Charles William Daeschner, Jr., MD

Interviewed by James E. Strain, MD

June 19, 2002
Galveston, Texas

This project made possible by donations through the Friends of Children Fund, a philanthropic fund of the American Academy of Pediatrics.
PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

James E. Strain, MD, FAAP

Dr. James Strain graduated from Medical School at the University of Colorado following his undergraduate education at Phillips University in Enid, Oklahoma. After completing a rotating internship at Minneapolis General Hospital and a pediatric residency at Denver Children's Hospital he entered the private practice of pediatrics in Denver in 1950. He served on the pediatric clinical faculty at the University of Colorado and was appointed Clinical Professor in 1969. He was elected Chairman of the Colorado Chapter of the American Academy of Pediatrics in 1967, became Chairman of District VIII in 1975, and was elected Vice President of the American Academy of Pediatrics in 1981. He served as president in 1982-83 when the care of disabled newborns was an issue. He returned to the private practice of pediatrics in Denver following his tenure as president. In 1986 he was called to assume the position of Executive Director of the American Academy of Pediatrics where he served until his retirement in 1993. Since then he has continued to be involved in Academy activities, including serving as the Academy representative to the National Advisory Commission on Childhood Vaccines.
DR. STRAIN: This is an interview with Dr. William Daeschner. It’s taking place in Dr. Daeschner’s home, on June 19th, 2002. We’re starting the dictation at about 2:15pm, our time in Galveston. Well, Bill, you were born in Houston, Texas, in 1920. Tell me a little bit about your family.

DR. DAESCHNER: Well, my father was a product of the war [World War I], and during that time he learned a fair number of technical skills. He was working as an electrician and as a builder of radios. That was back in the days when you couldn’t buy finished radios. You had to get somebody to build them for you.

DR. STRAIN: I see.

DR. DAESCHNER: He had been raised here in Texas. His father was a minister in the Evangelical church, which was a German-speaking offshoot of the Methodist church out of Pennsylvania. They farmed in various places and he preached all over Texas. My mother was from Abilene, Texas, and they met up in Ennis, near Corsicana, Texas, when they both were working up there. When dad went off to war, she promised she’d wait. She did. They married as soon as he got back in 1918. They decided to move to Houston, since neither one had a job at that time. He found employment in Houston’s first radio station. That was an interesting place, because it was right next door to a blacksmith shop run by a fellow named Hughes [Howard Hughes, Sr.], whose son [Howard Hughes, Jr.] later became a very famous entrepreneur of all sorts. But, it was the older Mr. Hughes who invented the rock bit in his blacksmith shop that made all the money. They’re still using it today to drill oil wells.

DR. STRAIN: I see.

DR. DAESCHNER: Mother and Dad lived all our years in Houston. I went to Houston public schools and graduated in 1938. I then went to Rice [now Rice University], which was a local school at that time. It was called Rice Institute in those days. It was a very good school and proved to be a very rich experience for me. I worked the whole time I was in school, and earned all my personal needs money. But the school didn’t charge anything; it was free. So, my education came very easily.

DR. STRAIN: Yes.

DR. DAESCHNER: By the time I finished Rice, the war [World War II] had just started. The military said we’d rather have you go on to medical school, since you’ve been accepted, than to go into uniform just now. So, I started
medical school [at the University of Texas Medical Branch at Galveston], and the next year they put me in uniform in the army student training program, or ASTP [Army Specialized Training Program]. I finished medical school in that program.

I interned at Hermann Hospital [now Memorial Hermann Medical Center] in Houston, which had just become the teaching hospital for Baylor medical school [Baylor College of Medicine, then Baylor University College of Medicine]. It had, in the previous year or so, moved to Houston from Dallas, where it had been for many years.

