

ASH: Were you still referring patients to Dr. Raaf for neurosurgery?

CARTER: Oh, yeah.

ASH: So there was still a tie there?

CARTER: Sure. Although at that time—you've got to realize that at that time other neurosurgeons were in town. There was Livingston and Davis out at Providence. William Livingston was probably the first full-time professor of surgery here. He had been in private practice in Portland as a surgeon, had been in the Navy during the war, had specialized in peripheral nerve injury surgery in the Navy. Came back here and became the first full-time surgical professor.

Up until that time the professorship had been carried by a person by the name of Thomas Joyce, who was the head surgeon at the Portland Clinic. And he passed away, oh, maybe '47 or '48, and then I think that Livingston—I don't know how they handled it, the professorship, until Livingston came along.

It was after the war that Livingston came along; it may have been very soon after Joyce passed away. And his son, Kenny Livingston, took a neurosurgical residency, I don't know where, and he came back to Portland as a young man, and a fellow by the name of Davis, who had taken his residency in San Francisco came back, and they two of them practiced neurosurgery at Providence Hospital.

ASH: So that made three neurosurgeons in town?

CARTER: Then there was a neurosurgeon who had trained with Dr. Raaf who was at Emanuel. So there was neurosurgery at Emanuel and Providence at the time that I went into private practice, and of course, I worked with them a lot, too.

ASH: Since we're talking about competition a little bit here, can we back up and talk about medicine in Portland and the town-gown relations before University Hospital was built here? Because I've heard that there was a lot of controversy in the community about University Hospital.

CARTER: I think it still goes on. You know, there's a lunch once a week where retired physicians from the Portland area get together and eat lunch and talk. And I have attended a number of those, and I enjoy attending them. But I'm probably the only person, or one of the few people, who have spent time on the faculty at this school who attend that lunch. And they still talk about how it seems to them the medical school is taking over.

So this to me causes me to feel, you know, that this resentment is still going on, or these people are continuing this feeling that they've had all along, kind of harboring resentment of how the school is usurping their right to the practice of medicine, which really isn't true. I don't think it's been that much competition, actually. The medical school over the years has tended to care for the indigent, the welfare.

ASH: Which is all it did when you were a medical student here?

CARTER: Which is all it did when I was a medical student. There was no competition for the so-called "carriage trade," you might say. The carriage trade is a term that is used to indicate the people who are wealthy enough to pay for their own medical care. And there really was not that competition, I don't think, for the carriage trade. But as I perceive it—and you know, this is all perception, and especially in view of the fact that I did have this experience of rotating through a private hospital in my internship year, having spent my four years of medical school here—I do have this comparison of perception of faculty versus the private practice doctor down in Portland, and really it wasn't until they developed full-time faculty up here that there was any competition.

I think the earliest perception was, "Well, those people up there are getting a salary; why should they be seeing private patients?" That was part of the situation. But I think it's got to be realized, too, that the salary that the early full-time clinician faculty received at the medical school was hardly commensurate with any private practice income. And so in order to get your children through college, you did see private patients to supplement the income.

Now, I'd have to look at the incomes, and I never saw the income—except for my own personal experience, and I can personally say that in order to have an income that permitted my family to have an average experience in life—and I mean average—I had to supplement my income with private practice. But I think that there was an idea amongst the private doctors that you shouldn't do that, that you're getting—you've elected to be a teacher, you've got an eight-hour day, and you should be satisfied with that and not be seeing private patients.

But that's a perception I have, but you've got to realize that when I was in medical school there really were no full-time clinicians on the faculty. All the teaching was done by doctors who would donate their time by coming from their private practice downtown up to school, giving lectures, going on rounds, going over work-ups with medical students and so forth. It was all donated time.

Even the surgeons: Dr. Selling and other doctors at the Portland Clinic, they all—and Dr. Baird originally was at the Portland Clinic. He was second, third dean. He was dean when I was

here. He was from the Portland Clinic also. And first he was given the job as dean, and he continued to practice at the Portland Clinic. Finally he said, you know, “This is too much. I either stay in my private practice and somebody else can be dean, or you’re going to have to pay me to be dean.” I think that’s what happened; I don’t know, but I would think that’s what happened, and they said, “Okay.”

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

ASH: It’s July 20th, 1998, and this is Joan Ash interviewing Dr. Conrad Carter in the BICC. This is tape two.

CARTER: Okay. So as I say, before the war years and during the war years, there were really no full-time clinical faculty, and medical students really didn’t have any contact with a clinician until their third year; they were all Ph.D.s or M.D.s with Ph.D.s. The teaching was excellent, I think—you know, for the time. They were preparing doctors to go out into the state of Oregon: Medford, Coos Bay, Pendleton, Eugene, Forest Grove, wherever. And the vast majority of the medical students in those days took one-year rotating internship, and they went into practice. Everybody takes residency these days, even in family practice. But in those days, maybe 15 percent of the class took residencies. They went out into Coos Bay, Cottage Grove, and they did surgery, and they did obstetrics and gynecology, internal medicine—they did everything. And that was what was expected of them, and that was what the school was teaching them to do, and they did it as best they could.

I remember spending a month in Newport, Oregon taking the practice of a family practitioner down there who needed a rest. There was no clinical lab in Newport; there was no x-ray. The closest hospital was in Toledo, the next city inland, and so any surgery, any deliveries, you got in your car and you zipped to Toledo. And the nurse gave a drop anesthesia, and you did what had to be done and went back to the office and finished up. And it wasn’t uncommon to see forty patients a day with no laboratory and no x-rays whatsoever. That was the practice of medicine back in those days.

ASH: When did you do that month?

CARTER: Oh, that was either the spring of 1954 or the spring of 1951. It was one of the two years that I was in Dr. Dow’s office. I decided, well, it would be fun to go down there and do this, while I still had the knowledge on how to deliver a baby, which I’d been taught in medical school and my internship, and still had the ability to take out an appendix and all those things. We took pride in being able to do those things, and I wanted to take advantage of that, and so I took this month. Dr. Dow didn’t like it very much [laughter], but he was good about it, and I was paid well, and we could use the money. We were saving up money to take a residency then. We put our money away. So that’s why I did that.

I remember I had one classmate who was on a troop ship—I guess it was during the Korean War, coming back from Europe—and his wife and he were coming back on this troop ship as

passengers, and there were a couple of doctors on there who had been trained at Harvard. Somebody got appendicitis, and they had never operated on an appendix. And of course this classmate of mine, he knew how to operate on appendices; he'd been in practice in Klamath Falls before he had to go in the service. So he went down and he did the appendix. The difference between the University of Oregon Medical School and Harvard, for instance: we were taught at that time to be all-around doctors and go out into the small towns and do good.

Anyway, I've diverged. Where was I? Oh, well, the first full-time physicians, Daniel Labby and Hod Lewis, Howard Lewis, they came on the faculty, and of course they started seeing some private patients, which was of some concern to the physicians downtown.

