BARTLETT - ENGEL INTERVIEW

January 7, 1983

(James W. Bartlett, M.D., Medical Director, University of Rochester Medical Center; George L. Engel, M.D., Professor of Psychiatry, Professor of Medicine)

B: Good morning. It's January 7, 1983, Rochester, New York. Dr. George L. Engel, Professor of Medicine and Psychiatry, is being interviewed today by me, James Bartlett, Medical Director and Senior Associate Dean of the Medical School for the Miner Library.

Actually, George, this is the second videotape that you've made. There was an earlier one for the AOA Series on "Leaders in American Medicine" where you with Sandy Meyerwitz reviewed a good deal of your scientific and clinical career. Today we want to focus on you and your time here in Rochester as a faculty member of the Medical School.

I was in 1946, I believe, after graduating some years before that from Hopkins Medical School, going to Sinai for your house officership and then to the Brigham for work there with Selma Weiss and others. And on to Cincinnati to the Department of Psychiatry and Medicine there that put you in a position in '46 to come on to Rochester.

I wonder what you found here by coming in as a new faculty member to this Medical School that was then 20 years old. What kind of faculty? What kinds of students? And what kind of an atmosphere was it?

E: Well, when I came here in 1946, I came with a very conditional frame of mind. John Romano had just been appointed the Founding Chairman of the Department of Psychiatry. I was an internist, had been in the Department of Medicine in Cincinnati. He and I had in Cincinnati been working towards developing what would be called psychosomatic teaching at that time within the Department of Medicine, which was my primary affiliation. And the question was: Was Cincinnati or Rochester to be the place where I would continue to do that.

I made a visit here, met with Dr. Whipple and Dr. McCann and others and very quickly we got the feeling that Rochester was going to be the place to come and why. It was a quite an experience to come here in 1946. It was a small school, twenty years old. That seemed like an old school to me then, but then I was only ten or twelve years older than the School. But there was a certain ambience and a certain characteristic and a certain flavor which I think had been established by Whipple from the beginning and by the people he brought with him, which I sensed would be extremely conducive to developing something which was different and integrated. Remember, there had not ever been this kind of teaching or program developed anywhere. We had already seen problems in trying to do this at Cincinnati, and my first meeting with McCann, who parenthetically was the

E: person who got the money for the endowment of the Department of Psychiatry and the money for the building of Wing R - in itself a testimony to a kind of openness and interest in the School as compared to a parochial interest in one's own department. And I think that was the essence of what I sensed right from the beginning.

The people I spoke with seemed to have a sense of commitment and dedication to the School as a whole, and even more important, made to the education of medical students. Medical students in most medical schools have never enjoyed first priority among faculty. The proposal I made to McCann was one that I don't know that he necessarily grasped its full significance. I don't know how one could - it was something brand new. But in essence, what he said, not in so many words, but came through loud and clear: "We're open to new things here. Go ahead. I'll support you in anything you want to do. And if you fall on your face, that's your problem, not mine."

Coming as I did as an internist with involving and developing psychological and psychiatric interests, I found myself right from the start in two departments. An administrative issue there with McCann with a twinkle in his eye had told John Romano: "We're very happy to have Engel here, but, of course, you're going to pay for him, and you're going to give him space." After all, who had gotten the money for psychiatry. I didn't even give that a second thought - what my primary appointment would be. My primary appointment has been in Psychiatry, but my main commitment has been in areas elsewhere. And one of the things that very quickly emerged well within the first year was that this was a school which was small. The Department of Psychiatry, of course, was brand new; and there were just John Romano and myself and a couple of residents beginning - one or two people who had been here. The Department of Medicine - I was, I think, the fifth full-time member of the Department. It was that small in those days. It was immediately post-war. And everybody knew each other. Everybody ate in the same dining room, and by everybody I mean students and nurses and nursing students and faculty, senior and junior. There was none of the elitism that I had grown accustomed to at Harvard and Hopkins and other places with separate dining rooms for chiefs of staff and that sort of thing.

I've described it many times as a School with very permeable inter-departmental barriers, and for what I was interested to do - to work across disciplines and around disciplines and through disciplines, this was absolutely incredible. I quickly found that with my white coat I could go anywhere in the hospital and anywhere in the Medical School without anyone asking me what are you doing over here.

