BILL ROBERTSON

Dr. Fitzhugh Mullan,
interviewer

[Note: The level of recording is very low. When an accurate transcription could not be made, [unclear] is inserted in the transcript.]

Mullan: Your date of birth?

Robertson: 11/24/25.

Mullan: We're in Dr. Robertson's office in the Children's Hospital and Medical Center. This is what may be characterized as a cozy and well-used office. Every surface is occupied by something useful and/or interesting. I do want to ask what the origin of the typewriter is.

Robertson: That was my mother's typewriter that she took with her to college. I took it with me when I went on board ship during the Korean episode. I learned to type on the darned thing. I went to get it fixed and, gees, the Remington people want to buy it. I still use it periodically. It's tough to get tape for.

Mullan: It gives perspective to the office here.

Robertson: Yes.

Mullan: Tell me a little bit about yourself, and let's start very quickly about where you were born and grew up.

Robertson: I was born in Brooklyn, grew up in Scarsdale, New York, and went to an Irish Christian Brothers High School in New Rochelle. The war came along and permitted us to accelerate the high school experience, and I was going to take a year of college before I went, and was drafted, but they offered us an opportunity to go in the ASTP or V-12 programs, and sent me to college. Then I worked in a Navy hospital for a while, and then they sent me to medical school, and the war was over before I completed the first year.

Mullan: Let's pause for a moment on your youth, growing up in Brooklyn and then Scarsdale. What took you from Brooklyn to Scarsdale?

Robertson: I was eight months of age when they moved up. It was suburban life versus city life. It's what the family wanted to do at the time.

Mullan: What did you dad do?

Robertson: He was a lawyer. He worked in downtown New York. He used to go commute on the railroad train, which was an interesting perspective, and it helped convince me that I didn't want to work in New York City and go down in a railroad train and

sit next to somebody for eleven years, and not really know who he was when he died, his face showed up in the obituary column. This was a common occurrence. People didn't socialize on the train.

Mullan: What sort of family life was it? What sort of youth did you have?

Robertson: I had a brother. I had a younger brother. It was great. It was a time growing up in the thirties, and we were fortunate, because the Depression didn't hit our family to the extent that it hit a lot of other families. But there wasn't the type of violence in the neighborhoods around which we grew up that we have today. There seemed to be, certainly beginning in '34, '35, an *esprit de corps* aiming towards World War II. Everybody was on board. It was different from the Vietnam War, when 51 percent were committed on this week, and 51 percent weren't so committed on the next week. So there was a lot of common concern of the future.

God, I would love to do it over again. It gave me an opportunity to see a number of people with illnesses who lived in the neighborhood. We got acquainted with them. We saw how the neighborhood really did an unusual job of caring for senior citizens in the homes, having some crippled children because polio was still very, very obvious in much of the society. And a family physician also seemed he was having a good time and who was doing a lot of good.

Mullan: This was your family physician.

Robertson: Yes. So that got me to thinking about going to medical school.

Mullan: Were you ill enough to see him often?

Robertson: No. I was healthy as a horse. My brother was sick a few times, and other members of the family had some illnesses. We'd see him primarily for minor types of problems, as far as I was recall.

Mullan: What appealed to you about what he did for a living?

Robertson: I think it was an awareness of his interest in people and in communities. He was interested, certainly, in people, but he was also interested in what was going on in the community. He seemed to know how things fit together. He was a significant leader in the community in development planning. Never been in politics.

Mullan: He was a GP?

Robertson: GP. He graduated from McGill.

Mullan: How about the influence of the church? I gather if you went to a Christian Brothers school, it must have been important in your family.

Robertson: It was very important to the family. But for me, I think it certainly impacted things before I was five, six, or seven, but by the time I was fifteen, I didn't outright rebel against the dogmatism, but it was very, very obvious. In retrospect, it seems very, very obvious. You didn't go for the scientific method; you didn't go for quantification as you do it today. You listened to what somebody told you was the thing to do. And that didn't seem to make sense.

Mullan: This is in terms of your schooling in particular, or the church in general?

Robertson: Just the schooling. I didn't have much argument for what they told you. "Don't steal. Don't do that." But looking at a solution to potential ways of coping with the future, I felt that they were stuck in the past. That message] came to the Republican party.

Mullan: The sense of community that you appreciated in the physician, did the church give you any sense of community particularly?

Robertson: Oh, yes. Yes. I went to this Irish Christian Brothers High School, a parochial school, was on the baseball team, football team, tennis team, etc. Parents were intimately involved in it, and grandparents were involved. I suppose this distorted my perception, because I kind of assumed that always parents were involved in the schools. You and I know that's not true. We also are very much aware of the fact that wherever the parents are involved in the school, the products of the school are sizeably better than if they're not.

