

UFHC 51

Interviewee: Dr. James Free

Interviewer: Julian Pleasants

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P: This is the 30th of January, 2002. This is Julian Pleasants. I am at the Oral History Office at the University of Florida and we're talking with Dr. James Free. Tell me when and where you were born.

F: I was born in Bromley, Kentucky, [on] September 16, 1934.

P: Did you go to local schools?

F: I did, public school in Kentucky. Bromley is a very tiny town right across from Cincinnati. It's a suburb of Cincinnati. My parents and grandparents were all from that area.

P: What did your parents do?

F: My father was an auto mechanic and my mother was a homemaker. As a young woman, she worked in a candy factory in Cincinnati until she was married. In those days when you were married, you quit work and became a homemaker.

P: Do you recall anything at all about the Depression period? Were you much aware of what was going on?

F: No, I was not. I was too little to really understand it. My father had a job throughout the Depression, though. He was an auto mechanic and he worked in a garage for twenty dollars a week or something, but he had a job. He did not have to stand in food lines. My parents lived with my grandparents so the family saved money by living together.

P: Who would you say would be most influential in your early years?

F: Probably my mother.

P: In what way?

F: I spent a great deal of time with her and she taught me a lot. She read to me.

P: Did you get an interest in books and reading and academics very early?

F: I believe so. I was an only child until I was nine and then I had a brother. I have a younger brother. It was like having two separate families. My parents spent a lot of time with me as a young boy.

P: What kind of student were you?

F: I was always a good student. I was not much of an athlete. I tended to be more [interested in] books. I participated in a lot of things. Eventually got into music, played in the band, and enjoyed that. I was always active, had a lot of friends, seemed to have a good time.

P: What instruments did you play?

F: Clarinet and saxophone.

P: Were you in the marching band at Florida?

F: I was. Gator band under the direction of Harold Bachman.

P: He is famous, and had been at UF many years. When did you decide you were going to be interested in medicine or the study of science?

F: I was always interested in science through school. In high school, I excelled in the sciences and I had an inclination that way. It was almost like a jump for my family because I believe I was the first one in my family on either side that went through college and got a degree. I didn't know how to express to them my interest in becoming a physician. I got the idea when I was in high school, I'm sure, and then pursued it as I went into college. As I saw that I was doing all right that way, I expressed it to my friends and to my parents. They were very encouraging to me.

P: Was there a teacher or a guidance counselor or anybody who had a strong influence on you?

F: I had a couple of teachers in high school that were influential. One was a math teacher who had a nephew who had become a physician. She guided me as far as some of the prerequisites and what it was all about. I guess there wasn't any one specific person.

P: Why did you decide to come to the University of Florida?

F: That's easy. My father wanted to come to Florida for a long time. We had relatives in Fort Lauderdale, not close relatives, but we had visited there several times during my childhood. I prevailed on him to allow me to stay in Kentucky until I was through high school. He did. As soon as I graduated, he had a buyer for his business and the home. We packed the car and took off and came to Florida. I knew this was in the making, so I registered for the University of Florida and the University of Kentucky and I was accepted at both. I was an

out-of-state student here for the first year because we were just moving in. My family moved to Fort Lauderdale and made a life for themselves there and I came here. It was the [right decision for me].

P: You started in 1952?

F: 1952.

P: Talk a little bit about your initial years at the University of Florida. What was the campus like?

F: My family drove me up from Fort Lauderdale. They were all in tears and I was ecstatic. To me, it was the most beautiful place. I was really excited. Being a late registrant, there were no dormitories available, so we looked around for housing and there were only dumps around here, over off University Avenue. It was really bad. The University had some temporary housing in buildings that were built during World War II and immediately thereafter, when the flood of vets came in. They were the temporary housing which were almost permanent because they had been here so long. It was not FlaVet [Florida Veterans Housing], but it was like FlaVet. I'm talking about buildings right here on campus. The first dorm that I was in was one of these buildings. They were sort of like a Quonset hut [military tent] except they weren't round, they were flat-topped, that type of a building. It was just south of the Hub, so it was real close proximity to here. The first year I was here, the Century Tower was built and there was an orange grove just across from the Century Tower. I remember waking up in the morning, smelling the orange blossoms and thinking I was in heaven. It was wonderful.

P: How many students were here then?

F: I think there were less than 10,000. I don't know the exact number.

P: What was your goal when you began your undergraduate studies?

F: I stated that I wanted to go into pre-med. They gave me an advisor. He was not the greatest because he directed me into some very hard courses. It worked out all right. I can't fault him. I enjoyed my stay here very much. I think the Gator band really helped me a great deal. I was not in a fraternity, I did not have that background as far as my family was concerned. I was not, socially, that interested. I came here because I had a goal that I wanted to study. I did and my first semester, I was in an honor society. I forget the name of it, whatever you get if you make a 3.5 [grade-point average] or something [like that]. That encouraged me. I can remember a few professors who were really excellent. I had an English professor named Dr. Wise. I don't remember all their names. I

had a chemistry professor that was very good. The classes varied in size, but you generally got to know your classmates and your professors pretty well. I enjoyed it and the Gator band helped me a lot. That's where I had made most of my friends. Colonel Bachman was a good advisor, easy to talk to.

P: Why did you decide on medicine as opposed to something like a Ph.D. in chemistry?

F: I wanted to do something [where] I would be working with people. I wasn't interested in doing an academic life.

P: Why did you choose the University of Florida medical school? Were there other options that you had?

F: I was in the right place at the right time. I think that's one of the stories of my life. Coming here to the University of Florida when I did, seeing it develop. I stated I wanted to be a physician and went into pre-med. I heard they were going to build a medical school [and thought] how wonderful. So I applied. I applied elsewhere. I was also accepted at George Washington University in Washington, D.C., and at the University of Cincinnati. I chose to stay here because of finances and I was encouraged by Dr. [George] Harrell, frankly. He was an impressive person and impressed on us what his goals for the medical center were. I was accepted.