One got to know people quickly. One discovered an interest in new people coming in. Very welcoming. And then I became quickly aware of the place

E: of students in this School. I think it was George Corner - he used the term, "the other end of the log." I didn't grasp what that meant until I'd been here for a while. But I had not been in any place, including Hopkins, which is supposed to be noted for that - in which there was such an intimacy between students and faculty. And in which faculty really did spend a good part of their time thinking about and wondering about how to work with students. Very impressive people in that regard. Whipple used to have them run the monthly medical meetings, and we all came regardless of what the programs were, whether they were in our area or not. John Romano often used the term "citizenship" of the School. And at first I thought that was something peculiar to John because he used it in Cincinnati too, but it wasn't quite as meaningful in Cincinnati as it was here. By and large, people did have that attitude about the School and about what they were doing.

B: What about the students, George? What kind of students did you find here?

E: Well, over the years I've come to feel that most people who get into a medical school are pretty good students. My Hopkins elitism and Harvard elitism - from the little time I spent there as a student and as a fellow - didn't last very long. Most people who get into medical school are pretty good.

B: Yep.

E: And have gotten better, I think. I think it was a period immediately after the war in which students coming in were largely - many of them were veterans. Quite a few of them were married and had families. They had had their lives interrupted, but they also had lived more. Graves of "Graves' Disease" a hundred and fifty years ago - more than that, 1730 - had written - I'm sorry, 1830 - had written and strongly recommended that before people come to medical school they should live a bit because you can't really know what it is that your patients experience if you haven't shared it. So that was a very exciting time in terms of the students' interest in what we were interested to bring. And John Romano had the wisdom to decide right from the beginning that we should teach only the class that entered with us, which was the Class of 1950, and then the next year take on two classes. We didn't have the faculty to do any more than that. And whether he expected it would work out as it did or not, I really don't know, but it was a brilliant notion because within a year the students who were not having experience in Psychiatry and experience with us, my colleagues and myself - the group that quickly formed in Medicine - were howling that they were missing out on something. And we set up electives, and so on.

B: What was your first teaching?

E: My first teaching was with house staff. Coming as I did with a primary appointment in Psychiatry, it became very critical to me to establish my identity in Medicine. I was a well established teacher and internist in Cincinnati and also at the Brigham, and so I volunteered to attend beginning in July, a few weeks after I got here. And--

B: Did people realize you were an internist fundamentally?

E: No, they didn't realize I was an internist, and there were amusing episodes that occurred where I would be praised for knowing so much internal medicine for a psychiatrist.

B: (Laughs)

E: There was a memorable incident where I made the - I think it was the first ante-mortem diagnosis of a perforated indoventricular septum, and as we were going down to view the autopsy, someone joined the group; and then the house officer, who was very pleased at their attending had done so well, mentioned to this man that Dr. Engel made this diagnosis of a perforated indoventricular septum. Thinking that I was a psychiatrist, he scowled, frowned a bit and said, "How did you do it? Did you put air in the ventricles?"

B: (Laughs)

E: He thought the only ventricles I would know were up here, and Whipple looked over his glasses when someone said, "You know, Dr. Engel made this diagnosis." He said, "You mean the new psychiatrist?"

B: (Laughs)

E: It eventually clarified in time, and--

B: So you started out teaching with the house staff?

E: I started out teaching with the house staff. I didn't any student teaching the first year. John Romano took the first-year class in psychiatry, and I got busy with our fellows. We had come with money from the Rockerfeller Foundation and Commonwealth Foundation, which was the reason I had been awarded at Cincinnati, but which we brought with us to begin a program. And I began with a number of people, most of whom were coming out of service, Peter Hamberger and Dick McKay and John Herra and others who--

B: Fellows in what?

E: They were internists, and the objective was to develop their skills in what we would now call the "psychosocial". I think then we would call it psychosomatic. The psychosocial aspects of medicine. And you have to remember that I had just gotten into this myself, that I had been at Cincinnati four years, but had only been - maybe the last two years at Cincinnati that I began to interest myself. So that I was very much of a beginner, and John Romano's taking a flyer on me and giving me a kinds of responsibility for teaching that were actually well beyond what I was prepared for. In fact, it constituted a remarkable source of stimulation and education for me.