Mullan: Tell me again how your college and medical school, your college education got telescoped by war. How did that all work?

Robertson: I spent one year at Hobart for three terms and then completed two more terms at the Rochester.

Mullan: This was which years?

Robertson: '43 'til '45.

Mullan: That was--

Robertson: Five four-month terms.

Mullan: And that constituted college?

Robertson: That's it. That was it.

Mullan: How as it educationally?

Robertson: Fine by me. The biggest challenge I had was in high school. The middle of the third year they said, "You want to get out early? You've got to take all the third-year classes and all the fourth-year classes to graduate." Should be able to do it. We did it. I've never worked that hard since, and really didn't have to work too hard then. It was an enjoyable time. The high school really developed in me the case method of learning. The teachers were taken away during the war and there was nobody to teach biology. So the French teacher said he'd do it. He said, "Now, I'm a French teacher. I don't know anything about biology. We're going to learn this together." No question the best course I've ever had in my life, because he helped open vistas, open doors, and he did it in a collaborative fashion.

Mullan: How did the medical school concept fit in in college? Had you been thinking about it, when did you decide, and how did that all come about?

Robertson: Well, actually, I'd decided on going to med school early on in high school. I mean, oversimplifying, I didn't think I was going to be a lawyer. I didn't know why. I didn't think I was going to be a banker, because my grandfather was. And I was darned sure I wasn't going to be a priest. The only thing left over was to be a doctor. [Laughter] No, I thought about being a doctor early on in school, and was hoping to get some of that in

before I went into the service, and ended up going down to SUNY down state, which was then Long Island College of Medicine. At the end of the first year, I was out of the service, and transferred back up to Rochester, and finished medical school up there, which was a very fortunate occurrence. SUNY down state was a nice school and all that, but the University of Rochester was undergoing a metamorphosis. It had the impact of the fields of psychoanalytic therapy and psychiatry that touched on all of the surfaces there.

Mullan: Did you like your medical school years?

Robertson: Oh, great. The faculty was amazingly supportive to learning by the student. Excellent role models, and the students that were with me in the class. We see this at other schools today. I think we got as good a deal as existed anywhere in the country. I maintained personal contact with a lot of the teachers after I left.

Mullan: What did you do when you left, and what were you thinking about for a medical career?

Robertson: I took a two-year rotating internship, because I wanted to be a general practitioner. They'd never had one there. They only had specialty internships.

Mullan: Really, at that time?

Robertson: Yes.

Mullan: The rotating internship was gone from Rochester?

Robertson: No rotating internship had ever been at Rochester. So we started, and it was a fantastic experience. Interestingly, none of the eight people who did ended up doing general practice. Not a one. Because after you got through, the doors that opened up in the seventies for family medicine, those doors were closed and locked. I think part of it was a result of the immigration that had taken place prior to World War II from Eastern Europe to the Eastern cities, where a number of our immigrant physicians never got on hospital staffs. They were in the community, but not part of the hospital system and not part of the medical system, and they were seen as the general practitioners, as opposed to others who were better trained.

Mullan: In a somewhat derogatory sense?

Robertson: Oh, yes. It was very much so.

Mullan: The LMD.

Robertson: Right. This has never been an issue out here on the West Coast. I learned that in 1963. The family doctor, the GP out here was a different breed of cat all the way up and down the coast. California and Oregon. If you're looking around even

today, Harvard and Hopkins still don't have family medicine departments.

Mullan: Absolutely. The Western validation of family medicine has gone way ahead of the Eastern.

Robertson: Yes. And I'm convinced something was different in the two sides. Rightly or wrongly, to me, as I saw some of the immigrant physicians who just never were accepted into the system, I felt that that was part of the problem.

Mullan: Was that palpable? It's a very interesting concept. In your, say, residency years, was the notion of the presence of these physicians, negative as it might have been, was that present?

Robertson: It was recognizable, even in a city like New Haven.

Mullan: Have you ever written or seen that written about? Or that's just your own theory?

Robertson: Just a postulate.

Mullan: Interesting. So at the end of two years of rotating about, what were you thinking? What did you do?

Robertson: I went into pediatrics. At the time, pediatricians took out tonsils, set fractures, put on casts, and we did everything for a population age group. By the time I got through--

Mullan: Actually took out tonsils?

Robertson: Yes. By the time we got through the training program, I ended up doing a year in Rochester, two years in the service, and two more years at New Haven. The surgical bit was gone. The orthopedic was still around a little bit. I had a good time doing pediatrics.

Mullan: Why were you drawn to pediatrics? I gather you're implying that if family medicine had been available, you probably have pursued it.