After internship, which was a general experience—I liked everything I did—I finally decided I really wanted to be a surgeon. So, they offered me a residency just as soon as I got back from service. My last rotation in that was with a very special man named George [W.] Salmon, a pediatrician in Houston [and assistant professor at Baylor University College of Medicine]. I’d always thought I didn’t like pediatrics, that [it] would be my last choice so, I put it off until the last of my internship. But it’s interesting, a close friend of mine, Phil DeWolfe [a physician], decided that he would offer me a month’s salary which, in those days, was a fortune, to obtain my pediatric rotation. I said, “Why in the world do you want to do it? You’re already set up to be a surgeon. Why do you want to do pediatrics? See, I don’t want to do pediatrics at all.” He said, “It’s really a good service.” Well, that made me decide. Money was not something I needed, because I lived in the hospital; I lived on nothing. So, I said, “Nope. Not going to do it. I’m going to take that rotation and see what it’s like.” Well, it was one of the turning points of my life, because George Salmon made pediatrics so interesting, and he made the study of the individual infant and child so thoroughly meaningful, that I fell in love with it.

About that time, we all got drafted. I went into the service in the Air Force and became a flight surgeon. But all that time, while I was serving in the military—and enjoying every minute of it—I was thinking, you know, I really like that pediatric service. I was not as turned on by the surgery as I expected to be, because I acted as a bottom-level surgeon in the military. After about 6 months in military, I wrote Dr Salmon and said, “Do you think I can get a job in pediatrics, and do you think you could get me out of that residency in surgery?” He wrote me a long letter, which consisted of, “No problem.” [Laughs]

He arranged for me to be a resident. I had thought he was going to bring me back to his program, but he said, “No, Baylor is too young and the program too undeveloped.” So, he sent me to St Louis, where he had come from, to work with Dr. [Alexis F.] Hartmann, chairman of pediatrics at Washington University School of Medicine]. That, too, was a very rich experience,
because it developed my love of the kidney and of renal disease and of water and electrolyte metabolism. I maintained that interest for the rest of my life.

In my second year there, as I was finishing up, Dr. [Russell J.] Blattner, chairman of pediatrics at Baylor of Houston, who had just come there to develop that department of pediatrics, came to St. Louis and said, “Wouldn’t you like to come back to Houston?” I said, “Yes, I really would someday. My wife wants to go back to Houston too.” He said, “Well, I’ll give you a job in the Baylor medical school if you will.” I said, “Well, if I am going to stay in teaching, I think I’d like a little more breadth. The difference between the 3 schools I’ve been exposed to—UTMB [University of Texas Medical Branch], Baylor and now Washington University—makes me think that diversity would be fun.” So, he said, “Okay, we’ll arrange to send you to Boston Children’s [Children's Hospital Boston] for a year.” Well, I got there and decided to get into a program where I stayed for 2 years. I was really very happy in it. Dr. [Charles A.] Janeway was my chief, and he was a wonderful guy. I learned so many things about how to relate to people and how to understand people from him, things that I just couldn’t get from anybody else.

So, I’m going to get carried away here with my history!

DR. STRAIN: Well, I was going to ask you about your educational experiences. I think you decided on pediatrics at the end of your rotating internship at Hermann. Is that correct?

DR. DAESCHNER: Well, while I was in the military, I did. I left that [internship] with the idea I’d be coming back as a surgical resident.

DR. STRAIN: Okay.

DR. DAESCHNER: Then I got out of that.

DR. STRAIN: Okay. Now, you were married when?

DR. DAESCHNER: We got married in 1948, when I got home from my military service.

DR. STRAIN: I see.

DR. DAESCHNER: I married a Houston girl who had grown up in the same part of town I had. We had very similar friends and the like. Except that she was a year younger, so her friends were somewhat younger. In a big town like that you tended to relate to people your age in your school.

DR. STRAIN: Yes.
DR. DAESCHNER: But, we’d been to the same schools and everything.

DR. STRAIN: You had children?

DR. DAESCHNER: We had 3. The first came in Boston. Our son Charles was born at the Boston Lying-In [Hospital, now part of Brigham and Women's Hospital]. The second came in Houston, after we came back to Houston to teach. At the end of the time in Boston I had to make the decision of staying on with Dr. Janeway, which would have been fun, or coming home. My parents were older, her parents were older, and her sister and my brother were both in Houston. It just seemed like a more logical thing for us to do to. So, we accepted Dr. Blattner’s invitation to come back to the Baylor medical school.

DR. STRAIN: I was going to ask you, Bill, what your professional and teaching positions have been through the years. You came back to Houston, and Dr. Blattner was chairman of the department at that time?

DR. DAESCHNER: Chairman of pediatrics, yes.

DR. STRAIN: Yes.

DR. DAESCHNER: I came as an instructor.

