UFHC 47
Interviewee: Dr. Jean Bennett
Interviewer: Nina Stoyan-Rosenzweig
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R: This is an interview with Dr. Jean Bennett conducted by Nina Stoyan-Rosenzweig. It is December 1, 2001, and the interview is being conducted in my office in the medical center. Dr. Bennett, could you tell me just a little bit about your early life – where you were born and when?

B: I was born January 13, 1936, in Justice, West Virginia. All of my primary and secondary education was in West Virginia. I graduated from Concord College before coming to the University of Florida.

R: In college, you majored in biology and chemistry?

B: Right, [I had a major in] biology and [a] minor in chemistry.

R: Did you know when you first entered college that you wanted to be a physician or was this a decision you made along the way?

B: As long as I can remember, I wanted to be a physician. That's interesting, because where I grew up in West Virginia in the coal-mining area, we did not have a single physician. We had a visiting physician that would come to various counties, maybe two days a month or that sort of thing. In terms of living in a town where there was a physician, there was none. I have often wondered what encouraged me. I don't know if it was a book somebody read [to] me or what. I had no personal knowledge of a physician until I was ten or twelve years old. I was even born at home. We had very little association with the medical profession.

R: What did your parents think of your interest in medicine?

B: They highly encouraged it.

R: You grew up in a very rural area. Was it expected that you would go to college?

B: Not at all. There were, I think, twenty-seven in my graduating class from high school, about fifty percent girls and [fifty percent] boys. I was just thinking the other day, I think six of the girls were already pregnant. It was just a way of life in the coal-mining section of West Virginia. If you finished high school, you immediately had a family with or without benefit of matrimony. Only three members of my class got to go [a] college of any kind.

R: Did most of the men go into coal mining? Was it still big there or was it declining?

B: Oh no, it was very big then. It was almost a rite of passage. You went to school, played football, and went in the coal mines.

R: How did you choose Concord College?

B: My mother had attended Concord College and several of my [second cousins]. At the time, it was a decision between Concord and Marshall University. This will tickle you a little. One of the boys in my class, who was one of the three to get to go to college, got a scholarship to Marshall and I didn't want to go where he went because he kind of smothered me. I went to Concord because he went to Marshall. There were other reasons too, don't misunderstand, but at the time, it was a major consideration.

R: It is funny sometimes how we make our decisions.

B: Right. Of course, going out-of-state, [with] no appreciable financial support, was out of the question.

R: Were you able to commute from Concord College?

B: I lived on campus.

R: You said as far back as you could remember you wanted to be a doctor. Presumably that was your goal then. Was there anyone who was particularly encouraging?

B: Yes. It was an amazing experience for a small college. There were eight hundred students there at the time. It cost about $800 a year to go to college there. There were two professors who made a tremendous impact on my life. One was Dr. Harvey Wells and the other, Dr. [Paul] Bibbee. They were all in the biology department. [In] many of my classes at that small college, for example comparative anatomy, I was one of three students with a Ph.D. professor. Which was, as you can imagine, a tremendous encouragement. I have very, very fond memories of Concord College and my mentors there.

R: Did you keep up contact with them afterwards?

B: Oh yes, as a matter of fact Dr. Wells died about five years ago. I have established a scholarship at Concord College in his [Dr. Wells] honor. He not only was a professor, but a true friend. I lived on campus, on weekends I was often invited to his home, went to the same church, sang in the choir with him,

did all those things. His family became my family, literally. His daughter is [one of] my best friend[s]. She's a Ph.D. geneticist at Case Western [Reserve University]. There's rarely a month we don't talk or write to each other, still.

R: That sounds like a wonderful experience. You majored in chemistry, as well. What raised your interest in chemistry?

B: My mentors suggested that if I were going to interview for medical school, that's what I should do.

R: You graduated *magna cum laude* in 1956 and you went straight to medical school. How did you choose the University of Florida?

B: That's another interesting story. My mother became very ill. We lived on, literally, the riverbanks of Guyandotte River and she was getting pneumonia two or three times a year and became very allergic to penicillin, which in those days was the only antibiotic. The doctor came to our house one day and said to my father, if you want your wife to live, you better get her to a sunny climate. Within a week, they had packed up what they could bring in a car and came to Dunedin, Florida, where they have been ever since. They came here in 195[4]. I stayed on and finished college. I so wanted to go to West Virginia University to the medical school because some of my friends were going [there]. Mother and Dad wanted me to come to Florida. They heard about the new medical school and they wanted me to be close [to] home, of course. Very naively, I made a deal with my father that I would go to whichever school chose me first. Little did I know that no school may have chosen me, but I was very naive. That's the only two places I applied. I received my acceptance to the University of Florida one day before WVU. I was heartbroken. In retrospect, it was one of the greatest things that ever happened to me, [but at that time] I was crushed. My friends were going to Ph.D. programs, a couple to medical school. At that time, [at] WVU, you had two years of undergrad and you were guaranteed a place at University of Virginia medical school. Since then of course, WVU has their own school. That's what would have happened had I gone there.

R: Were you interviewed at Florida?

B: Yes.

R: So you came down for an interview first.

B: Right.

R: Was Dr. George Harrell interviewing the students?

B: Right, and Dr. Wilson, who was chair of the department of anatomy. Those were the only two that were on campus in the little trailers up on the campus there.

R: Dr. Harrell, at least with the first class of students he selected, seemed to be almost conducting an experiment as to how he picked people and who he picked. A lot of the class were older, had worked, some had Ph.D.s. It must have been a fairly diverse group of people.

B: Exceedingly so, yes. I was I guess one of the few who was coming straight out of a college program. A lot of my classmates had Ph.D.s in biochemistry, etc. I think he had a big vision, even then, about putting together people who had to work together.

R: About creating a community, I guess.

B: The whole thing, yes.

R: Did he ever talk to you about why he selected you?

B: We talked so many evenings after he became a semi-invalid. We talked on the phone often. I'd call and check on his wife who was in a care unit. He said to me one night, I just liked your spirit. He said he liked my family values and my beginnings, which were about as simplistic as one could have. He did make that statement to me probably two years before he died.

R: Were you living in Gainesville and not with your parents because that would have been a fairly long commute?

B: Yes.

R: Where were you living on campus?

B: Dr. Harrell even did that for us. There was a lady called Mrs. Miller who was the sister of Senator Miller who was from Micanopy. Mrs. Miller lived fairly near the medical school. He arranged for me to live there and he even chose my roommate. I had no problem, you know. It was maybe a half-mile from the medical school. Kay, who was in my class also, we shared a bedroom and Mrs. Miller very graciously would cook dinner for us occasionally. She was a widow and fairly lonely. I think she enjoyed having students there. That was my first rooming experience in Gainesville.

R: There were three women in this first class of forty. Your roommate was Kay. What was her last name?

B: Kay Miller. She married Bob Whittier, one of my husband's best friends. I remember Betty Robinson. That was the other one.

R: You ended up as the first woman graduate because you were the first named, alphabetically.

B: Back to that interview with Dr. Harrell – when I brought my transcript from Concord College he looked at it and said, you're too heavy in the sciences. My senior year, he basically said, if you'll do these things, you can have a place in the class. I had to take a subject called The Family. I had to take philosophy, Economic Development of the United States since 1920 and Art 101. Well, of course I wanted to go to [medical] school, so I went right back and signed up for the classes. Also he was impressed [that] I had a great interest in music, [and was] a pianist. He encouraged me to continue with that art as well [and] gave me a little sermon about that I should not marry when I was in medical school. That's the last he ever said about that.

R: I know the humanities were important to him and he really felt that physicians should be well-rounded people. I've already interviewed Francisco Herrero.

B: He and his brother Frank played at my wedding. One the piano and one the violin. They're marvelous musicians.

R: When you mentioned music, he came to mind because I know that that was important to Dr. Harrell as well. He really wanted doctors to have knowledge of the humanities and contact with art, as well. You played the piano, did you play that throughout college?

B: I began as a child. I'm not an accomplished musician, by any means. I was a pianist for my church. I played for some choral groups, mainly for enjoyment.

R: You continued that?

B: Still.

R: That's wonderful. After your parents moved to Florida, did that make a difference as far as your mother's health was concerned?

B: Absolutely. My mother will be eighty-four in February and she's stronger than either one of us. She's a terrific lady, she works at our Foundation, our hospital, DAR [Daughters of the American Revolution], teaches Sunday school every Sunday. Tremendous, a lot of community work. As a matter of fact, [she] was

one of the nominees for senior citizen of Dunedin last year. Her health has really, really turned around.

R: Since you were in that first class, tell me what it was like, as a student, to be entering even before the hospital had opened. It was a fairly small class. Can you tell me something about student life then?

B: Sure. There are so many things [for which] I'm grateful to the University of Florida, but being in the first class has to be the height of my enthusiasm. All forty of us became good friends, some of us closer than others. Of course, as I'm sure in your interviews you've learned, we were divided into groups of four for study units. Then we had our friends next to us in our cubicle. We had a geographical relationship in our cubicles and then a group relationship in our groups of working, which we maintained over the four years. I made a statement [when I] spoke at the class reunion about ten years ago, that you had the feeling even today you could call up one of your classmates and say, I'm really in a bind and I need some help. You have that feeling still that they would come to your rescue. I feel that way about my classmates. As in any group, you get closer to some individuals. Your spirits meet better. I have some very, very dear friends with whom I communicate often. Of course living here in the state, we've referred patients to each other, talked about our patients still, just like we did in 1960. I think the idea of teaching us early on that being a physician is being a member of a group, of a larger community, has really stuck with all of us.

R: Do you think that was typical of medicine or medical education at the time or do you think that was more Dr. Harrell's vision?

B: I think it was Dr. Harrell's vision, because I had friends in other medical schools who didn't have this relationship. It was not as competitive as it is today. I understand, especially [in] some of the larger schools, that there is little camaraderie, it's all cutthroat competition. We never sensed any of that. I think in comparing conversations with my friends in other schools, this was an extraordinary experience.

R: Obviously, there were women in medicine, but it wasn't as common as it is today, where about fifty percent of the students are women. Did you have any sense of particular treatment or experience because you were a woman?

B: Absolutely not. I think I can say that I never was given anything special because I was female and nothing was ever taken away. I sensed my entire career here that the playing-field was as level as it could be. I have friends in other schools where that was absolutely not true in the 1950s. I always considered myself just one of the fellows.

R: Again, that was part of what made Florida unique.

B: Oh, yes.

R: Do you think it was related to Dr. Harrell or partly just to the newness of everything? I could see that maybe at an older school there would be more traditions, it would be harder to break through those.