Robertson: I think I would have. I mean, I like kids as much as the next person does, I think, but I like adults, too. But the breadth of variety that pediatrics offers as opposed to my perception of what internal medicine was offering at the time, heavily oriented towards chronic disease that didn't seem to get any better. Nutritional problems and obesity was a problem then as it is today, but the medical professional really wasn't doing much about obesity in an optimistic sense. In contrast, the pediatric profession, dealing with diets as it related to kids,

was very, very optimistic. It was coming up to some alternate ideas about how to deal with it. It looked more optimistic.

Mullan: You pursued that both before and after the service?

Robertson: Yes.

Mullan: And in the service, you were where and what did you do?

Robertson: I was down in Norfolk, Virginia, working in industrial medicine. I got there and the CO said they didn't need another pediatrician, "You're assigned to the occupational medicine program," the repair of Navy airplanes got me even more immersed in the chemical world so I ended up with toxicology.

Mullan: What got you started on that?

Robertson: I got started on that because I liked high school chemistry. It seemed to come to me, and something I found out, things that come easily I tend to like.

Mullan: Then it was back to Yale?

Robertson: Right.

Mullan: For two more years of pediatrics.

Robertson: Right.

Mullan: How were they?

Robertson: They were very good. The chairman of the department there, a man named Milton Senn, he brought in pediatrics much more of a behavioral component, rather than a mechanistic component, in terms of childhood. He'd been a close associate of Benjamin Spock at Cornell. Those changes in child-rearing practices really caught on.

Mullan: A well-trained, well-experienced pediatrician coming out of Yale, what did you have in mind? What did you see as your horizon in medicine? What did you do?

Robertson: Well, at the time I was thinking about what I was going to do, I was looking at a practice group in Indiana who were interested in getting someone. A colleague of mine, who was in Columbus, Ohio, got drafted, and he asked me would I fill in for him while he was gone, on a part-time basis, working as the medical director of Ross Laboratories, which made baby food, and run their medical research and educational activity. The other half of the time I'd be teaching the medical students at Ohio state. I told him, "No. That's crazy."

He said, "Before you say no, come out and take a look at it," and I ended up doing it.

It was a remarkable experience, meeting with industry, the government, with the advertising world. It opened up vistas that I had never dreamed of in terms of communication activities. So I did that until he came back at the end of two years, and I stayed on there with him, then went full time at the university. By then I had gotten into the--

Mullan: You dropped the Ross Labs part?

Robertson: Right. I was involved in the dean's office there, in research in medical education to kind of bring some of the ideas that I thought were important from Rochester to Ohio State, which was a big school. They were very receptive. So I stayed there in Ohio for seven years, and then was invited to come out here. Came out in the middle of the winter, a day like today, not a cloud in the sky. I got off the airplane. The dean and I had met before. I said, "I hear it rains out here."

He said, "No, it's like this all year long." [Laughter]

So that convinced me. That was a treat. And the school here, like Ohio, is a big school, and with a lot of enthusiasm. Yale was a smaller school hide bound by tradition. Out here, not hide bound by tradition, I was going to be involved in some of the decision-making as to what was going on in the future. I think we've been very fortunate. The single school in the state in a four-state region. We cover what's called the Washington, Alaska, Montana, and Idaho, "WAMI" region.

If you hear people talk about the reasons for our expansion--oh, God, we were so interested in this and that. But one of the real reasons was, we'd just finished building up some space for teaching, and the government in 1970 said, "If increase your student body size by 5 percent, we'll give you $3,000 a body for everybody in the school."

The faculties all over the country said, "We can't possibly do that."

But we repeated said, "I thought you said something about $3,000," every faculty reconsidered. We went ahead and expanded but we couldn't them all into the classrooms. The fire marshal said, "You can't teach that many students in these classrooms," so we had to look elsewhere. That expansion was very, very good educationally, because we decentralized and gave the students an opportunity to see a lot of ways to skin a cat. We got an amazing amount of support from the communities.

When I came out, one of my jobs was to run a general practice preceptorship program. That had been mandatory for ten years, then it was made elective. By the time I came here, it was very elective. The dean said, "We should build this back up again." During that subsequent seven-year period, some 262 students took the program.

Mullan: What was a general practice preceptorship?

Robertson: The requirements were simple. A physician in one of the four WAMI states who was not on report with the Grievance

Committee of the County Medical Society or with the State Licensing Board qualified. In other words, a licensed doc who would host a student into his or her house, feed them, and let them shadow them. They'd take those students at no charge. I never got turned down asking for help. I'd call up the docs, "Would you do this for the school?" Every one of them said yes. Now, that made a big impression on those students and me--I'll tell you that. They weren't getting a nickel for it.

Mullan: Develop that, if you would. You came in 1963. You've been here through a period of huge change in the school and the region and in the nation in terms of growth of medical education. Washington has remained at the forefront of generalist education, has done, for a leading research-based university, probably the outstanding job in the country of keeping perspective. Why is that? What were the factors that made that possible? And what role did you play in it?