Just to diverge a little bit, I ran into an elderly gastroenterologist just the other day in the outpatient clinic. He's retired, and I remember as a junior medical student he had taken a gastroenterology fellowship outside of town, came into town and started practice as a young man. And he was the first internist, gastroenterologist, to stand up in front of the class and say that peptic ulcers could be treated medically. Up until that time it was a rule that every one was operated because the percentage of cancer that developed was so great that you had to have a gastrectomy. So they had a number of Billroth I, Billroth II, vagotomy—they were all operated on, and everybody thought this guy would lose his clinical faculty position for getting up and saying that. He did it, and he survived [laughs]. It changed the whole way things were treated, peptic ulcers. But anyway, that's a little bit of a divergence.

I guess the next step would be when I took my rotating internship at Good Samaritan Hospital. These were all private practice doctors, and for some reason they were very, very jealous of their practices. They were very concerned about maintaining their practice, and I guess this was a holdover from the Depression years.

I remember one well-known—he became a very well-known internist in time, but he remembers coming back to Portland, being a native son, training at Johns Hopkins and Peter Bent Brigham in Boston—very well trained—came back here as an internist, and for the first six months he saw something like three patients in his office. He had to have enough money to pay the rent and wait until he was able to develop his consultation basis and his reputation, and in that era a doctor's practice was based on word of mouth recommendations from one patient to another.

ASH: So when was it that person had such a hard time?

CARTER: Oh, '32, '33. And that wasn't uncommon. You really worked to develop your practice. After all those years of being paid almost nothing for your training, you would come into town here as a specialist, and it was tough going.

ASH: But actually when you were doing that rotating internship, the physicians at Good Samaritan had busy practices?

CARTER: They had busy practices, but they were very jealous of them. It was very upsetting to them if a patient of theirs would end up with another doctor in town. I heard this discussed and talked about. The surgeons, especially, because of course they had to make out schedules for prime time in surgery. Those who had the most surgery got the prime times. And most of it was elective surgery in those days. So they had to have big referral sources and big practices to schedule enough patients to maintain their prime time schedule.

So this is my perception, that they were all very jealous. In fact, one of the internal medical residents down there—they have a list every day of the scheduled surgery, and he called it the “jealous sheet” because all the surgeons would look at it and see who was doing how many—or at least that was his perception that that was what they were doing.

So reputation and size of practice was very jealously maintained among these doctors, and this was pretty citywide. In those days there were actually two private hospitals in town that were entirely run by one doctor who took care of all the patients in that hospital. They were glorified nursing homes, for all practical purposes, but they did surgery, for instance.

ASH: That was Physicians & Surgeons? Was that one of them?

CARTER: Physicians & Surgeons was one of them. The Coffey brothers were the doctors there. Then there was one over in Eastmoreland; I forget the name of that. But I remember going over there and donating blood for \$15, I think, or something like that, when I was a medical student. There was just one doctor there, and he did surgery, and he had about twenty beds there, and it was kind of a glorified nursing home. And that was his practice.

ASH: Let’s continue with the time when you were an intern. Some of the University of Oregon Medical School faculty were practicing part-time downtown? I mean, those who were not volunteers; there were some who were being paid up here to teach, like Dr. Swan, who also had private practices elsewhere?

CARTER: Yes. Let’s see. You see, I don’t know if these people were paid from up here. For instance, the professor of urology had his private practice at Good Sam. Many of the surgeons who did surgery up here had their private practice at Good Sam: Rockey, for instance, was one of those surgeons. Dr. Raaf, he spent one day a week up here, doing their neurosurgery up here. And of course many of the internists came up here and taught. Dr. Swan, I forget if Dr. Swan ever was affiliated with a private hospital or not. I’m not at all sure about that. But he came up here full-time very quickly.

ASH: The private practitioners donated time up here, but what I’m trying to get at is, was there jealousy when faculty members here who were actually paid had practices elsewhere, before the hospital was built? They must have.

CARTER: Well, yeah, there was jealousy before the hospital was built, but you’ve got to realize that it wasn’t long after the University Hospital South was built that they started developing

full-time faculty up here, a full-time urologist, a full-time neurosurgeon, a full-time ophthalmologist, full-time internal medicine, full-time ENT, et cetera. And that caused problems because many of the full-time people also kept a private practice downtown.

For instance, the first professor of urology as I remember had his private urology practice at Emanuel.

ASH: Was that Clarence Hodges?

CARTER: Yeah, I think that was the one. This of course was very upsetting to the professor of urology, who was a private practitioner at Good Sam. He didn't think that was right for somebody to come in and have a private practice in one of the private hospitals and still be professor of urology.

This varied from case to case. The internists were very accepting of Howard Lewis, very accepting, and I don't think Howard ever—well, I know he never had a practice in any of the private hospitals or downtown. I know that he did help some of the internists out by making rounds on Sunday at least one of the private hospitals. I think there were a bunch of internists who took rotations, and he was asked to be in on that rotation, because I remember, as an intern at Good Sam, Dr. Lewis making rounds on Sunday morning. And of course this was great for me because here was a big professor [laughs], and I'd catch him and then go on rounds with him just because I wanted to hear what he had to say, and he was very good about teaching.

So this varied from case to case, and I could almost go from case to case. For instance, Dr. Raaf, ever since he came into Portland, which was about '38, after a surgical residency at Mayo Clinic—very competent, capable surgeon as well as a very capable neurologist, because they were required to learn their neurology at the Mayo Clinic before they could be neurosurgeons—he gave lectures here at the medical school, both on neurosurgery and neuropathology; besides donating, as I remember, one day a week to the neurosurgical patients in the County Hospital.

By that time he had developed a neurosurgical residency of his own, whereby one-third of the time was spent here at the medical school under his supervision, and the rest of the time was spent at Good Samaritan Hospital, where all the neurosurgery was done, for all practical purposes, in those days.

ASH: So there was no neurosurgery residency at that time here, except as rotation through—it was basically at Good Sam?

CARTER: That's right. And then they decided to have a full-time professor of neurosurgery, and this—I'm not sure of these details, but I think it's right that they developed a search committee, which consisted I think of Dr. Davis, the neurosurgeon out of Providence, and there were two others. And he [Raaf] wasn't on the committee. And they obtained a full-time neurosurgical professor to be a professor here at the medical school. And he was going to develop his own neurosurgical residency.

Unfortunately, I don't think that he related well to Dr. Raaf, and I don't think that Dr. Raaf thought it was his place to be the one to do the relating, but I could be wrong on that because I don't know what transpired. But ultimately when the professor of neurosurgery first got here, Dr. Raaf's residents continued to rotate here until he could develop his own residency program, and then we ended up with two residencies in neurosurgery in Portland, which—well, depends on how you look at it; some people would think that was kind of too bad. And Dr. Raaf never related again to the medical school until very late, late, late in his career when he endowed a chair. And so Dr. Burchiel, who is the chairman of the division of neurosurgery now is the Dr. John Raaf endowed chair of neurosurgery in a situation where there was to the best of my knowledge no connection between Dr. Raaf and the medical school until ...

ASH: Who was the first chair of neurosurgery here?

CARTER: Dr. George Austin. He came from University of Pennsylvania Medical School Neurosurgery, and Dr. Paxton replaced him.

ASH: So was there a personal animosity between the two, or it was simply a matter of competition for residents?

CARTER: Oh, I think there was animosity. I don't know this, but I think Dr. Raaf probably felt that he should have received more consideration, in that he made a lot of commitment to the medical school over the years in neurosurgery, and then all of a sudden being not involved in making the choice of the first professor and suddenly being excluded. I think if it had been me, I would have been resentful.

