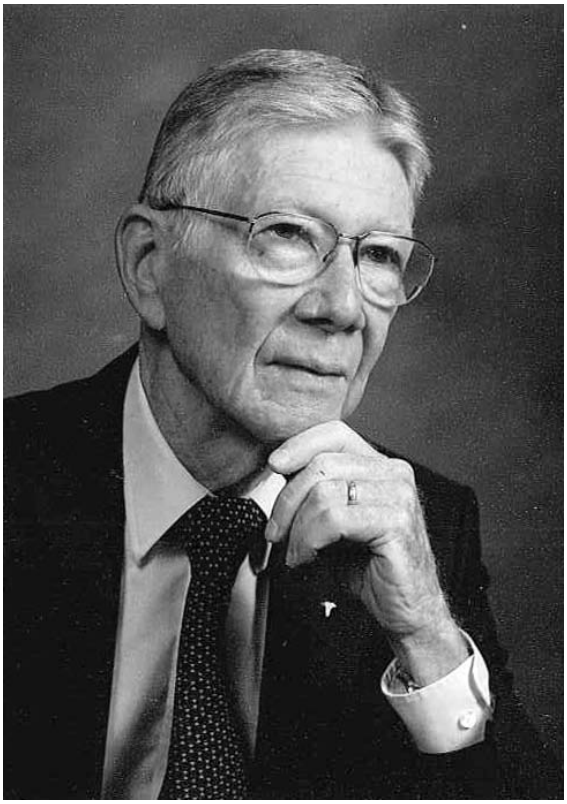
Dr. Mathis Blackstock

An Austin Physician's Life



From Interviews with Dr. Blackstock in 2011 and 2012
conducted by Drs. Jacqueline Kerr & Jeanne Cook

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with Dr. Blackstock

Dr. Mathis Blackstock

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Early Life 1925-1939

I was born at Baylor Hospital in Dallas, February 16, 1925. We had a family friend, Glen Wilson, an architect who came to see Mother and me while we were in the hospital. He said to Mother, "I saw your bull calf there in the nursery," and that offended Mother deeply.

Dad was on the faculty of Trinity University in Waxahachie, his first job out of the University of Texas. His next job was at Sam Houston College in Huntsville in '26 or'27. I have had a hazy memory of the trees in Huntsville, tall pines; I understand that Mother would leave me outside in the yard with a rope around my ankle, staked in the ground.

We moved to Austin in about '28. I was roughly three and my earliest memories go back to that time. We lived on Rio Grande in the 2800 block. Dad entered graduate school and took an MBA, which took a couple of years, and then he entered law school in '30. Dad and I would walk to school together along Rio Grande to 26th Street, passing in front of Seton Hospital. There was a long approach up the steps to the porch of the hospital and every morning there was a tiny man out on that porch… a fascinating little man. I never knew anything about him but assumed he was a security guard and was going off duty about that time. I would drop off at Wooldridge Elementary School, which was on 24th just west of Guadalupe, and from there Dad would walk on over to the campus.

We lived on Rio Grande for a couple of years and were there until 1930, when my brother David was born. Soon after that we moved out to a house on Duval Street in the 3500 block and about that time Grandfather Barrickman moved from Dallas to live with us. My grandparents had lived in Dallas but lost their home in 1930, because of the Depression. When they moved to Austin, Grandfather Barrickman came to live with us and Grandmother Barrickman went to live with Mother's sister and her family in Travis Heights. They lived apart from each other the rest of their lives, because of the Depression.

In many ways, Grandmother Barrickman was the most important person in our family, that is, on Mother's side of the family. She had a powerful presence and was a quiet and loving person. She enjoyed taking my brother David, our cousin Barbara, and me out in the wood. We'd walk a couple of hours and she would teach us all kinds of things about Nature. The year that they moved to Austin, 1930, Grandmother Barrickman introduced me to the Congregational Church[1] and that's one of the best things that has happened to me[2].

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[1] *From Mary Blackstock: Grandmother (Harriet) Barrickman was one of the founders of the Congregational Church of Austin.*

[2] *The people at that church are liberal Protestants and, in the 70+ years that I've been at the church, that prevailing philosophy and attitude have never changed even though the membership has changed through the years. Of course, the sermon is the central piece of the service and the sermons from the current minister, Tom VandeStadt, have been the best we've ever had. I was a member of the choir at that church for 15 or 20 years.*

Grandmother Barrickman died in 1939 from complications stemming from a hand injury which I believe resulted from a thorn. She went to Doctor Henry Ware Newman, a pediatrician who took care of everybody in our family because they demanded it. Putting things together, I think Dr. Newman must have become uncomfortable continuing to take care of her, as the hand had become badly infected. Dr. Betty Gentry officed in the same building as Dr. Newman, the Norwood Building[3] at Seventh and Colorado, and he must have asked her to take over the care of Grandmother Barrickman. Several decades after my grandmother's death, when I looked up the death certificate, I saw that Betty Gentry had signed it. She and I knew each other well. She was second in command at the City Health Department and, all the time that I knew her, I never did know that she had taken care of my grandmother. Grandmother Barrickman had septicemia, endocarditis and a septic embolism to her brain; it was all on that death certificate.[4]

In the summer of '39, Clyde Littlefield was a coach at UT. He had pneumonia around the same time that Grandmother Barrickman was ill. Sulfanilamide[5] was available in Dallas but not in Austin at that time and some of it was flown by plane from Dallas to Austin for him, which probably saved his life. That would have been around the time that Grandmother Barrickman died. I was 14 years old.

High School, College and Medical School 1939-1948

I started high school in '39 and the zoology teacher there, Sigman Hayes, had a lot of teacher's pets, most of whom were boys that he was trying to persuade to go to medical school. I wasn't paying a lot of attention to him. I loved botany and, if the War hadn't been on, I think I would have gone into botany and forestry. The draft boards weren't exempting botany majors so I tagged along with some of my friends into pre-med at the University.

Dad joined the Army in 1940 when I was in high school and he said, "You should take typing and shorthand because, if you are in the Army and have that kind of skill, it will keep you out of combat." So I took those courses and still use the typing, though I forgot

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[3] *The Norwood building was the primary medical office building in Austin in the 1930's, built by an entrepreneur of the same name. At that time, most of the physicians in Austin located their offices in that building. It was a huge building for that time and was located at 7th and Colorado. Back then, St. David's Hospital was located on 17th St., Brackenridge on 15th St., and Seton on 26th St. Traffic wasn't a problem and there was easy access to the hospitals from the Norwood Building.*

[4] *The status of medical expertise in Austin in the early '30's, when I was in grade school and junior high, seems quite rudimentary, surprisingly so in retrospect. For example, people with serious internal injuries could not be adequately cared for because there wasn't any surgeon in Austin that had the expertise to manage trauma.*

[5] *I remember hearing stories of doctors caring for kids with meningitis in the 40's. The doctors would give them Sulfanilamide, the pharmaceutical endpoint being blueness of the skin. This wasn't due to cyanosis; it was a skin discoloration from the drug. The physicians would back away from whatever dose had resulted in the blue discoloration to the next lower dose for the balance of treatment, and that cured most of those kids.*

shorthand long ago. After I graduated from high school I had some feelings of guilt about not having gone into the War. I think that, at that time, many young men my age must have had strong feelings of guilt if they hadn't joined the War effort.

Our first course at UT in June of '42, fresh out of high school, was zoology which was a six hour course taught by a Dr. D. B. Casteel, who was well up in years. We had class and lab from seven 'til noon five days a week, Tuesday through Saturday, and got six hours off in six weeks. It was one of the best courses I've ever had.

I attended UT from '42 to '44[6]. During the years of WWII one could complete 90 hours of under-graduate studies in 24 months. There was not a four year bachelor's degree before medical school during those years. The War was drawing a lot of people away from the University and medical school, both students and faculty.

There was a pro forma interview with a faculty member as part of the process of applying to med school. One of the questions in my conference was, "Why do you want to go to medical school?" I couldn't think of a good answer at the time and, a day or so later, I was walking by the Congregational Church along 23rd Street west from Guadalupe and saw the pastor, Milton Maxwell. The parsonage was in a frame house right next to the church and he was out working in the yard. I told him the question and asked for his perspective. He said, "Well, if I were considering a career in medicine, I think it would be because it would offer an effective tool for addressing people's problems." I thought that made sense at the time.

I got to medical school in Galveston[7] in June, 1944 and was having trouble believing that I had been accepted. I was pinching myself all the time. There must be a tendency to repress unpleasant memories from medical school. I have many good memories although Galveston was dead at that time. It wasn't a port; the port was Houston so Galveston wasn't a great place to be.