DR. STRAIN: Okay.

DR. DAESCHNER: For the princely salary of $250 a month. Since I’d been making almost nothing up to that time, I thought it was princely. I really was almost embarrassed to accept it. [Laughs]

In Houston, Dr Blattner had responsibility for the pediatric services in multiple hospitals. Texas Children’s didn’t exist, but there was Hermann [Hospital], Saint Joseph’s [Saint Joseph Medical Center]and City-County [Jefferson Davis City-County Hospital, now known as Ben Taub General Hospital of the Harris County Hospital District]. I discovered very quickly that the City-County was the least popular with the faculty. None of the faculty wanted to go to City-County. So, I began going over there, thinking that the students over there needed some supervision. I was sort of shocked at the lack of supervision, and decided to make a career of working with the City-County Hospital. I found a little closet up there.

At the same time, Murdina Desmond, who was a pediatrician, had come to Baylor 2 years earlier. She and I hit it off right away. We just thought alike and worked well together. She wanted to take care of all our newborns, of which we had a huge number there. So the 2 of us decided to dedicate our
careers, at that point, to the City-County hospital and to supervising the house staff there. That proved to be a very rich and rewarding experience that I still think of very warmly.

Later, we were joined by Martha Yow in infectious diseases. Martha came to me and said, “I’m a regular pediatrician, but I haven’t practiced in 6 years while I’ve been having my children.” She had 3 at that time. She said, “But could I just follow you around for a while and sort of refurbish my brain, then see if I couldn’t be of some help over here?” I said, “We can use all the help we can get, no matter what.” Well, as the world knows, in 6 months she was one of the best pediatricians in the house and a real leader in our teaching program. For 9 more years—or 8 more years, I guess—the 3 of us worked as a team and just had a wonderful time. That was my only major reluctance, when they offered me a job to come back to my alma mater [University of Texas Medical Branch at Galveston, or UTMB] as chairman. Because they were such wonderful people to work with. I just enjoyed every day, even though we worked about 16 hours a day—worked harder, almost, then we had as residents. [Laughs] But we still enjoyed it all, and I think Ina [Murdina] and Martha would both say the same thing today. It was a great time. We made the decision and we did it. Dr. Blattner was happy to have us do it. So, it became a very useful part of the education program at Baylor.

DR. STRAIN: Yes.

DR. DAESCHNER: The 3 of us were supervisors.

DR. STRAIN: When did you go to Galveston?

DR. DAESCHNER: Well, I had a close friend in college. He was Kenneth [M.] Earle, and he was later chief of neuropathology at the, Armed Forces Institute of Pathology. Kenny and I were close friends. We sat next to each other in most of our classes at Rice. He had become dean down here [UTMB] in the meantime. They needed somebody to replace Dr. [Arlid E.] Hansen, who had left Galveston 3 years earlier. They had not had much luck persuading people to look at the job. Lew [Lewis A.] Barness almost took it, and then decided, no, that’s not where he wanted to live. He ended up in Florida. Several other people looked at it and said no, and they were getting pretty desperate. So he [Kenneth Earle] came up to see me one day, and said, “Bill, I want you to look carefully at this. This is your alma mater, and you got a free education there.” You see, it didn’t cost money to go medical school in those days.

Well he hit the right note. I came down and looked at it maybe 7 or 8 times in the next 6 months. The need there was growing, as Dr. Hansen had left so long ago that many of the other faculty also left. Pediatrics was in pretty bad shape; we were down to 4 faculty. It just wasn’t enough to keep up. The
ones who were here were really hard-working people. But, it wasn’t enough, no matter how hard they worked to do it all. So, that’s when I made my decision to leave Baylor and come here. I did it with a great deal of misgivings, because my career at Baylor had kind of taken off. I had been made an assistant and then an associate professor, and I had been nominated for full professor that year. And, as I say, Baylor was a nice place to work with people I liked. I liked Russell [Blattner].