B: I think it's a combination, new grounds, I think the faculty he brought in was by and large – and he and I have talked about his choice of faculty – he wanted to bring in young people who had a career before them. I think they wanted to establish tradition. I think they wanted to be different. I think they wanted this school to be unusual, not only its curriculum, organization of curriculum, but also in how the medical students, house officers were treated. They really broke ground.

R: Everybody had a particular vision?

B: I think so. My chairman, Dr. Richard Smith, was the youngest professor in the whole United States the year he came here as a professor of pediatrics. Thirty-five years old and that year [he] was chosen as one of the men of the year [for] the [Chamber of Commerce]. He had established himself in Texas already. At age thirty-five, to chair a new department, that had to be dynamic.

R: You mentioned that their ideas for the curriculum were new and different. How did that differ from other medical schools at the time?

B: I think the emphasis on groups [was different]. I have no knowledge of how they organized what courses you took when. It seemed to me that there was tremendous continuity. For example, if you were studying something in microbiology, you might weave in a little bit of pharmacology at the time. I don't think that that sort of experience existed in traditional schools. There was a true interweaving. It was a multi-disciplinary approach.

R: They gave you the basic skills and showed how it connected to other subjects.

B: Of course, in the last two years [they were] interweaving the clinical aspects. Still, constantly throughout our school, we stayed with the basic sciences.

R: How much did it cost to go to Florida at the time?

B: You know, I don't remember.

R: Did you receive any scholarship money or were you working at the time?

B: My parents supported me. I can tell you this, I received $15 a week to eat. We had a little snack shop here at the time. A lot of us would get together in the evening and go over to P.K. Yonge. They have a little cafeteria in the basement, you could eat for a dollar or so. I remember that every Saturday when I [went] to my mailbox here, dad had sent me a ten and a five-dollar bill. That was a struggle for them.

R: What did your father do for a living?

B: He was a coal miner until he came to Florida, then he worked in a General Motors parts store, distributing automotive, lawnmower parts, that sort of thing.

R: You started talking about the faculty and that they were young and pretty dynamic. Do you think because the class was fairly small and it was a new school that their relationships with the students were unique or perhaps closer?

B: I really do. Each of us was assigned a mentor who was responsible for us for the entire four years. I think when he [Harrell] brought in the young faculty, they were just as eager to make a place in life for themselves and their department as we were eager to get through medical school. We became a team. The excitement of taking your boards or seeing how we compared with other medical schools, I'm sure they were more excited than we were. We just wanted to get through.

R: You weren't as interested in the comparison as the faculty were. Did you begin clinical work at the same time the hospital opened or were you doing your clinical work elsewhere?

B: We were farmed out. Has anybody told you about the Blue Goose Bus?

R: Yes.

B: We took our physical diagnosis at the VA [Veteran's Administration] hospital in Lake City. They would load us on the bus, three or four professors and we would go at least one day a week, sometimes two, and do our history and physical. Even then Dr. Harrell had a vision. We were a group of two at that point. One of us would take the history and the other would do the physical. Together you would do the presentation to the professor. We worked as a team even when you were [examining] one patient. We were farmed out to Baptist [Hospital] in Jacksonville, also to the County Hospital there and to Sunland Training Center. I did a lot of my pediatrics there. About that time, of course, the hospital opened. Everybody wanted a patient.

R: I know community and rural medicine were important to Dr. Harrell. Did you have any particular interest in that, given your own experience growing up?

B: No, actually, when I went home to practice, Dunedin and Clearwater were very small towns. As a matter of fact, when I went there, there were only three pediatricians.

R: At what point did you decide what to specialize in or did you always know?

B: Isn't it interesting how you can almost go to a spot or to an experience and determine how it affected your life? I was making rounds. We had to rotate through internal medicine and pediatric surgery, etc. I was on pediatric service. At the time I did not know what I wanted to be. I watched Dr. Richard Smith perform with patients and with the parents. I remember we were standing there, we had racks of charts that we would present. I remember standing by that chart rack and hearing him teach after we got out of the patient room. It occurred to me, I said, please God, let me be one ten-millionth as good as he is. That was it. Nothing else ever crossed my mind. He and I have become good friends ultimately. I always chided him. I said, you could stand at the bed of somebody with leukemia – in those days it was a death knell – and make them happy they didn't have rheumatic fever. He had that capability. Dr. Harrell said to us repeatedly, the practice of medicine is not a science, it's an art. I saw the true art of healing at the hands of the pediatricians that were here on the staff at the time.

R: Obviously, his influence and example was important. Were there any other faculty members who were particularly influential for you?

B: Yes, actually almost all of them in some way affected your attitude, your desire to excel, your performance. Of course, once I honed in on pediatrics, we had Dr. Eitzman who, as you know, has been a trendsetter here in terms of neonatology for the whole South. Dr. Schiebler, [it] goes without mentioning the tremendous impact on the practice of pediatrics in the entire nation. Our faculty was just filled with people like that who were on the move and trying to make improvements in medicine and ultimately a name for themselves, and they did. At one time I recall, the professors from the department of pediatrics had supplied more chairs of pediatrics in the nation than any other school, to give you some idea. They were young, of course, they showed their prowess and then were selected to go to various other schools. I think Dr. Harrell saw that as the ultimate reward, if you will.

R: He had a sense that he was training faculty as well as students.

B: And faculty that the rest of the country saw as being stellar.

R: We've talked about some of the aspects of Dr. Harrell's vision. What are some others? He would have a vision, but he would also have very specific ideas about how to accomplish that.

B: Absolutely, when you were in his presence, you had a sense of complete organization. I remember one of his family members telling me that when they were developing the biochemistry lab here, he would come at night and look at where they were putting various water supplies or electrical supplies or Bunsen burners. He would get up early the next morning, come down, talk to the workman, and say, that's not right. We're not going to have it there, we're going to move it an inch. He had a great deal of attention to detail. When he made a presentation it was without a pause. He had everything organized. I remember some of the words that he used, I find myself using a little now. He would say, clearly such-and-such. As a practical matter, such-and-such. Furthermore. There were some funny things about him too. I'm sure your previous interviewees have talked to you about the vertical transportation.

R: No.

B: He never called anything an elevator. He called it a vertical transportation. We all thought that was pretty cute. When we were building the hospital and he was envisioning the other colleges to be put around it, he would come – we would have a class meeting every now and then – and bring his blocks and situate them very, very precisely. We all got a big kick out of him bringing his blocks to our classroom.

R: Actually, I don't know that I've heard about the blocks.

B: Get Jim Free to tell you about the blocks. He and I laugh about it a lot. That and the vertical transportation.

R: Did you ever find out if there was a particular reason why he didn't use the word elevator?

B: None of us ever knew. He would give these presentations about our mode of vertical transportation. I'm sure you know that the concept of the cubicles was his. That's been propagated in all the current medical schools. It was a tremendous idea that we all had a quiet place, a place to store our things, and yet a place where you could be close enough to a classmate if you wanted to discuss something. You look at it and you think, that's pretty simple, but nobody had ever done it. You'd go find a hole somewhere and study.

R: You had to carry your books around with you everywhere you went.

B: Of course, his true love was the library. He was convinced that the library was the heart and the soul of any medical school. In the last letter he wrote me when we were talking about taking care of his ashes and things, he asked that the inscription be placed, "the written word shall prevail". I think he was convinced even with all the technologies that we have, that it was a necessity to read current literature and to preserve it for those who came after us. That was one of the last statements he ever made to me, the written word shall prevail.

R: It's a wonderful thought.

B: Yes.

R: I interviewed Ms. Donegan recently and she talked about him as a diagnostician and as a physician. That aspect of his personality isn't often emphasized.

B: That's how he became renowned. The materials I sent you about Rocky Mountain spotted fever [show] that he did really tremendous work in that disease, which was carried over and explained a lot of other pathophysiological processes in other diseases. He used that disease to demonstrate, especially about hemorrhagic shock and that sort of thing. He had numerous publications, medical ones, long before his administrative ones.

R: Did you ever see him dealing with patients?

B: Yes, he was always very kind and thorough. Very attentive to the personal details for the diet, activities, to family interventions and all.

R: He was interested in the case history.

B: The whole person, yes.

R: Were there things about Gainesville that changed while you were a student? How did the hospital opening up affect life for you?

B: One of the things that happened that probably hasn't received much attention is that I-75 was built through here just about the time the hospital opened. Dr. Harrell and the legislators, when giving funds to the school here, had calculated how the capability of people coming from south Georgia or the whole state of Florida would be influenced by their ability to go on the interstate. That happened almost simultaneously with the opening of the hospital, and indeed it has made a tremendous impact. Prior to that it would take probably a whole day to get through south Georgia. He talked a great deal about the importance of the highway system. I think the legislators felt that we would have bigger and better patient loads because of it and therefore were more benevolent with their

funding for the school. We saw all that happen. We called it the J. Hillis Miller Health Center at the time, [and it] became a mecca in some people's minds. Of course, that was long before USF [University of South Florida], and the University of Miami was so far away people didn't even know it was in the state. It became the ultimate place to go if you had a diagnostic problem. We saw all of that unfurl. The opening of the hospital was a tremendous experience. The first patient was a little girl with leukemia. You probably have seen her picture. Of course, we couldn't do anything much for her. We didn't have anything but prednisone in those days. She lived a little while, whereas I guess had she not come to the center that her life may have been shortened. The enthusiasm in trying to make a difference in that one little girl, it just turned all of us on to find answers and to make things happen if you will.

R: Did they encourage you to do research?

B: I spent a summer doing research. I did adrenalectomies in rats for a whole summer and its effect on neurotransmission. I did that in the department of physiology. They encouraged us to be inquisitive and take on projects, not necessarily as a course, but to take on areas of interest and pursue that.

R: When you worked in the department of physiology, who was the chairman?

B: Dr. Otis. He still is here. I saw him at a function at the George Harrell Club meeting not long ago. I had not seen him for awhile. He still remembers all of us. I guess the professors remember everybody in the first class because we were kind of family. We grew up together. He was the chairman.

R: Did you work with him or were you working with someone else?

B: I worked with Dr. Wright, electrophysiologist.

R: Where did you go for your internship?

B: I stayed here and [also for my] first year of residency. The third year I went to Georgia Baptist because my husband went there as an intern in OB/GYN. We had one baby and another on the way. I guess it was expected I would go with my husband, which turned out to be a good experience too. The staff here didn't want me to leave. They wanted me to stay on to be chief, but when you become a mother and a wife, there are other priorities you have to seek occasionally. That's how it all happened.