I remember that there was an amphitheater used for anatomy class that was shaped like a funnel: steep sides with a tiny floor space at the bottom. Our instructor was Dr. Raymond Blount and he loved to clown around. One morning he was trying to help us to understand what happens with evagination and invagination during embryonic development. The students were hooting at him, provoking him and he started to clown around. He grabbed a

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[6] *In December 1943, while I was in college, I had signed up at Ft. Sam Houston for the Navy V12 Program, which was their program for kids that were going to college, medical school, engineering school, seminary, etc. The Army had a comparable program called the Army Specialized Training Program and the Navy and the Army would pick up the tab for the education of people who participated. Eligible men would be in the draft if they didn't sign up for one of these programs. We wore a Navy uniform about halfway through medical school until the War ended in 1945. Several months after Japan surrendered we were mustered out but held as Reserves.*

[7] *Around 1942, Baylor Medical School moved from Dallas to Houston and initially operated in a warehouse there. Southwestern Medical School then took over the Baylor facility in Dallas. So there were three medical schools in Texas in the early '40's: Southwestern in Dallas, Baylor in Houston and UTMB in Galveston.*

sheet and was using it to demonstrate. When he jumped up on top of a cart so the students could see him better, two guys on the front row just wheeled him out of the room! There was a rumor that those two failed the course. Sometimes Dr. Blount would be clowning down on the floor of the amphitheater, and the medical students would start throwing pennies at him. They'd heat them up with a cigarette lighter before they threw them down there. Of course, this would be shocking behavior today.

Biochemistry in medical school was not a great course. The professor, Dr. Hendricks, was well up in years and had been involved in a laboratory explosion which had injured one of his facial nerves, so his face was drawn to one side. In the class ahead of us a student had flunked the final exam, or possibly didn't do as well as he thought he should. He approached Doctor Hendricks and said, "Doctor Hendricks, I thought I wrote a pretty good paper," and Dr. Hendricks said, "Too much hay and not enough bullshit." During our final exam he was proctoring the exam and seemed rather bored, so he went over to the blackboard and drew eight pup tents across the board. Underneath he wrote, "Who?" meaning, "Who is going to flunk out of school and go to war?"

When my high school class graduated, my zoology teacher, Sigman Hayes, left teaching and went to work for the Sanitation Department of the Austin City Health Department. There were a lot of tasks that he was capable of but wasn't allowed to do because he didn't have an "M.D." behind his name. He became frustrated with this and decided, "I'll show them. I'll get an M.D." He went to UT, finished up his pre-med requirements, and we became classmates in medical school. After graduation he came to Brackenridge for his year of internship, with the intention of entering practice in Austin.

Transition: Ganado, TX and Mary Landry enters the scene 1948

The story of how Mary and I met and decided to marry is strikingly different depending on whom you ask. This is my version:

It was 1948 and I had a four month hiatus (February 13 until the end of June) between graduation and internship.[8] There was a Dr. James Bauknight in Ganado, Texas, a medical fraternity brother, who sent word to the fraternity that he was seeking help and inquiring whether anybody was available during those four months. Ganado is located near El Campo on Highway 59 on the way to Corpus and at the time had a population of 1500 people. I

[8] *We weren't expecting any summer vacations when we entered medical school in 1944. We ended up with summer vacation in our junior and senior years because WWII had ended in August, 1945, so the schedule decelerated, a process which required a few years. It had been accelerated in order to bring physicians into the Service more quickly. Pre-med education had been reduced from four years to two years, medical school from four years to three years, internship from twelve to nine months and there were fewer residency openings. During the war, physicians entered the Service after completing an internship. In August of 1945, when the War ended, the deceleration started. It took from 1945 to 1948 for the schedule to straighten itself out. That's why we graduated in February instead of June.*

went for an interview and, as I walked into the waiting room of his office, the receptionist, Ruth, said, "Hello, Dr. Blackstock," a welcome experience. I wondered how she knew who I was. I had just gotten off the bus and walked over.

The doctor and his wife allowed me to live with them and their family, which included their four children ranging in age from Barbara, age 14, to Bruce, age 5. Their home was located next door to Dr. Bauknight's office, with a big yard between the two buildings.

Dr. Bauknight was the only doctor in town. In 1931, he moved to Ganado with his physician bag full and rented space from a car mechanic. The space turned out to be a corner in the mechanic's garage and that's where he would see his patients, practicing out of his bag. He was from Galveston where there was a Bauknight Hotel, a tall frame building on 17th St. three miles from the medical school. The hotel was owned by his parents and he worked as the night clerk managing to get his studying done while on the job.

I happened to be at dinner with the Bauknights one evening and, as we were about to begin our meal, I glanced outside toward the office and saw a small bedraggled family traipsing across the yard. Dr. Bauknight knew he was going to have to get up to attend to them and let supper wait. That's hard work. He was tied to his practice but he seemed to accept it. I considered him to be a reprobate, though possibly not in a serious way. Nevertheless, he was conscientious and hardworking and I would have loved to have continued working with him, except that he was a control freak. I was in love with the town and would have gone back except for that concern.

The night before hunting season started Dr. Bauknight would stay up all night drinking with his hunting friends. About 6 o'clock in the morning he'd get on the phone to a woman patient who imposed on him a lot and was very demanding and he'd tell her that they'd like to go over to her house for breakfast.

Mary had graduated Our Lady of the Lake College in San Antonio in 1947, the year before I came to Ganado. She and Winnie Harang, her college roommate from "The Lake" and one of her closest friends, had both taken teaching jobs in the elementary school in Ganado after graduation. There were three other young women who lived in the teacherage, which was known as the "pullet roost"[9].

One evening, Barbara, Dr. Bauknight's 14 year old daughter, borrowed her mother's new Chrysler, drove around the corner to the pullet roost, and came back accompanied by three of the teachers. Here was this tall, blue eyed brunette. When I saw her I thought, "That's it, the end of my search."

Mary and I had those four months in Ganado in 1948 and, on August 4 of the following year at the end of my internship, we married in Mary's hometown, Abbeville, Louisiana. I had more pleasure practicing in Ganado those four months than any place else I have ever lived, perhaps because I was finally applying what I had been learning in medical school.

[9] *a pullet is a young hen*

Internship, Residency and a Stint in the Navy 1948-1953

After leaving Ganado, I did my GP Internship and the first year of an OB GYN Residency at Hermann Hospital in Houston. My plan had been to go into practice at the end of the year of OB GYN training, but I changed my mind and arranged to do two years of GP residency in Denver[10]. I guess I had gotten spooky about how much I didn't know.

I started my residency in Denver in July of 1950. About 4 or 5 months into the Residency, during the Korean War, I was called into Navy service[11] as a physician and sent, initially, to Kobe, Japan. I worked in the 8th Station Hospital, which was an Army Hospital in Kobe, taking care of mild and moderately severe Korean War casualties. The more serious casualties went to Tokyo. There was a plastic surgeon on staff in Kobe, Dr. Fischer, an Army physician, so I am sure there was work there for him to do. Japan is a beautiful area, a fascinating country. I'm glad I was there.

In the spring of '51, I was sent to Oakland, California, where I worked in the Dependents Clinic with the wives of noncommissioned officers, who were very unhappy with their lot. I don't remember many details but I do remember that they talked a lot about what they didn't like. That's when I learned to listen; I did a lot of listening there. The Naval Hospital in Oakland was very peculiar in that it consisted of a lot of small buildings spread over a large area of rolling hills. There was no single hospital building.

While I was overseas in Japan in late 1950 and early '51, Dr. Bauknight hired Mary to work in his office, although she didn't have any medical experience. While she was there, a patient of his with advanced breast cancer came in and he advised her to go to Houston to have it taken care of, but she wouldn't do it. She said, "You're going to operate on me or I'm not going to have it operated on." He acquiesced to that, unfortunately, and he had Mary in the operating room with him with the anatomy book. Unfortunately, the patient didn't survive. It was sort of brazen and arrogant but, on the other hand, GP's at that time had to do a lot. If they were skilled enough to do what needed to be done well or adequately, the patient was well off and fortunate.

After I returned to Denver from Navy service, I completed the two year GP residency and Mary taught at a Catholic elementary school there. I remember that she had a child of one of the families of the Brown and Root construction outfit in her class and his family took him to Europe one summer. He was telling the class about it when he got back to school in the Fall and he said, "In the best hotels in Europe, you can't flush the toilet after 9pm." Apparently the boy's mother, Ms. Brown or Ms. Root, wasn't impressed.

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[10] *I believe that I was paid $25 per month in internship and $50 per month the first year of the OB GYN residency, which was bountiful. As interns, we got housing and laundry service. I think I earned $130 a month once I got to Denver.*

[11] *In 1950, the Navy had 600 physicians that had come out of the Navy V12 program for whom they didn't have a use. The Army had no physicians so the Navy loaned those 600 physicians to the Army; they were wearing a Navy uniform and working for the Army.*

Kerrville 1953-54

When I started practice in Kerrville in 1953,[12] I called on the local doctors, including Dr Dwight Knapp, a surgeon there. It was mid-day and I was sitting in his waiting room, which was otherwise empty except for his nurse. She told me that the doctors in Kerrville were charging $2 for an office visit and said, "I don't want you charging a penny under three." I charged $125 for OB when everybody else in town was charging $75. I think patients were willing to pay that, taking into account my more recent education.