So, it was a hard decision to make, but the level of need at Galveston was great. Dr. Hansen had been gone so long. He would come back occasionally for visits, and he encouraged me, too. I had not known Dr. Hansen as a student, because he came during my senior year. But he was very nice, and I liked him. I decided that this was something I could do and that I should try. My good friends at Baylor, they all encouraged me to try. It did give me an opportunity to set up an educational program based on my basic philosophy: that our job was to produce a good doctor for every child. So, whether it be a medical student who didn’t go into pediatrics or whether it be a pediatrician—no matter who saw a child—they needed to be a good doctor. The harder we all worked doing that, the better off children generally would be. So, with that thought in mind, I took the job. I really didn’t have much of an idea what a chairman was supposed to do. I didn’t have much of an idea of what resources I would need to do anything. Unlike people today, who negotiate very carefully, I just said, “Okay, Kenny, I’ll take the job.”

[Phone rings, recording interruption] Anyway, that’s how I got here.

DR. STRAIN: You were chairman for how long?

DR. DAESCHNER: Almost 30 years. About 29-1/2 years.

DR. STRAIN: I see. You were the John Sealy Professor and Chairman…

DR. DAESCHNER: Well, later the named professorships came to Galveston, and I was made a John Sealy professor. John Sealy was the person who built our hospital. He was a merchant from Galveston, and he endowed the original hospital [the former John Sealy Hospital, now part of the University of Texas Medical Branch at Galveston].

DR. STRAIN: Then there was another endowment, that of Ashbel, A-S-H-B-E-L Smith.

DR. DAESCHNER: Ashbel Smith was the first chairman of the Board of Regents in the University of Texas system.

DR. STRAIN: I see.
DR. DAESCHNER: He was a founder of the idea of a medical school here in Galveston, which was the first school in Texas. Back in about 1885, I think it was, somewhere in there. He was a brilliant fellow, originally from the East, and also spent time in the Carolinas. He had a major influence on the early life of Texas, back in the days when we were a republic. His biography is really very worthwhile reading and gives you a very clear idea of what early Texas was like, from the point of view of a rather cultured, Eastern gentleman. But Ashbel Smith, a physician himself, was the founder of this medical school. So, a number of years ago, when they wished to develop a system for commemorating the achievements of their alumni, they set up the alumni awards as the Ashbel Smith professorships I was awarded one of those along the way.

DR. STRAIN: Very good. Bill, you were sub-boarded in pediatric nephrology in 1974, and many of your publications have been on that subject, on the subject of nephrology. How did you get your training in nephrology?

DR. DAESCHNER: I got part of that through the residency, while working with people like Jack Metcoff and Bill [William M.] Wallace when I was in Boston [Children's Hospital Boston]. There was Dr. Hartmann and Gilbert [B.] Forbes in St Louis. They were all people interested in the kidney and how it maintained the balance of electrolytes and other things in the body. I became fascinated by that when I was working with Dr Hartmann. It seemed like everywhere I went I ended up working with somebody who was fascinated by the kidney, and I became fascinated by it. Dr [James L.] Gamble in Boston was very, very good to me and very helpful educationally. As you know, he’s an excellent teacher but, a very quiet and shy person. He doesn’t go out to find somebody. If they happen to find him, though, he’s very good to them.

DR. STRAIN: Yes.

DR. DAESCHNER: That was my experience. So, all of those things just led me in the direction of the kidney. I came back to Baylor to teach about fluid-electrolyte balance and the kidney. I had been exposed to some of the premier people who had developed our skills and the use of them, like Dr. Gamble and Dr Hartmann. So, in doing that, I realized that I needed to know more about how the kidney worked. There was a young man in the pharmacology department here, an internist at Baylor named John [H.] Moyer. John ran a renal function laboratory. The renal function concept had just been established a few years earlier, when they developed an inulin-type measurement of the glomerular filtration rate. So, John took me in and said, “Gee, I need somebody from pediatrics to work on the children who we’re working with.” His main interests were in drugs and how they influence the kidney—how they influence blood pressure, and if blood pressure influence was a negative effect on the kidney, things like that. So,
he gave me free access to his laboratory. I used it all I wanted to, and that’s where I got started on my laboratory work.

Meanwhile, from [the perspective of] clinical things, Ellard Yow—who was Martha Yow’s husband—was also in internal medicine. We became very close friends. We had similar attitudes toward what an academician ought to be doing. He had taken over the internal medicine service at the City-County hospital for many of the same reasons we had. We just needed some better help. He gave me full access to his laboratory for infectious diseases. In a way, I functioned at Baylor almost as a member of the Department of Internal Medicine, rather than the Department of Pediatrics. Pediatrics didn’t have any interests there, until Martha Yow came along with her interest in [pediatric] infectious diseases. That was about 4 years later.