P: You started medical school in 1956, is that correct?

F: Yes.

P: The medical school was just beginning. What was it like in 1956?

F: It was just the medical science building, physically. There were only forty of us students in this big building, so it was largely empty. There was only a handful of professors in the basic sciences. The clinical sciences were not even here yet – medicine, surgery, and so forth. The professors that were here were anatomy, physiology, biochemistry. Doctors Wilson [in anatomy], Putnam in biochemistry, Dr. Otis in physiology, Dr. [Thomas] Maren in pharmacology. For our first two years, we had just a handful of professors, but we got to know them intensely. The forty of us got to know each other quite well, studying in small groups and all of that. Dr. Harrell had a remarkable plan for the health center. He talked about it all over the place of course, building it up for the state as well as for the students. The students were really his focus, I believe. He spent a lot of time focusing on what could be done to enhance our education.

P: I understand that Harrell wanted students to be general physicians first and then

specialists later. Was that his basic idea?

F: I believe so. At least he wanted us to have a broad education, not only in medicine, but in the humanities and literature and all of that. He tried to bring in special programs [and] events for us to attend [as may have been available]. If you were in a larger established place, you might have access to. May or may not attend. We generally as a small class did everything together, so we got to know each other well. He tried to enhance our education that way.

P: It's very clear he was interested in his physicians being humanists and interested in patient care. Is that lacking in medicine today?

F: I don't think it's totally lacking, no. I think there's a lot of that. The trouble is, I wonder if the people are not too focused on their own little bailiwick and what they're doing, and not as much interested in developing the students as a whole individual.

P: What were the negative aspects of a new medical school like this?

F: We didn't have much depth in going to other people. We had a handful of people that we could go to, to teach us. The advantage was that we [were] very close to them and we could go sit down like you and I are, and talk. I think we felt free to make appointments and go in and speak to any of our professors at any time that we had a problem.

P: Talk a little bit about some of the faculty. I know, for example, Tom Maren was very successful in pharmacology. What was your assessment of him?

F: He was very interested in the students and research. To me, I always considered Dr. Maren to be the most research-oriented physician. I have just learned that he was also a very literary person, because they have this reading center that they're developing over there for him. I was surprised, because I always thought of him as being primarily a laboratory man, which he was. But he had this other aspect. I knew Dr. Maren pretty well, but I never worked with him directly. He was a good professor, good teacher.

P: It seems to me that Dr. Harrell did a rather extraordinary job of bringing faculty into a medical school that really wasn't yet completed. Apparently he brought in a lot of younger faculty who had great potential. How do you think he managed to get all these talented people to come to Gainesville?

F: I don't know. I hardly have a clue.

P: Other people have indicated to me that he talked about what it could be and the

plans that he had. It must be intriguing to get in on the ground floor.

F: Right, absolutely. I think that certainly is an inducement to bring people in. It gives them an opportunity to develop their own department the way they want to develop it, within Dr. Harrell's guidelines. At the time the medical center was built here, I think there was only one other campus in the nation – that was Wisconsin – where everything was on one campus. Medicine and everything. Most schools will have the medical school elsewhere. As you probably know, there was a large faction of people who politically wanted it to go to Jacksonville. Dr. Harrell was very opposed to that. He thought it should be here with the university so the whole university could function.

P: William Shands of course had a lot to do with that.

F: And J. Hillis Miller [president, University of Florida, 1947-1953] too, I think.

P: Exactly. Describe your feelings on your first day in medical school.

F: Let's see if I can remember that far back. I'm sure I was nervous and we had a lot of things to fill out and to do, orientation. I remember the first lecture in biochemistry that I heard. I thought, I will never be able to comprehend this. What in the world is he talking about? It all worked out. We had help when we needed it.

P: Was it a pretty typical medical education – where the first two years were primarily lectures, then the second two years were clinical work? How did you organize those four years?

F: Because it was new, we had no clinical work here. The first two years are basic sciences anyway, except for an introduction to medicine in the second year. Our first year, we had anatomy, biochemistry, physiology. I don't remember just what all, but all of those basic things. The second year we started getting into pathology. We had bacteriology our first year. Our second year, we were introduced to patients. There were no patients in Gainesville except for at Alachua General Hospital. They took us down there a few times, but basically they took us to Jacksonville in buses to Duval Medical Center and to Lake City to examine patients at the VA Hospital. That's where we learned to examine patients. The faculty would ride with us on the bus, which was an old school bus, up to Lake City and do this. I'm sure it was an ordeal for them.

P: I guess most of the practicing physicians in Gainesville were all private.

F: Right, they were.

- P: I understand that before Bill Enneking came, there were only one or two orthopedic specialists in the whole city at that time.
- F: There probably were. I don't remember, but it was small. Alachua General was a very tiny hospital.
- P: Where did you get your nurses?
- F: When the hospital opened in 1956, of course, they did like any hospital would. They advertize all over and people are interested in coming. My wife was a nurse. She had been working in Clearwater in a doctor's office and had a friend who came up when the hospital opened [who] encouraged her to do so. That's where I met her. She was a nurse working in the recovery room.
- P: This was before the nursing school was established, right?
- F: No, the nursing school was established right then, I believe. I'm not sure [when] Dean Smith, the nursing dean, came. [I don't know] how long [it was] after Dr. Harrell [came] here. I know she was here in 1956, she had to be here before 1956.
- P: Did you have any courses in ethics?
- F: I don't remember a course as such.
- P: Was it stressed in your training?
- F: I believe it was stressed in discussions, in groups, just with rounds when you talked to people. Dr. Jape Taylor was a very influential person for all of us in the first class. He would stress ethics a lot, just in rounds. You're talking about a patient, you're talking about events. Dr. Taylor was interested in all kinds of things, politics and so forth. You'd get involved.
- P: I know about him, from my interview with him and from talking to other people, that he was a great believer in the bedside relationship with the patient. He spent a lot of time with the patient, learning about them, talking to them, trying to understand them. Do you think that's been eliminated now with HMOs and with money being the bottom line? Do doctors not have the time to spend with patients anymore?
- F: They don't take the time, many times. This is an individual thing. I'm sure there are doctors who do. I don't like to point a finger and say everything had changed and gone to pot just because of that. There are doctors who are more that way and doctors who are not. Some doctors will tend to go into specialties

that eliminate that, for instance, if you wanted to be a dermatologist, you don't need to talk to the patient a whole lot. What do you want me to see? They point to it and that's about the history, you know?