And I don't think that Dr. Austin was as diplomatic as he should have been. Dr. Raaf was the grand old man of neurosurgery and should have been recognized as such—I think, in my own humble opinion. And I don't think that was done by Dr. Austin. New young man on the block, and he was going to take over, and nobody was going to interfere. I think that that was the attitude.

ASH: How is it, then, that Dr. Raaf ended up endowing the chair here?

CARTER: That I don't know. That I don't know—unless, I think—you know, he spent all those years and years and years at Good Sam, and he contributed a lot to Good Samaritan Hospital. He always had a huge practice, lots of surgery. Neurosurgical residency. And these were the good old days at Good Sam when the Episcopal Church was the supporter of the hospital. The doctors ran the hospital, took a great deal of pride in the quality of what the hospital did, the hospital work. And all of a sudden some company from back East comes and takes over and says, "Well, we're in charge now, and this is the way things are going to be."

And so I'm only surmising—I've never talked to Dr. Raaf about this—I'm only surmising, but I kind of suspect he became somewhat disillusioned and wanted to leave his legacy in neurosurgery somewhere in Portland and felt that the medical school was the place to go. And

rightfully so, I think, because this is where neurosurgery is going to be perpetuated as far as a teaching situation is concerned and this is where the research is going to go on, at least in the foreseeable future, and I think Dr. Raaf has a great deal of respect for academic excellence.

So that would be my idea as to why he ended up endowing the chair that he did, and I've been told that he even—at least until fairly recently he used to come to grand rounds in neurosurgery. He'd sit in the back: the grand old man of neurosurgery.

So that's the way it was in neurosurgery.

ASH: What about neurology?

CARTER: In neurology, here again Dr. Dow—well, you've got to realize that Dr. Dow was a very unusual person. He grew up in McMinnville, Oregon; I think he came from a Baptist family—most of them did in McMinnville. Went to the University of Oregon in Eugene and came to the medical school here, and really was a shining light as far as academic excellence was concerned here at the medical school. Excellent anatomist and he wrote some papers on the lung as a medical student in anatomy and excelled; so that his brilliance, his academic commitment was recognized very early by Dr. Larsell and Dr. Allen in the Anatomy Department.

In those days, of course, after medical school one—most of the internships were in Portland, at one of the private hospitals, but there were a few elite internships: two or three students went back to the University of Wisconsin in Madison, two or three went to a hospital in Minneapolis, and there may have been one in Michigan, and Dr. Dow received one of the appointments to University of Wisconsin in Madison. That's where Bill Youmans was from, as you probably know.

So he interned in Madison, and by that time his capabilities were so well known that actually I don't think he ever took a neurology residency. The year after he interned he went to Belgium, where he spent a year with an internationally known histologist—whose name I don't remember now. He had written a book, and we used his book in premed and in medical school. And I can look that up if it's important. Bremer[?]. His name was Bremer, and I'm not quite sure how to spell that. Internationally known. And he worked in Bremer's lab for a year in neurohistology.

Came back and spent a year at a research institute in New York City; do you remember the name of that? It was a world-renowned research institute endowed by Carnegie or Vanderbilt or somebody, and the name will come to me about the time I go to sleep tonight. But anyway, he spent a year doing research there. And in those days you only needed two years of training to be board certified. Evidently it didn't have to be clinical neurology.

So he came back to Portland and went into private practice with Dr. Raaf. I guess Dr. Raaf was already here. And one of his first duties was of course to work up Dr. Raaf's patients. And then he branched into neurology as a specialty—because you've got to remember, neurology in those days—they really didn't think you could make a living being a neurologist by yourself. You were a

neuropsychiatrist, and most of the neurologists did psychiatry for their bread and butter, and neurology was frosting on the cake.

So Dr. Dow was probably the first full-time neurologist in Oregon and possibly the whole Pacific Northwest. Dr. Selling was a neurologist, but he did internal medicine and took great pride in his capabilities in doing internal medicine. So neurology was kind of the frosting on the cake for him.

When I took my residency actually, the private neurologists who taught me in St. Louis all had psychiatry practices, and they all had inpatient psychiatric patients, and every morning they would go in and do their electric shock, which was kind of their bread and butter.

We were expected to have at least six years of residency in psychiatry to be eligible for our boards. And of course I had my year, so I was in good shape. I don't know how Dr. Dow got around that, but he came back and went into practice with Dr. Raaf.

I think you had to be in practice for a couple of years before you were eligible to take your boards after your residency in those days, and he took his board and he passed it, and he was probably the first board-certified neurologist in—certainly in Oregon.

During this time, though, he taught at the medical school here. He was one of our lecturers in anatomy—not only in neuroanatomy, but in anatomy. And he would come walking up in the morning with his little black bag filled with his reflex hammer and tuning fork and all those things that neurologists used, stethoscope, blood pressure cuff and everything. Doctors had little black bags in those days. He'd come walking in for the eight o'clock lecture, put his bag down, get up and start lecturing.

On Saturday mornings, there was an elective lecture on neuroanatomy, and he would lecture—oh, I forget, ten o'clock in the morning, something like that. It was an elective. Students from all classes would come to that lecture, and none of them were obligated to attend the lecture, and they weren't tested.

ASH: Did people come?

CARTER: Oh, yeah. He filled it up. Here was this man in private practice, who was going back down to his office to see patients on Saturdays—there were office hours on Saturdays in those days—who stopped and gave a lecture which everybody realized was of such quality that you'd be stupid not to take advantage of it. And he did this for no fee, that I know of, besides continuing to enter into the full-scale teaching of anatomy here at the medical school.

I remember, he was a member of the group that would give us orals in our anatomy; we had orals about twice a year, as I remember, and there would be three professors there, and Dow frequently was one of them. He kept an eye on our grades, and if your grades were going down, he'd call you in.

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

CARTER: So he was very interested in the academic aspects of the medical school, made a strong commitment to it, and he ran the EEG lab. There were two EEG labs in Portland; there was one that he had which was in a little room or group of rooms just below the Portland Clinic, in the same building as the Portland Clinic. I guess he leased it from the Portland Clinic. And then there was this six-channel EEG lab he had at the medical school, and he would come up and interpret those EEGs a couple of times a week; and he was in charge of the lab and got the technicians and so on and so forth.

Besides making rounds on all the neurology inpatients in the County Hospital and besides coming to the neurology clinic, he made a very strong commitment, besides having a very busy private practice. And it was his life; he enjoyed it. And he was Mr. Neurology, and very capable and responsible over those years.

I remember, just to diverge a little bit, there was a concept of so-called “musicogenic” epilepsy, where a certain tune or song would allegedly precipitate an epileptic seizure in a patient, and they called it musicogenic epilepsy. And this was the only thing that would produce a seizure in these people. And so a patient came into his office and said, “Every time I hear ‘You Are My Sunshine,’ I have a seizure.” And that that time it really wasn’t known whether or not this was psychogenic or if music or a tune could precipitate an epileptic seizure.