DR. STRAIN: Did you have scientific interests other than nephrology?

DR. DAESCHNER: I don’t recall that I did in terms of, you might say, the pure sciences. I had, almost from the beginning, a great interest in the science of how people work: how people acquire new knowledge, how people develop their latent skills into useful applications. Things like that. But I didn’t really get involved in thinking about that seriously until after I came to Galveston and had responsibility for shepherding an educational program.

DR. STRAIN: Now let’s shift years for a minute, Bill, and talk about the positions you’ve had in the American Academy of Pediatrics. Do you recall the specific responsibilities you had with the Academy?

DR. DAESCHNER: The one I remember most, though I’m not sure it was the first, was working with Bob [Robert G.] Frazier and his team on the education program at the Academy. The Committee on Medical Education set up classes in the programs around the country. I served on that for quite a long time and thoroughly enjoyed it.

While on that committee, I got the idea for some sort of self-evaluation program. At about that time internal medicine got interested in that, too. I worked with some of my internist friends and ended up developing something we called SEEP, S-E-E-P [Self-Evaluation and Education Program]. The purpose was to help people stay current and continue adding to their knowledge through the years, rather than just going into practice with what they had in medical school and never adding to it. I felt that could be a problem.

DR. STRAIN: Did you develop the SEEP program? Were you involved in that?

DR. DAESCHNER: Yes.
DR. STRAIN: As the director, I believe?

DR. DAESCHNER: I had been made the chairman of the committee [AAP Committee on Medical Education] by that time.

DR. STRAIN: Yes. You were chairman from 1966 to 1971.

DR. DAESCHNER: Yes.

DR. STRAIN: The 2 things that seem to be most significant were the ABP [American Board of Pediatrics] courses that were under development at that time…

DR. DAESCHNER: They were already going pretty well by that time.

DR. STRAIN: Were they? And SEEP, self-assessment?

DR. DAESCHNER: SEEP was brand new.

DR. STRAIN: I see.

DR. DAESCHNER: It met with a lot of opposition.

DR. STRAIN: Yes?

DR. DAESCHNER: Because various people perceived this [SEEP] as an effort to interfere with the freedom of the individual practitioner. So, it was never a mandatory program. If you wanted to do it, you could.

DR. STRAIN: I see.

DR. DAESCHNER: It eventually became mandatory. But, that was a long time later.

DR. STRAIN: Yes.

DR. DAESCHNER: But it was a fun program to do. I had some excellent help putting it together. In the second year, I think, we put together a bibliography to support the person who took it so that he could look up pertinent articles relative to any question he missed or wanted to know more about. The person who helped me do that was Jimmy [L.] Simon, who’s now at Bowman Gray [Bowman Gray School of Medicine] but who was then my deputy chairman.

DR. STRAIN: I see.
DR. DAESCHNER: Jimmy is very good at bibliography. Very good. So, he helped do a major part of that with me. But SEEP was a lot of fun. I learned a lot. We were originally going to do it as only multiple-choice questions, where you solve one problem then it leads to…

DR. STRAIN: Algorithms?

DR. DAESCHNER: No. Kind of like an algorithm, but using patient management problems. Where you manage it, then each step takes you another way. Or it takes you in the wrong direction. You’re corrected, and you go back in the right direction. Those were a lot of fun to do and were quite a challenge. We decided to do the whole second edition of SEEP in that format. Since Dr. [John P.] Hubbard, who was a pediatrician and on the National Board [of Medical Examiners], was interested in that….

[recording interruption]

DR. DAESCHNER: So, we got our appointment with Dr. Hubbard. He encouraged us to do the patient management problems as a means of evaluating people and, at the same time, providing a teaching format. So, we did this for about a year. When we came back to see Dr. Hubbard again to review it with him, he said, “Fellas, I hate to do this, but I don’t think you should use the patient management problems. We’ve been studying them from the point of view of their validity and we cannot establish high validity for them in terms of judging peoples’ skills.” We said that wasn’t really our main purpose, anyway, and they were a lot more fun than just plain multiple-choice answers. No matter how you vary multiple choices—and there are many formats to do that—it still gets a little boring after a while. So, we wanted to go ahead and do this. He put his foot down. That was the first time that John and I had any disagreement, because from the first moment I’d liked him. It turns out that one of his early papers in the medical literature was on paroxysmal atrial tachycardia. One of my first papers in the literature was on that same group of patients at Boston Children's 20 years later. I went back and got some of Hubbard’s patients – found some of them for prognosis reasons – and added a fair number to them. He and I just hit it off great together. But, he wouldn’t budge. I got kind of upset with him, but we went along with him and did not use the patient management problems.