R: When did you marry? You mentioned earlier that Dr. Harrell suggested not getting married during medical school.

B: Right. It was in June of 1959. I had just finished my junior year.

R: When was your first child born?

B: November of 1960. I had just finished my senior year.

R: How did that impact your internship? Did you have to take time off?

B: As it turned out, I was very ill during parts of my pregnancy. I was hospitalized a couple of times. Finally, [when] Sonny was born, I took a week off and came on back to work. You see, it was quite an imposition on your fellow house officers because there were so few of us. There were like three interns, a junior resident, a senior resident, and a chief resident. If one of the interns is out, it was quite an imposition. We got through it and made up the time. It all worked out okay. [End of side 1, tape A]

R: You were the first class, so you didn't have any students to act as mentors. How did you serve as mentors for the classes coming in after you?

B: I think we served as a source of information, for class help, that sort of thing. I think the professors had so much time to spend with the student, you either had one or two classes, that they filled the biggest gap, the professors did.

R: I was just curious because I haven't heard a lot about just what was going on between the classes of medical students.

B: We didn't have time for parties and things. As a matter of fact, we went to school year-round and we had Saturday classes until noon. The only day you had to do your own thing was Sunday. Very frankly, most of us would be back to our study cubicles as soon as you went to church on Sunday morning. We were together, but not in a social setting. I think we had one class party a year, and we did senior skits. In terms of parties with the rest of the classes, I don't recall that we did much of that.

R: You took a week off when your child was born. What did you do for child care?

B: I was very fortunate to find a lady. We lived here in Shuct Village. [We were] very fortunate to find a lady about a mile-and-a-half from here whose husband was a student. She was a part-time student and had two children of her own. She kept our son. As it's turned out, she finished here and ultimately became the person to design the Tampa International Airport. She was his babysitter. We always tell her we're very honored that he had such great beginnings.

R: You did a year of internship and then a year of pediatric residency and then you moved to Atlanta in 1962 and did a year of residency there. When was your second child born?

B: Born just after we got to Atlanta. Good timing. We have one Georgia peach.
R: How were you juggling things like child-care and things like that, at that point?

B: In Atlanta? We had marvelous black lady who came to the house. Georgia Baptist student housing was directly across from the hospital. She would come in the day. We would juggle our schedule and we would literally sometimes meet at the yellow line in the middle of the street – one of us coming and one going. We were blessed with good day-care there.

R: What were you doing for finances while you were an intern, how you were supporting yourselves?

B: I made $125 a month, which was big-time. Of course, I had a husband in school. My parents continued to support in a minimal way, but it was all they could do. My husband's parents [helped] in a minimal way because of some family situations. Ultimately, we borrowed some money for his last two years. I went into practice before he finished his OB/GYN residency. Of course, I had to borrow money to go into practice. We borrowed some. We lived very frugally. I know 110 ways to cook pork and beans. Hominy grits can go a long way. [Laughter]. Somehow you get through it and you look back and they're fun times. In some ways, it's one of the best times of your life. You have to work together.

R: You really do have to pull together.

B: You really do.

R: Was he in the year after you?

B: Two years, he had been in the service.

R: As a resident, did they pay you much more?

B: A little bit. Maybe $200? It was not anything significant.

R: What was your daily routine like as an intern?

B: Let's assume that I was just coming on service in the morning. We were expected to draw the blood, do the lab work by ourselves or with a student. Then we did the history and physical on the incoming patients. Decide what

plan of action and then present the patient to the professor when we made rounds. We would accompany our patients to various procedures. For example, if they had to have an x-ray. We would literally take our patient to the x-ray department, see the whole process, stay for the interpretation, bring the patient back to the ward. We did a lot of procedures. Spinal taps, subdural taps, things that a lot of the students now don't even have to think about. We didn't have lab technicians, we did it all ourselves, every urine exam, stool exam. We had a laboratory on each of the floors. We would prepare the specimens, do the testing ourselves.

R: Was that typical of medicine or of hospital work or was that something unique to Florida?

B: I don't know the answer to that. It was the feeling of the faculty that we should know all facets and we should examine the body fluids ourselves. One patient would deserve our entire attention.

R: Certainly no one is accompanied to their x-rays by their physician these days.

B: We spent a lot of time talking with family. Parents, in particular.

R: You mentioned earlier that your husband was still in his OB/GYN residency when you started your practice. Did you select Clearwater because of your parents being nearby or for another reason?

B: That was one of these situations, pure serendipity, Dr. Smith called me in his office one day and he said, I have a letter from a Dr. Stem in Clearwater, Florida, who wants to have a locum tenens [a physician who substitutes temporarily for another] for six weeks. He's been in solo practice, his children have grown up, he wants to get away and spend time because they're growing up, graduating, etc. He has written me to see if I had a house officer that would be interested in doing a locum tenens. He said, I thought of you immediately because you live near there. Dunedin and Clearwater are separated by a line. I took that opportunity, which was my second year of residency. Dr. Stem was very kind and we got along so well. He said, when you finish your residency, why don't you come back to Clearwater and I'll help you get started. So when I did finish in Atlanta and came back, he took another six weeks off. Our deal was when I worked his office for those six weeks, that I would get half the money and any new patients I saw. Literally, the day he got back from extended vacation, I moved across town. I had made so much money, I thought I was rich. In retrospect, it wasn't a whole lot, but compared to $125 [it was]. The main thing was the new patients, so when I moved across town, I already had a practice started. His staff was very kind. They had new patients call in and [if] they didn't have a spot, they would send them over to me. That's how I got started.

It was just a matter of serendipity, being at the right place in the right time. [It] pleased my parents, of course, because it was home. My husband loved to sail and race, so Clearwater is a big race center. He was very delighted to go there.

R: Were there opportunities for his practice there as well?

B: Yes, in those days every body was in solo practice. There was not a single group when I went to town. Even those in OB/GYN, in the main, were solo practitioners. I think we had one group of two. He went into solo practice. We built an office together. One side was Ob[stetrics] and the other pediatrics.

R: It does sort of mix well together.

B: I told him we should call it, from womb to tomb. [Laughter]

R: You borrowed money to set up the practice. Was there a hospital or a lab in town, or were you doing much of the lab work yourself?

B: In my office, we did the blood counts, all the urine exams. One of the things I'm most proud of, I was the first one to do in-office cultures. I had had a fair amount of experience here in some spare time learning to do cultures, reading cultures. I set up the first in-office incubator culture system for my town. [I] set up the first answering service in our town. We did a few little innovative things like that. To this day we still do a lot of our lab work in our office. From the very beginning I did all my lab work, except sophisticated things. If you had to do metabolic profiles, you'd send those out, which in pediatrics is not very common.

R: What was your daily schedule like in your new practice?

B: I'm an early riser. As a matter of fact, I was taught here that eighty percent of all meaningful work anybody ever does is done by 1:00 PM – did you know that? I guess that stuck with me. By nature I'm an early riser. I would be at the hospital making rounds by 6:00 [AM]. The first days there were four of us pediatricians, we would meet every morning and, believe it or not, discuss patients. We weren't discussing managed care or the deplorable things I hear in the doctor's lounge now. We would truly meet together and discuss patients. We began cross-coverage with each other. We would discuss night calls, who had called and what we did. Then [I would] go to the office by about 9:00 and I'd work til about 4:00. That has changed tremendously now. At our practice, we begin seeing patients at 6:30 in the morning to accommodate our working parents. Now we make rounds at 5:00 in the morning. We're at the office before 6:00, do our exchange and truly begin seeing patients at 6:30. Worked our way through, which some days as early as 3:00 [PM]. Other days in the

winter of course, it's longer. We front-end our practice and the town I went into always kind of did that. If a parent can get home by 3:30, you've got the afternoon and evening to be with your family. We think it's a good system.

R: Being in practice by yourself, though, were you called a lot in the evening or at night?

B: Yes, we had no emergency-room physicians, no neonatologists. We had a county system of medicine. All of us were expected to give one day a week free to the county. We'd go down to the county health department, examine the children, do the circumcisions, whatever. We would get a little check from the state of Florida with a great big orange on it for ten dollars. That's the truth. I went on Tuesdays. We were expected to give a day a year to go to the schools to examine those children who did not have physicians. I will never forget this. There was a sign-up sheet in the nursery, we were to choose the school that we would go to. The fellows chose very fast and there was one left, it was called Ridgecrest. I thought, well, what's the difference from one school to another? I didn't know any different[ly]. As it turned out, it was the black school in the middle of a very, very depressed area, [a] very dangerous area. They thought that was a little funny. I didn't know any better. The day before I was to go, the sheriff appeared in my office and he said, Dr. Bennett, I will accompany you to Ridgecrest school tomorrow. I said, you don't need to; I have a car. He said, you don't understand. He said, a white woman can't go down there in any kind of car. I had a sheriff accompany me there and stay with me the whole time. You tell people that now, they think you're making it up, but it really did exist. People that came in [to ER] unassigned or had no pediatrician, the county patients, could choose which pediatrician they wanted. We did not do a rotation system. That got to be a little much at times. If they came to the emergency and had what they felt was an emergency, they would say to the secretary, you call Dr. X. That's who I want. I spent many, many, many nights [there]. We did all of our Caesarian sections, all our own resuscitation, preparation for transport. Pediatricians did that. We didn't have any neonatologists. [It] wasn't even a word until Dr. Eitzman created it. We did a lot of things like that I don't think hurt us in any way, but it's certainly a different climate than it is today. You have a specialist on every hand now.

R: What were the prevalent health conditions at the time? Was there sort of a profile of health or ill-health?

B: In pediatrics, the major thing always is infectious disease, especially respiratory illnesses. Asthma has always remained a major issue, even then and now. We saw a lot of failure to thrives because it was a very depressed area and nutrition was a major problem. I think respiratory illnesses and nutritional problems [were the main problems].

R: Was that more true among county patients or your private practice?

B: County patients. But see, we were expected to take care of them, else you could not have your hospital privileges renewed. It was part of the package.

R: What do the hospital privileges consist of?

B: Being able to go see the patients. It consisted of giving your time so you could go see your private patients. That was it.

R: You started there in 1963. Have health problems changed over time?