B: But you and John had been together for all the years - how many years in Cincinnati?

E: Well, we'd been four years in Cincinnati.

B: Yeah, and then before that at Brigham.

E: He and I had been together five years.

B: There was a flyer on five years of observation.

E: But my interest in psychiatry and even in matters psychological was very slow in developing. And I talked about that on the other tape. I don't want to repeat here.

B: Yes, I remember after your stand as Acting Chairman in Psychiatry when John was on sabbatical. As I recall the House Staff gave you a residency certificate. You were finally completing your residency in psychiatry by chairing the department.

E: Let's see, that was 1959-1960, and I was Acting Chairman for the year John was abroad. And on the very first meeting with the residents, they brought a patient and asked my judgment. It turned out to be a schizophrenic patient. I had to say I knew very little about schizophrenia. They were shocked. How come I was acting as chairman. Fortunately I had - the department of Psychiatry had very excellent people, and I had no concern about matters not being taken care of, but they gave me a certificate at the end.

B: So the fellowship program with the capacity to establish it came with you from Cincinnati, and you really went right into that--

E: The fellowship program was the first thing we did, and we just began working, the fellows and I on the medical service. We established an

E: We established an outpatient clinic, which we called the Special Medical Clinic, which actually became the precursor of the Psychiatric Outpatient Clinic, although in those days we were seeing outpatients who were, what would now be referred to as psychosomatic kinds of problems. And in the early days of the fellowship program, the internist coming in did not yet have any clear model with whom to identify, and about half of them moved over into psychiatry. There was a good deal of uncertainty about roles at that point. And the psychiatrists, as the program began to evolve, would press our fellows with "why don't you do the real thing," and the internists would press them, and say, "What are you fooling around with this stuff. And it was about five years, I think, before what might be referred to as a liaison identity formed, that people began to realize that it was possible to stay in medicine - I think Bill Greene was one of the first people to emerge in this role and continue to be an active and vigorous teacher and investigator in the Department of Medicine. We started with students in the second year - that would be 19-- - about '47. The fall of '47. John asked me to take over the second-year course, and that was really a challenge. As I said before, it involved my undertaking teaching areas with which I had no real knowledge or familiarity. I hurried to learn as much as I could. But it was a wonderful group of students. And I don't know if they knew how ignorant I was, but we got along very well--

B: (Laughs)

E: Even how anxious I was. I remember any number of classes I would come into wondering exactly how I was going to handle this interviewing a psychotic patient when I had had very little experience. But it turned out that by and large, the patient usually made the exercise in any event. And I began distributing notes. I would write notes for myself and I began to distribute the notes to the students, and that eventually became my book, PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE, which went through seventeen versions--

B: That sort of grew out of the syllabus of the second year.

E: That grew out of the syllabus, and it was seventeen years before I finally decided that it was ready to be published as a book. It didn't appear until 1962, I think it was.

And in the third year we began our teaching on the medical service with once a week two-hour rounds in the regular medical schedule.during those students twelve-week assignment. That was always very exciting. I continued to round with the residents in the summer. I kept a very busy schedule in those days. And the first-- Well, until 1961 I did the second-year course all by myself. And until 1950 I did the third-year

E: rounding all by myself. The second year course once or twice a week through the year, and then I rounded with every group on Medicine four times a week. There were four groups, in any one time. Bill Greene was the first of the fellows who stayed on as a faculty member. He came. He came through the residency in medicine and joined us as a fellow in 1948. Became a faculty member in 1950. By 1950 Bill and I were sharing everything. And then after that the group grew very rapidly. Franz Reichsmann, Art Schmale - and a total of more than one hundred thirty or forty people came through that training program over the years.

It was a very active clinical program, but I think an important element of it was that in one way or another most of us involved in the teaching, because we were involved in clinical research - that means we were actually working with patients, we managed to interdigitate and to incorporate a good deal of the research aspect right into the teaching. Simple enough. I was working with patients with ulcerative colitis at that point, and in particular. And Bill Greene with leukemia, and so on. Patients whom we saw on teaching exercises the second or third year readily became part of the material. And we were so involved in our evolving new understanding, new insights and new discoveries that these aspects-- I think there was an element of intellectual excitement which was communicated to the students.