The first baby I delivered in Kerrville had a true knot in the cord, and he was born dead. I dealt with that by grieving along with the parents. The parents of that stillborn child turned out to be among our closest friends in Kerrville.

The doctors' offices and the hospital in Kerrville were all in the same building so I could just go up 2 flights of stairs from my office to deliver a baby. I started off office hours at eight and, if I had people in the hospital, I'd see them before I got to the office and then work 'til late afternoon. House calls were easy because it was a small town. I usually didn't have to work after dinner, but that changed once we moved to Austin.

I recall that when the Salk vaccine came out about '53 or '54, they lined up all the school kids and gave them injections. One little guy didn't move on so he got a second injection. The physician giving the injections wondered aloud, "What's that going to do to him?"

The relationships in Kerrville were different from those in Austin somehow. The doctor that delivered our youngest child, Edward L. Dyer, was the kindest person I've ever known in my life. I shared call with him. He always had a cigar in his mouth and was quite rotund. One morning, Dyer was over in the labor room and some poor woman was really crying. He stuck around for a few minutes, patted her on the bottom, and then walked out and said, "Doesn't come out as easy as it got in, does it?"

One night I was sewing up somebody down in the emergency room, a character that had gotten all carved up, and it was going to be an hour's worth of sewing. Dyer came along; he was just wandering around in the halls. It was about 9 o'clock in the evening and he didn't say anything, just put on some gloves and started sewing along with me. We got the guy put back together and sent him on his way and Dyer said, "I'll bet you he owes me two or three hundred dollars." He didn't care. He just went ahead and took care of him.

There's a family in Kerrville that we are still very close to. The man, Fred Tally, was principal of one of the elementary schools. He's been dead a long time but we see his family when we go there. Kerrville was a wonderful place to live.

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[12] *I started carrying malpractice insurance as soon as I entered practice, but I don't think it was common for physicians to be sued in those years. I think I paid about $35 a year.*

Private Practice Austin 1955-1974

We would come over to Austin from Kerrville to see my mother and dad and, one time when we were here, I went to see Sig Hayes. He told me that he was going to be in Germany with the National Guard for two years, in '55 and '56, and was looking for somebody to take his practice during that time, and I told him I'd do it. When he came back, we formed a partnership and we were together until 1974. We built an office at Grover and 49th, across the street from the State Health Department, and we had a practice that we were really pleased with.

My work day was a lot longer in Austin than it had been in Kerrville. Hayes had a huge practice when he left to go to Germany and, very unwisely, I didn't limit my hospital work to one or two hospitals when I took over his practice; I covered four hospitals. I would spend from eight to ten in the mornings making hospital rounds. This meant that my office was not in use during those two hours and when I'd arrive at 10 o'clock, the parking lot was full. You'd say you would "Work from Can to Can't", break for lunch at 12:30, resume at about 1:30 and continue until about six, go home and eat, and then go back to the hospitals and finish about eight or nine. I'd see about 25 patients a day in the office between ten and six and on busy days, the number could get up to 37. On those days I'd pitch the charts over to the inbox and try to come back and dictate them at the end of the day. I'm sure you'd lose a lot by that time. I'd usually work 60-65 hours a week. That's what most of us as GP's and Internists did and we'd have a half or full day off in the week – usually either Wednesday or Thursday. The number of weekend days we'd cover would depend on the size of our call group.

I would guess that I might have done one or two surgeries a month, scheduled or emergency. I did about 50 to 55 deliveries the first year starting out and the number declined straight down from then on. Deliveries and emergency operations came out of office time and resulted in patients having to reschedule or wait; scheduled operations involved blocking office time in advance. It's interesting what your patients will tolerate. Example: if there's a reasonable amount of obstetrics in your practice, your patients will understand when you have to leave for a delivery. The same is true if you have to leave to do, say, an emergency appendectomy.

A few years back, I ran into a friend at the drug store who had been a patient, along with her family. She had been cleaning out a room at home and found a receipt from me for $4 for an office visit. It's ironic that we were both happy with it; I was making a good living on $4 office visits. When I joined my partner, Hayes, he was charging $4 for a house call. I said, "Wait a minute, that doesn't make sense" so we went up to $6.

When I first started practicing, Blue Cross Blue Shield was the most prominent health insurance company. Some middle class people bought it but most people couldn't afford it. As I remember, it paid doctors well and covered most conditions. When Medicare started in '65 they would pay the bill, whatever it was. I can't imagine that now, but I think that's the way it started out. There were a lot of older people that had had to wait to have elective procedures because they couldn't afford to have them done until Medicare came along.

People would often have insurance while they were working but most did without after they retired before there was Medicare. It was so very expensive to buy insurance on an individual basis. Medicaid started about the same time as Medicare. Prior to that, health care for children in low income families was paid out of pocket. And, there was a lot of pro bono work.

About five percent of our practice was pro bono which was, in part, due to our office location. I'd say five to ten percent of most physicians' practices in Austin in those days was pro bono.

In our practice we didn't have clinical assistants. Our nurses were usually LVN's. One of our most important nurses was an LVN named Lura Duncan. She had worked with a GP in the Norwood building in the 1930's and 1940's, a Dr. "Happy" Klotz, who practiced in Austin through the War as did many other doctors. When he closed his office in the 1950's she applied for a job with me. As we were discussing salary, she told me that she'd made $150 a month with him but she wasn't going to work for less than $200, which is what I ended up paying her. But it just wasn't enough. Looking back, I'm not satisfied with what we paid our help. I think the pay scale would seem low by current standards.

There was an exception. Dr. Ben H. White, an Austin pediatrician, had a concern about the low pay scale for medical office help in Austin. So, on his own, he chose to pay his staff at a significantly better level. There was a big disparity between what physicians were making and what they paid their help, and we all should have been ashamed of that and done something about it.

Even though I had done one year of an OB GYN residency, I didn't get to do a C-section in that year. I loved to do OB but, initially, I had to call somebody when a patient needed a section. There was an obstetrician named M.D. McCauley who approached me and said, "I want you to do sections, and I propose that you and I do five sections together on your patients. You'll do as much of the section as you can on the first patient, you'll do all of the section on the last one, and you'll incrementally increase what you do in between." That's how I learned to do sections.

In our practice, Sig Hayes and I both did OB and orthopedics. We also did general surgery. I did more surgery than he because he only had the internship. I did hysterectomies, sections, tonsillectomies and appendectomies. That was about it. I didn't do cholecystectomies.

I also didn't do mastectomies. In those days, they were all radicals and I guess a lot of those women had post-operative lymphedema. There was a Dr. Halstead at Johns Hopkins and his was the prevailing approach at that time. The surgeon would resect all of the nodes in the axilla, not knowing if they had tumor in them or not. They didn't know about sentinel nodes at that time. Mastectomies were huge operations for every woman that had breast cancer. I'm sure that Bud Dryer, a GP in town, did mastectomies.

I used to think there were some patients whose problems were so confusing I couldn't even figure out what kind of specialist to send them to. If it's that way starting off when

somebody comes in with a new problem that's confusing and one doesn't know exactly what's going on, things will usually start to fall in place after the patient's been back two or three times. It seems that the brain subconsciously processes the situation because, by about the fourth visit, things would often look a lot more clear.

During the years I was in private practice I took care of a young man who, as a teenager, had been out at a nightclub, the Avalon Club I believe, on the Dallas highway or the old Highway 81, which is now North Lamar. He was with a group of kids out in the parking lot when somebody fired a revolver into the crowd, hitting him at about C4-5. He was 18 years old when this happened and I took care of him until he died in his early 40s. About 98% of what I know about quadriplegia I learned from him. He was unfunded so I begged a lot of services for him from various specialists and they were glad to help. If the specialists saw you giving your time that was good enough for them. They were glad to do the same.

Another story involves a family: the parents, their son and, eventually, the young woman that he married. The son and his wife had a baby, which I delivered for them, and there was dissension in the family which resulted in the son and his parents aligned against the young woman. When her baby was only a few months old, I got a call one night about three, "Come up, there's been an accident." The young mother had driven out to the edge of town and shot herself in the heart with a rifle. It's a very somber thing, a sad thing, and it stays with me.

I didn't start out understanding much about behavioral science, but I always come back to something from one of our faculty, Dr. Willard Cook, professor of OB GYN at Galveston. He was talking about thyroidectomies and said, "It's a procedure you should never attempt 'til you've done it at least five times." One time when David [Wright] and I were talking to the interns and I related this little tidbit, David was the only one there who thought it was funny. For me, that is what it's like when you hang your shingle up; you feel like you're way behind starting out.

As part of my residency, I had a rotation on psychiatry and, from that experience, I came away with the belief that GPs ought to be having psychotherapy sessions with their patients. I would set aside 45 minutes to talk to somebody and I did that for a while. In the end, I didn't think that it worked well so I quit doing it. I came around to the feeling that the optimal way for FPs to use their psychiatric and psychological skills is just along with the organic problems that are at hand.