So he made arrangements for the patient to have an electroencephalogram up here at the medical school with a movie camera. And I remember I was appointed to orchestrate this, and we had this EEG going, and we had this 78 per minute record of “You Are My Sunshine,” and this patient lay down on a table with EEGs attached to his head, the electrodes, and we played this and the patient had a seizure, and it was recorded on the EEG, the first time in history that this was actually recorded. And he took it back to the American Neurological Association meeting, which was in New Jersey, Atlantic City, and reported this. And it came out in journals and so forth.

Anyway, this is an unusual person that was really committed to excellence in his area.

I remember—I guess I was in the Air Force at the time—he invited me to attend the American Neurological Association meeting and room with him. It was more economical to room with somebody. And being in the Air Force, I was able to hop from one base to another to get there, and they let me do it from the base, so I went up to the American Neurological Association meeting, which is a very elitist group, mainly East Coast people. It wasn’t until later that the American Academy of Neurology was developed by Midwestern professors who felt like there should be some kind of educational forum for people who were interested in residents and so forth. But that’s another story.

Anyway, this was a very elite group. And he told me at that time that he was going to go out to dinner with a group of people because there was a neurologist there who was being considered

for the chairman of the Department of Neurology here. It was really a division of neurology, it was under Medicine in those days.

ASH: And that would have been the first one?

CARTER: And that would have been the first one. And I found out later that was Dr. Swank, who was at the Montreal Neurological Institute at that time, just starting out in his research on the clinical care of multiple sclerosis by a low-fat diet.

Of course I was a part of the group that went out to dinner that night, but later on it turned out that Dr. Swank was appointed as a full-time professor of neurology here at the medical school.

ASH: Did he go from being an assistant professor there to being a full professor here; do you know?

CARTER: I don't know what his rank was at Montreal Neurological. I just don't know. But he had had his residency at Harvard—as you know, a very elitist group in those days: Ray Adams, Denny Brown—big names in neurology all were at Harvard at that time, and Dr. Swank had taken his residency there and it was probably one of the foremost elitist neurology residencies of the day. Baltimore would argue about that and St. Louis would argue about that, Columbia University would argue about that, but face it: they had the elite and they had class.

So that's when Dr. Swank came here, which probably would have been maybe late fifties. I'm trying to think whether he was here when I arrived back from St. Louis or not. I arrived back here in '56, and it had to be at least between '53 and '60 Dr. Swank arrived. Maybe it will come to me.

And whether—and of course I don't know what Dr. Dow's opinion was based on that one evening meal that he had with the group there in Atlantic City, and I don't know if Dr. Dow even was a part of the decision-making process; but my memory of the situation was that Dr. Swank was very accepting of Dr. Dow's involvement in the whole thing, as I remember. Dr. Swank wanted to maintain Dr. Dow's involvement. But also Dr. Dow had started a neurology residency sometime in the mid-fifties at Good Samaritan. But it was a two-year residency, and the third year—or maybe it was a one-year—it was originally a one-year residency which was really a preceptorship at Good Samaritan, and then they went down to the Veterans Hospital in San Francisco, Fort Miley, for the last two years. So there were a number of, a few neurologists in the Pacific Northwest who obtained their neurology background in that manner.

And then when Dr. Swank came they developed a residency in which the residents spent either one or two years at Good Sam and one or two years here at the medical school. So they had a combined residency program.

Then conflicts developed, and I don't remember the entire basis of the conflicts, but there were conflicts; and they may have had to do with resentments about private practice on the part of

the neurology faculty here at the medical school. Jim Austin came on the full-time faculty not too long after Dr. Swank got here. He was trained at Columbia and later became chairman of the department at the University of Colorado. Janice Stevens came; she was trained at Harvard.

ASH: In what department?

CARTER: Neurology. And they were all doing some private practice to an extent, all of them. I think Dr. Swank was doing the most private practice, and it wasn't because—and of course Dr. Dow had all the private practice he needed. But there were some problems there. There were some problems in relationship to responsibilities of residents; and there ended up a complete schism: an absence of communication.

Dr. Dow started his own residency at Good Samaritan, a three-year residency in neurology. Dr. Swank had his own residency here, supported by the National Institutes of Health, and I think the National Institutes of Health supported Dr. Dow's, also. So there were two neurology residencies in Portland, without intercommunication, for all practical purposes—which, you know, was very tragic. People nationally in neurology, and I know this because I have friends, looked upon this as not being a good situation because they really didn't think that there was enough good training material in a place like Portland to support two residencies.

So a number of times individuals or groups of individuals came to Portland to review this whole situation, with an idea towards providing information as to whether or not this was really sustainable. Fred Plum, who was the first Chairman of the Division of Neurology at the University of Washington, came down, too—and he was a bright young man in those days, and went on to a very illustrious career and is still very active as a professor at Cornell—came down one time to review the whole thing.

I never read the reviews, so I don't know how they came out, but no matter how they came out, the two chairmen were able to preserve their training programs—until finally the powers that be, and I don't know who these people were, said, "Okay, now, enough's enough. You either combine your programs, or we are going to eliminate accreditation."

And as I say, this is unofficial. This is the way I remember it. I never saw it in writing, but I do know that the two of them got together and combined their programs. And I think it was just because they realized that the time had come; either there was going to be none, or they were going to get together and provide one program between the two of them, and that neither of them were going to be able to keep their program independently. And that's how this combination—uneasy combination, you might say—occurred.

So as I remember it ended up with one year of residency at Good Sam and two years here at the medical school. And that's how the program went for a number of years afterward. In fact, it continued until within the last two or three years when Dr. Zimmerman eliminated the Good Samaritan one.

An interesting aspect of this—and of course this was very important to Dr. Dow, having this residency program. I think he visualized having an independent neurological institute with both research, good research, basic research, as well as excellence of clinical training at Good Samaritan Hospital. This was his dream.

ASH: Did he start NSI over there?

CARTER: Yes.

ASH: So that was his dream?

CARTER: Oh, yeah. He started it. And he worked to develop an endowment for that over the years. And I remember even in his last years I'd see him at a meeting, some kind of a dinner together or something like that, and he would talk about people that he was going to have dinner with the next week and talk to them about contributing to the endowment for the perpetuation of the Dow Institute in Neurology at what became Legacy, which was Legacy at that time. He worked for that until probably the last day of his life.

Another interesting aspect of this—which I think I can say in public because one of his colleagues at his funeral got up and said this—that this colleague had visited Dr. Dow when he was fairly close to death but still lucid, and he said to that colleague, “Don't let them take our residency.” It seems so sad that after his death his residency did disappear. Interesting commentary on a person who I have outlined as being a person who was committed to the field of neurology, both basic research and the clinical aspect of it, who really wanted to develop a perpetuated neurological institute designed to continue his ideals, and it just didn't happen.

ASH: Now the NSI is part of OHSU...

CARTER: Right. It seems like it's all come back. Dr. Raaf has committed his endowment to the medical school. Dr. Dow, everything he has built up over the years is coming into the medical school, and Dr. Dow's ideal of being able to develop an institute in a private institution, like the Mayo Clinic, for instance, or Presbyterian Hospital in New York, just wasn't feasible in the city of Portland. He wanted that to happen. It makes a very interesting story of a person who had a very goal-directed life.