B: George, you talked about that in terms of teaching the medical students, the work in two departments, Medicine and Psychiatry. And also the low departmental barriers here. How did you find it with other departments? Did the focus go on and extend some into other departments or was this mainly a medical-psychiatric.

E: Let me say a little bit more about psychiatry. At this point it became very important for me to learn more about psychiatry.

B: Yeah.

E: Which I started as soon as I got here and had seen the handwriting on the wall. And in addition to what I was doing with our fellows and then with our students, I also undertook to attend as best I could on Psychiatry and learn as much as I could and then to supervise residents in psychiatry. With psychaitric patients. That's how I got to - that's how I gained some familiarity with clinical psychiatry. I never really undertook the care of psychiatric patients. In all the years I admitted a total of three patients to Wing R, and two of them were a mistake. They shouldn't have been admitted to Wing R. In the very early days. An example of the permeability of the barriers is our study of the child Monica, when Franz Reichsman sitting in the dining room, that wonderful dining room, that doesn't exist anymore, and a pediatric nurse, Miss Murphy, who I think

E: is still here, says to him, "We have a very interesting child with gastric fistula who seems to be very depressed and upset. Wouldn't you people like to see her?" That came from a nurse at the lunch table. And Franz went up and did see her and realized that this was the ideal object for study. In our just beginning investigation of behavior and gastric secretion. To make a long story short, I went to see the child with him on her next admission, which was a few months later. We recognized the unique opportunity here. Here we were all set to go ahead, and it required only saying a word to the Chairman of Pediatrics, and at the moment I can't remember whether that was - It was still Clossen, I think.

B: I think maybe Bradford had just come in.

E: Yeah, Bradford had just come in. I think you're right. But Bradford just with a wave of his hand said, "Sure, go ahead." And there we were on the Pediatric service. And it ended up actually that we studied intensively three children. Here we were, neither one of us had never worked with children other than, you know, a month or two on my rotating internship. But that didn't deter anybody. And then I got involved with gastroenterology, of course, and my area with E_________ Price. And I got involved with Surgery.

B: Now did Monica every get involved in medical student teaching.

E: Monica got tremendously involved in medical student teaching.

B: (Laughs)

E: It was so exciting to us that we took - made films of her - It turns out we are still working with her. This is now 30 years later. And she became an integral part and in fact the major vehicle for the teaching of child development. It's part of my teaching philosophy that the patient is our teacher, that the well-studied patient, no matter what the issues are with the patient, demonstrates, provides information, demonstrates data from which one can develop principles and develop generalizations. So, it didn't really bother me that anyone could say that Monica was as unrepresentative of average child as could be. I could also say, "Well, where else do you have the opportunity to take one child beginning in early infancy and follow her year by year. And the students got very involved in this. Actually the year that Franz Reichsman left to go to Downstate, which was 1964. The students of that class included Monica in the yearbook. And beginning in about 1965 there was no school student plays which did not include Monica. She became an integral part of the teaching. We would spend many, many hours just going over with the students the films, and tape recordings, occasionally have Monica come in as she got older and learning about observation of children.

E: That's how I learned it. And then we got other children. And one of the house officers had a baby, and we wanted to have more material from which students could observe how to have babies and he and his wife made home movies and we edited that and showed that the first 15 months. There was such a-- I'm really still talking about the ambience of the school--

B: Yes, how you got involved in Pediatrics and then spread out beyond from medicine and psychiatry.

E: Surgery - many of these areas we didn't ever get into formally, but I wanted to-- I did pursue my patients wherever they went. Many of my old encephalitis patients ended up on Surgery, and so there I was on surgery, seeing my patients. Some of them I took care of medically. Some of them I took care of psychotherapeutically. I did get psychoanalytic training during this early phase, more to develop the skills and a perspective about this than to become an analyst as a practice. We did that for about twenty years.

With students and with fellows what it really comes down to is that any patient is of interest. You can't lose working with a patient. And when the general clerkship developed, which was what--19-- early sixties,

B: Yes.