I remember working with an alcoholic patient and the main thing I learned from him was that he was a very expert manipulator. I really let that person wind me around his finger. I tried to be everything to a patient if they had that problem, but that won't work. I eventually learned that, if one is helping somebody with that kind of a problem, there is AA and you have got to use them. It took me a long time to figure that out. There was a Dr. Seale on the faculty at the medical school in San Antonio who planned and implemented a weeklong CME on alcoholism and I learned a lot about AA there. And there were certainly psychiatrists that would tell you about AA; Stuart Neimer was one.

In those days, there were plenty of psychiatrists and they were doing psychotherapy as well as pharmacotherapy. They weren't primarily managing medication as most do today. There were tricyclic antidepressants such as Tofranil and Elavil but the side effects could be problematic, for example, cardiac arrhythmias, constipation, urinary retention, and sedation. I prescribed those medications, but I was respectful of them because of the side effects. When concerned, I might refer a patient to a psychiatrist who would often recommend a larger dose of the same or a similar drug. I've seen this often when primary care doctors refer to specialists. The specialist will many times stay with the same mode of treatment but is more comfortable pushing that treatment further.

In terms of lifestyle issues in those early years, physicians learned over a long period of time how bad smoking is on your body. I remember in the '50s, at a CME course, somebody was quoting Ochsner's report[13] [14] which said that the incidence of lung cancer had gone up as the prevalence of smoking went up. The response by some physicians at the conference was, "Well yeah, sales of General Motors cars and women's stockings also increased at the same time that the incidence of lung cancer went up." Nobody was buying the statistics. Of course, like in the general population, a lot of doctors smoked in those days, but I think they got away from it before everybody else did.

Women were very thankful when the first birth control pill came along in the '60s. They were far less expensive in those days, two or three dollars a month I believe. Physicians weren't doing abortions because they weren't legal until 1971. There was a comment among the people in the OB GYN section, "Every community needs a good clean outlaw abortionist." People would go to Mexico to get a safe abortion.

Over the time that I practiced medicine, there was a very definite shift from the paternalistic authoritarian approach over to the collaborative, but that happened over a long period of

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[13] *Alton Ochsner, the son of German immigrants, was born in Kimball, South Dakota in 1896. His uncle, A. J. Ochsner, was founder and president of the American College of Surgeons. In 1927, Ochsner, with the help of his uncle, A.J. Ochsner, was appointed as Head of Surgery at Tulane Medical School in New Orleans.*

In 1939 Alton Ochsner and Michael De Bakey published an article suggesting that there was a link between cigarette smoking and lung cancer. As a result of his research, Ochsner established the Ochsner Clinic in 1942 and pioneered the "War against Smoking." In 1955, he published "Smoking and Cancer: A Doctor's Report."

Ochsner was on the board of the American Cancer Society and later became president of the organization.

[14] *From Dr. Blackstock: Oschner organized one of the first multispecialty groups in New Orleans; groups up until that time had all been single specialty. Our dear conservative colleagues looked so askance at this that somebody sent Oschner a little felt purse with 30 dimes in it, i.e. 30 pieces of silver. There have been so many things along the line that physicians have been afraid of, just like this.*

time. I worked with a psychologist named Vic Appel for many years and one thing he talked about was asking a patient what *he* thought was wrong. I found that when I did that, I'd often learn something that I hadn't thought of before or I might learn that I needed to do some educating of the patient for one reason or another. It's much harder work if you take an authoritarian position. When the relationship is collaborative you are using the patient's energy.

Since I have retired from seeing patients I have had a kind of consultation practice. I get calls from friends or former patients who want help understanding what's going on with them medically. This is something that I have enjoyed.

Family

Mary and I have three adopted children: Greg, our son, Katy, our middle child, and Clare, the youngest.

We'd had an application in with Catholic Services for roughly a year and a half when the social worker who had been working with us called Mary in Kerrville, where we were living at the time, and said, "We have a baby for you. Come and get him." So Mary flew to Denver and when she walked into the social worker's office, the social worker said, "My gosh, I forgot you were so fair and this kid is as dark as he can be." Mary said, "Don't worry about that." She flew back to San Antonio with Greg, and a couple whom we were close to in Kerrville, the Tally's, and I drove down, met them at the airport in San Antonio, and brought them home.

We arrived in Kerrville about ten o'clock in the evening and put Greg in his bed. We had a good sized dog, our first, and her name was Brunhilda. I brought Greg into the house and put him in his bed and here comes Hilda, curious as to what this is. And here are her paws on the mattress and she is sniffing away. Greg slept all the night through and when he woke up crying at 6 am I thought, "What in God's name is that sound?" We got him in May of '54 and moved to Austin in September, when he was four months old.

Greg's background is German and Polish. Mary would run into women at the supermarket with her beautiful dark baby and they'd say, "His father must be awfully good looking and awfully dark." When Greg was very young, five or six, his grandfather, Olias, in Louisiana would take him to Panama City where they'd spend a couple of weeks during which he would get so tanned he'd look purple. On their way home one year, they stopped in a restaurant in Mobile and went in and sat down and the manager said, "We can't serve black people." My father-in-law went ballistic and he pulled Greg's shorts down and said, "Look at that, if you think he's black." The fellow apologized, but that wouldn't do. Olias wouldn't have any of it and stomped out.

Greg lives out in Crestview, about fifteen minutes north of here toward Anderson Lane. He has two children and three grandchildren.

Katy came along in '56. I've known her birth family's name but cannot recall it now. It was a Swedish name, and there was a file in the Family Health Center with that name on it. I know it was that family but I never looked at the file. The family lived out near the old Bergstrom Air Force Base. Katy and her husband live in Santa Fe currently.

We got Clare, our youngest, through a private adoption. Her birth mother lived in Austin and, before she went into labor, she went to Kerrville, by pre-arrangement, to have the baby. I had arranged for Doctor Dyer to deliver her. We went up and brought Clare back from Kerrville when she was a day old. Clare and her husband live in Austin and have two children.

The number of hours I worked was pretty hard for Mary and the kids. She's never let me forget that I wasn't around more during those years that the kids were growing up.

My children are precious to me. That's what it comes down to.

Early Austin Medical Community

In 1954, when I returned to Austin, Travis County Medical Society had 250 members; current membership is about 3300. Seton was on 26th St. between Rio Grande and San Antonio and Brackenridge was at its present location. Seton was a large brick building and Brackenridge was about the same size, I imagine, as Seton and was also brick. All the education was taking place at Brackenridge. They had room for 14 interns but sometimes they didn't get that many. Their low year was four. Unmarried interns would live in the hospital and both the unmarried and married interns took as many of their meals as possible in the cafeteria. I would imagine that they had scheduled nights off, maybe every second or third night. When I was in my internship at Hermann in Houston, call was supposed to be every third night but it didn't turn out to be that bad, fortunately. At that time, when people finished their internship they would leave to go into practice or do a residency.

St. David's was located on West 17th St. near Rio Grande. I had a friend when I was growing up who lived with his grandparents on West 17th St., a block or two from the old St. David's. My friend would trap pigeons, butcher and dress them, then he'd take them up to the kitchen at St. David's and sell them as milk fed squab. At one time, say in the 50's and 60's, if you were practicing at St. David's and asked for something that was a little cutting edge for your patient, the eyes would glaze over. You could get it at Brackenridge but they didn't know quite what that new technology was about at St. David's. It was always characteristic of St. David's that that staff was very congenial. In the 50's there was a Dr. Lange Holland, an internist, who owned an electrocardiograph machine and St. David's did not. When a patient needed an electrocardiograph, Dr. Holland would bring the machine over to the hospital and do one for the patient. One time I asked the nurse, "Why doesn't the hospital buy an electrocardiograph machine?" She said, "Well, we don't want to offend Dr. Holland." I don't remember when St. David's built their new hospital on 32nd Street but, in my opinion, it is the best hospital facility, from the standpoint of design, of any hospital in town.

Holy Cross was located at 2600 East MLK and had been built in 1950. A unique hospital in a lot of ways, it was run by a nun order. There were certain doctors that were so sold on that hospital that they would have had their practices there, but some patients wouldn't go there because of location and lack of convenience. They were used to the hospitals on the other side of town. The hospital was open to everybody. Babies were delivered by a nun, Dr. Celine Heitzman, and "package" OB care was $75. Holy Cross was special because it was serving a marginal segment of society in East Austin. I think there was a lot of idealism involved on the part of the nuns that ran that hospital and the physicians and nurses that worked there.

Since I moved to Austin in the early 50's, my knowledge of the medical community only dates from that time. I think that, back then, most primary care doctors, i.e. GP's, internists, and pediatricians, aligned with one or two hospitals, usually Seton or St. David's, with a few that would use Brackenridge. The social elite, patients and doctors alike, gravitated toward St. David's. I was aware from the beginning that there were a lot of doctors that preferred to work in only one hospital; I am sure that was true well before the 50's. Dr. Happy Klotz would say, "You can't make a very good cake in somebody else's kitchen." For specialists, there was less latitude because they had to go where the patients were. Patients had preferences too. I think it was negotiated between patients and doctors as to which hospital the patient would use.