B: Certainly the major emphasis of pediatrics is still infectious disease. We see a lot more reactive airway disease, we do a lot of growth and development, that's a given. Pediatrics and parental information. I think school problems probably take far more of our time now than it should. Whether or not we didn't recognize it early or there are more problems or more treatable problems, I'm not sure what the issue is. I spend a tremendous amount of time now with children with learning disabilities, learning problems of one kind or another. Defiant behaviors and certainly Attention Deficit Disorder. Again, these are words that didn't even exist in the 1970s. It's an excellent example of why one has to continue in medical education because there are new horizons, new areas of emphasis. Every Monday night is my study night. My family knows not to bother me. This is something that Dr. Harrell really instilled in us, you never can quit learning. You need an assigned time, a private time to keep up on journals. I've tried to do that, and it's a lot of self-education you have to do in order to remain conversant. Another example [is] alternative medicine, which is a new concept. Whatever we think about it, we do need to be conversant. I spent a great deal of time trying to learn [the] why and the if's of that area of medicine. I think Dr. Alan Neims is really involved in that now. I spent a week, two years ago, at the University of Virginia on this issue. They announced that sixteen medical schools this past year would require a formal course [in alternative medicine] in order to graduate from medical school. That's an example of an area that didn't exist.

R: Things can change and you need to know what's happening.

B: More medical dollars are spent on alternative medicine than traditional medicine now. Did you know that?

R: No. On research or just procedures?

B: People buying it, the herbs and the massages and all of these thing that they're using for treating illness that traditional medicine has failed [to cure]. People will

come in – you'd be surprised – with all sort of jars and tubes of this that and the other, and they'll say, is this okay for my baby? It will have a list of umpteen things and I'll say, I don't know what this is, but I have three new books, I'm going to go get them, we're going to sit down together, we're going to learn together about it. I think that's better than saying, well that's a bunch of hogwash and I don't know anything about it and I don't want to know about it. I'll tell you a funny story that happened not long ago. I had this British family, delightful family [whose] grandmother had sent a balm from England. Mother said, is this okay for my child? I said, I don't know. Again, we get out the books. Well, it was going to cure anything from hangnails to you-name-it. The last thing was that it improved your sexual prowess. I said to the mother, get your mother on the phone, have her send us a barrel of this, we're going to market it. It's an area that's going to increase, just get ready for it.

R: When you first started your practice, there were three pediatricians in the area, but you all would get together and talk about patients on a regular basis. Now you're in practice with several other physicians.

B: I have three associates.

R: When did you start that?

B: I was solo for twenty-five years. Then Dr. Johnson came and stayed thirteen years. He's on sabbatical now at Vanderbilt and doing a sub-speciality but he'll be back. Then Dr. Savel came ten years ago, Dr. Vaughan three years ago and Dr. Kelly two years ago.

R: Did you encourage this or did they just sort of appear on your doorstep and say, let's go into practice?

B: No, I pursued a partner after twenty-five, twenty-six years. Obviously [I'm] getting older and the practice had grown tremendously to where it was really a volume overload and I needed help. I just couldn't do it all anymore.

R: You have seen a lot of children grow up over the years. How has that affected you?

B: Oh, it's a marvelous experience. Now they come in with their own children, so I call them all my grandbabies. There's some exciting experiences. Just what happened last week would be an example. A fellow had applied for medical school and I had written a letter for him, I had raised him from a baby. I was in the middle of a conference with some managed-care dignitaries. He just opens the door, comes in, picks me out of my chair with a letter in his hand, he'd been accepted. Well, the dignitaries thought that was pretty neat. I use that example

to tell you that the excitement you share just being selected to go to a professional school. I have a number of my patients now in the war. I write them every week. One of them is a cartographer for all of Afghanistan. When they're getting ready to go to the service or getting ready to get married, they bring in their brides, grooms, their attendants. You become an integral part of their family. I've really had the best job in the world. It's so delightful to see them grow up and their dreams come true and be a little part of it.

R: Have managed care and HMOs [health maintenance organization] affected that relationship?

B: Not really, because I won't let it. I have a conviction that if you do your best every day, everything else will fall in line. I truly mean that, that's not lip service. I don't spend any worry-time about it. The reason I can do that is I have been tremendously blessed with staff. I have twenty-[four] staff members, currently. Ten of whom have been with me over twenty years, [three] of whom over thirty years. You can ask anybody in my town about our practice. They will tell you that their relationship with the staff has been just as important and in many aspects, more important than with the doctor. And we work that way. Whether it's the triage or the referral person or the billing person, whatever, they know that they're going to talk to the same person day after day. I can truly say any success we've had has been generated by the loyalty of our staff. A lot of them are Gators [University of Florida] that come from our school of nursing and we've grown up together and we've made a career together. We've been fortunate enough to prepare for their retirements in a very handsome way. I have a feeling these people have given me twenty, twenty-five, thirty, in some cases thirty-five years of their lives and I owe them something. I owe them security. We have built our practice with that and provide for them the best insurance money can buy, the best pension money can buy. We are truly a team. I guess I got that from Dr. Harrell. You're no stronger than your weakest link.

R: Was that something that he emphasized?

B: Oh, yes.

R: When you went into practice then, you had that sense that everyone with whom you worked was important.

B: Equally important. I remind that staff that the most important person in that office is the one who picks up the first phone the first time. If that person doesn't make the right judgment, no matter what you do out here, it's not going to count. We have fine people, well-educated, some of whom I've trained and some who came in with training. Fine nurses, all of whom are current with their CME [continuing medical education]. They've been trained to do lab work and to do it

very proficiently. We take exams on it. As a matter of fact, next Friday we have an examiner coming to look at each of us – how we preform our lab tests, interpret them, record them, all of that. They have a sense of pride, that they can do things that other people maybe can't do, that they get rewarded very nicely for.

R: They have a real sense of loyalty. They know that you'll take care of them.

B: That's right and I think they know that there's an element of honesty, as you say pride, and they're all part of it. Anything that this practice has accomplished is truly a result of their commitment.

R: When you set up your practice, did you start with a nurse?

B: No, not even a nurse. I started with a music major. I said, well, maybe you can sing to the babies while I examine them. She's still with me, [it has been] thirty-eight years. Of course, I taught her. She was a major person in triage. I'd pit her against any nurse. The parents know when they call and ask for Cheryl, they're going to get the right answers. She's not a nurse.

R: How many people do you have working for you?

B: Twenty-[four].

R: When did you start adding to your staff?

B: It's very exponential. When you bring in a partner, you need more nurses. Of course, managed care has dictated that. For example, we have three full-time people that do nothing but referrals. Paperwork. They're all very professional too. I have an office manager now. As of three years [ago], I never had an office manager. I'd always done it myself. I'd done all of the investments for the pension plan and whatever. Now we have people who do that so my job is a breeze. I get to see the babies now. Any time you add one person, it truly becomes exponential.

R: It says on your CV that you're involved with two hospitals.

B: The All Children's and Morton Plant [Hospitals].

R: Are both of those near your office?

B: All Children's is in St. Petersburg is about twenty minutes from our office. As a practical matter, Morton Plant [in Clearwater] just closed their pediatric unit last year. The day of the local hospital having pediatric care is past. These children

deserve a children's hospital, children's nurses, sub-specialists. It's the pediatric nurses that make the difference. You've got to have a big volume in order to maintain your expertise. I've been a strong proponent of and [have had a] major thrust throughout the years that our children should go to All Children's Hospital. I've met with a great deal of criticism in the local community, why would you forsake our local hospital? Well, I didn't forsake it because I still do all my newborn work there. I think the days of partial care should be over. Our practice is a very sophisticated group of folks and they know what appropriate care should be.

R: What does a pediatric nurse have or offer that a regular nurse does not?

B: I think patient interaction, how to hold, how to touch, how to talk, how to comfort, how to console. Not to mention the techniques that they do, IV's, respiratory therap[y injections].

R: They are dealing with smaller veins and things like that.

B: Right, but mainly the art, which is far different than dealing with an eighty year-old stroke victim, you know. I couldn't do that. We have some tremendous nurses. You walk in a room with them to see a patient, you can feel the love and care exuding and it's real.

R: Did All Children's Hospital exist when you started?

B: No. I was probably one of five initial sponsors of the hospital.

R: Did you work then on getting it started? Did it have to be legislated or was it a matter of fundraising?

B: It was a local project. By being a sponsor, what I meant was sending patients there. I've been on several committees there. We stole some of the professors from here to come to All Children's. I may have had a little voice in that.

R: Who, for instance?

B: Dr. Barbosa, our pediatric hematology oncologist. One of the pediatric cardiac surgeons, he's now retired. That's what we train them for here. To go out into the highways and hedges, bid them to come.

R: You are on the ethics committee at Morton Plant Hospital. What sort of an ethics committee do they have? How does that work in the hospital?

B: I was on the initial committee assignment there. As a matter of fact, Dr. Eitzman started the ethics committee here almost simultaneously.

R: Do you remember when that was?

B: It's been fifteen years or more. He and I exchange books and things. He was getting organized here, we were getting organized at Morton Plant. There was very little written at the time. Now of course, there's a plethora of material. We began setting up the committee, it was composed of a few physicians, but [also] a great influx of community leaders, representatives from various religions and from administration. Initially, it was just to study and to make a policy statement of the ethics involved in our hospital, but now it's very far-reaching in terms of prolongation of life and all of those decisions that physicians and families have to make. The committee serves basically as advisor to the hospital but also, on occasion, a physician will want to come and present a case. Sometimes family members request a visit with the ethics committee.

R: I talked with someone in rural Montana who said a lot of those in the really rural parts of the West, the physicians and the nurses don't have a lot of support as far as ethics is concerned. Is this unusual for a rural hospital, or is that something that is more prevalent in the East?

B: Probably nobody has had an urge to do it in a small area. I think by-and-large in rural areas, people see the doctor's word as the last word. Living where I do with so many retirees, very wealthy sophisticated retirees, they ask a lot of very searching questions. We present two or three unusual cases at each of our meetings and I'll sit there sometimes and think, just when I think I've heard it all, here comes a new little twist. Humankind changes in attitudes and expectations. I think it's a great support unit. Your friend in Montana has a wealth of materials now that he or she could choose from.

R: Do you think the socio-economic nature of your area has changed over time?

B: Sure. As I've said, a tremendous number of wealthy people have come in[to] the Clearwater area, a lot of industry, technological industry. TechData, IMR, all of those are there, GE, Honeywell. They bring in the younger and middle-aged executives. A tremendous number of people are choosing to retire in that area because, after all, the coasts of Florida are getting pretty full. I always remind my family that God's not making a whole lot more ground. There's just x amount. I think the whole economic strata has changed. I read the other day, I don't know if this is true or not, that Pinellas County, where Clearwater is, is the most densely populated county in the U.S. now. I find that a little hard to believe, but I saw that in print. We're pretty tight.

R: It's no longer an isolated or rural area.

B: A few little areas, a few little spots left.

R: It is also wealthier.

B: Yes.

R: Is that reflected in the patients?