Although John and I did have some fairly vigorous arguments and the like, we did get to be good friends. One day he asked if I wouldn’t serve on one of the test committees, since he knew I was interested in testing and in evaluation. I said yes, I’d love to, because I’d like to be exposed to some of his people like Chuck [Charles F.] Schumacher, who was their statistics expert. There were a bunch of others there who I thought a great deal of.
One thing led to another, and I got more and more involved working with that committee and with others. Then they asked me to serve on the Board [American Board of Pediatrics]. So, I did that, and that brought me still closer into the midst of the thing.

I realized that, in spite of all the criticism of the National Board [National Board of Medical Examiners] that I had heard, they were a very genuine, serious lot who were doing their best to make more scientific a technique that had never been very susceptible to scientific analysis. They really worked hard at it. They spent huge amounts of time and threw away lots of stuff just because they couldn’t make it do what the statistics said it had to do to be reliable enough to judge somebody’s performance. After all, if somebody has had their education, you ought to be able to measure that in such a way as to say he is well enough educated to accomplish these tasks. But, in fact, there isn’t any method for doing that perfectly. The National Board probably has come as close as anybody can, now and then.

So, I got interested in the undergraduate examinations. I had worked out here with a man named Harold [G.] Levine. He’s a specialist in education who was trained by a fellow at Chicago who did a training study for the orthopedic boards [George E. Miller, MD, founder of the Office of Research in Medical Education at the University of Illinois College of Medicine]. Harold was one his products, and we worked together a great deal here. Coming back to Galveston, which, I have to at this point, we were trying to develop a curriculum that was more appropriate to the needs of the medical students, not the pediatric resident. Too much of our program was aimed at treating each student as if he were going to be a pediatrician when, in fact, statistics showed that only about 10% of them were going to be pediatricians. Ninety percent of them were going to go out, and many of them were going to take care of children but they did [not] have very good preparation for it. Often, they learned a great deal in medical school about rare diseases that bore no relation to the kinds of experiences they were likely to have. By contrast, they learned very little, in some cases, about conditions they were very likely to encounter in the general practice of family practice or anything like that. So, we decided that what we needed to do was to find out what were the fundamental things that you needed to teach somebody if he only had 6 weeks and you wanted him to be able to take care of children with the best possible results. In other words, if otitis media was what they saw the most, then they ought to know a lot about it. By contrast, if tsutsugamushi fever was something they never saw, we shouldn’t talk to them about it. Because in 6 weeks, their mind was already so crowded with knowledge.

The habit we had of applying the pediatric residency curriculum to the medical student instruction period, we decided, was entirely inappropriate. True, the residents could help teach the students, but the content of the curriculum had to be aimed at those common things that the student was
going to see as a general practitioner, surgeon, internist—anybody who saw children besides a pediatrician. We were not going to teach them the rare diseases. Some people objected to that, saying, “Well, rare diseases are something they need to find.” What we decided, in the long run, is that the majority of general practitioners would refer the rare diseases to those specialists. So, there was very little justification for spending their precious moments on learning that. It would be much more important to spend their precious moments on things they were going to see frequently. They mess up every single case of diabetes they see, that’s not a very big deal compared to messing up every single otitis media they see. So, we need to teach more about the latter and less about the former. At the same time, we need to teach recognition and referral skills. The diabetic certainly needs to be referred. It really shouldn’t be the providence of the general practitioner.