P: For a cardiologist, that is different.

F: For a cardiologist, you have to talk to the patient. I don't like to make generalizations, there are excellent physicians who spend a lot of time with their patients. I think, in general, the system is such that you're not rewarded for that. My biggest gripe about what's happened today in medicine is [that] the cognitive services, where you have to gain information by being with the patient – as psychiatry, psychology, internal medicine, family practice should be – are not rewarded. The system does not reward you for what you know and can relate to the patient. They reward you for procedures. Medicine is going towards who can do the most procedures in the shortest period of time to get the most money for the period of time that you have to work. The people who can help people by talking to them and making a correct diagnosis, without doing thousands of dollars worth of procedures that are not necessary, those people are not rewarded.

P: The object is to do the procedures because they have to pay for them. Jape Taylor had a sort of intuitive knowledge after talking with people. He could almost always make the correct diagnosis even before he did the test.

F: That's right. That's what he was trying to teach us. That's why he was such a good teacher. I tell you, just being with those people for the time that we [were] was just invaluable.

P: What makes a great teacher in medical school?

F: They have to be able to relate to the student and to the patient. They have to have the knowledge and the ability themselves [and] be able to express themselves to the student and to have enough information at their fingertips that the student learns something every time you are with them. Dr. Taylor was that way. When I interned at Grady Hospital in Atlanta, and I had Dr. Willis Hurst as my attending, he was the head of the department. He is a cardiologist. Although I did not go into cardiology but internal medicine, these two men taught me infinite numbers of things just by their store of knowledge and their willingness to pull it out. We were not as we used to say, "getting spoon-fed." They're teaching you to find that information for yourself.

P: You learned a lot just by observing.

F: By observing, and by a fear that if you don't look these things up and know it

ahead of time, you're going to be asked that question.

P: I understand Jape Taylor could find out pretty quickly what everybody knew. Give me a typical day when you were in your fourth year of medical studies.

F: Then you were mainly seeing patients. You were assigned to a rotation, pediatrics, internal medicine, surgery, or one of the sub-specialties like cardiology, endocrinology, neurology. You'd go in early and you would make rounds. Usually that was with a group of residents and interns and you were divided up. You were assigned patients. As a senior student, we had to work up three patients a week on whatever service we were. That means you were assigned this patient, you did everything as if you were the primary physician – you took the history, examined them, wrote it all up. We even had to do a lot of lab work at that time. Today, they just write an order and everything is done. We had to go down to the lab and do urinalyses and blood smears, some of the simpler of the tests that could be done. If you had a diabetic, we would have to do all the sugars and things that were necessary.

P: That's also a good way to learn, isn't it?

F: Yes. It saved the hospital money and the hospital didn't have the technology that they do today, nor the technologists to do the job. We would work up the patient, then we would make rounds. On rounds, you would have an attending physician. The student would give the history and physical before the group he was working with which included interns, residents, the house staff. Then you would have a discussion of it. These rounds would last an hour or so. There would be several patients presented during this period of time. Usually every patient that had been worked up the previous day, or within the previous couple of days, would be presented to the attending. The attending would make a note and have a discussion and you'd decide what else needed to be done, whether your diagnosis was likely correct or what else needed to be done to make [a] proper diagnosis.

P: This would be 1960, so by now were there more buildings and a sufficient number of patients?

F: The hospital opened in 1958 and by 1960, it was pretty full. It was not big, though. That's why I went to Grady Hospital for my internship, because that's a huge city hospital. I felt like I needed to see that other side of medicine, which was a culture shock.

P: How did you decide on your specialty and when did you make that determination?

F: I know I made it when I was in medical school during my last two years. I liked the diagnostic aspect of internal medicine. Every case, every patient that you saw was not a case necessarily, it was a patient, but that patient was like a new story, a new mystery. You're the detective and you have to find out what the problem is. There are a lot of things you have to think about and go through to find the answer. It was exciting, the diagnostic aspect of medicine was exciting.

P: As an internist, you have to deal with many different issues.

F: Certainly.

P: It's much more challenging in many ways.

F: It is challenging, yes.

P: Did you ultimately develop a sub-speciality in nephrology?

F: I did. I came back here to do my residency. After my internship at Grady, I went into the Air Force. In those days you had to either go in before, during, or after. There was no question. I went in after my internship for two years and had a good time. [I] lived in Arizona at Davis-Monthan Air Force Base in Tucson and was married. My wife was from Florida and we knew we wanted to come back to Florida to live, eventually. I was accepted into the Emory program, but also I was accepted here into the house staff program in internal medicine. We came back here in 1963 and I spent 1963-1966 as a house staff member. [The chief resident was] Dana Shires, who I had known before medical school – I didn't know him well, but we had some classes together – in medical school he was a class behind me and we worked together during the summer in the anatomy lab. My second year, when I did an experimental medicine project, I worked with him in the lab. We became pretty good friends.

P: What were the research facilities like when you were in medical school here? This is medical school, as opposed to when you came back.