B: We have a highly professional group of parents now. Part of that is that the county has its own system now to deliver care to the indigent and to the Medicaid population.

R: You don't have to work at the county one day a week anymore?

B: No. That's not expected anymore. We have some very nice health facilities for our lesser-privileged people.

R: Has the percentage of poor people declined with the growth in the county?

B: I don't know the answer to that, but I'm kind of out-of-the-loop today. I figure twenty-six years of that is enough to give for being able to go to the hospital.

R: Was that how long you were involved in the county health service?

B: Probably not that long, but a good twenty years.

R: You mentioned that you see a lot more of the behavioral disorders, ADD [attention deficit disorder] and ADHD [attention deficit hyperactive disorder]. Do you end up prescribing Ritalin [drug to counteract ADD and ADHD]? It is a question now as to how often Ritalin should be prescribed.

B: I think the most important thing is making the proper diagnosis. There are so many parameters of learning disabilities. I spend a lot of time interviewing the parents, the patient, then I have the teachers send also their opinion of the child's behavior. The parents and I meet again after we gather our information. I give them a book they have to read about various and sundry learning disabilities and then we sit down and come to grips with the diagnosis. Many times it has nothing to do with Attention Deficit Disorder. It may be Pervasive Developmental Disorder [PDD] or Defiant Disorder or Tourette's. That whole area of medicine is a spectrum. Here you have Tourette's for example, the PDD, the ADD, the HADD, and here you'll have autism and Asperger Syndrome. Many of these children are misdiagnosed. You can give Ritalin until Jesus

comes, you're not going to help this child with Asburger Syndrome. We spend a tremendous amount of time making the right diagnosis. We talk, assuming that you come to that conclusion there is ADD, for example, then we talk about other ways of dealing with it. For example, one of my favorite therapies is karate, which is a very therapeutic sport for these youngsters. Then we talk about behavioral modifications. If and when we come to medication, it's number six or seven on our list and always laced with a multi-disciplinary approach involving the teacher, frequently a psychologist, group youth leaders [such as in the] Boy Scouts, sports. Medication is the very last spot on our program. If indeed we decide to prescribe Ritalin, Adderall, there are sixteen [medications], I guess. They pick up their prescription each month and they have a form they fill out and they have to write me every month about what's happening at school [and] at home.

R: That way you can see how things are working, whether the Ritalin is really making a difference. That's a fantastic approach. Before we moved to Florida, we were in Idaho. I think that state has the greatest per capita prescribing of Ritalin. It seems to me a lot of it is really just your approach to it and whether you just want to give them the drug.

B: It's simple to throw a pill. There are so many comorbid factors with ADD that one better recognize all these others.

[End side A2]

R: At what point did this concern with the neurological or developmental syndromes become more a part of pediatrics?

B: Certainly [it] began to light up in the 1980s. I remember we used to come back here for our CME and I remember the first lecture that we had here at the medical school on learning disabilities. It was a whole new world. They brought in educators. It was just like a new area of medicine. I think that was in the 1980s.

R: It seems like dyslexia is something that has been recently recognized.

B: That was recognized before ADD.

R: Is it a matter of recognition or is it something that is actually becoming more common?

B: I think we're learning to recognize various aspects of educational problems more readily. When I was in school I remember vividly that if somebody couldn't learn, they just put you in the back row and let the other kids go ahead and do

whatever. You get a sheet of paper for graduation. I remember in high school, one of the football players, in order to pass and get his diploma, had to write the Lord's Prayer. In retrospect, Charlie, I know, had a learning disability. Great fellow, center on the football team, everybody loved Charlie. He just never learned to read. I'm sure, in retrospect, he had a severe disability. He wrote the Lord's Prayer out of the Bible and he got his diploma. Nowadays that would not happen, so I'm sure it has existed always. Hopefully we're a little more sophisticated about recognizing [problems]. Are we better at treatment? I don't know. That's one of things that's so exciting about the Brain Center. The technology of recognizing the areas in the frontal lobe that have to do with learning. I think that's exciting.

R: What do think about the theory that the measles, mumps, rubella vaccination is implicated in autism?

B: [It] has [been] proven, and I can show you numerous studies, that there is no element of truth in that. I was just in Washington, spent a week looking at new vaccines, complications of existing ones, etc. Of course, this was discussed but there are numerous other studies to support that. Now there are parents who are insisting on dividing the vaccine. Get measles here, mumps here, rubella here at monthly intervals and hope that if there is any element of truth to it, that if you separate them it would not occur. That's all well and good but you can't buy mumps vaccine as a single entity. At this conference, the Pediatric Infectious Disease Conference, which is probably the most renowned conference of its type in the whole U.S., they suggested very nicely to us to not argue with the patients, that you go ahead and serve them as best you can. I just had a mother who is a professor at USF whose best friend has been doing some "research" in this realm and has convinced her, the other professor, that there is some truth to it. Because of that, I've had to divide her child's doses. Which I'm happy to do and she's well aware that I can't buy mumps vaccine. When and if it becomes available, we have her on the list. You don't argue with patients. You steer them. We have a fair number of patients that don't want any immunizations, especially our chiropractor families, in the main, don't want it. A number of our fundamentalist families. Some that have just read an article. You don't argue with them. Every time they come, it happened right before you called yesterday, actually. A mother is an agent for an alternative medicine company. I simply said, are you still at peace with Ashley not having her immunizations? She said, oh, yes. I just make a note and go on.

R: Aren't there some vaccines that are required for a child to enter school? Can they get that rule waived?

B: They can have a religious exception. There's a place on the form they can do that.

R: Is that a growing issue?

B: No, it stays stable.

R: Even with a greater number of vaccines, infectious disease is still the biggest issue you deal with in children?

B: Respiratory illnesses, RSV [respiratory syncytial virus] and reactive airway disease. Certainly, that's on the rise. Tonsilitis, sinusitis. With the new pneumococcal vaccine, we've been able to reduce ear infection from that particular organism by fifty-one percent. [We have been able to reduce] meningitis by ninety-eight [percent] and pneumonia by ninety-three [percent].

R: When did the pneumonia vaccine come out?

B: We've had it now about two years. It's called the Pneumovax, Prevnar is the trade name for it.

R: Do you see any antibiotic-resistant ear infections?

B: Sure. Even more so in sinusitis. I think in infectious disease, sinusitis is going to be the cutting edge of trying to understand the pathophysiology and anatomy. We really are a long way from making an impact on sinusitis.

R: My husband has had a lot of sinus problems. He keeps ratcheting up the antibiotics that he gets in terms of strength.

B: I have a feeling that's not the answer. I think ultimately we're going to have to think totally about prevention, whether it's vaccines or preventative medicines to prevent the swellings and the mucus formation. Because once mucus forms and it gets caught, it's going to abscess.

R: It's a breeding ground.

B: It is, and the sinuses are the best breeding grounds in our body, I think.

R: Do you see any pediatric AIDS or HIV infections?

B: I've had one death, one patient. The mother and the child both died.

R: That must be horrible.

B: It is. A very dysfunctional family. They went within a month of each other.

R: Do you deal much with pediatric cancer?

B: Fortunately, that's very rare. I may have a new malignancy every three years. It's a minuscule part of pediatrics.

R: Because of what you hear on the news, it sounds like it's more prevalent than that.

B: It's rather glamorized, like that little boy in Bogota [Colombia] who is dying of cancer. It was on the front page of our paper yesterday. His father is being held hostage by some rebels. His dying wish is to see his father before he dies. Of course, that's glamorized because he's given very little time because of invasive malignancy. It's glamorized more. It's great for fund-raising. Well, it should be, because my goodness sakes, most childhood tumors now are very curable. Not just treatable but curable.

R: Once you've cured it, the child has an average life span?

B: Right.

R: It's gone for good?

B: Not always, but sometimes. That's the hope that we go into treatment with when we do diagnose it. Let's get it fixed and get on with living.

R: How would you say, in general, your practice has changed?

B: [I come in] a little bit earlier, but we've always been early people. I think certainly the public is more sophisticated, a bit more demanding and that's not a criticism, that's just an observation. Certainly you have to dedicate more of your staff to conform with managed care practice. In terms of the disease processes, they've changed. We spend a lot of time nurturing. One of the things we do in the practice that I started when Dr. Johnson came was really a carry-over from what Dr. Harrell taught us. When we have a child come in for a well-baby visit, one of us does the physical and another doctor will go in and do what we call quiet-time. The parent is then allowed to ask some questions and we have prepared an educational packet for each of their visits. They see at least two doctors with every visit. We had an evaluation by a group out of Philadelphia looking at the efficiency of the practice and [suggesting] things we could do better. They just had a tizzy that every person that came saw two doctors. What a waste of time. Interestingly, after spending some time and seeing the patient satisfaction, they asked me last year to write an article for *Medical Economics*, which I did. I guess we gave them a little lesson. We do really neat things. For example, at the nine-month check-up, which is one of my

favorites, our educational packet is on discipline. We assign books, give them books, talk to them about the tripod of discipline. At two months we teach them about the concept of fever. Everything is written. We've done it ourselves. This is nothing we got out of books, [they are] things we have found that are appropriate and very efficient for the family. We have arranged four rules that if they'll follow, they'll never make a mistake in dealing with fever. It gives them some comfort. We do a whole packet on home safety. Really, the one I enjoy most is at age three – we begin talking about kindergarten readiness, checklists and the importance of the birth order and the birth dates. Then we help them with choices of schools. In our area we have free choice of schools which is a new concept in our state. We play a big role in anticipatory care.

R: It sounds as if you really do know your patients so you can help them choose where they would be happy in schools.

B: The main thing is [asking whether] they are ready to go to school. We spend a lot of time on issues like that.

R: It really does sound as if your practice is guided by the concept of the patient as a whole person.

B: Well, we hope so.

R: How do you select the people who practice with you? Do they have your same philosophy?

B: We really do. Now we come from very diverse educational backgrounds and geographical backgrounds. [Dr.] Johnson is from Arkansas, Dr. Savel from Boston by way of Miami, he graduated from the University of Miami and then lived on the east coast of Florida. [Dr. Vaughan is from USF.] Then Dr. Kelly is from the Boston area, then went to USF for post-graduate training. We come from very diverse family backgrounds. Dr. Savel happens to be Jewish, the other three of us are not. In terms of delivering health-care, some of us work more rapidly than others, some spend more time talking than others. We don't have any such thing in our practice as his and her patients. Every patient belongs to the practice. Our income is totally devoid of how many patients you see. Our only goal is that every patient's need is taken care of as far as that patient [needs]. If it takes you longer for one than the other, so be it. We never have one word of conversation about income. It's a little different in that regard. The people that came from Philadelphia had a tizzy with that. Yet they have called back to ask us about [how] things [are] working. They are truly into productivity and I think that's wrong. If you see twenty patients and don't see them well, are you a better doctor than if you see fifteen and see them well? I

can't subscribe to that and none of my partners do. There's no element of jealousy. No place to be jealous, because it won't matter.