He was quite a capable administrator on top of being able to give to the world basic information on basic science. You know, he wrote a book on the cerebellum during that year he was in Italy, and it was the first full book on the cerebellum, just about the cerebellum itself. And he sat in a library there, with no heat, overcoat on, scarf around his neck, writing this book and doing this research in Italy for this darned book [laughing].

And of course being a clinically excellent individual, developing the specialty of electroencephalography—he was President of the American Electroencephalographic Association one year. He orchestrated a research project during the war in which they put an electroen-

cephalographic machine into one of the shipyards, and immediately after a head injury they would do an electroencephalogram before they sent the patient to the hospital. I don't think they would do that in this day and age [laughing]. And they wrote a paper on the effects of head injuries and electroencephalography. And this was what he was doing back in the forties, with the help of a senior student.

And then of course he got into the business of administration and developing his neurological institute and so forth. Amazing man; somebody should write a biography on him.

ASH: At what point did he stop teaching here at the medical school?

CARTER: When the schism occurred between the Division of Neurology, Dr. Swank, and Dr. Dow.

ASH: When the two residencies began?

CARTER: When the residency broke up, and I could go back and find out when that year was. Dr. Stevens, Janice Stevens, an excellent electroencephalographer, she was running the EEG lab, so he could get along without the EEG lab after that. Dr. Austin was here, Dr. Stevens was here, Dr. Swank was here; they could do the clinical stuff.

And that brings us to the point: how did I get here. I came here full-time in '61, as I remember. There weren't many neurologists in the country at that time. There weren't many neurologists in Portland. Dr. Swank was committed to basic research in MS. That was what he wanted to do. He made rounds once a week on Monday morning, and he was through for the week clinically.

Dr. Austin was very committed to his research, too. He was developing his status in neurology and doing some excellent basic research on neurological diseases. And Dr. Stevens was very committed to her research. And Dr. Swank felt that there was a place for a full-time clinician who could take weekend calls, who could take night calls and could orchestrate the residency program, who could be sure that rounds were made, and so forth.

I had been coming up to grand rounds here in neurology, had been contributing because I'd had a good clinical neurological residency program. I was as clinically capable as anybody, probably.

And so he gave me a phone call one day at my office and said, "Come on up here; I'd like to talk to you." And he offered me a full-time position, to come into the division, which was a division at that time. So I had four children by that time; I felt as if I was being run ragged.

ASH: You were still in solo practice?

CARTER: I was in solo private practice. And I thought, “Well, the income might not be as great, but on the other hand, I can enjoy my family a little bit more than I have, much more than I have. I’ve got vacation every year.” You know, if you’re in private practice, you get four referrals two hours before you’re supposed to take off on a vacation. Your husband has had that experience, I’m sure [laughs].

ASH: Yes.

CARTER: And so that’s how I came aboard, actually. I was the clinician and the resident organizer.

ASH: And you closed your office?

CARTER: Closed my office. One of Dr. Raaf’s trained neurosurgeons came into town after spending time in Honolulu, and he needed an office, and it worked out very well. He took over my lease, he took over my patients, although I was allowed to see private patients here on the hill, and they could come to me if they wanted to, and if he felt as if there were patients he didn’t especially feel competent in, they’d be referred up here. And I was very lucky, I was able to drop right out of private practice and come up here full-time.

ASH: That was a very brave thing for you to do, though, at that point in your career, such a switch from full-time private practice to academic medicine.

CARTER: Well, I suppose it was, but I’ve done some foolhardy things in my life [laughs]. That may have been one of them, although I’ve never regretted it.

ASH: So how did your life change at that point? Was it a reality that you were able to then spend more time with your family?

CARTER: Well, it was a reality, sure, because we were allowed vacation time. Weekends—you know, in private practice, patients all day every day, Saturday morning office hours. You had patients in the hospital, and at that time I had them in two or three hospitals because Dr. Raaf and Dr. Dow only went to Good Sam; and so I had patients at Emanuel, I had patients in the Adventist hospital, and I had patients at St. Vincent. So in making my rounds, which I usually did in the evening, I would go to three different hospitals.

So I’d go home and have dinner and head back out, make my rounds, work up patients that had been admitted during the day. Saturday was the same way, Sunday was the same way, and that was my life. Which—you know, it was very heady; I enjoyed the activity, I enjoyed the challenge, but it was hard on the family. And it was hard on me because the kids were growing up, and I didn’t know them. So I realized that I had jumped from the frying pan into the fire when I decided to go out on my own, and it probably was kind of an ego trip, which was stupid in the long run and self-defeating.

On the other hand, I did gain an experience of private practice, which I was able to pass on, I think, to residents, which Dr. Swank, Dr. Austin, and Dr. Stevens had really no concept of. So I had a pretty good feeling as to what they needed to learn, rather than the more esoteric academic neurology, and I think that helped the program, and I think it helped the residents.

ASH: Did you teach medical students, also?

CARTER: Oh, sure. Lectured—I forget how it was, but we had neurology lectures for juniors and seniors. We had medical students rotate on the neurology service. So I had didactic lectures as well as the clinical on the ward stuff.

ASH: Then for the residency program, you did selection of new residents, or part of that, and then scheduling and ...

CARTER: Yeah, had to schedule the rotations, and not only selection but we wooed—we wanted to get the best residents we could, and so you have to give them the old college rush.

I remember, one of the reasons I went to St. Louis was I had made applications for a number of neurology residencies, but the professor at St. Louis called me personally and said, “We would like to have you. We’ve read your resume here, and we would like to have you.” And he was the only one of the applications that I’d made who communicated with me personally. The rest of them I got letters back saying that I had been accepted, but there was no—so that word of mouth impressed me, and I learned from that, that just correspondence isn’t enough. They want that personal feeling that they’re wanted and would be liked, and I think that helped because, as I say, in those days it was very formal. You sent an application, and you got a formal reply back, and that was it. I think that that had a great deal to do with me going to St. Louis.

So yeah, we wooed, rushed the residents, we made the appointments, and we rotated them.

ASH: How many did you have at a time?

CARTER: Usually one for each year to start out with. And of course it wasn’t as scheduled as it is now. In the old days of having residency, the idea was that you learned through preceptorship, and you didn’t get formal lectures or formal rotations. You had one grand rounds a week. We had usually a neurology-neurosurgical combination in those days, and that’s what we had back in St. Louis, too. But that was the residents’ show. The faculty wasn’t really expected to teach. And the residents would take the case, and we would present the history, the physical and whatever imaging studies we had, which wasn’t a lot.

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

ASH: It’s July 20th, 1998. This is Joan Ash interviewing Dr. Conrad Carter in the BICC, and this is tape three.

CARTER: So the senior resident would be in charge of grand rounds. It was his show, and he'd present the patient and all his material; and then he'd start asking the faculty for opinions. And faculty would get up and say, "Well, I think that this is this, because of this, this and that, I think it's this because of this, this and that," and we would bring the patient, and they would be examined by the faculty. They would come up from where they were sitting and ask the patient questions and do some reflexes and so forth. And that was our grand rounds for those days. And of course we pretty well knew what the patient had.

ASH: You had all seen the patient before?

CARTER: We had seen the patient—oh, yeah, we'd worked the patient up to a T, and there were some patients that we presented where we were puzzled, and we wanted to get a lot of opinions on them, but usually we did, and sometimes, you know, we were even guilty of playing—we got pretty well so that we knew if we presented a certain type of information to one faculty member, he would say this, but we knew that another faculty member would say something different. And so we would actually present a case just to hear these two people argue with each other about this [laughing].