F: There were adequate research facilities. There was a good bit of space for that day and time because the buildings were new. The faculty was being built up, so they had space. It soon became crowded. As far as the students were concerned, there were student laboratories on each floor. I don't know [if they] even exist anymore. I don't think they do. The anatomy department had student laboratories as did physiology and pathology. Each of the floors seemed to have a lab where we took classes and lab classes. The faculty each had labs because they were all doing independent research. Many of the students got jobs with the faculty. During my summers my first two years, I worked with Dr. James Wilson in the anatomy department. That's where I was

working when I met Dana Shires. I think the research facilities were quite adequate at that time.

P: How did you pay for medical school?

F: My parents paid for it. I did not have to work a lot. I didn't spend a lot of money either – just the necessities.

P: Do you have any regrets about attending a new and developing medical school?

F: No, I think it was the most wonderful thing that ever happened. I was excited about it and still am. Like I said, I was in the right place at the right time. I just can't be thankful enough. You might say it was serendipity or that I was blessed or that God willed it. I have absolutely no regrets.

P: Talk about your experience at Grady Hospital in Atlanta. My understanding is that the emergency room there is quite frenetic, particularly on weekends. What were your duties as an intern?

F: In those days, the interns and residents still went out in ambulances sometimes and went to homes where people were having trouble. There were no paramedics, so it was like the first attempt at being a paramedic without knowing what you were doing or having adequate training. I felt totally inadequate. I took a straight medical residency because I knew by that time I did want to go into internal medicine. Willis Hurst was the director of that program. We did have to spend time in the ER. We spent twelve hours on and twelve hours off. You'd basically spend twelve hours on, go home and sleep. You'd come back and it was very hard. I was married and we had an apartment, but I did have a room in the building there. The building was new, it was only three years old. That building had been built before integration as mirror-image buildings. There was a white building and a black building. There was no mixture between the two, except in perhaps radiology and surgery.

P: Did you work on both sides?

F: You did, you worked all over, you alternated. There were two emergency rooms, a white one and a black one.

P: Did you have any African Americans or women in your medical school class or while you were in medical school?

F: [There were] no [African Americans], [but] we had women. We had three women in our class.

P: How did they do?

F: Well.

P: Did you notice any discrimination?

F: I don't believe so. I guess there could have been but I think they did well.

P: When did you first work with minorities as a physician?

F: As equals? I don't recall having any at Grady. I don't remember having a lot when I went into the service. There were some, but not many. Even when I came back here, I don't recall any here during my training period.

P: What did you take away from your time at Grady? How did that help your medical career?

F: It helped me make decisions faster, because there was such a large number of patients to take care of. It helped me organize myself better in coming to a decision of what you were going to do, just in treating patients. When you go from seeing three patients a week as a student to having wards full of patients and clinics with hundreds of people lined up to be seen, it was a lot different. It makes you speed up your thought-process.

P: Does it help you see the great variety of illness that you might not see under other circumstances?

F: It does, certainly, and the emergencies and all of that.

P: You go into the Air Force – you mentioned you were in Arizona. What was that experience like in terms of your medical career?

F: It was wonderful. I had a great time in the service. I was married before I went to my internship, actually, and my wife was a nurse. When we went to Arizona, she worked a little bit, but mostly stayed home. We lived on base, there was about a fifty-bed hospital there. I was a general medical officer, so I first started in the clinics just seeing patients. There were a lot of retired people in Tucson, so we saw them as well as the active-duty people and their families. They had a pediatrician there, so I didn't see pediatrics. I was interested in internal medicine and they had a board-certified internist there who was Mayo Clinic-trained who was running the medical ward. He took me under his wing, because I expressed interest in this. I told him I knew something about EKGs [electrocardiograms]. He let me read EKGs with him. He taught me a great deal about it, because he was also a flight surgeon and we had to examine all these flight surgeon physicals who had EKGs. He let me do that. I made rounds with him and

helped him. I became his assistant actually, so I didn't work in the clinics as much, because I did more in internal medicine. But I did have to be medical officer of the day.

P: That's just like being a general practitioner.

F: Yes. I had a couple of days in the clinic [each] week. The rest of the time I'd make rounds with him and help take care of the patients that were in the house.

P: And you spent your whole two years there?

F: Two years, yes.

P: At that point, you decide you want to come to Florida and you come back for your residency, then you do a post-doc. Is that right?

F: The residency was three years. You're a junior resident, a senior resident, and then the third year, you have a choice of another year as senior or chief resident or go into a sub-specialty. At that point I had met Dr. [Robert] Cade and was excited about what he was doing. He was an exciting teacher, [a] very caring person. I chose and was accepted to work with him for a year in the laboratory.

P: Was he a factor in your decision to come back to Florida?

F: No, I didn't know him at that time. I met him after I came back. My decision to come back to Florida was because I really knew that I wanted to practice medicine. I thought I wanted to stay in Florida to do that and that it probably would be a good idea to come to the University of Florida to finish my training and then find a place in Florida to live.

P: Did you ever have any interest in academic medicine?

F: Not a big interest. Back in those days, it seemed like in order to get a good position, the directors of programs wanted to hear that you were interested in academic medicine and I guess I did express some interest at one point. I always, deep-down, wanted to practice medicine.

P: When you got back to Florida in 1963, what was the hospital like three years after you had left? Had it expanded quite a bit?

F: Yes, it had flourished. The ambulatory area was open and they had a lot of outpatient clinics that they did not have when I was a student, which had just been beginning. They were having an influx of patients from all the surrounding counties. The hospital was completely full with waiting lists. We had lots of

referrals from the surrounding cities. It was a busy practice. During the time before intensive care units were available, we did develop an intensive care unit on the medical floor. I know Dr. Thomas who was interested in research, developed a clinical research wing.

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F: Dr. Thomas had this metabolic floor where he'd bring people in. When you were on endocrinology service, you would spend some time there learning how they did studies on people to find out dietary hormonal excretions and [collected] of a lot of urine. It was required to keep these people stable on diets, so they were kept in the hospital for varying periods of time on these studies. It was a good hospital.

P: Describe a typical day as a resident.