I went to four hospitals. In retrospect, that was really a mistake. I would have been better off if I had not worked at Seton, because it was out of the way. The reason I did was that my partner was satisfied there.

Certainly it was true back then that Brackenridge was the trauma hospital and had a corner on the sickest patients. The "blood and guts" doctors gravitated toward Brackenridge. However, some local white citizens devalued Brackenridge because it was perceived as a charity hospital. Dr. Bud Dryden, a GP, used Brackenridge almost exclusively. In medical meetings he enjoyed saying, "This patient went over to St. David's where the *real doctors* are." In reality, in those days patients were a lot safer at Brackenridge than at the other hospitals because of the presence of interns. Also, Brackenridge had programs for med techs and x-ray techs and much of the nursing education took place at Brackenridge.

Seton had a diploma nursing program at the time as well. I am at a loss about how to characterize physicians who practiced at Seton. There were a lot of specialists and GP's who were well satisfied with Seton and confined their work to that hospital.

As I mentioned previously, there was a group of 25 or 30 GP's that came back from the War but there were a lot of older GPs that had worked right on through the War here. So in the late 40's and early 50's there were more General Practitioners than specialists in town and they could outvote specialists on issues of hospital politics such as hospital and operating room privileges. Of course, they can't do that anymore. It seems very ironic now that GP's outnumbered the specialists back then.

In 1952-53, before I moved back to Austin, there was a movement by some of the general surgeons, OB GYN doctors and orthopedists to take away operating room privileges for GPs. It was a bitter fight and both sides eventually backed away. They just figured they weren't getting anywhere. At that time there was no General Practice section at Brackenridge. There were Internal Medicine, Surgery, Pediatrics, and OB GYN sections. The GP's would usually join the Surgery or OB GYN sections because they wanted to have a voice in hospital policy in those areas, specifically, issues like operating room privileges. GP's participated on the Surgery service and Bud Dryden was a key member. I participated on the OB GYN service, and I always went to the OB GYN section meetings. There was often tension between OB GYN's and GP's because they were competing for the same clientele. A GP from that time named E. B. Chauvin would often say, "OB GYN is the specialty with the least reason to exist." Back then, GP's made sure they attended those monthly section meetings; they didn't want anything going on that shouldn't be going on in those meetings. Subsequent to that, attrition took care of GP operating and delivery room privileges, along with prohibitive malpractice premiums.

Early Austin Physicians

In my early years in Austin, there were a number of physicians who left an impact on the community because of their capability and skill. One who comes to mind is Dr. Jim Kreisle, an Internist, who was in a two person practice and later joined ADC. He was a true gentleman. I had a patient at Seton who was recovering from an MI and doing well. But about the third day, his wife felt he needed a cardiologist, although there were none at that time in Austin. I felt that Dr. Kreisle would be a good choice. He went over to Seton at my request and spent a lot of time with the patient then called and said, "You don't need me." He was that kind of man.

Don Pohl, another Internist, was an outstanding physician. He had taken a fellowship in cardiology, although he was primarily perceived as a general internist. I took care of a man that had alcoholic liver disease who would get in trouble, bad trouble. A couple of times when he was in Brackenridge I called Don, who saved the patient's life on at least two occasions. The next time the patient became ill and came into the hospital around midnight, when I called Don he said, "No, the patient and I came to an understanding that I wouldn't be doing anything with him in the future." So I had to do take care of the patient myself after that.

The first cardiologist in Austin was Dr. Bob Anderson, who was at ADC. Bob had done general practice in Refugio for some years. One day he had two young children in the emergency room, sibs who had ingested something, and there was Ipecac available. There are two forms, one is syrup and the other, I believe, is an extract. One form is weak and the other very potent. One child got the weak form and survived and the other one, who received the more potent form, died of Ipecac poisoning. Bob eventually left Refugio and, sometime after that, he came around to see Hayes and me and said he was looking for a place to go into general practice. Ultimately, he decided not to come in with us, to my disappointment. I think that, at that point, he went to Galveston and took a Medicine residency and a Cardiology fellowship.

When Bob came back to Austin after the fellowship, he said he wanted to do all the cardiology in town. I don't think one individual could have managed to do it all. Besides, I wanted to do cardiology with my own patients. In the 50's and early 60's, we kept the patients who'd had MI's in the hospital for two weeks, and it didn't matter whether your doctor was a GP or an Internist or Cardiologist, the treatment was the same. I remember that there was a lot of Xylocaine that was used as an IV infusion for arrhythmias, both prophylactically and therapeutically, but there just wasn't much else to do in those early days. It wasn't until coronary units came along in the 60's and technology began to evolve that there became a difference between primary care doctors and cardiologists in the management of cardiac conditions.

Pulmonologists arrived after the Cardiologists, George Handley being the first. He was impressive for his expertise and was quite articulate. I recall that he would often arrive to give a presentation in a long white coat. We all felt, "This guy is coming straight from the pulmonology lab. He must know everything." He was a good man.

There was a Dr. Lee Edens who I knew the first several years I was in Austin. He was a dermatologist and syphilologist. Since syphilis had such a big impact on the entire body, including the skin, dermatology and syphilology were often lumped into one specialty. I later learned by chance that Dr. Edens had been a general practitioner early on and had even done surgery. I never knew that about him until he was well out of the picture. He was a very important physician at Brackenridge.

In medical school, our professor of dermatology was named Chester North Frazier. I am sure he was a syphilologist as well. He and the dean of the school, who was a pharmacologist and not a physician, were attending a program on the treatment of syphilis. I think it was the dean who was going on about how wonderful mercury had been for the treatment of syphilis. Dr. Frazier responded by saying, "Yes, well, the covered wagon had its day."

I worked in the Austin State Hospital in '46 and '47, during the summer vacations of the last two years of medical school – 3 month vacations. The State Hospital had a huge patient population at the time, probably three or four thousand. There were a lot of syphilitic patients who had been treated with Neoarsphenamine and they kept them around the hospital for reasons I'm not altogether sure of. In the early 1900's, syphilis was treated with an arsenic compound, Arsphenamine; Neoarsphenamine, also arsenic based, then came along and presumably had an advantage over Arsphenamine. I became aware of Neoarsphenamine in the 40's. It was given by IV injection once a week. Penicillin started to be available in the early 40's and was used to treat syphilis in some places, but must not have been used to treat patients at the State Hospital with that disease when I worked there.

One day of the week was spinal tap day, and one of us medical students, of whom there were roughly five or six, got to do the spinal taps. The student would sit across from a bench and the attendant would bring the patient in, sit them on the bench with their back facing the student, and the student would do the tap, pull the needle out, and then the next patient would sit down. I don't remember people complaining about spinal headaches. We didn't know anything about them then.

Doctor Truman Morris was a prominent OB GYN and Dr. Bill Kelly was outstanding in that field and one of the medical leaders in Austin. Pediatricians Clift Price and Ben H. White were standouts. It is hard now to remember all the outstanding physicians from those years.

Marvin Cressman was up at the top of the list of good neurosurgeons in those early years but there were other neurosurgeons who came to Austin before him. Albert La Londe was the first neurosurgeon in Austin and started before 1954. He was very good and practiced a long time. At that time, Austin had no neurologists. La Londe lived in Buda back then and got one call after the other from Brackenridge and the Emergency Room so he spent a lot of time on Hwy 81, later I 35, going back and forth. He acted as sort of a neurologist as well as a neurosurgeon, which was an uncomfortable situation. I think he may have stayed in Buda after he retired. He had a small farm there and was a solid man.

La Londe brought Bob Farris in. Bob was a very smart guy and a very good guy but he was extremely obnoxious in the operating room, abusing the nurses and the staff. One time Bob, his wife, and their two daughters were returning to Austin in a small plane that he was piloting. As they approached the airport, where Dell Children's Hospital is now, they ran out of gas. The plane crashed in a residential area over in Ridgetop and they were all killed. That was a spectacularly horrible event.

The third person in that group with La Londe and Farris was Bill Turpin. His reputation lingers after his demise and what an unpleasant person he could be. He didn't confine his abusiveness to the operating room. He was in intensive care one morning on rounds, maybe in the 50's or 60's, and really crucified the nurses. There was an orderly there, a good sized man that happened to be black. He said something to Turpin like "Don't ever do that again". There were exceptions to Turpin's behavior however. One evening, way way back, there were homes and apartments very close to the University on the north side. The University has since expanded and those homes are now gone. There was a woman, probably in her 30's, who lived there with her mother. She had had her first seizure one evening and I brought her down to the Emergency Room at Brackenridge. I hadn't known her before that. I thought that she had papilledema and called Turpin and he came out. He said that it wasn't papilledema and explained why. He and I spent the better part of an hour together and in that time he taught me a great deal about how to take care of her. She turned out to have had an alcohol withdrawal seizure. Turpin could be that way, a very good teacher.