So that's the way our grand rounds were in those days when we first started out in neurology here. Senior resident would present cases, and the faculty would sit in the front row and look very wise and pontificate. And we didn't have formal lectures. The electroencephalograms, the resident would come and he would be present when you read the electroencephalograms every day, and then he would get to the point where he was reading some, and you're going over them with him.

But they didn't have the specialty rotations that they do today, and they didn't have the—today, you know, residents get a certain amount of information formally in neuroanatomy, neurophysiology and so forth, and of course they have to have that in order really to pass their boards in this day and age, where in the old days the boards were just—you'd come together in a place and a bunch of professors would ask you verbal questions, and they'd show you a couple of electroencephalograms, and you'd look through a microscope at some pathology, and that was the boards. Today, you know, it's a very sophisticated written test that they have to do first, and then they have a lot of clinical patients.

So as I say, it was mainly on-the-job training in those early days of neurology.

ASH: Did you see children as well as adults?

CARTER: Oh, sure. We expected to be pediatric neurologists as well as adult neurologists, and so we saw neurology consults in Doernbecher, and of course had rounds on the pediatric neurology problems. It was expected. That was a part of the private practice of neurology in those days: you saw the pediatric neurology, whether it was inpatient or outpatient. You were supposed to be capable of doing that. In fact, the pediatric residents did pneumoencephalograms on the kids, part of being a pediatric resident. I don't think they ever did it in private practice, but they were expected to do it as part of their training at Doernbecher.

ASH: So how long did you stay as—was it called Director of the Residency Program, or coordinator—how long did you do that?

CARTER: Well, let's see. I was here as long as Dr. Swank was here, and that was into the 1960s. In 1960 or '61, I was a visiting professor of neurology at Washington University at St. Louis, really a 12-month sabbatical that I took back there. Did some basic research using short-lived isotopes, and then I came back and was on the faculty here until Dr. Yatsu arrived. It was early sixties, I think.

ASH: He must have come around '76.

CARTER: Oh, yeah, it would have been—yeah, it was '70 or '71 I went back to Washington. I came here in '61. I went back to Washington U around '70, '71. He came in about '76. He was the second full-time, and when he arrived, of course part of the deal was that it would become a department, that the neurology—neurology had always been a part of the internal medical departments in medical schools, and there was this surgence of becoming independent departments over the years; and Seattle still, I think, is a division, but probably the only one in the whole nation that's a division. Portland was a division, and Dr. Yatsu said, "If I'm going to come here, we're going to be a department." And that was quite acceptable to the internal medical department here because I think they looked upon us as a nuisance. Anyway, I think Dr. Bristow was chairman then, and he was perfectly happy without us, I think.

And so that's when we became a department, and Dr. Yatsu came in as chairman. And I remained for a number of years when Dr. Yatsu was here before I resigned to go into private practice.

Is it of relevance, as to what that was all about?

ASH: Sure.

CARTER: Well, at that time I had the feeling, and here again it probably wasn't rational, that my activity within the department was becoming too academic, and I wasn't involved with patients enough—which is perfectly logical; Dr. Yatsu was developing an academic department, and I was getting involved in a lot of clinical research, in stroke, for instance, and I was spending a lot of time with academic issues and wasn't seeing the nitty-gritty of everyday clinical neurology, which I thought was my forte. And so I decided I wanted to get back into private practice.

A former student here, who also had taken his residency at Washington U in St. Louis, was practicing in Eugene by himself and needed a partner, needed some help. And I thought this would be a good time for me to get back into the nitty-gritty of the private practice. So I gave up the whole academic business and went to Eugene, which was really a lot of fun.

It was a real eye-opener because I think I had lost track of what a neurologist had to be. And I know the department had lost track of that, because here I was in a situation where I was on call for the emergency room, rotating with other neurologists, I had patients in the intensive care unit, besides seeing office-call neurology. And as I say, this was an eye-opener. We weren't allowed to have patients in the ICU here at the medical school, so the neurologists we were training really didn't get responsibility in the ICU unit; they only saw patients in consultation.

Here I was in charge of these patients going to the ICU. A patient that came in with coma, for instance, from a brain hemorrhage, that was my baby. I could refer the patient if I needed internal medical help or something like that, but that was my baby. The neurosurgeons, they were only interested in patients who could be operated on, and so if a patient came in with a subarachnoid hemorrhage from an aneurism, they would take a look at the patient, and they'd say, "Okay, you take care of this, and when the patient's ready in ten days, we'll operate. But it's your patient until that happens." And that was my baby. That would have been all placed under a neurosurgeon here at the medical school.

Meningitides, we saw. So I really got into an area—and had to learn fast—of neurology that wasn't available here at the medical school for our residents, which I learned as a part of survival, really. And it was great. I really enjoyed the challenge, making these life-and-death decisions and so forth.

ASH: What about the workload? There were two of you?

CARTER: Two of us. That again got to me. We worked—I don't know, maybe I was too successful [laughing]. I was hoping, you know, that I could kind of slow down, and I was too successful.

In the meantime, I had been consulting at the Veterans Hospital in Roseburg, and finally after a few years in Eugene they said, "You know, we need a full-time person here, and we'll give you your own ward in neurology, and we'll give you your outpatient clinic, and you'll have a 40-hour week." And that sounded pretty good to me [laughs]. And so here again, you know, I took off and went to Roseburg full time at the Veterans Hospital, which again was a great experience, but it—you know, I was my own worst enemy; I was too often available.

ASH: Was it really 40 hours?

CARTER: No [laughs]. It could have been forty hours if I wasn't as conscientious as I am, but it was more than that. So it was a great five years down there, but then one day, you know, I said, "Well, let me see how much money I would have, how much income I would have if I retired right now." And I was overwhelmed with what would be available to me. I'd never looked into it. And I thought to myself, "I'm too old for this." And my wife and I just thought, "Well, enough's enough," and we retired.

ASH: That was when?

CARTER: Oh, it would have been—let’s see—probably about ’88. Came back to Portland mainly because our children are here, and I went to Dr. Zimmerman and said, “Do you need any clinical help?”

“Oh, yeah, sure.” He needed clinical help. So ever since I’ve been a clinical faculty member with—receiving no income from the school.

ASH: How often do you come up here?

CARTER: Oh, it varies. At first I came up, oh, a couple of days a week to see patients that were referred from our outpatient clinic, things like that, because the faculty is busy doing their thing. Again, this conflict between doing what faculty should do, such as research, writing papers, giving lectures and so on and so forth, and the nitty-gritty of taking care of patients and teaching residents in the outpatient clinic.

So started out with a couple of days a week, and I’ve gradually cut it down so that now I just follow my old patients that need to be followed, I will take a new patient every so often, and I come to the residents’ rounds every week that I can and keep up with neurology as best I can, and just enjoy myself.

ASH: So retirement has been good to you?

CARTER: Very good. Very good. You know, you don’t have to be anyplace at eight o’clock in the morning. You don’t have a seven o’clock meeting preceding your first patient at eight o’clock. You don’t have a five o’clock faculty meeting. You don’t have to have noon hour meetings. You don’t have to come in through rush traffic at eight o’clock in the morning. And that’s pretty nice, you know. Full-time faculty or just the practice of neurology is a rat race.