F: You'd get up early, you'd make sure that your patients were taken care of. If you were on-call, of course, you may have admitted people during the night. You had to have those people pretty well worked-up as far as history and physical exam and initial laboratory tests before the attending physician came by to make morning rounds. Depending on what year you were, whether you were a junior resident or senior resident, you reported up the line of command who had come in. By 8:00 in the morning, the senior resident had to know all the patients that had come in the previous day and what they had, and take that information to the attending who was in charge of the floor. Everyone who had any responsibility for that patient had to know about it by that time. It kept you busy. You did have help with students and assistants. The senior resident would have assistance from the junior resident and so forth. It was a chain of command. It still works that way in hospitals. It's a good teaching technique. As I said, there was a lot we had to do for ourselves, like drawing blood. There weren't all these technicians for this, that and the other. There weren't a lot of diagnostic procedures. There were basic x-rays and things were all being developed. You'd go to radiology, perhaps, with your patient and see what was being done there, see the films. Back and forth. It's an active thing. You're all over the place.

P: Shands really becomes ultimately a referral hospital, does it not?

F: Yes, it always was. This hospital, Shands, always was a referral hospital.

P: Is that a benefit to you because now you're going to see perhaps more serious cases and cases more dire than you would have seen in the Air Force?

F: You see things that are not run-of-the-mill. It's not a run-of-the-mill hospital.

From an internal medicine standpoint, it was more exciting because you had an opportunity to see things that were unusual.

P: It is interesting to see how physicians relate to patients. How do you develop bedside skills?

F: By watching a good physician do it. I think this is part of the nature of Dr. Taylor's teaching abilities. You try to mimic the people that do it well.

P: Do you find that patients will tell you things they might not tell family or close relatives?

F: Yes.

P: A lot of that has to do with the trust between the patient and the physician. Has your approach always been basically holistic?

F: I believe so. I think from the very beginning this medical school tried to impress that feature upon us. Maybe we didn't use the term holistic, but that is part of Dr. Harrell's approach. He wanted us to be well-rounded in everything so we could understand the patient and relate to them well.

P: You started working with Dr. Cade in 1965. What were your responsibilities and duties?

F: I had an appointment as a Research Fellow for a year. One of the projects I was going to work on was reno-vascular hypertension. We were doing some studies, and at that time it was exciting about making diagnosis of unilateral renal hypertension that [was] surgically correctable by removing the affected kidney. I set up a bio-assay using a rabbit aorta strip, which had been described by a researcher in Indiana, to measure renin, the hormone that's made by the kidneys that causes reno-vascular hypertension. We were doing some studies on that. Of course, the big event that happened that year was the development of Gatorade, which came shortly after I became a Fellow. Again, I was in the right place at the right time.

P: Did you have a dialysis unit at that time?

F: We did not. There was a dialysis machine. I don't know if there was more than one machine in the hospital. It was an old Travenol, tub-type dialysis machine, first-generation dialysis. We'd push it around to different places [in the hospital]. It was only used for acute dialysis. There was no chronic dialysis at that time. During that year, [Dr. Bill Pfaff] did the first kidney transplant [in the medical center]. As you know, he's still here.

P: The technology in that has changed dramatically.

F: Yes.

P: Talk about the beginning of Gatorade. Everybody has a little bit different perspective on it. My understanding is that it really started with the football players who were perspiring a lot and losing weight, but did not have a need to urinate.

F: That's correct.

P: How did you get involved in trying to deal with this problem?

F: Dana Shires was a Fellow, also, who was ahead of me. He had been a Fellow with Dr. Cade the previous year. He was doing some projects in the lab. He knew an assistant coach who presented the problem to him, along with the rest of us who were having coffee one day down in the coffee shop. This fellow presented the problem of the players who were not urinating and many of them were getting sick, throwing up, having to go to the infirmary and get IVs after practice or even staying in overnight to be re-hydrated because they were so weak. It was obvious to us just from listening to him for a few minutes, and us talking about it, that the problem was dehydration. Why should that be? They're sweating, it's August in Gainesville. They put on pads and go out there. The trainers said, if you drink water it will make you sick, so they gave them salt pills. We said, that can't be good.

P: It would seem to me that if you perspired a lot of water, your sodium level would be up anyway, wouldn't it?

F: It would. You're a historian, you're not a physiologist, and you know that. It's obvious.

P: Also the sugar level would be affected too, would it not?

F: The sugar level would go down, obviously.

P: You could be hypoglycemic.

F: You could, but the main problem was dehydration. We said, we think we know what the problem is, but we don't know how to get the fluid into them. That's the problem, how to get the fluid into them to make it accessible [and] get it absorbed into the bloodstream where it's needed to correct this, while they're playing, if water makes them sick. We know now that water really doesn't make you sick,

but it's not absorbed as fast as it should be. If they drank a whole bunch of it while they were out there on the field, it didn't have a good outcome for them. We started working on this.

P: This was just something that was of interest to you?

F: It was of interest. It wasn't anything that we had planned ahead. [It was] August, the players were here. Coach [Ray] Graves [head football coach] was the coach and the trainers were Brady Greathouse and Jim Cunningham. Dr. Cade said, I'll go to Coach Graves and see if he'll let us run some experiments on his players to try to find out and document what's happening to them during practice and see what we can do about it. He did. He presented the problem to Coach Graves. Coach Graves said, you can use the freshman team. We used the freshman team, they were volunteers. They came in two at a time, over a couple of weeks period of time. We would do studies on them. We weighed them, we took blood volumes, extra-cellular fluid volumes, and measured all their chemistries before and after [practice]. We collected sweat and measured the electrolytes in the sweat and so forth. From just seeing their weight measurement, you can get an idea of the total body water loss because any change in their weight from before and after has to be water loss. We tried to compartmentalize it. We found [that] their sodiums went up because they were dehydrated, their sugars went down.

P: That can really affect your cognitive ability, can it not?