R: Do you have any problems with malpractice?

B: It's fascinating the questions you're asking, because we're having to change our malpractice coverage because the company is going out of the state which happens every now and then. I was filling out some papers just this week for the new company. There's an aggregate of fifty-five years that the four of us have spent in that practice. We've been very fortunate. We have had not even one inquiry. We've had no cases, not even one inquiry. Haven't we been lucky?

R: From what you said about the way you treat your patients, it doesn't surprise me.

B: There's still always a risk. You can't please everybody. Every now and then we'll have a patient that's disgruntled about somebody that didn't smile the right way. I line them up and I say, look even Jesus Christ couldn't please everybody. That's why they killed him. You just can't, but you try. You take home in your head that one patient that was not quite happy. Maybe the 150 others we saw that day that were pleased, you kind of leave them in the office. That's human nature, isn't it?

R: Sure, you really do want to think about that, about what you can do differently.

B: What did I do wrong?

R: What you're telling me sounds a lot like Dr. Harrell's philosophy or at least a philosophy of medicine which he espoused, as well. How much of that did you take with you from Florida or how much do you think was just the way you would have approached medicine anyway?

B: I don't know how to measure that but certainly the influence of the entire staff here which I assume was a reflection of his intention. I think he hired people that he felt would manifest his goals and strive for his goals. I have to be very grateful for the attitude that was [inculcated in me].

R: When you find physicians that share that philosophy, is there something similar about them, do they have a greater background in humanities?

B: One of my partners is a very accomplished musician. One of my partners is a college quarterback. One of my partners is just interested in general things, Dr. Karen Kelly. She's had really a very hard life. She doesn't have any special area of expertise except she's a marvelous person. Good values, good mother.

In terms of the humanities, I would say she has some general interests, but no specific one.

R: I'm just curious as to whether there's any common thread.

B: I think the people that came into the practice kind of knew the reputation of the practice, because all three of them were at the University of South Florida medical school for three or four years. Dr. Vaughan, who was a quarterback, I raised his wife. It's kind of like having a son in the practice. When they had their first child, while he was a resident, I took care of that child. He got to know us. I think they knew the type of practice from hearing people talk, good or bad. I think they knew the kind of attitudes that were prevalent there.

R: So they're self-selected, in a sense?

B: I think so, yes.

R: You've remained involved in the University of Florida, the College of Medicine. Do you have sense of things changing here?

B: Certainly the class selection has changed. As you mentioned early on, [it is now] fifty percent female. I remember being at the overseers committee the day they announced that it just happened. The MCAT [Medical College Admission Test], the interviews and whatever. Suddenly at the end of the collation somebody looked up and said, it's fifty percent female. That certainly has changed, be it good or bad. I think our leadership here is very stellar. We've been blessed with some good leaders. Our major problem right now, which will escalate, is that the legislature is less Gator now than ever before. [It is] less University of Florida, we're going to have a harder job with programming and fund-raising. The alumni are going to have to step forward. I think that's going to be a real struggle for our administrators.

R: You mentioned that medical education has a more competitive edge now. Are they selecting people who are more competitive and has that affected medicine?

B: I don't know. I can tell you this, if I draw a scenario of going to the doctor's lounge for coffee in the morning twenty years from now versus now. You used to go and talk about patients and what we can do to make our hospital better, things we can do togther. Now I call it gloom and doom. I'm not making it, guess what this managed care did. Frankly, I quit going. I thought I don't need to start my morning in depression. I really did. Before, I loved to sit with my friends. We'd work crossword puzzles sometimes. Talk about our family, how they're growing up, where they're going to school. Just really neat things. Now it's all negative. You just don't want to get involved in that. I don't. You want

to go to work with one thing on your mind and that is [that] the patient in the room deserves your undivided attention.

R: I think I'll end on that note, this is the end of the interview with Dr. Bennett.

[End of interview]

R: Today is April 13, 2002, and I am finishing up an interview with Dr. Jean Bennett. Since the last time we spoke, have you had any thoughts about anything you wanted to add about your practice or things that you felt were missing from the other interview?

B: I think [what] we missed the first time was the role of the medical school here after I left school and providing post-graduate education for the pediatricians. I think the pediatric department was outstanding in that regard in comparison with the other departments because, almost immediately, continuing educational programs were set up for us. One of the innovative things I believe that George Richards started, maybe [with] Dr. [Gerold] Schiebler [associate vice president for health affairs for external affairs, University of Florida College of Medicine; distinguished service professor of pediatric cardiology], was pre-football game seminars for every home game. We met for approximately four hours before each game and [had] speakers from the department. We got to keep up with our classmates over the years and our resident-mates. I think that was very innovative at the time.

R: Does that continue to the present day?

B: Yes.

R: Do you still participate in that?

B: Not as much as I used to, because I have other commitments on campus on Saturday mornings. Oh my goodness, I guess for twenty years, I never missed one.

R: That helped you to keep up with and to remain in touch with the college itself, as well as with your peers.

B: And also to meet the new professors brought in to the department. I think it aided in our ability to communicate and specifically decide if we wanted to have a consultation for patients with that particular individual.

R: To what extent did you send patients to Shands or to the University of Florida for consultation?

B: Initially, when I was in practice, it was really the mecca. We did not have, for example, All Children's Hospital in St. Pete, had very little association with Tampa General [Hospital] at that time, which was basically an indigent hospital. Obviously, those programs have blossomed in the interim. Any diagnostic problem or certainly life-threatening problems, we sent immediately to Shands. As a matter of fact, I personally accompanied patients here that were in life-threatening situations. Nationwide, **Dr. Eichsman** set up the program of transporting newborns. My office happened to be very near a small airport. We have many times met at the airport and transported newborns from our hospital, here to Shands.

R: Was the newborn transport system only set up to transfer by helicopter or plane?

B: The newborns, yes, neonatal transport. Now, of course, it exists everywhere. I know that he was here. We met recently. We were on the forefront of setting those programs up, of course cooperating between the distant local hospital and Shands.

R: I know that when Shands was created, there was some tension between the doctors at the hospital and those in the community. Was there any resentment with you taking these patients somewhere else or was there no problem, since you were the consulting pediatrician?

B: No, I never felt there was any question about our medical decisions. Of course, at the very inception of Shands, even the medical school, not even Shands, there was the concern of the mix of the town-and-gown [meaning University of Florida and Gainesville relationships]. I think the concern was far greater than what ultimately culminated because Dr. [George] Harrell [dean, University of Florida College of Medicine, 1954-1964] and some of the other department chiefs really courted, if you will, and won over the major players in this community. **Dr. Webers** comes to mind and Dr. William C. Thomas, Sr. They actually were incorporated into our teaching curriculum here. **Dr. Webers** served on the advisory committee to the dean. He was brought in and functioned until the committee was disbursed. I happened to be on the committee with him. He and I have talked at times about the town-and-gown situation. I think it was as beautiful a marriage as one could really envision. It took the personalities to do it, the Harrell's and the **Webers'** and the Thomas', that sort of people. [Dr.] George Dell and Dr. [Tom] Brill, the [Gainesville] pediatricians, came in and actually taught the pediatricians about private practice. Dr. Brill happened to have an area of expertise in allergy at that time. We had no one in our department who was conversant with allergies as we know them today. He came and shared his information. I always felt a camaraderie with the pediatricians in town. **Dr. Webers** was in surgery, Dr. Thomas [was] in OB/GYN

[obstetrics/gynecology]. As a matter of fact, Dr. Thomas came to our last session in obstetrics. He sat at a big long table, I'll never forget. All the students were gathered around up in Dr. [Harry] Prystowsky's [professor and chairman, Department of Obstetrics and Gynecology, University of Florida College of Medicine] office. Dr. Thomas sat there talking to them about the evolution of the practice of obstetrics. As tears flowed down his cheeks, he said, I know all of you know and love my son Billy [William C. Thomas, Jr.; professor of medicine, 1957-1986], who teaches here. I want you to know that everything he is, is because of his mother; I was so busy in the practice of medicine that whatever our children turned out to be is a compliment to his mother. He used that as a springboard to tell us about trying to integrate family life into the practice of medicine. Of course, in those days, medicine was truly your mistress. I remember sitting there and tears rolling down. He was so proud of his son who had come here from [Johns] Hopkins [University], and [he] shared those feelings with us. He was a great man and certainly was an influence in the town-and-gown situation here.

R: The college did offer what was really available nowhere else in Florida, at that time, and that was a chance to get continuing medical education [CME] credits.

B: Right, as far as I know, that continues in all the departments to this day. Dr. [Lamar] Crevasse [professor of medicine, University of Florida] enlarged that to subjects that the legislature has mandated, such as spousal abuse and AIDS and medical malpractice. Actually, before he died, they developed a national program that you could come to campus to study or you could do it by tapes and take exams. He reached out not only in the medical didactics but also those courses that are mandated.

R: Could you elaborate on what makes pediatrics distinctive? I know at one point in the earlier interview, you mentioned that you felt it was important to have a separate hospital where people are trained in pediatrics. Why is that necessary? What is it about treating children that requires experts?

B: Let's talk first about the technologies that are necessary. Then we'll talk about the most important thing, that is, the people. Obviously, it takes different technologies to deal with smaller body parts. A very common one is bloodletting, it's totally different [in terms of] the techniques that are necessary. Surgical procedures, setting up operatories that are designed for smaller individuals. As a matter of fact, at All Children's [Hospital], we just this past week dedicated a whole new area totally equipped with pediatric instruments and laparoscopes and things. We wanted to do a lot of non-invasive or minimally-invasive procedures. I think traditionally in medicine, we have been taught or thought that children are just little adults. That is not true. Their entire

physiological processes, for example fluid therapy, has no resemblance to what you would do in an adult.

R: How is that different?

B: For example, a young child's body is [composed of] far more water than an adult. That's why when we re-hydrate a child, it's the nominal, the amount of fluids we have to give them in comparison to a dehydrated adult. The composition is different, as well. Aside from the technologies, the instrumentations and all of that, it takes special people to deal with children. I think you have to earn their respect. You have to talk to them differently. It takes a whole different nurse-type personality and I think a whole different physician personality to deal with children, to be able to communicate. If you don't earn their respect and their trust, therapy is very difficult.