E: It was one of the strong principles which I think the development of which I think was influenced by the atmosphere that already existed, but in addition I think by what we were doing. That the teachers should be working in areas in which they were not necessarily most expert. We wanted to encourage internists who were from the surgical service. And so on and so on. So that students would have instruction in that which is common to all of medicine, irrespective of the discipline. Some faculty were uneasy with this, but it worked.

B: As I recall, even before that, the medical-psychiatric group was very active in the teaching of physical diagnosis and both physical diagnosis and history taking, the old precursors in the traditional end of the second year.

E: Yes, the physical diagnosis was taught in the end of the second year, two or three afternoons a week, and while physical diagnosis had been - Physical examination had been an important area of instruction, in most medical schools, probably in all medical schools in the early days - certainly it was when I was a student, a tremendous amount of time was

E: spent learning how to percuss properly and so on. Very little attention had ever been paid to the interviewing of the patient - and those aspects of the personal contact with the patient. The teaching of physical diagnosis, as it was called, meant taking "taking a history" - which you were supposed to somehow or other know how to do out of your hip pocket--

B: Or follow an outline, say--

E: Or follow an outline--was something that was difficult to get people to do. Most teachers found it somewhat tedious and boring. It didn't have the excitement of being the attending on the floor, etc. So we had the good fortune of coming into a sort of vacuum situation. We wanted to teach interviewing, and I recruited all of the people in my group and set them on this. And I can't remember whether Ralph Jacox was in charge of that at that point. I think someone before him had it, but he soon took it over. But in any event he welcomed the addition of attention to teaching interview. And we re-wrote the format for the writing up of the history. It used to be OB had their form, and Medicine had its form and Surgery had its form, and the student had this peculiar notion that there was something called the medical history and the surgical history and so on. So our group re-wrote that and then as time went on over several years, the - we moved into a vacuum.. By the mid-50's or late 50's we were in position to play a very considerable role in this teaching and to bring about a very considerable form. And again the ambience and the structure of the school, enough of this got generated so when the Committee of Six - I was not a member of the Committee of Six - and I wasn't a member of the Committee that had to do with the general clerkship - had gotten enoubh into the ambience and the atmosphere that some of these people had been students here and some of them had been house officers, and some of them just worked with us in one way or another, but the work didn't go on <u>in camera</u>. Lots of people sought me out to talk about it and so on. And when the general clerkship emerged, it emerged out of experiences that we had had.

B: Mmhm. Even if there was a vacuum in the examination of the patient, in filming it, you must have experienced an occasional resistance once in a while.

E: There has never been a period, in spite of all the things I've said, in which there was not resistance. And the resistance came from a number of sources. One source of resistance was what I refer to as the irreduceable number of people that will resist anywhere even under the

E: best of circumstances--

B: Even in Rochester.

E: Even in Rochester, who like people who are tone deaf or color blind do not have whatever it takes - and I'm being very vague - to grasp and sense and organize social and psychological material. I would say very strongly, this is not criticism. That's just a statement of fact. And those people are not necessarily opposed. And they may be obstacles. But they're not necessarily even obstacles. I can think of one person in another school who was able to say, I just don't grasp what this is about, but inside I have the feeling that it's got to be important. So go ahead and do it. That was Ludwig Eichner at Downstate. He was a Professor of Medicine. So there was the kind of resistance from that source. Then there was the resistance that came indirectly from people who, for whom this was threatening. There is no question that when you begin to work with psychological and social data it is threatening to some people. And there is also no question that when you begin to do something new it's threatening, regardless. That's human.

B: Yep.

E: And the third source of resistance which I think has gradually increased over the years by the nature of the beast are people, the many people who join our faculty from other shcools where this atmosphere has not existed for whom this is strange and different. And who make sort of a priori misinterpretations. Mainly they tend to think of all of us as psychiatrists, which then also becomes a convenient way of making us aliens.

B: (Laughs)

E: Alien, alienists.