One of my closest colleagues was Sam Todaro, who was educated in OB GYN in Boston. He practiced GYN but not OB and workers comp cases comprised much of his practice. He styled himself as a GP and a surgeon, an indication that post graduate training was broader at the time he trained, which was in the 30's and 40's. Sam and my partner, Sigman Hayes, were my closest collegial friends. The relationship with each of them was like a father son relationship even though the difference in our ages was only 11 and 12 years, respectively. Sam had an office on West Martin Luther King, just west of Rio Grande.

Sam was a very interesting man, a very smart man. One time he and I were leaving Brackenridge Hospital as a bedraggled man was entering the building, looking like he wasn't good for much longer. After we were out of earshot Sam asked me whether I believed that

the meek would inherit the earth. I never have come up with an answer to that. I know that comes from the Bible, the Sermon on the Mount I believe, but recalling that reminds me of the kind of mind that Sam had, an inquiring mind.

Sam and I would operate together at Holy Cross Hospital, primarily on my patients who needed GYN or general surgery. He would assist and it was important to him that I learn to do procedures exactly by the book. I can remember that we did hysterectomies together, which was very helpful to me. I had the impression that, when he assisted me on surgeries, Sam didn't bill my patients.

One time he was performing an operation at Holy Cross. It was in the winter time and the weather was pretty nippy. The nurse anesthetist was a nun and the anesthetic was open drop ether, a satisfactory and safe anesthetic for years. At that time the gases came along out of tanks like the ones that are used now and, when Sam got through with the operation and was taking the drapes off the patient, he looked around and noticed a small gas heater in the corner just burning away. He said, "Sister, I know the Lord meant for us to be here a long time."

Often, when we were discussing one thing or another, Sam would say something like "It's well to be sober and distrustful." His personality must have reflected the culture of his family, who were immigrants from Italy. His father was 14 when he arrived in this country. He moved to Temple and eventually started a produce business and became very wealthy. Sam went to Rice and then to Tulane Medical School where he knew Michael De Bakey, whose family was from Lebanon. Because he was Lebanese, De Bakey was shunned and ridiculed by the other medical students, who gave him the nickname "Black Mike." However, he proved himself much smarter than many of his classmates.

There was a famous story about De Bakey. At one time when he was going to remarry, his intended was a fairly young woman. Somebody tried to very diplomatically say, "You know, this could be a real burden on the cardiovascular system." The story is that De Bakey replied, "If she dies, she dies."

I believe that Sam retired in the '70s. He eventually developed renal carcinoma and declined treatment. One time his wife, Phyllis, called and asked me to come visit them. Sam was pretty well along in his illness at that point and, when I arrived at their home, Phyllis said that he preferred not to see me, not wanting me to see him in his current condition. Phyllis and I talked for a long time that afternoon and Sam died fairly soon thereafter. At their request, I gave a eulogy at his service.

Early Austin Group Practices

In the 1950's, Virgil Lawlis, Homer Goehrs, and Len Sayers entered practice together and then Henry Renfert, an endocrinologist, joined the group. They took the name Austin Diagnostic Clinic early on.

Dr. Renfert was in East Austin on a house call one evening, where the patient was in extremis [the final stages of dying]. Renfert thought he knew exactly what to do so he took out a syringe and gave her an IV injection, and the patient suddenly died. One of the men in the family that was there said, "Doc, that's fine. You ease her out real nice."

Mother was a patient at ADC, probably at my recommendation, and she called it "Mount Olympus". I said, "What? That wasn't a very friendly remark." and she said, "I didn't mean it to be." But she had a wonderful doctor, Terry Collier. We had the same doctor, she and I.

ADC initially had an office at 26th and San Antonio which had been a fraternity house and was catty-cornered across the intersection from the old Seton. I am sure that most of their practice was at the old Seton. The clinic was later re-located to West 34th Street where they remained for a number of years before moving up to the North Austin Medical Center.

ADC was one of the first big physician groups in town along with Capital Medical, which was organized by Charlie Darnall and Horace Cromer, who happened to be Dad's doctor. Capital Medical has been located in Medical Park Tower for many years now. Their policy was initially that all members would be graduates of Mayo Clinic, although that eventually changed when they found out that there were some pretty good physicians who didn't train at Mayo. Initially, ADC and Capital Medical had both general internists and sub-specialists. Neither group had GP's.

Capital Medical's policy regarding patients referred to them proved more acceptable to referring physicians than ADC's policy. Referral to ADC was often complicated by the patient being encouraged to stay with the specialist in that group rather than being sent back to the referring doctor. With ADC it came down to the fact that doctors who accepted your referral were competing with you. This was not true with Capital Medical; they would send the patient back. Some patients stay with ADC and a whole battery of specialists. We like to think that the more sophisticated patients prefer family doctors or general internists.

ARC, Austin Regional Clinic, came into existence in the 1970's under the leadership of Dr. Norman Chenven, who is still in a leadership role and actively practicing there. They do have primary care doctors as well as specialists in that practice.

Early Women in Medicine

We had eight women in our medical school class. I recall that there was a Dr. Bengie Brooks in my class, who practiced in Houston. I don't remember her specialty but understand that she proved to be an outstanding doctor in that city.

Dr. Ruth Bain was another medical school classmate and she was getting started when the large group of doctors came back from World War II in the '40s and was a little younger than those doctors. Ruth was the first woman president of the Travis County Medical Society and the second woman president of TMA. She was an outstanding person in medical politics at that time.

I think the women physicians were generally well received by male physicians. It was nice for many of the women patients to have a female doctor. In those early years, there was Ruth in general practice and Georgia Leggett in OB GYN. I don't remember any women pediatricians or internists.

Transition from GP to FP

General Practice (GP) phased over to Family Practice (FP) over time. The basic difference between the two was that GP's carried on a truly general practice, defined at the time as one that included every aspect of medicine. They performed much of the surgery that was done for their patients, along with obstetrics and orthopedics. The quality of their work was generally high and their specialist colleagues supported their operating room and hospital privileges as being desirable and necessary. Of course, if you go far enough back in history there wasn't anybody around to do all those things except the general practitioner.

The physicians that I knew well in the 50's and 60's, many of whom were GP's that had come back from WWII, did an outstanding job of taking care of patients. They had gained their medical education in the 30's and 40's as well as from various forms of internship and residency during WWII. Beginning with the end of the War and going on for approximately 20 years, there was a group of roughly two dozen of those General Practitioners who had returned from WWII in Austin and, almost to an individual, these people were excellent doctors.

In the 1950's, there was also an influx of formally educated and certified specialists and sub-specialists who represented a quantum improvement in the quality of specialty services in Austin. Thus, one could generally "trust the label", i.e. assume that a given doctor who came with such qualifications could be depended on to be competent and reliable.

The GP's my age, who were a half a generation behind the GP's who came back from WWII, didn't get all the training that the previous group of doctors had gotten. So, for the amount of time you spent in post graduate education, you had less to show for it if you came out in the 50's than if you came out in the 30's or 40's because the education in the 30's and 40's was broader; the doctors in training got to do more surgical and obstetric cases. There were surgeons and OB GYN's as well in the 30's and 40's, but not that many.

During the 30's and 40's physicians would get to do gallbladders in a GP internship. That was not happening when I came along. Gallbladders are tricky. I think my education in that area came from relatively few patients, one of whom had been operated by a seemingly unqualified physician for gallstones. There was damage to the common bile duct and that operation doomed her to severe disability the rest of her life, resulting in her becoming an addict. This wasn't my patient; she was Hayes' patient and he thought she needed another operation. The surgeon we used was Dr. Murphy Nelson and, thinking he could help her, he screwed up his courage to do the surgery. When they had her on the table her situation became difficult to manage and Nelson wanted to abandon it and close her up. Hayes, who was assisting, wouldn't let him do it though and they attempted to correct the initial

complication. Unfortunately, they were unsuccessful and, after that second surgery, she continued to live on with her disability.

GP's in the 1950's sometimes got themselves into trouble because they believed that they were supposed to be everything to everybody and they didn't realize that things were changing. That included me.

Family Practice was established as the 20th medical specialty in 1969. The impetus for the formation of the specialty of Family Practice developed from a socioeconomic movement within the U.S., whereas earlier specialties had come into existence on the basis of specific technical medical expertise.

In the late 1960's, a national medical education organization[15] established requirements for accreditation for residency programs, including a policy that, after 1973, there would no longer be any "freestanding" internships that were not part of a residency program. Therefore the Brackenridge general internship, begun in the early 1930's and of excellent quality, could no longer be officially certified unless there was an associated residency program.