F: Absolutely, yes.

P: You might throw an interception.

F: Absolutely. No telling what [might happen]. The challenge was to try to figure out what to do about it that would make it acceptable. We ended up making this fluid that we thought would be helpful. We tried it on the freshman team and used it on them for about a month before it was accepted on the varsity team.

P: What was in your initial fluid?

F: It's really not any different from what is in it today. It's salt, sodium chloride, some potassium, a little phosphate, and five percent glucose. The glucose enhanced the absorption of the sodium. It was found that we basically made an isotonic solution, meaning the tonicity of it – a chemistry term meaning the way it goes across membranes – in order for it to be absorbed across the intestinal membrane, is basically the same as plasma, so that it is absorbed fast. The water and the glucose and the sodium were all getting in fast.

P: Were the players willing to experiment with this?

F: They did. There were various ones that didn't like it at first. I think they all accepted it very well, and the freshman team ended up really doing well on it. The thing that we demonstrated was that it didn't make them sick. They could take it and they felt better afterwards instead of worse.

P: All of this would be anecdotal, not scientific. It would be difficult to prove specifically how this had worked in terms of their ability to play football.

F: We also did post-studies with it. We did the same thing by having them drink a certain volume of Gatorade during their practice, measuring their sweat and checking their extracellular fluid before and after and their weight to see if we were correcting the problem that we had diagnosed to start with. It did.

P: Who actually made up the formula?

F: I'm sure it was Dr. Cade. I was there, but he was our mentor.

P: Initially I understand it was put in milk cartons. Once it got to be at least accepted by the University of Florida, the knowledge of this new drink spread rather rapidly. Is that correct?

F: Yes, it did.

P: Other universities wanted it as well?

F: It started with just the schools around this area. The high schools wanted it because they heard about it. Then other universities, then people as far as California contacted Dr. Cade about it. I was here only the first year that it was made, then I went into practice in 1966. I went to Clearwater. In 1966, when football season started again, floods of letters came in. Requests, not necessarily letters, phone calls and so forth, requesting Gatorade. That's when it started being made more readily available.

P: I understand you were the one who came up with the name.

F: Yes, that's correct.

P: Initially you wanted it spelled Gatoraid?

F: It may have been. We talked about various things. I believe that we had discussed it one way and another. I recall that I came up with the name, then I made this sign and put it up on Dr. Cade's lab door. It said, Gatorade, and I did

spell it the way it is spelled now. The sign that I made said, Dr. Cade's lab: Home of Gatorade, hand-made by licensed physicians. They left that up for a long time.

P: This was a formula you had created, but you had no copyright on it at that point, is that correct?

F: We did not, in 1965. But in 1966, we got together when it became obvious that more people wanted it than just the University of Florida, that it might be a product that could be commercially produced. Six of us got together and formed a little unit, [a] company, if you will.

P: Was it called Gatorade, Incorporated?

F: I believe so. We went to a lawyer and they fixed up something for us and applied for a trademark. We got the trademark at that point.

P: All six of you had equal shares in this?

F: We may have, but I can't remember the details of that. I just don't have that at my fingertips.

P: Once you have done this, you ultimately sell it to Stokeley Van Camp?

F: Correct.

P: Who decided that? Was that something you decided collectively or did they approach you?

F: Kent Bradley was one of the fellows that was in on some of the development of it, he was not one of the first four of us, but he was a friend and worked with Dr. Cade. [He] went to Indianapolis to be a physician at the VA hospital there and developed a dialysis program for them. [He] met one of the Stokeleys at a party of someplace in Indianapolis and was relating to him that this was something he thought would become a commercial product. They became interested in it. We had very good legal advice.

P: Was Shires also involved in this process?

F: Shires was not there that year, but the following year. [He was involved] during the early years, yes.

P: I was at the basketball game last night and I noticed the University of Kentucky giving out Gatorade in those cups with the thunderbolt logo. Did Stokeley come

up with that logo?

F: I think so, yes.

P: Once you sold it to them, they were pretty much responsible for it.

F: That's true.

P: Talk about the conflict with the University of Florida. I understand that Cade went to the Vice-President of Research and they said, we're not interested in this, we don't do this sort of thing. When it became very clear that it was going to make a lot of money, the university then wanted, as I understand, all the profits from Gatorade and you end up in litigation for quite awhile. How did you feel about that?

F: I was in turmoil about that because I was just starting my career as a physician in Clearwater and [I] was annoyed about all the phone calls that I was getting all the time and the depositions, having to go here and there for meetings and so forth. We got a little money from it in 1967, and from then until 1972, when that was all settled, we did not have confidence in it enough to spend one cent of that money. I really just put it in the bank.

P: You thought you might have to give it back?

F: Absolutely. I fully expected that someday we were probably going to have to give that money back. It wasn't a lot. It was just a nominal amount. As I said, we had excellent legal advice from Claude Spillman, our attorney in Indianapolis, and [he] helped us a lot. It went into federal court in Indianapolis and, in 1972, it was determined by the federal judge there that the University of Florida should get twenty percent of everything and it still does. That's fine, I'm happy.

P: Do you think that was a fair settlement?

F: Certainly.

P: The NIH was involved as well, because apparently they were paying for Dr. Cade's lab or paying the salaries of two or three people. Is that right?

F: Probably so.

P: They never did get anything.

F: Not that I know of. Like I said, I was trying to develop my career in Clearwater at that time and I was not first-hand involved with a lot of this except for depositions.

I do have a funny story to tell about it though. That is, I went into practice in 1966 and it was 1969 before I really took a vacation. We had two small children and we took my mother-in-law. We rented a cottage, a chalet, up in the mountains of Tennessee near Gatlinburg. We were going to spend a week there in the mountains. I went, drove up, and we got the key from wherever we had to and we drove up the mountain with all the switchbacks. There was a note on the door, Emergency, call Claude Spillman in Indianapolis, our attorney, immediately. So I had to leave the family, go down the hill. There wasn't even a telephone up there. [It] ended up I had to fly up to Indianapolis to give a deposition. That was during the time of contention.