B: (Laughs)

E: And there were times when the resistance got quite intense, and I remember one occasion - I could hardly forget it - when Larry Young became Chairman and the first meeting of the full-time staff, and it was at that point that several very respected members of the Department of Medicine spoke up and said: "Is this psychosomatic stuff really necessary during the clerkship?" Larry spoke up and said as long as he were chairman this he felt was an integral part of the education of the student and the house officer. And there it rested. It does say something I think very significant, namely the leadership, in whosever hands leadership is, whether we like it or not, is a very powerful factor in directions. When a department chairman takes that position, barriers come down.

B: Mmhm.

E: And McAnn took that position - I'm never convinced that McAnn really understood what we were doing - but to me the mark of a scholar and of an open person is the ability to do that in areas with which they are unfamiliar. It takes courage.

B: Yes, it's an interesting kind of leadership, isn't it?

E: Yeah.

B: Because it goes beyond one's own capacities.

E: Yeah.

B: George, speaking of the general clerkship, a book came out of that also, which you and Bill Morgan wrote, which I think a great many of our students - and the rest of us too - "Clinical Examination of the Patient," was it?

E: THE CLINICAL APPROACH TO THE PATIENT.

B: CLINICAL APPROACH TO THE PATIENT. Would you--how did that develop?

E: Well, that evolved again, like my other book, out of the syllabi that we had prepared over a number of years, and we gradually expanded it. It existed in mimeographed form, photocopies form, that we handed out to the students, and then at some point it just seemed logical to put it into book form. It was actually the first text in that area which gave any attention strangely enough to the patient.

B: Yes, the text or format used to be called "physical diagnosis," had a lot of pretty or unpretty pictures of various normal and distorted things about patients and very little about the approach.

E: Yeah, and interesting parenthetically, Evelyn, my wife, who was acclaimed as a medical illustrator at Hopkins, did the illustrations; and when we were doing the illustrations, she, of course, was surprised with the textbooks of anatomy and so on, that Bill and I somewhere along the line - and Evelyn - got into great conflict because we kept saying these pictures are wrong. And she would say, "Yes, but, you know, I've gone to the other textbooks of physical diagnosis, and so on, and I've checked them out, and they're right." And do you know that in the pictures in most textbooks of physical diagnosis of that period showing the regional location of the viscera and also hernia and the genitals were drawn, were taken, from cadavers? And are incorrect. The liver is way too low.

B: Yeah.

E: We'd say the liver has to be above the costal margin, and she'd say, "Well, look here, here's the best recognized text, and where the liver is."

B: I remember that Evelyn and I went through the pictures, but you were the model for some of them, including the hernias. The examination - she completed the only appropriate--

E: Our students modeled. Bill Morgan appeared in some of those. You will recognize him.

B: What about the curriculum? You talked about students and faculty and organization of the medical school here. What have you seen about the curriculum over the years that you've been here? And also, you've looked at the organization of curricular teaching around the country in many of the medical schools.

E: Well, rather than get involved in details of curriculum - because that's a word that stirs up a particular context - I'll pick up on your last remark, that I've visited many schools. I've visited about 75 medical schools now in this country and Canada and abroad, Britain, Australia mainly. And if there is a distinguishing feature about Rochester from all the other medical schools, it is that in one way or another the educational program - I use that term rather than "curriculum." The educational program has evolved in such a way that students at Rochester are more oriented - everything is relative - are more oriented than students at other schools towards the patient. Rochester students and Rochester graduates are more likely to see themselves working with patients, not just with disease. The nature of our curriculum as it has evolved, as it evolves for the student from the first to the fourth year incorporates a great deal more of opportunity for the student in a paced, orderly and systematic fashion to begin to learn about human beings in the context of health care, illness, etc., and it is done in such a way that it is natural. In moving, for example - if you look at time allotments in our schools, you will see that the amount of time that is devoted to these areas of patient is in most schools miniscule. Even the time devoted to psychiatry is very limited. I've often said that-- And many of these courses are open to a great deal of criticism by students, and I've often said that if pathology, for example, was given as little time to deal with its subject matter as psychiatry and what I call the "peoples' sciences" - whatever names they use - as those courses are given to deal with, all that's involved in human behavior and illness, etc., pathology would be damned as a terrible course. This is a growth process for students, and it's often the educational

E: organization of the school which is heavily biased towards content. That is a reflection of the nature of the beast, that much of what the students learn in the first two years does involve concepts, should involve - but doesn't as often as it should - general principles, and so on. But the fact is that the physician is not going to become with rare exceptions a biochemist or an anatomist or a physiologist - and especially since the laboratories have gone out as part of student experience, and science has become more complex from a technological point of view, students are all too much placed in the situation in which they deal with content and with substance and don't really have much ground to be involved in process and experience.