That was the philosophy upon which Harold and I started this program. We invited Luther [B.] Travis and George [T.] Bryan, who later became our dean to join us every Thursday evening for what we thought would be about 6 months. We had a hamburger in my office, and the 4 of us sat around and worked on this principle of how you decide what’s really important to teach in every dimension of medicine. It took us 3 years! [Laughs]

**DR. STRAIN:** Now, you developed this within the Galveston medical school?

**DR. DAESCHNER:** Yes, for graduate students.

**DR. STRAIN:** And were you focusing on the 6 weeks of pediatric training?

**DR. DAESCHNER:** Yes, yes. Because nobody had ever done that.

**DR. STRAIN:** I see. It was a curriculum development…

**DR. DAESCHNER:** Yes, it was the development of a curriculum for a medical student.

**DR. STRAIN:** Yes.

**DR. DAESCHNER:** We ended up putting it together in the form of a book. We exported them to everybody who wanted them—gave them away—and I would say two-thirds of the schools in the country got copies and used it in some way or another. But the reason I bring it up now is because the National Board was fascinated by this and realized that, in a way, much of the National Board content, [which was] developed by specialists who were on their committees, wasn’t appropriate to the general practitioner that we
were trying to license through National Boards. What we needed for each subject was to do what we had done for pediatrics: try to discover what we should include and what we should not.

Meanwhile, I was also on the American Board of Pediatrics, and Fred [D.] Burg got interested in this concept. Fred and I became very close friends and worked together a lot. He tried to do this with a number of committees at the American Board [of Pediatrics]. They all took the textbook, divided up into units and tried to see how much they could learn about each one of those things without regard to the commonness or the relevance of the particular thing. So, we ended up with a stack of paper this high—I’m not joking, not exaggerating. It was hopeless. We couldn’t possibly build our curriculum with that much in the way of recommendations. So, the same principle that we had gone through—the 4 of us here at UTMB [University of Texas Medical Branch at Galveston]—we went through with a small group of leaders from the American Board of Pediatrics. We put together something that we called the [Foundations for Evaluating the] Competency of Pediatricians. Then we took that to the National Board about this time and convinced them to do the same thing, and we called it the Comprehensive Qualifying Examination. That is, you qualify to be a doctor, but you don’t know everything. You aren’t expected to know everything. You just have a reasonable amount of knowledge that should serve the purpose that the public expects. Those documents and that period of study was a very exciting period of my life.

DR. STRAIN: Yes.

DR. DAESCHNER: Harold is still a good friend of mine. He lives just a few blocks over here. He used his educator skills and George Miller’s background material. We [also] consulted with George some, and he encouraged us. It was all very exciting, because we felt like we were breaking new ground. We were discovering the richness of the soil and areas that had never been explored. Mainly, how do we use the student’s time with maximum efficiency?

DR. STRAIN: Yes.

DR. DAESCHNER: You don’t have to be quite as efficient in residency, because you have 3 years—or 2 at that time. But for that poor student who only has 6 to 8 weeks—sometimes only 4—you really have to be critical about what you’re teaching. You dare not teach him everything. We finally decided that what you needed to teach him was principles. How do you go about getting a really good history? How do you go about doing a really good physical examination? How do you go about developing skill in listening to mothers? That was the focus of it.
DR. STRAIN: Your examination—which was Part 3 of the National Boards, as I recall, the clinical examination—was key to this concept of what students need to know.

DR. DAESCHNER: Yes.

DR. STRAIN: You had something to do with the FLEX test development too, did you not?

DR. DAESCHNER: FLEX [Federation Licensing Examination] was a byproduct of the CQE, the Comprehensive Qualifying [Examination]. FLEX, of course, was for the foreign medical students. But the same principle was involved. It was really just another development out of that. It was a separate item because so many other people around us were so rigid about not abandoning the older techniques that we had been using.

DR. STRAIN: I see. Now, let’s talk a little bit about the American Board of Pediatrics. You were an examiner for a number of years, a board member—and did I read in your biographical sketch that you were president twice?

DR. DAESCHNER: Yes.

DR. STRAIN: [President] of the Board?

DR. DAESCHNER: Yes.

DR. STRAIN: That’s a little unusual, isn’t it?

DR. DAESCHNER: Yes, it was unusual, and I’m not sure why it happened. They were about 6 years apart, as I recall. I came onto the Board when [F.] Howell Wright was our president. I must say that he is another one of those people in my memory that will never, ever be diminished. He was a wonderful person. He was just one of those humans—you have a special privilege in life when you get exposed to people like Howell. He was so consistently the right kind of thinker. Everybody who knew him well worshipped him in the same way I did.