In the early 1970's, residencies in internal medicine, pediatrics and family practice were established at Brackenridge Hospital. A surgical residency, which had already been in operation, continued and an OB GYN residency, affiliated with UTMB, was established. In those early years, the residency programs at Brackenridge were under the umbrella of the Central Texas Medical Foundation which was a part of the Travis County Medical Society. The family practice residency was called the Central Texas Medical Foundation Family Practice Residency. A psychiatry residency at Austin State Hospital had been in existence for a longer period of time than I can recall and eventually also became affiliated with the residency programs at Brackenridge[16].

Since the beginning of my time in Austin as a practicing physician I have noted that many physicians in the Austin medical community have been very interested in having a major role in teaching interns and medical students, without compensation. This has been an essential element in the success of the residency programs in Austin throughout their history.

Dr. John Kelly, an Austin GP, along with Drs V.C. Smart, Ruth Bain and others were instrumental in bringing about the new FP residency in Austin. Dr. Kelly became the first director and Dr. Bain joined the faculty as associate director, offering her office on W. 17th St. as the first site of the residency. After Dr. Kelly left, Dr. Paul Shedler, who had practiced in East Texas for a considerable time, became program director for a few years.

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[15] *The ACGME (Accreditation Council for Graduate Medical Education)*

[16] *From Dr. Bill Race, Austin psychiatrist: The psychiatry residency at Austin State Hospital was established in the mid 20th century and Brackenridge Hospital was one of the sites through which psychiatry residents from that program rotated. They continued to rotate through Austin State Hospital and MHMR outpatient clinics after administration of the residency was assumed by CTMF.*

In 1977, the director of medical education for CTMF, Dr. Earl Matthew, asked Dr. Glen Johnson to serve as director of the Family Practice Residency program. Dr. Johnson was a recent graduate of the Howard University Family Practice Residency who had moved to Austin to practice a few years before. Dr. Bain continued as associate director. By about 1978 the residency had moved to a location at the intersection of E. 49½ St. and N. I-35 and, shortly thereafter, Dr. Johnson persuaded CTMF that it would be advantageous to build and own a clinic building for the residency. This project was carried out promptly and the program moved into the new building at 4614 N. I-35 in 1981 and was named The Family Health Center. It operated there until the late 1990's when Seton assumed management of the CTMF residencies and the family practice residency program moved to its present location in the Brackenridge Professional Building.[17]

I can remember noticing the degree of respect that Glen Johnson showed for the residents, which was so contrary to the way I had been treated as an intern and resident. Consequently, I had to do a 180 and really rethink my approach and change my attitude. If I hadn't changed my attitude, I think I would have been abusive. I have an abusive streak and I think it would have come out. I still remember the way Glen related to residents: respectful, thoughtful, and considerate. Thinking about Glen Johnson, he just seemed to have a knack for keeping a lid on situations that could have become tense. Glen eventually retired and began to live part of the time in Trinidad where he was originally from. I am still in occasional cell phone contact with him.

After Glen Johnson left, David Wright was director of the residency for a number of years. Then there was a succession of directors and interim directors: Dick Leverich, interim director, Jim Knale, myself as interim director, Cynthia Brinson, Russ Thomas, Sam Adkins and, the current director, Dana Sprute[18].

Russ Thomas once said something interesting. He was director of the Family Practice Residency for a couple of years, as I remember, and then decided that teaching wasn't what he should be doing so he went back into practice in Eagle Lake. One of his last OB patients at Brackenridge, while he was still the residency director, developed DIC, and she died. He said that when he got ready to dictate her record he couldn't remember her name and that indicated to him that it was time to leave. He went on to say that the OB GYN faculty didn't offer any help when he was trying to save the patient's life but, after she died, they were very quick to slam his management of her. I think that what Russ Thomas said is very significant.

The paid faculty of the family practice residency program consisted only of a director and associate director for several years and gradually increased to the nine full time physicians they have today. Pro bono participation on the part of many local FP's and GP's for a

[17] *The Family Health Center was renamed the Blackstock Family Health Center when Dr. Blackstock retired from active practice there in 1991. After retirement, his association with the Blackstock Family Health Center and the Family Practice Residency Program continued for the rest of his life. The clinic retained the name Blackstock Family Health Center when it moved to the Brackenridge Professional Building after Seton assumed management of the residency program.*

[18] *Full list of later directors of the Family Practice Residency Program provided by Dr. David Wright*

number of years made it possible to operate on a relatively small budget and this arrangement allowed the residents to acquaint themselves with a variety of medical attitudes and philosophies within the community.

A faculty comprised of many professionals other than physicians has tremendously enhanced the substance and quality of medical education at the family practice residency program. Psychologists, social workers, nutritionists, and educators have enlightened the faculty physicians along with residents in areas of expertise essential to the effective care of patients.

When I came out of residency in the early 50's, the number of physicians going into in general practice was starting to fall off. The nadir in the number of medical students choosing family practice residencies came in 1974, five years after the formation of the specialty of Family Practice. By the late 70's and 80's, family practice residencies were attracting a lot of students. For the past several years, the popularity of the specialty with graduating U.S. students has declined due, among other factors, to a deterioration in income. The need for generalists, especially family practitioners, increases in parallel with a rapid rise in the number of specialists. In other words, service to patients becomes progressively more fragmented when there is no "captain of the ship" in the picture.

General practice stemmed from times when there were few specialists. In those days, if a given medical task had to be done it was performed by a GP, in contrast with our present situation in which specialist expertise abounds and generalists ask themselves "What is there left for *me* to do?" A response that comes to mind is that the overwhelming need in medicine today is for personal physicians, ones who hear what their patients are saying and who are thinking carefully about what they are hearing.

An aspect of general practice that impressed me as a medical student in 1946 was that one could make a good living by being attentive to his or her patients, "tending to business". The UTMB instructor that, unbeknownst to him, persuaded me to become a GP was, himself, an endocrinologist with an overwhelming fund of medical knowledge in *all* fields of medicine. I wanted to be like him, something I haven't accomplished despite much effort throughout my professional career. But I have enjoyed the mental pleasure of "shifting gears" with each new patient and of learning "greedily" throughout my professional life.

How are GP's and FP's different from each other? What was special about family practice that it needed to be distinguished from general practice? The scope of what the general practitioner had to be able to do is, of course, broader than that of the family practitioner. The role and standing of general practitioners died hard because there was no time in history when physicians agreed among themselves, "Now is the time when certain procedures will no longer fall within the realm of general practice."

Those who have gone through FP residencies have had a much easier time in their practices than the old GP's did. Family practice is a more intellectual type specialty than general practice was. FP's don't expect themselves to perform an emergency surgery, do a delivery, go to the ER or make an urgent house call in the middle of office hours the way GP's did.

Many of the GP's, including me, were grandfathered in as FP's after it became a specialty, but I still slip up a lot and say I'm a GP.

Indigent Care in Austin

Indigent care was provided through MAP, the City Medical Access Program, which initially funded the Brackenridge Specialty Clinics and now, of course, funds patients at the City Health Clinics as well. I am unsure when the MAP program started although, at the time I started practicing in Austin in the early 50's, MAP funded the specialty clinics at Brackenridge. There was no General Practice clinic at Brackenridge, just Internal Medicine, Pediatrics, Surgery, OB GYN, and Dermatology. GP's, other primary care doctors, and specialists on the Brackenridge staff, primarily, would volunteer to attend whatever clinics they wanted to. Those volunteer physicians would have a regular schedule, staffing a clinic once or twice a month. There were a few physicians on staff at Seton or St. David's that went over to Brackenridge to staff clinics as well. As I recall, I worked the Internal Medicine Clinic. It wasn't burdensome.

I believe that the majority of doctors in Austin at that time felt they had an obligation to people without resources since there wasn't much available to low income people other than Clinic Card [an early name for the MAP card]. I think that both primary care doctors and specialists expected to do pro bono work for those patients.

Issues of Race

In the 1950's, The John Birch Society became very prominent and active and there were several doctors that belonged to it. I would assume that, prior to the 1960's, many doctors had separate waiting rooms in their offices for black patients. This is speculation, however; we didn't visit each others' offices and, as far as I am aware, doctors didn't discuss this. I never heard of black patients being refused care by any physicians in Austin.

Dr. Bud Dryden officed immediately next door to Brackenridge with three associates, and I am satisfied that their waiting room was integrated. I believe his practice was about 95% black patients.

I recall Dr. Bauknight's waiting room in Ganado, TX, where I practiced during the hiatus between medical school and internship. He answered the question by having a waiting room that was informally divided physically, so that white patients and black patients automatically went to one part of the waiting room or the other, but nothing was ever formally said about it. In addition, there was a large contingent of Hispanic patients in his practice and I believe they waited with the Anglos.

In Sig Hayes' and my office there was only one waiting room. That was beginning in 1954. I can remember that one time, there was a young black woman, a patient of mine, who was inadvertently bypassed in the waiting room. The nurse got mixed up and took another patient ahead of her. So the question arose in this young woman's mind, "Was it because I am black?" She happened to be a very volatile sort of individual and she raised a lot of cain

about that. Later in the day her mother called without any element of antagonism. Her approach was measured and sensible and she asked me if I treated patients differently according to their skin color. On thinking about that, I responded by saying, "The only way I would know how to answer that would be to ask my patients." And that satisfied her.