B: You're also suggesting that as students grow during medical school and where the educational experience should work hand in hand to facilitate the growth of the student as he becomes a physician.

E: Yeah, that you have to, when you're learning to become a physician, you're learning a role. You're learning to become someone and to do something. That's not happening when you're learning biochemistry and anatomy, etc. You have to do it. That's not what's happening. So in the evolution of the teaching of the psychosocial aspects of medicine, which broadly refers to everything human, behavioral, social, all those aspects of medicine, for the student to a much less greater extent requires content. In content you're learning as you go along, but unless the student also learns how to elicit the information upon which that content is based, how to relate what's involved in interacting with another person, whether it be the patient or the family or visitor or what not. And do this in an orderly, systematic fashion, and to come to recognize that this area is just as accessible as to the scientific method, I mean, systematic, careful observation, checking for reliability, using methods which are reproduceable, and so on and so on. And so on. Much that's taught in other schools leaves no impact. As a matter of fact, it's really not much more than the average person can pick up in lay publications.

B: Mmhm.

E: You know there are all kinds of articles about psychological and social things in the public press these days. Now what has evolved in our program - and our program in the University of Rochester program - and it's sort of gotten built into it as a way of approach, is that over from the first to the second to the third and to the fourth, the student more and more becomes a participant, more and more is using that which, is beginning to use that which is going to be his or her way of life. And our graduates, I think, leave the School - they don't know this is happening while they're here. It's only after they get out - and I have innumerable feedback--

B: You've surveyed the students as well as visited a great many. Many have kept in contact with you spontaneously.

E: Yeah. I did a survey of the class of - I think it was '68, '69, '70, or maybe '69, '70, '71 - a year or so after they were out, and I sent out a very simple open-ended type of questionnaire in which I just asked, "In which ways did you feel yourself better prepared than your peers as an intern from other medical schools? In which ways did you feel yourself less well prepared?" And then, "How long did it take you to catch up in the areas you felt less well prepared?" And "How long did it take them in the areas in which you felt less well prepared?" And the upshot of that was that ninety per cent - and we got a seventy-five per cent yield on the questionnaire - and ninety per cent of our respondents,who were free to write as much as they wanted to, responded to this question by saying that they felt more comfortable, more competent, more capable in all the areas - and I'm using that broadly - that had to do with patients as human beings. And where they didn't feel as competent scattered among the graduates. Some said, well, I didn't know as much dermatology; someone else: well, I didn't know how to do procedures. Whatever those were, by and large, the students, the graduates reported they caught up within months or certainly by the end of the year. With respect to their peers catching up, it uniformly came back that they never caught up, and several of them wrote eloquently saying that "nothing happened in the house officership which would facilitate their catching up." In essence, if you haven't got this built in in the course of your undergraduate education, the chances are it's not--it may not ever come. Now we're working more nowadays with residents, most of whom are coming from other schools in the Associated Hospitals Program and General Medicine Unit, and so on; and this is quite evident, that after all the people who elect to do this are people who are genuinely interested. That's the people who applied for fellowship. But it's a long haul for many of them, and I've had a number of residents this fall, a number of residential fellows who made this kind of statement: "When I just begin to see, I am finishing my residency"- or four years out or five years out. "And now I discover that I have - that I don't have at my fingertips the kinds of skills to work with people that I need. And I'm angry." One man said that. "I'm furious. This all was neglected." Such ordinary simple day-to-day circumstances of how do you behave when you walk ingo a patient's room and they're are visitors there? Do you follow a rote and say, "will you please leave?" And so on and so on. All of these are what I call micro-decisions, the usual decisions - for which there is available a body of information which allows you to say one thing works better than another. Or if A, B, and C comes out, you make decision one. And if C, D, E, comes out, you make decision two. There are no--

B: George, you have been a teacher here for a while now - a good deal longer than any place else in your career. What's it been like personally? That would have been the satisfactions and frustrations and changes that have gone on.