ASH: Yeah, I know.

CARTER: You may know about that, [laughing] having a husband who’s into that. It’s a rat race no matter whether you’re at the medical school or you’re in private practice. Number one importance in any practice is availability. If you’re not available, people aren’t going to refer you patients, and neurology is a referral service. Another is affability. And third is ability, unfortunately. So number one is availability, and that means commitment, and it’s hard on the family. And number two is you can’t afford not to be pleasant. You can’t be the grumpy professor type who knows it all and is critical of referral sources.

ASH: Do you think there’s a real advantage to having gone back and forth between the clinical private practice and the academic?

CARTER: Oh, I think so. You know, neurology, the practice of medicine changes so fast; and medical schools can become very stagnant and traditional, and practice passes them up. We

didn't have a CT scan here at the medical school until they were in some of the private hospitals in Portland, and we should have been on the cutting edge of that development.

Same way with ICU, we're just at the point in our department now where we have a full-time neurology ICU specialist. Yet if somebody is going to go out and practice in the community, they should be able to handle themselves with ICU patients because they're going to have them. They're going to be in coma from a stroke, meningitis, overdoses, and things like that. And I think that we should have firsthand training in that sort of thing in a neurology residency. But the problem is none of the faculty ever had that traditional training as part of their training, in an ICU. They didn't have ICUs when most of our present faculty joined the faculty. And so the whole concept is foreign to them. And they were able to get along without learning about ICUs, so the current residents should. And that means—personally I don't think we're preparing our residents well for going out to what really is in the community.

ASH: Well, I don't want to keep you much longer, but I think that this is relevant to the town-gown issue because what I hear you saying is that the community may have some concerns about the kind of medicine that's practiced at the medical school. Is that part of why there is probably still a rift between community and academia?

CARTER: You mean about the quality of medicine that's practiced at the medical school? Well, I think so. You know, in the early years, the forties and the fifties, I think that it was pretty well felt that because of the capability of the trained private practitioners, it was kind of second-rate care at the medical school. I don't know if it was second-rate care, but it's true that all the surgery was done by residents—not all of it, but a lot of it was done by residents, without a surgeon present.

When I was in medical school, I lived in the County Hospital because I had a job of taking emergency x-rays at night. And so there were two of us, and we were on every other night, and anything after 5 o'clock and before 8 o'clock in the morning, we took x-rays, and we learned how to be x-ray technicians very fast.

So we were in the County Hospital, and we would be taking x-rays of broken hips at night, we'd be taking x-rays of what we called acute abdomens, people with acute onset of abdominal distress, whether it be an appendicitis, obstruct bowel, et cetera, cholestasis, hot gall bladder, whatever, we would be taking x-rays of that. The senior resident in surgery would take the patient to surgery if it was necessary, and he would call up a staff man and assess him of the situation, and then the resident and the interns would go in and they would do the operation all by themselves.

ASH: This was during the war?

CARTER: During the war, uh-huh.

ASH: Do you think that was unique to the war years?

CARTER: No, I think it had preceded the war, too. This was the way people were trained in those days. They were expected to do it without supervision. Even in my internship, we didn't see staff men very often after five o'clock. In fact, the emergency room was manned by interns, who were just out of medical school, who were probably the least capable of dealing with the emergencies and the quick judgments and quick treatments that would be necessary in emergency rooms; but we were expected to do that.

I remember one night some fellow came in that had been shot in the chest with a bullet ...

ASH: Was this in St. Louis?

CARTER: No, this was at Good Samaritan in Portland. He was shot in the chest. So I called up—there was one chest surgeon on the staff, and I called him up and assessed him of the history and what I had found in my physical and so forth; and he told me to put a certain sized needle between a couple of ribs in certain place on the chest and aspirate and call him back, which I did.

Called him back, told him what I got. He told me what to do after that. I did what he told me to do. We put the patient to bed. Didn't have ICUs in those days. It was a general ward. The doctor came in in the morning and went over the patient with me, and the patient got along fine, I was very proud of myself [laughs]. Something that, you know, wasn't taught to me in medical school, and it was done over the phone, and evidently the doctor himself felt that this was an acceptable way to take care of patients. It was after five o'clock, and he had an intern there and did what he was supposed to do, and this was acceptable treatment.

So the private sector wasn't the only sector in which maybe patients were cared for by people who were learning. And this was the same thing, as I say, at the County Hospital. Senior surgeon resident would operate on these people at night. Nurse would come in and give drop ether, or they'd give a spinal. I suppose from that standpoint they would say, "Well, that was second-rate care," but it was as good of care as you were going to get anyplace in those days, unless there was some feeling that the private surgeon could do as good a job, which probably wasn't true.

By the time you were a senior resident in surgery, you were darn good, very good. And you know, you'd lived it for three years, and you had done a lot more surgery probably in that time than had any private surgeon during that period of time because you're seeing more patients. The private patients were divided up amongst the surgeons, and they were doing more elective surgery, not a lot of emergency surgery like they were doing up here.

So I think that as far as ego was concerned, sure, the private doctors thought that they were doing a much better job downtown than they were up here, and that maybe even there was enough jealousy for them to feel that those who did do the teaching up here weren't as good as some of the private doctors down there. Personally, I don't think that was true at all. Those who did teach up here and those who did take the responsibility of teaching up here were very responsible doctors, for which they were not paid.

Larry Noall was the orthopedist up here, and he'd come up here on a Saturday night at ten o'clock in the evening, and he would—with the surgical resident they would pin a hip or do a new hip fracture that had just come in, any time of night or day, and I don't think he was paid for that at all.

ASH: It's amazing.

CARTER: Yeah, it is amazing. And as I say, they provided good, conscientious care. The doctor was different in those days. He really felt it was a privilege to be able to do that, and do what had to be done, even though by our measure it was pretty crude in those days.

So I don't think the doctors up here felt that the doctors downtown were inferior. I don't think the doctors downtown were realistic if they felt what was being taught up here was inferior, and in fact, you know, what was being taught up here was being taught by the private doctors.

But I think a huge amount of jealousy developed when they brought—well, I shouldn't say “brought”—full-time people came in. Usually they were from another place in the country, and feelings were hurt because people were dropped out of involvement who had made a strong commitment over the years. And one could argue that some, many of those who came in were a bit snobbish about developing their own turf.

ASH: The volunteer faculty were told they were no longer needed? Is that what I'm hearing?

CARTER: In many cases, yeah.

ASH: And was that the new department chairs who were coming from elsewhere who were doing that, because they wanted to build up their full-time faculty?

CARTER: Yeah.

ASH: Why do you suppose that was? Was there some financial reason?

CARTER: I don't know why that was. I would suspect it was a matter of ego: “I'm in charge now.”

ASH: It seems a little insensitive.

CARTER: Very. Very.

ASH: And so this happened in many departments?

CARTER: I think so. I think it happened in urology, I think it happened in neurosurgery. It may have happened in ophthalmology; I don't know. Dr. Swan is a pretty sensitive person. On the other hand—well, of course he was such a capable person himself he didn't need outside help, and

so I don't think they were asked, but I could be wrong about that. Of course, ENT was taken over by a town person, so that probably went smoothly. Dermatology, I think, went that way. Psychiatry probably went that way, although we didn't have many psychiatrists. But I'm pretty sure psychiatry went that way.