P: Did you all have to pay the legal fees at this point?

F: I don't remember. I don't remember anything about that.

P: Did you have any sense at this point of the extraordinary success that Gatorade would have?

F: Absolutely not, no. We thought it was exciting and we knew it was a product that could be commercially available, but we had no sense of what it would develop into. Or I did not. I think Claude Spillman did. Claude was a remarkable man. Dana Shires knows him much better than I. He was very admirable in many ways. I think he had foresight. I had not had the business or legal experience to really know that.

P: You weren't involved with the other drinks that Cade developed, like Go?

F: Absolutely no, I was out of here. I didn't have any involvement with that, except we kept in touch with Bob all the time. We are still are very fond of him. I love him.

P: There is some sense that this has earned over \$30,000,000 for the University, or something like that.

F: Oh I'm sure of that. They're making about \$6,000,000 a year now, I guess.

P: You all would make about the same amounts?

F: The other eighty percent goes into what's called the Gatorade Trust and there are many people [who are] in this, not just us who were there at the beginning. Some of the units have been sold or given to other people. It's spread out into a lot of people now.

P: Nonetheless, for each of the individual four, you would have made many millions

of dollars off of this.

F: Well, we have.

P: It's something that just started as a matter of interest and ended up developing into a multi-billion dollar business. It's something you hadn't clearly anticipated doing.

F: That's right. It had not been planned that way. When I look back on it, the really important thing is that it was the first thing that brought to the world's attention to re-hydration in athletics. Out of this has developed a whole field of sports medicine. Before that, sports medicine was only orthopedics. Now, it's a big metabolic thing.

P: I understand that all of the people involved have been very generous in giving money, in addition to what goes to the University, because that money has been a great boon to the University of Florida. I understand that other people, you as well, have given additional funds.

F: That's an individual thing. What each person gives to is their own private business, but, yes, I think when you have been blessed that way, you need to spread it around.

P: Talk to me a little bit about your private practice in Clearwater. What was your major interest during that period of time?

F: I came there as the only person who had any training in nephrology or hypertension and that was only a one-year residency. Dialysis and transplantation were in its infancy. I did a lot of consults on people who had kidney disease. We had no programs for end-stage kidney disease at that time. In the early 1970s, when Medicare started taking care of end-stage renal disease and dialysis units sprung up, there developed a dialysis unit in Tampa. Then the University of South Florida started with their program. It was very fortunate because Dana Shires and Alex DeQuesada, who had been in Indianapolis, came down to be on the faculty at the University of South Florida with Dr. Behnke, who was the head of the department and had come from Indiana and brought them with him. It ends up the three of us were in Tampa and have been there ever since. That was nice. As far as the practice of medicine and nephrology, I did a lot of hypertension and kidney disease consults during the years of my practice, especially in the early years. Later, some younger, better-trained nephrologists came to Clearwater to practice. I encouraged them and gave them opportunities. I did not practice with them, but I referred lots of patients to them. My [main] practice throughout the years was internal medicine. I worked as a private practitioner. I had a partner and we

built an office building together. There were six of us who covered for each other and would rotate [being on-]call. [I] practiced at Morton Plant Hospital for thirty-one years, that was the hospital that I used for admitting patients. I was on every committee that I'm sure existed in that hospital throughout the years. I was involved with the development of the first intensive-care unit there. I was active with numerous committees [involving] patient care. I became president of the staff in 1983 and [served] on the board of trustees of the hospital following that. I served my time with all the politics of medicine as well as [the] practice. It was very rewarding. It's a great community, it still is. We have a wonderful hospital. Now we have the most state-of-the-art emergency room in the nation at Morton Plant Hospital. It just opened two months ago.

P: How has all the new technology over this thirty-one year period affected your practice of internal medicine?

F: I'm retired now, I've been retired for four years.

P: I know, but up until the time you retired.

F: It's wonderful, because as the technology comes in, you have more sub-specialists that know how to use it, so it has greater tools for how you can help your patients. Take cardiology, for instance. When I went into practice, the cardiologists, all they could do was give Digitalis and diuretics, you know. Now they can do all these balloon angioplasties and stents and reperfusions, everything imaginable. It's just wonderful.

P: What is the state of dialysis treatments now?

F: Most hospitals have acute dialysis facilities and chronic dialysis facilities either in or outside of the hospital. There is a huge pool of people who are living everyday lives who go to the units for dialysis two or three times a week. Acute dialysis is done within the hospital setting. There are nurses who are trained to do that and there are physicians who do nothing but nephrology and oversee all of this. It's beyond my scope, because I would have had to go back and do another residency to catch up with all of this. You can make a diagnosis and call the right consultant to do what's necessary for your patient. That's the way medicine works. We all have to work together.

P: What is your view of HMOs?

F: I never liked them and I never was involved with them. I elected not to hook up with them when I was in practice. It's difficult because the hard thing is when you're an internist, you are the one who is trying to make a diagnosis. In order to do that, you may have to have special tests done. [If you are aligned with an

HMO,] every time you do that, you have to go ask permission or make out forms. It's made the burden of practicing medicine greater. It's a greater burden, just the paperwork. You have to hire people to just do this portion of it because you can't physically do it. Calling to get permission for doing a test and then sending a person to a consultant. Everything has to be fed back and permission received in order to do that, to take care of the patient properly.

P: The initial idea behind HMOs was to cut costs. Have they actually done that?

F: The problem is, it's added another layer of cost. It's added the cost to the middleman, the HMO, to get money out of it. The only way he can do that is by cutting out what's allowed for the patients. I just never did like the idea.

P: What's the answer to the problems of health care in America? Is it the Canadian system or a fee for service or some combination?