Robertson: As I see it, it was dependent upon two major physicians. When the school recruited the chairmen of the departments in the fifties, instead of recruiting local people or people in the state, they recruited established investigators from East Coast schools. That put them in a pivotal position of obtaining research support, and built a physical facility, an *esprit de corps* in the local scene, that gave research a real status within the school.

At the same time that that went on, the administration had some people in it who were interested in innovations in educational types of things. They all seemed to get along together. They weren't at each other's throats. I think one of the critical timings was, when this school got started, all of the residents were made residents of the University of Washington first--not residents of the hospital where they were working. This led us to establish a rotational system of residents that everybody takes for granted today, but when it first got started, it disturbed the hospitals and the Robber Garon residency directors. The school changed all that.

The last point is, and I'm biased here, because I got involved in it, the town-gown issues were focused on two or three relatively resolvable situations, and they weren't philosophical in nature, nor did they focus on the different qualifications of the gown physicians or the town physicians. There was a mutual respect, and that's gone on ever since.

Mullan: All are salubrious factors, but none of them explain why generalism has flourished as well as it has here.

Robertson: A young physician named Ted Phillips was instrumental in that. I'm sure you know him. He came here, was a relatively inexperienced young person at a time when expansion and decentralization was a challenge to the school, and by his role-model behavior--he was here less than a year--when more than half the students wanted him as their faculty advisor, because they

went to see him and heard him talk, and it was like Colin Powell talking. Everybody said, "Oh, this is what we want to listen to." Whether it was right or wrong--and I think he was absolutely right--everyone listened. Of course, the legislature gave funding to a family medicine departments as a line-item in the university budget. In other words, nobody could fuss with it. It was there. And family medicine was off and running.

Mullan: Tell me about the development of pediatrics here and the generalist-specialist tensions within it.

Robertson: As I see it, at least in my particular area here, the generalist issue, by the time I came in '63, was not a question. People were very instrumental in looking at nurse practitioners and physician assistants and what those people could do in lieu of a general pediatrician. But there wasn't any training program for exclusively general pediatricians, any more than there were general internists.

Mullan: But in that day and age, there were many fewer specialists being trained. I trained as pediatrician, finishing my training in 1972, and the term "general pediatrics" never crossed my mind, because everyone was a general pediatrician. Some minority, small minority, went on to be cardiologists or pulmonologists.

Robertson: Well, see, out here, in the mid-sixties, many, many people were doing specialty fellowships in other things. They still went through as generalists, and then by the early seventies, with the change in training program, some of the people would do a year's internship, but they were still rotating, then do a year of pediatrics, half of which they did in that specialty fellowship. Then they did two years of fellowship, and that was all they trained. They didn't know a damn thing about general pediatrics or coping with kids. Then over the last few years, we caught the--as least as I see it--conflicting problem as going on in the East, where "medicine-pediatrics" combination training programs have popped up to compete with family medicine. To me that's nonsense--who the hell's going to want the product or the medicine-pediatrics program, unless you're going to be an infectious disease specialist to the Walla Walla Clinic, where you might see both kids and adults. But it's a training program to be a general "family physician." Those training programs--training of obstetrics and gynecological problems is zilch.

Mullan: Orthopedics.

Robertson: Only (unclear) had their training in psychiatry is not very good either, particularly the pediatric. I just don't think its a proper avenue to pursue.

Mullan: The attention within pediatrics between the general pediatrician and the specialty movements, where do you see that headed?

Robertson: I don't see too much problem with the specialty movement except an excess number. What I do see is a problem for the generalist pediatrician. As it's become more behavioral and immunization focused, there's no reason why a lesser trained individual, scientifically a physician's assistant, nurse practitioner, whatever you want to call it, can't do any of that. So the wise pediatrician in the future is going to have a cadre of staff working for him or her. Well, training programs are not training these emergency physicians to be managers--which they should. And we should be training less pediatricians to encourage this department, which we've not done. I think that's going to be a major problem for the specialty. As larger groups get together, the family doctor, who's pretty good at dealing with these common behavior problems, and has more insight many times to the family dynamics than the pediatrician does, should be able to compete and do very, very nicely.

Mullan: So both physician deputies and family physicians pose a threat to the general pediatrician.

Robertson: Absolutely.

Mullan: Meaning that the land and the terrain of general pediatrics may get carved up between the nurse practitioner, the family doc, and the specialist.

Robertson: Absolutely. And I think there's no reason why training programs in endocrinology can't train a physician to be adequate in both adult and pediatric endocrinology, rheumatoid arthritis, you name it.

Mullan: Good.

[End of interview]