What other departments are there?

ASH: Cardiology?

CARTER: Cardiology. I don't know what happened to cardiology. Sorry. Just don't know.

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

CARTER: Howard Lewis was a native. He attended Oregon State University, where he was an engineering student. He went to medical school here. He did well in the service in World War II. So he was a well-liked native son by everybody and respected.

Now, the internists back in the thirties and forties had a very elite group; it was called the Portland Academy of Medicine. And once a month they would dress up in tuxedos and have a dinner, and they would have a speaker or something like that. And this elite group would get together; you know, you only could join this group by invitation. And Howard Lewis was the only one on the Hill that I know of that belonged to that group.

So I get the feeling that Dr. Lewis tried to prevent this in internal medicine, and was so well respected by the people downtown that nobody ever said anything; nobody downtown really was very concerned about competition from the internal medical department or the quality of the internal medical department because he was kind of their man, I think. And so I don't think this happened in internal medicine until probably later on, until they got into a lot of subspecialties.

Dr. Lewis was one of these people who felt that an internist was an internist, and you didn't need subspecialists. They could all do their internal medical thing. So this may have occurred in subspecialties in internal medicine, such as gastroenterology, for instance, cardiology and pulmonology, et cetera. But that would have come later, and I didn't know anything about it.

ASH: Is there anything we haven't covered that we should cover?

CARTER: Well, there may be. I'm getting kind of tired here, and so things will come to my mind, and maybe I can let you know if there are things, and then you can decide whether they're worth talking about.

ASH: All right.

CARTER: Maybe I can enlarge on some of these things, too, because there are names and dates and so forth that I can look up very easily that don't come to my mind immediately now.

ASH: All right. Well, I thank you so much for giving so much time.

[Pause]

ASH: We're now talking about the movement to unseat Dean Baird, and I have heard a little bit about that.

CARTER: Oh, you have? Because I didn't know whether it was a part of my imagination or a misconception on my part because—but there are some aspects of it that have always caused me to feel a little suspicious that this may have been going on.

ASH: Apparently it was the Multnomah County Medical Society.

CARTER: Is that so? Well, I know that there could well have been psychiatrists that were involved in this, also. Let's see, what was the name of the professor of biochemistry? West, E. Staunton West. The sister of one of the psychiatrists in Portland was a chemist and may have done research here at the medical school; and both West and this psychiatrist had training in St. Louis before they came here. And there was a feeling, I think, that Dr. Baird wasn't as sympathetic with the interests and the needs of the private doctors in Portland as they would like. Maybe it was a matter of their not being able to control Baird; I don't know.

I remember going to a dinner party at a psychiatrist's home, and Dr. Brookhart—who had come as the department chairman of physiology, who was a very dignified, capable individual, who I think it became quite evident soon that he was going to be a very influential part of the medical school—he was invited to this cocktail party, dinner party, and I remember there was talk about what a terrible dean was at the medical school, what a terrible person Baird was—you know, I'm using "terrible," but there was criticism. They didn't say terrible, but that's what it boiled down to.

And somebody said to Dr. Brookhart that arrangements could be made for him to join the University Club, for instance, because he was on the faculty. But the talk evidently reached a point where Dr. Brookhart felt as if he had to take a stand, which he did. I remember him standing there and saying, "You know, I find Dean Baird is a very capable individual who runs the school very well, is able to take responsibility, and I personally feel that he is quite satisfactory as a dean," which was interesting to me at the time because of the people I was around, the doctors I was around, the talk was always that something should be done about the inferiority of our deanship.

I can't help thinking that maybe Dr. Brookhart had felt at that time that he needed to make a stand, that they were asking him to make a stand, either join them or not join them. And he followed his conscience and followed what he had come to believe as a consequence of his experience at the medical school up to that time, and he took his stand and that was it. I don't think he was a member of the group any longer, but I don't know that for sure, but I think—I remember that part of it.

Evidently there were people who felt that the dean should be replaced for some reason, and maybe it was felt that he wasn't as kindly to the interests of the private practice group as he should be, although he had been in private practice and he was a part of the Portland Clinic. Maybe there was jealousy that the Portland Clinic played too strong a part in the teaching and controlling of the medical school.

And certainly that was the case. Dr. Selling was a professor of medicine, Dr. Joyce was a professor of surgery, and they were both of the Portland Clinic, and many of the doctors, orthopedists, ENT specialists—one of the ENT specialists became the first chairman up here—all were very active in participation. On the other hand, they did a good job. They were good doctors, good teachers. They committed themselves, time they weren't paid for.

At that time, the Portland Clinic even had a medical journal. Once a month they published a medical journal called the *Proceedings of Case Reports at Portland Clinic*, or something like that. They were that committed to academic excellence and to excellence in the practice of medicine that they did that.

So there may have been jealousy there, and there was this feeling and drive, "We've got to get the Portland Clinic's domination of the medical school away," and the way to start that is to eliminate the dean, who may well have perceived his role as being primarily committed to the Portland Clinic rather than the medical school.

But as it turned out, the Dean was there and responsible for bringing the medical school from an entirely clinical orientation from private practitioners to full-time practitioners and, you know, very few of the Portland Clinic were really involved in that. The ear, nose and throat specialist was the only one, really, who came up here full time from the Portland Clinic.

So as far as that aspect of the town and gown is concerned, I remember that; and I think you can argue that maybe the dean felt very strongly that he shouldn't let any of the private pressures in Portland be involved in developing the full-time training programs, which he did, for all practical purposes, except for ENT and Dr. Lewis—and Dr. Lewis wasn't appointed from the town, he was appointed by the dean because he was known both in the town and at the medical school as being an excellent, committed clinical internist. But everybody else was brought in from out of town, which, you know, had its good parts and its bad parts. The good part of it was that the town wasn't going to control that person. The bad part was that the town resented the fact that they couldn't control it or hadn't made the appointment.

Also there is that problem that there may be a tendency amongst medical schools, when they have a weak faculty member to give them too high of a recommendation someplace else [laughs]. So there were people I remember back then that were appointed who came with great credentials from other medical schools who didn't work out too well, and I've always felt personally that their places of origin were kind of glad that they came here [laughing] and that we got—we were conned, and we were pretty naive in those days. Search committees were naive, and the dean was naive, the

faculty was naive, and that was not their fault; it's just that they were pretty isolated from the mainstream of academia in medicine.

So you know, as I say, I think the dean was smart in bringing people in from the outside; otherwise he would have had difficulty in control, I think, and if he had any confidence in himself, he wanted to have control and needed to have control. Every dean of a medical school has control, should have control, and that's why they appoint him—because of his ability to measure people and to see the overall picture rather than being biased in one specialty or one clique-ish group.

So that's the way I see it. And Brookhart was really very strong in supporting the dean in that area and was a person that the school was very fortunate to have at that time and through the years.

ASH: I'm sorry we didn't get to interview him.

CARTER: It is too bad. It's too bad. It's hard to believe that he's gone because he seemed like one of those people who would always be here.

[End of interview]

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