R: Children don't automatically see the physician as an authority figure?

B: I think they see them as a friend. I hope so. That's what we intend to do. For example, in surgery people probably spend less time developing their communication skills and more on their technical skills. Internal medicine, more on their communication skills, because they spend a lot more conversation time with the patients. Obviously, the patient is older, has many more systems involved in their diseases. As a practical matter for the child, it's a single entity that one is dealing with. It takes less time, but I think more intense communication and earning trust time.

R: With an adult, a problem is likely to affect a number of different organ systems?

B: Right.

R: Before, you talked about particular standards of patient care and a lot of those are involved in establishing the relationship with the patient. You talked about how you managed to maintain that in the face of pressures to change, such as from insurance companies. Is there anything that you would add about how you were able to do that or what the challenges are in the face of those pressures?

B: I have a very simplistic conviction, that if one does one's best, delivers the best care, that the best people around you are delivering care, that everything else will fall into place. Another physician this past week – we were talking about this very issue – said, basically, I think that's a very infantile attitude. I said, it may be, but it has served me well. I still believe that. I think how one delivers care, their reputation follows them. If you [have] a good reputation, the insurance companies are going to come and ask you, would you please participate? There's going to be patient pressures on various companies. I want Dr. X to be

on my insurance because Dr. X is the doctor I want to go to, the doctor I trust, the doctor I want to see. We've been very fortunate that has happened in our practice. I guess I will maintain my simplistic conviction because I sincerely believe that.

R: That approach seems to imply the absence of other things, such as a desire to make a lot of money. It seems like that would be incompatible.

B: I think if one practices good medicine, has a good reputation, availability, the money will come. I don't think you have to spend a lot of time calculating how many dollars are going to come from where. I just have a feeling it kind of takes care of itself. You can become so overwhelmed and spend so much time in meetings or about contracts with your stockbroker [that] you have no time to practice medicine. Not only is it lack of time, but you may very well be in the room with a patient and you're worried about what IBM is doing. I teach all the students that come through our practice, and hopefully have taught our younger associates, that the patient in the room at that moment deserves your undivided attention. Everything else has to be left at the doorstep. If one becomes so involved with [thoughts like], am I making as much money as I did last year [or] as much as John Jones is, those thoughts creep into your mind as you're trying to listen to patients. I think that will ultimately detract from your clinical capabilities.

R: That approach certainly has worked in your practice. It doesn't seem like there's any point in calling it simplistic or infantile.

B: Some perceive it that way. All of us as individuals have to do what is comfortable for us. After all, we went into the practice of medicine to serve mankind. Whatever techniques one must use to do the best job they can do, every single day of their lives, has to be individual.

R: What impact do you feel you have had on the course of pediatrics in Florida or your region?

B: From my own involvements in my community, I set up the first answering service, which was initially just for the seven of us pediatricians in the general area and then it spread to our entire hospital. From that has grown a very elaborate answering call system. In my own community, I was the first one to set up intra-office cultures. I think that has made a big impact in treating respiratory and neurological diseases in a very efficient and timely fashion. [I have] had some impact, hopefully, in developing the nursery. It's very antiquated. To give you some idea, when I went to Morton Plant Hospital, it was segregated. We had just little bassinets, hardly any resuscitation equipment, hardly any IV materials, etc. It was a relatively primitive setup, to tell you the truth. It was

hopefully innovative in that regard. [I] actually personally purchased resuscitation material, brought in the first nasal prong. We started doing positive pressures, things like educating us about umbilical catheterizations. These were all new procedures in newborns. We spent a lot of time, not only learning ourselves, but also bringing it home, teaching the nurses, and convincing [the] administration that we needed funding for these pieces of equipment or technologies. Now our nursery, I think, would stand up to any nursery in the state of Florida. I was the first one to have an integrated office practice in my town and from that, carried it to the hospital, when we integrated our black and white babies. When I first went there, I might have a four-week-old baby with meningitis, a black child, in a room with an eighty-year-old black man who'd had a stroke. All the blacks were in the basement and all the white children were upstairs. I do believe I made an impact in that regard, long before it was mandated, [in] encouraging integration with the children.

R: Do you think that separation did affect the care of the children?

B: Of course. You might have one nurse in a room taking care of a post-op black person or a recovering black mother, a black newborn. In those days, it was nothing to admit three or four patients a day with meningitis. Of course, it affected our black children far more than white children. It has them right in the same ward. I wonder now how we didn't spread more diseases than we may have.

R: Do you have any comments on the changing nature of medicine in general?

B: I spend more time today doing paperwork, talking about reading reports. You have to initial every one that you read, making sure that it is sent to the proper partner or the proper department within your practice. I probably spend more time in one day [doing that] than I would have in the past in six months. That takes a tremendous amount of time, takes a tremendous amount of staffing to make sure that all those pieces of paper go where they're supposed to, to the proper individual, etc. Certainly, that takes time that you wish you could spend with the patients. I fortunately have an office manager who relieves me of 99 percent of the contractual situations, all the managed-care [people] that come to investigate your charts, OSHA [Occupational Safety and Health Administration], CLIA [Clinical Laboratory Improvement Act]. I have gathered around me some people that I trust implicitly. They really carry out their responsibilities very effectively. Otherwise, I would spend a tremendous amount of time in that regard. I don't go to meetings about contracts. I send my manager. He does the right thing. If I did not have those individuals, I would really be spending a lot of time because, in the practice, I happen to be the financial officer of the group because I'm the senior member. I think one has to gather around you individuals that you can trust, individuals that are savvy. I have twenty-four

employees, ten of whom have been with me over twenty years. They're just like your right hand. I have just been unduly blessed in finding the right people, training them so we're all playing on the same page. People that are willing to learn, people learning to bend if there's a new idea. You take individuals in their fifties or sixties, they don't bend very easily. The people with whom I work are very flexible, if we can prove to them it's a better way to do it.

R: Do you think that you attract people who are flexible or do they become flexible after working with you for awhile?

B: I'm not sure. I just thank God every day for the people I know. I have hopefully treated them well. I have provided for them the best insurance money can buy, the best pension plan. When individuals come in to evaluate our practice, they're astounded at what we do offer. I kiddingly said to the staff at a meeting not long ago, [that] when I die, I just want one thing on the tombstone and that was, she was fair to us all. I really feel that way. I hope I never will have had an employee that felt they were in any way treated less than fairly.

R: I'd like to work for you. [Laughter]

B: Well, come on down.

R: I also want to talk to you some more about Dr. Harrell and your contact with him in the later years after your graduation. Clearly, you maintained a friendship with him. Did that start while you were there and just carry on?

B: Actually, we didn't have an unusual relationship. I had no different relationship [with Dr. Harrell] than the other class members. Of course, when you graduate, you've got to go through the graduate training. You're having a family. You're setting up a practice. Your interaction with your former professors is not as much as it would be as time goes on. [I] began, at times, to come back to the institution in later years, especially when I became involved in the alumni association here at the medical school. Then the George Harrell Club was established. I was fortunate enough to be the first president of the George Harrell Club. Of course, each succeeding year, when he would come back from Hershey, [Pennsylvania] or from his retirement at North Carolina, we would spend time together. We would talk about what we were going to say at the meetings and catch up on the family. He brought his dear wife and we always had a very good time together. From that grew a relationship really discussing disease processes. For example, being a pediatrician, I was very interested in Rocky Mountain spotted fever. He wrote one of the initial articles on that. It was subsequently published a few years ago. It was a renewal of that conversation. We would talk at night, especially after he retired. Then, after his wife was in the assisted-living facility, he had a lot of time at night where we sat

and pondered and talked about numerous issues. From his selection of the faculty here, to that and Hershey, really about medical diseases, processes. He was especially interested in hemorrhagic shock. We would spend sometimes an hour in the evening talking about it. As time went on, I would send my journals to him. For example, the *New England Journal [of Medicine]* and *JAMA* [Journal of the American Medical Association], that sort of thing. He was not subscribing to them at the time. I would read them and send them on. We would circle articles that we thought were of mutual interest. He would write me back [with] what he really thought. He would critique the articles. He was very sharp right up to the end. I've spent some very precious moments [with him]. I feel so fortunate to have had those private moments with him and understand the evolution of medical education. You know, when you're here as a student, you just think you're going to classes to try to pass. You don't understand how it has evolved from nothing.

R: You weren't as much in contact with him, then, when he was heading up the school at Hershey. It was more in his retrospective years?

B: Right, after he retired, actually. Of course, I would see him here at the meetings quite often. Really, my main interaction was in his last ten years.

R: What were Dr. Harrell's reflections on Florida or Hershey? I interviewed Max Lang at Hershey since I last spoke with you. He had a lot of contact with Dr. Harrell there and felt Dr. Harrell was adding to or subtracting from his ideas about medical schools as he went along. How did Dr. Harrell feel about the school in Florida? Were there triumphs or things that he tried to do that he wasn't able to do?

B: He wrote to me, I guess two or three years before he died that, yes, he had been involved in other institutions, from his education to his professorships in North Carolina and his coming here and then back to Hershey. He said to me, my heart will always be with the University of Florida. I think he saw this truly as the ultimate creation that he had dreamed. He had a firm feeling that you should bring in young professors on their way up, not going to institutions such as [Johns] Hopkins or Harvard and bringing in people that already had made it. If you look at the initial department chairs, every one of them were young men with great capability, but had not yet made their mark. They made their mark here at the University of Florida. You can just go down the list and look at Tom Maren [department of pharmacology and therapeutics, University of Florida], Dick Smith [chairman of pathology, University of Florida], Jim Wilson [professor of anatomy, University of Florida College of Medicine], and Harry Prystowsky. I think that was a very unusual approach. On the surface, you think, bring in some big names and the legislature will look at us more favorably. He really wanted to build their reputation and see to it that they had the tools here on campus to do it.

That's why he was so anxious to ingrate the medical school with the existing colleges within the university, which I think he did in a real good way.

R: One thing I have heard is that he wanted more medical humanities at Florida and wasn't as able to do that as he was at Hershey. Medical humanities became a bigger program at Hershey. Did he ever talk about that?

B: I think probably the time was not right. Very frankly, when the medical school was started – I sensed this, nobody ever told me – it was such a tremendous expenditure by the legislature and by the university and by the community and by the people in the state of Florida that there was a great deal of envy amongst the other departments. I sensed that. He never told me that. I think if you look at medical schools in general, that feeling prevails. The medical school is the sacred cow and everybody else gets what's left over. I think it's not just at the University of Florida. I think that's in general. Have you sensed that where you have been? People look at the medical school as the favorite son, so to speak.