G: Well, I've had innumerable opportunities to leave, and--

B: And you've stayed.

G: And I've stayed, and that in itself says a lot. And now that I've retired from the directorship and I'm phasing out my activities, people still say, you know, "Why are you staying in Rochester?" Well, it's been an absolutely marvelous place to be. And I know people are likely to say that about many institutions, but I know that it would have been impossible for me to do what I did here in many schools of this country. Notably the name schools. The big schools. There is no way that, I think, that anybody could accomplish this kind of, have this kind of experience that I've had which has been exciting and generative and creative and lots of edifying feedback and the opportunity to innovate things. There is no way one could do that in schools like Harvard or VNS and so on and so on, because they are so weighted by tradition and so structured independent-- almost independent units that hardly relate to each other. I've grown with the School. The School now is what? Sixty years old?

B: Almost.

G: Almost 60 years old, so I've been here two-thirds--

B: That's right.

G: Of the School's life, and that makes a difference. I have to say that it gets more difficult as the School gets bigger, but at least so far - and I hope it continues, those in leadership have had the wisdom not to let happen here some of the things which have plagued other schools, such as not allowing there to develop a kind of independent operations and fiefdoms and power centers. We have our share, but they no way compare - There are people around here who grumble about how things are in Rochester. I very quickly find out that they've not been anywhere else. Or they don't know how difficult it can be in other places where there are power structures, and so on. And we have a large enough sprinkling of our own graduates, which I think serves a very important moderating effect.

B: Yes, most people speak of the desirability of bringing together people from all over; and you've spoken several times of the desirability of having a core of Rochester people.

G: I think that has an historical anomaly, perhaps. I think it's an historical anomaly because Rochester unfortunately still is the main center for this kind of development, and it's lonely. I would hope it's not going to be much longer before these kinds of changes begin to take place elsewhere, and that will no longer be an issue. But I see there's still a somewhat delicate plant, you know, in the recent couple of years, with the recent five, six years in the educational planning. I think we saw what happened when we had someone who was thoroughly versed in the basic philosophy of the School and then someone who came from the outside, and now again, the first person who was not a graduate of Rochester but had been in the Program for a while, and then someone who is a graduate of the School, who has-- And those two people have the sense of what certain almost intangible strengths are here - which is very difficult for an outsider to grasp, unless they've worked at it.

B: Mmhm. George--

G: I might say to that - I don't want to leave the impression that simply because someone comes from the outside that they are incapable--

B: Sure.

E: That's far from true, and I'm very glad that, you know - we've only had four deans. But the three deans who came, all came from the outside. All came with no knowledge or familiarity about this, and the first to the second and third who have finished their tenure - not only left with a very strong and positive supporting view and one even joined our group. And the present dean - you wouldn't find him saying the kinds of things he says if he were at some other school.

B: You'll be "emeritus" a couple years from now - how is this - and you've been an important part of this focus, but how are things going to continue? I know--Is there to be a professorship there or not?

E: There is going to be a professorship and I have very encouraging news about the ability, of how the fund-raising for that is coming along.

B: So there would be an Engel Professorship. What role can that play in preserving this?

E: Well, I think it plays a very important role. An ___________ with my name attached to it would be the first endowed-- And first of all, the Unit which now is headed by Robert Ader, who is an experimental psychologist and was brought here to get it years ago. It's the first acknowledgment by the University that the discipline now called

E: "Behavioral and Psychosocial Medicine" is meaningful. And it's a new discipline. Just as immunology once was a new discipline and biochemistry once was a new discipline. For a university and for a medical student to publicly acknowledge that, I think it's a very important occurrence. I've often said this. That what we need is some kind of public acknowledgment by a foundation or by what-not, that this is an important area of education and training. And if there were established the "So-and-so Foundation Scholarships" in Psychosocial Medicine, or whatever, whatever they're called, for funding to develop chairs. That's a social sport. There is no question that things don't move without society's support. So I think this is a very front development. I hope it will become a reality soon. I can't tell.

B: Well. (Closing remarks are lost)