I knew a black man once whom I took care of along with his family and he was a few years older than me. His medical problem could be managed in a couple of different ways and I wanted to get some idea from him of whether he had a preference. He would not say. I tried and tried and tried and he just would not say. He had this sort of noncommittal response. He was of the old school; you just don't tell a white person what to do. His wife was very different. His children were different. The man worked for the post office and he was very well liked, I believe, by the other employees, who were white.

There was another black man, younger than the patient mentioned above, who was a patient in our practice and also worked in the post office. I understood that he was very outspoken at work about what his position should be in relation to his fellow employees and he wasn't very well liked there. His son, who I met when he was about five years old, grew up to hold a prominent political office in this state. Sig Hayes was their family's doctor, but when he wasn't there I took care of them. The wife in the family is still alive and we still talk every so often on the phone.

I remember a story about another black man who was the first black intern at Galveston Medical School. I believe he was involved in a traffic accident in Galveston with a white driver. My understanding was that, after they got out of their cars, the white driver attacked and beat him and he was hospitalized at John Sealy Hospital. His stepfather, who lived in the Austin area, went down to see him and the young doctor asked him if he should bring charges. The stepfather's response was, "Don't. If you don't, you'll have won a friend." He didn't bring charges and I believe they were okay with each other after that.

There was an orderly that worked in the operating room at Seton, a black man, whose wife developed breast cancer. Seton did not admit black patients at that time, therefore she was admitted to Holy Cross Hospital instead.

I recall hearing a story about another black woman who was trying to "break the color line" and called in to the admissions office at St. David's saying that she needed to be admitted. It came out that she was refused over the telephone although when she showed up at the hospital she prevailed upon them to admit her. That would have been in the early 1960's, I believe. At that time most Blacks were admitted to Brackenridge or Holy Cross.

Brackenridge had a separate ward for black patients until sometime in the early 60's, as I recall. This was before there were Coronary and Intensive Care units. I remember an ostensibly healthy black middle aged man in the ward in Brackenridge where black patients were hospitalized dying of an MI. I don't know if his odds would have been better on an integrated ward or not. That made a real impression on me.

Practice at Rosewood Zaragosa Clinic 1974-1980

In 1974 Sig Hayes moved up to Bertram. He thought he was retiring but people up there wouldn't let him so, after several months, he went back into practice up there. I went from private practice to the Rosewood Zaragosa Clinic in East Austin and worked there from '74 to '80. In that clinic, there was a nurse practitioner, an LVN, a med tech, and our administrative people. We had a group of nurses that officed in the same building and made house calls and they made a lot of calls that I would have made if they hadn't been there. I made some house calls as well, but not many. Over time, my practice there became progressively more problematic in that I had a lot of responsibility but didn't have the authority, administratively, commensurate with that responsibility; so it couldn't work. I eventually knew I was going to have to resign.

In 1973, during my last year of private practice, a group of doctors, including me, and some other professionals organized a volunteer clinic at San Jose Church in South Austin which served, primarily, low income members of the South Austin Hispanic community. A mistake that we made when we established a board of directors for that clinic was not using local residents as some of the board members. We put all of ourselves on the board with the attitude "we're going to do this for you." In the end we realized that wasn't the best idea.

David [Wright] and I met at that clinic. He, along with Sheri, his future wife, showed up as a Vista worker and a med tech, respectively, and she worked in that clinic as well. David subsequently went on to medical school and then started his FP residency here in Austin in 1980. All of the volunteers worked hard caring for patients at that clinic although there wasn't any way to send people for lab or x-ray or to specialists, so it was pretty tough going. David would show up on his bicycle and, come closing time, he'd take off and be up there on Congress Avenue waiting for me as I went by in my car on my way home.

I worked at the volunteer clinic the last year I was in private practice and the first year I was at Rosewood Zaragosa Clinic. I remember thinking how good Rosewood Zaragosa seemed compared to the volunteer clinic, where we didn't have any referral resources.

When I first started to work at Rosewood Zaragosa I referred patients to the specialists I had used in private practice, but after awhile I felt I was imposing on them. I eventually decided to quit imposing on my specialist colleagues and just used the specialty clinics at Brackenridge. Despite the imposition that the referrals were for them, many specialists were very interested in what I was doing at Rosewood Zaragosa.

Austin Family Practice Residency 1978-2012

In 1978, I ran into Glen Johnson in the parking lot at Brackenridge and he said, "We've got to talk. Come out to the Family Health Center as Associate Director." That was a welcome idea for me because I had been teaching pro bono since I'd begun practice in Austin and I enjoyed it. I did both jobs for two years, from '78 to '80; Rosewood Zaragosa in the mornings and the Family Health Center in the afternoons. Glen would go from the Family

Health Center in the mornings to his office on East MLK in the afternoons, which he shared with his partner, Dr. Ira Bell.

I had to make some adjustments when I started teaching residents. Of course, I had had one to one preceptorships with medical students in private practice for many years. Moving to residency teaching involved changing the focus from one learner to several learners. Those two situations are very different from each other. The one to one setting is simpler and more straightforward whereas having several learners introduces a consideration that the needs of each learner differ from one to the next. In addition, the composition of our residents changed over time. Our first residents were, almost to an individual, white men. Over the next 30 years they phased over to approximately half women and half men, along with residents from many cultures around the world. All of those factors enter into the teacher's planning.

Medicine as Currently Practiced

In the way that medicine is currently practiced in this country, sufficient time is not allowed for physicians to talk with and evaluate their patients. This has resulted in too much reliance on technology. If the physician doesn't have time to think, he or she is more likely to order a diagnostic procedure.

In the early days, before there were all the tests we have today, physicians had to be good at physical diagnosis and this, along with having the time to talk with the patient, would benefit physicians, patients, and health care costs today. I remember one of the interns about a year or so back asking how you can tell how big a heart is on physical exam. I had to wonder what they had taught him about physical diagnosis in medical school.

It seems to me that the best way to keep hospital expenses down is to minimize the ordering of unnecessary procedures. The ostensible reason for all the procedures performed in the hospital and the emergency room is liability risk, but I don't buy that. It appears to me that the incentive has instead been financial; the more procedures that are done, the more money a hospital makes and the more money the procedural doctors make. It is hard to imagine how to reverse this situation since there is so much self interest involved.

Another issue currently is that there are so few primary care physicians, relatively speaking. As I have said before, years ago GPs could outvote the specialists on issues that affected their interests in the Medical Society or in hospitals. Now that balance of power has shifted with such a small proportion of FP's in the community. I believe that if there were a large number of primary care physicians practicing, including FP's, medical care costs would decrease because patients would get more of their issues addressed in their primary care doctor's office and not with multiple specialists or in the ER.

What's the future of family practice? In an ideal world, people might say, "Yes we do, after all, need primary care specialists, including family doctors, and we'll do what's necessary to increase their role in the care of the American people. We'll pay primary care specialists at a level commensurate with other specialties, making the primary care specialties financially attractive enough to once again bring adequate numbers of new doctors into the field." I don't know whether that's the way it will work out. It's hard to weigh the many forces that will determine the future of family practice and the other primary care specialties.

Chronic Illness and End of Life

I spoke with Dr. George Tipton recently. He is 98 years old now and is a retired surgeon. He graduated from Galveston Medical School a number of years before I did then went to Houston after graduation to take a year of surgical residency before being called into the Service. After he left the Service in '45 he went to Galveston for a 3 year surgery residency which overlapped with my last years in medical school, and I knew him from that time. After the residency he moved to Austin and set up his surgical practice, which would have been several years before I got back to Austin.

In our conversation, I spoke with him about my melanoma and he told me about 2 people with metastatic melanoma that he had taken care of, one of whom was a woman who had major metastases in the head of her pancreas and her duodenum, all of which he took out. She lived 9 years after that. The other person was a man who had a major metastasis in his inguinal area and he lived 9 years after having that metastasis removed. As I listened to George, I realized that what he was saying was making me feel better about my own problem and that he must have had that effect on his patients too. They say if a major metastasis is removed it has a positive effect on the other metastases.

I have been asked to speak to the residents on my experience with terminal illness and on end of life issues. I hope to make a presentation to them sometime this summer after I recover from this next round of radiation therapy for brain and spine metastases.

Dr. Blackstock died at home on July 3, 2012, less than 2 months after our last interview with him. He was not able to give the presentation on his experience as a patient with a terminal illness to the family practice residents as he had planned. We know that it would have been insightful and wise, filled with rich detail, and delivered with the wry sense of humor and twinkle in his eye that so many of us came to know and love.

JK and JC: Matt, it has been such a great experience to work on this project with you.

MB: You all are easily impressed.

As was their custom, when each of our visits drew to a close Matt would take his hat off the rack by the front door and carefully put it on. He and Mary would then walk us to the curb and bid us farewell. Here they are in front of their home on one such occasion in March, 2012.