R: [Yes]. The librarian here says the medical school is the 900-pound gorilla because it brings in the money and has so much influence.

B: That's right. I guess [if] you bring in the most money, you think you have the biggest say. I would suspect that's one of the reasons there was difficulty in the marriage. It could have been the attitude of the existing president. I really do not know, but it certainly was a dream of his. He made sure we went out into the community and observe those children in school settings, for example. We went to various hospitals and looked at their settings as well. We had very few opportunities when you think about it. This was truly rural Florida. You had to go to Jacksonville for patient material, in many instances.

R: When you're talking about the town-and-gown relationship, one thing the medical school probably did was draw many more people into the community.

B: Just think of the thousands of people it takes to serve an institution of this size. We did not have many patients in the first two years. It was his concern that we knew, understood, and took care of every facet of that person's being. For example, if they came in with leukemia, we needed to know what grade that child was in, how the teacher was going to react to this issue, the feelings of the parents. We would take one person and look at all the parameters, their spiritual needs. It was not like you had to have twenty cases of leukemia to understand the disease. You would take one patient and perhaps, through that, understand their various needs and how we as physicians were to minister to those needs. I think that was very good because some of us went to post-graduate training where all you did was plug in and out the numbers and

sure, you saw more diseases. Did that make you a better doctor? I'm not sure. I think his idea of total patient care was really unique and very fruitful.

R: Did Florida stand out for him as his spiritual home?

B: It really did. We would talk at night. You could just feel from his conversation the love and affection he had [for Florida]. This is where he wanted his remains to be. There was no question in his mind where he wanted his last remembrances to be.

R: In retrospect, when he went to Hershey, did he ever say, I learned how to do this at Florida, now I'm going to do it a little differently?

B: Not really. We didn't spend a lot of time talking about why he went there. I think it was Dr. Prystowsky that encouraged him to come there. Dr. Prystowsky went there [on] some appointment, I'm not sure what. I believe he's the one who recruited Dr. Harrell, if you will.

R: Do you know why he chose to retire? He retired to North Carolina after Hershey.

B: Actually, he went to school in Winston-Salem [Wake Forest University]. He was at the medical school there before he came to Florida. I think he kind of went home. The campus there offered ideal settings for an elderly couple who might ultimately need assistance in living. They had a guaranteed entrance into the hospital, which as it turned out was exactly what happened for him and for his wife. He made a very wise decision.

R: Did his children remain in Gainesville?

B: One son is in Jacksonville, I think, one is here. Of course, his granddaughter is a graduate from here and is on the faculty.

R: What were his thoughts about medical education?

B: We talked about the importance of continuing basic sciences through the entire four years or even into graduate training, that there should not be any compartmentalizing. Today, you do microbiology, tomorrow, you do skin grafts. It was always, let's take this information at the basic level and integrate it into whatever procedure you were doing at the time. I think that was his basic philosophy. [He stressed] the tremendous importance of basic sciences, a continuation in understanding those things, because with the advent of television and the Internet, the proliferation of medical information is just phenomenal. That's why he felt the library had to be the core of our continuing education. It

was there, whether we looked at videos or whether we [looked at the] Internet or whether we did readings. [He wanted] all those technologies housed in one setting.

R: He had medical students write a thesis. Did you have to do a research project when you were a student?

B: I don't remember that.

R: I think it was the case at some point here, although it's no longer the case. I know that there were many students who did write a thesis, which was basically a description of research they had done. That would certainly fit in with his idea about the importance of basic science.

B: I did research one summer and co-authored a paper. I don't recall that it was required. I did that for living money, to tell you the truth.

R: I spoke with Dr. Jim Free [internist; associate of Dr. Robert Cade, developer of Gatorade] a couple of months ago. He talked about Dr. Harrell's blocks that he would carry around.

B: Yes, remember when in my first interview I said to you, you've got to talk to Jim Free about the vertical transportation and the blocks? We've had a lot of laughs about it, but it was very informative. If you ever have a chance in an informal setting with Jim Free, he will demonstrate the blocks to you. [Laughter]. He can do it. I'm so glad you talked to Jim. I think he personifies the kind of physician Dr. Harrell dreamed he would produce. He certainly, in our community, had exemplified that.

R: How would you describe that ideal physician?

B: Oh my goodness. As you know, he's retired. He was beloved by his patients. He did the whole-patient thing. In internal medicine, you have to deal with husbands and aging parents and whatever. He did that in such a stellar fashion. And spiritual needs, he put great emphasis on that.

R: Dr. Harrell, especially with the first class where he really chose you all himself, had certain ideas about how valuable statistics, such as exams, might be in selecting a physician versus the interview. Did he ever give you any sense of how he felt about current procedures for selecting medical students? Did he feel that it was moving away from what he thought was ideal?

B: I don't think that we talked about it.

R: He did pursue interests in medical history.

B: Right, he uncovered some papers that no one knew had existed. Those were published. He found them approximately fifteen years ago. He was probably the world's authority on the history of medicine.

R: Where was he doing research or where did he find the papers?

B: I think in some library in Canada. Don't hold me to that. It was out of this country that he uncovered those.

R: Did he retire after he left Hershey?

B: Yes.
R: But during his retirement, he was very active in doing his medical history research.

B: Right, and he continued to keep current in medical literature as well, not just historical facts, although he was quite interested in them. He could discuss with you any newly-described diseases. Of course, we have about ten to twelve new pediatric diseases every five to ten years. He was very conversant.

R: Was he interested in the new hemorrhagic fevers that have emerged recently?

B: Exactly. As a matter of fact, if you look at that paper on Rocky Mountain spotted fever, he described, for the first time, an element of shock that was a very new concept. As it's turned out, it was shown to be true. He told me that his paper was rejected and the editor wrote back [as to] what an absolutely absurd idea this was. Then when the paper was republished a few years ago, [they printed] the whole retraction that George Harrell was right in the first place.

R: Was he still alive when that was released?

B: Yes, and he took great delight. As a matter of fact, one of the letters from him that I have sent you has to do with the apology concerning his rejection. [End of side 1, tape A.] One of his sayings was, as a practical matter. There was another one, I'll think of it in a minute, that you find yourself picking up, that makes conversation more connected, without an argumentative aspect to it.

R: Sort of a transitional phrase.

B: Exactly, but without threatening the other conversant. There are certain words that do that.

R: Words that are more dogmatic.

B: Instead of saying, don't you know? You would say, it's agreed, clearly.

R: He is the only person who has ever founded two medical schools. If he'd had a chance to do a third one, what would it be like? Would it be a lot like Florida?

B: I don't think he would have changed it much. The groundwork that he laid here, he took such pride in coming back and seeing that it had been expanded. I'm not sure he would have changed things. The thing he would like to change is how one obtains a medical school and how one perpetuates it and potentiates it with funding. Let's be honest. Whatever medical school you're talking about, it won't roll without money. I think he had to spend an inordinate amount of time making sure that those funds were given by the legislature. It was a hard job to sell the concept.

R: At Hershey, someone had a lot of money that they were willing to donate.

B: That was very different. It was [a situation of] ask and you shall receive. Here, it was beg and you might receive. That hasn't changed.

R: I guess part of the problem is that rather than concentrating and really throughly funding a few institutions, there's always a tendency to say, we need to open more, create more.

B: We're going through that now.

R: There seems to be a really powerful school spirit associated with medical school alumni. They are very involved in the school, have wonderful memories. Is that your sense?

B: Absolutely. I hope the subsequent classes will always feel that way. There have been individuals that have fostered that. Now that Dr. [Hugh] Hill [professor of obstetrics and gynecology, University of Florida College of Medicine] has retired, he has been the spirit of the school. The alumni, I just hope that someone will step in and be as dynamic and enthusiastic, really excited about the students. Just, for example, the day they get their matching papers, if Dr. Hill had won the Super Bowl, it couldn't have been a better feeling. I just hope somebody will step in and take that place and potentiate the excitement that this place has. It's going to take a very, very unusual individual, isn't it? We're going to miss his presence for sure. I hope he lives to be 110, so he can come back and pump us up.

R: Hope he comes to all the reunions.

B: He might retire, but we don't want him to go.

R: For the early students, did Dr. Harrell pump you up and give you that spirit?

B: No, he was never a cheerleader. He was not the rah-rah type, but you could sense his pride.

R: Did you graduate before Dr. Hill moved into that position?

B: Yes. He was a professor in the department of OB/GYN.

R: Your class size was so small that everybody really knew each other, didn't they?

B: Everybody knew everything about everybody. I don't use this [term] loosely; it was truly a family. We truly cared for each other. The wives cared for the friends of their husbands. I never felt there was any jealousy about the time, for example, that their husbands had to spend here. There was none of that whatsoever. We always included the wives in what few get-togethers we had. We didn't party much. None of us had any money to party to start with. Of course, we were all so into just studying. We had nobody to tell us, look, you don't have to do this ten times, just do it five and take a little time off. We felt that we had to do our best every single day. We had no basis for comparison. We spent an inordinate amount of time [studying]. I'm talking about nights, Saturday nights, all day [on] Sundays. Of course, we had Saturday morning classes, which I don't think exist now. I'm not sure of it. When you spend seven days a week with somebody for four years, you really get to know them.

R: Dr. Free talked about a lounge where people would get together and watch TV. What was the one program did everyone watch? I think it was a Western.

B: It's probably *Gunslinger*.

R: I think it was.

B: And we would play hearts. Just take a break every now and then. It was just like your family room. Everybody would come and participate. Every now and then somebody would bring in a little food. It was truly a feeling every morning, a feeling you wanted to be there and a sense of commitment to each other. I can say this personally. It was not that you just wanted to get through school yourself, you wanted all your buddies to go with you.

R: There wasn't a real sense of competition?

B: Not at all. We would do study groups at night together and get ready for exams. Somebody would take subject A and go through it in complete detail and get up and present it. We would have all-night sessions and help each other.

R: Someone out at the University of Washington said there's really not that same sense of school spirit there.

B: Is that an older school? I don't know.

R: I guess it is. I don't know that it's that much older. It might just be bigger. Maybe it also has something to do with being in a big city.

B: I suspect we were unusual in many ways, from appearance to our origins. When you look at the class origins, you'll notice that there's no two of us from the same beginnings.

R: Is there anything else that you would like to add? Any other thoughts?

B: I would like to say how grateful I am that I got to be in the first class. Even to come to the University of Florida, but to be in the first class, it's more than anyone from my beginnings or my status could have ever dreamed would be possible. I'm just so grateful. I fumble even to try to say that.

R: That concludes the interview with Dr. Jean Bennett.

[End of interview]