F: I wish I knew that. I don't really know. I would hope that it would retain the individuality of the practicing physician to make the right choices, but I think there still have to be guidelines and corrections. [Physicians] do the best thing, but the problem is ordering. You can't let them order tests carte blanche. You can't just give them an à-la-carte menu and say you can do everything. Still, there's got to be an easier way to work the system.

P: Should there be some government oversight or regulation?

F: I don't know if it should be government, but there should be some regulation of how many tests or whatever can be ordered. I don't know that I'm smart enough to give you the answer to that. I think there are a lot of people smarter than me working on this problem.

P: And they haven't worked it out yet. When you look back on your medical career, what do you see as your greatest accomplishment?

F: I really think my greatest accomplishment is that I practiced good medicine for thirty-one years and took care of many, many people who had a relationship with me. We developed a terrific close doctor-patient relationship. Many of them are still very good friends. I have had a nice community to live in where I have been highly considered. I just feel very fortunate for all of that. I think I've contributed to the well-being of the community that I lived in and I've had a good, loving family.

P: Do you miss medicine?

F: Yes, I do. I still work in a free clinic twice a month. I keep my educational

credits up and I keep my medical license active. I have been working in the Clearwater Free Clinic. Of course, that's funny because of my name. When I say, I'm Dr. Free, they laugh.

P: They think it's your clinic. I notice you're a director of LifeLink Legacy Fund.

F: I am a director, yes.

P: Can you tell me a little bit about LifeLink Legacy Fund?

F: That's the endowment, or the foundation portion of LifeLink, and LifeLink is the organ-procurement agency in Tampa [where] Dana Shires is the CEO. The Legacy Fund has a certain number of dollars that have been donated to it. We oversee the investment of that and the disbursement for use by LifeLink as any endowment would. Some of the gifts are designated and others are undesignated. I just talked with Al Galloway, the chaplain of LifeLink, but he is the staff person who oversees this. He has quite a bit of money in what's called the Good Samaritan Fund and a lot of people have donated to that, because it's [money] to help in any way, patients who are undergoing transplantation, to purchase medicine or to help them in an emergency. We have been discussing how we could use some of those funds.

P: When I talked to Dr. Shires, I was rather fascinated with the harvesting of the organs and the determination of who gets them. Once you have a kidney, how do you decide to whom that kidney is given?

F: I'm not sure you're asking the right person that question. You might get better information from Dr. Shires or someone who is working more directly with the patients in that aspect. As I understand it, there are local people who need kidneys and other organs and then there are people elsewhere. There's a huge immunology lab. The tissue is obtained. The immunology lab gets the blood that they need to make a diagnosis. They put this all in the computer and match it up. They already have all the people on the waiting lists in the computer. The computer tells them where the matches are. There may be a local match and if there is, hopefully that would be the best approach. Of course, now the government has gotten into it because it's a Medicare program. If it's funded by the government, they're going to try to tell you where it should go. Now they're saying that the liver should go to the person in the greatest need. If it's in New York City, then it should go there before the person in Tampa gets it, even if the Tampa person is top on the list. There's a lot of different facets to this. It's a matching-up thing. They try to give it to the person who is in the greatest need [who is] accessible and [is] the best match.

P: What do you enjoy doing in your retirement?

F: I'm trying to learn to play golf, but I'm not doing very good at it.

P: I said enjoy. [Laughter]

F: I have five grandchildren and I enjoy spending time with them. My wife and I enjoy a lot of community activities and we have a lot of friends. We're busy most of the time. I enjoy coming up here [to Gainesville], I've had a nice couple of days here. Retirement gives you options to do things that you used to always be too busy to do. I have recently joined a bicycle group and we ride bikes on Tuesday mornings from twenty to forty miles. They're mainly engineers from Honeywell who have retired in our area, a couple of physicians and other people. There are about twenty of us that meet on Tuesday morning and ride bikes. [Retirement] gives you a chance to do things you've never done.

P: Is there anything that we haven't talked about that you would like to discuss?

F: I thought we were going to talk a little bit more about Dr. Harrell. I would just like to say that Dr. Harrell was very influential to me in medical school. When we got there, he impressed upon us, not only this holistic approach, [but] that there was more to life than medicine – to read, [participate in] the arts, enjoy yourself in all aspects of life. He developed for us this wonderful health center at the University of Florida. I spent part of yesterday with Nina Stoyan, who is one of your associates in history, [viewing] what she's doing with the Harrell [History] Center. I'm real encouraged [that the J. Hillis Miller Health Center history is being saved.] [Dr. Harrell] was a remarkable man and I'm glad that his memory is going to be retained here in an honorary way.

P: I think everybody we've talked to really sees him as the architect and the moving force behind this. Without him, it may have ultimately achieved success, but not nearly as good and not nearly as fast. Would that be a fair assessment?

F: Yes, absolutely yes. I also had the fortune of him being my faculty advisor when I was a student. It was his idea that each student should have a faculty member to go to, as their advisor. You should go about once a month and sit down across the table and just discuss [whatever was on your mind].

[End Side A2]

F: Dr. Harrell was my faculty advisor when I was a student and for the four years of my undergraduate medical time, I would go in and talk to him once a month about anything. If it was one of the classes that was bothering me or something [else]. Even if I didn't have a problem, he wanted to see me just to see how I was doing. Of course, he wanted his students to go on to their highest and best achievements and wanted us all to get good residencies when we got out of medical school or internships. I think he was very helpful in getting me into

Grady Hospital with Dr. Hurst. He encouraged me to interview [at] places [with] high academic [ratings]. I [interviewed at] Johns Hopkins, [Cornell, Virginia, and University of North Carolina at his urging]. Still, it was an educational experience. I really thank him for what he did for us here at the University and for the whole state.

P: Is there anything else that we need to talk about?

F: I don't think so, except I'm sorry Dr. Proctor [is not here] today.

P: On that note, let me end this interview and I thank you very much for your time.

[End of interview.]