DR. STRAIN: This was when the Board was in Philadelphia, as I recall?

DR. DAESCHNER: Yes. This was when [John McK.] Mitchell was still executive secretary. He had been dean at the University of Pennsylvania before that. I think of him often, too. He’s another remarkable human. Anyway, he was our executive secretary, and he ran the whole board from his home out there in Philadelphia. He was a marvelous guy. It was all done by hand, much like Hubbard ran the National Board by hand for many years. If we have some free time I will tell you a funny story about that.
McK. Mitchell was a relative of Charlie Janeway’s wife and he was a lovely human, just as Charlie was. So, he was right in the Board, and I came on as the new examiner. Between Howell Wright and Howell's wife, and McK. Mitchell and his wife, I just felt completely at home and warm with that group. Most of them were people whose names I had heard, people whom I had help up high, and here I was meeting them firsthand and talking with them and the like.

DR. STRAIN: [Laughs]

DR. DAESCHNER: They were just the kind of people that you wish the whole human race would be made up of. Anyway, it was a fine group of people, and it was a rather small group in those days. After a few trial runs, when I would be invited occasionally—I was still at Baylor then—they asked me if I would be a regular examiner. I said, “Yes, I’m thoroughly enjoying it and I would enjoy doing that.” They put me on the committee to help with the written exam. I helped develop written questions for ages, and when I cleaned my office here, I threw away what must have been 20 or 30 pounds of old questions that I had accumulated over the years. [Laughs]

DR. STRAIN: Well, you were chairman of a committee to evaluate the quality in pediatric practice. You were also member of a committee for the evaluation of residents—within the Board?

DR. DAESCHNER: Yes, that book was a product of that. I started out on those committees, and after a year or so I became chairman. We worked hard to produce those things.

DR. STRAIN: What was your thought about the oral exam versus the written exam: the value of each and your opinion about whether the oral exam was important or not?

DR. DAESCHNER: Well, I think it [the oral exam] has an importance that was not weighed sufficiently when the decision was made to abandon it. But that was after I left the active role on the boards. It is certainly true that the oral examination is very unreliable and that, statistically speaking, you can’t defend it. But there was something about the experience of sitting down with a group of the leaders in your profession and discussing pediatrics with them, and having them support—by passing you—what you had learned. That had a deep impression on the individual doctor, and I think it made an impression upon him as to the kind of pediatrics he was going to practice. One of my examiners was Bill [Waldo E.] Nelson, and he could be a real curmudgeon when he wanted to be.

DR. STRAIN: [Laughs]
DR. DAESCHNER: He decided that I was one of those smart aleck kids who had 3 years of training already when most only had 2. He just gave me a hard time. He did, and I missed a few key points through misunderstanding. But I came to be a very good friend of his through that mechanism, largely because we both felt that somehow or another this exposure was more than just gathering knowledge. It was evaluating the person. So, the way that I would argue with him—and he used to love to argue—was different from that of the usual exam where there’s no interaction between the examiner and the examinee [in a written exam]. There just isn’t. The examiner may have prepared the question months before, and he is a thousand miles away. The examinee is in a room someplace looking at a piece of paper that may or may not have the questions spelled out accurately and appropriately. They may think they are, but that stuff isn’t always approved. It’s much better when they’re talking to one another and interacting. I would not have been among those to vote to abandon it [the oral exam]. Now, I can’t argue with the point that it was a very expensive process, and that the cost of doing it was going up, up, up.

Off the record, I’m critical of some of our leaders who, at that time, made no effort to keep the examination and to curb the cost by having less lavish expenses. We didn’t need to spend the amount of money that we spent on those oral exams. We did it because it was fun for us. Now you can say that was payment for doing it. Most of us enjoyed it so much that we didn’t need any payment. Most of us had good jobs and that little extra money didn’t make that much difference. So, all in all, I feel like we have lost a certain amount of interface between a successful practitioner—the kind that you want people to emulate—and the run-of-the-mill person who can pass the exam. I think there were a lot of people who could pass an exam who you just really wouldn’t want treating your grandchild. You couldn’t put your finger on that and you couldn’t measure it with the usual exam, but you can sort of evaluate it when you’ve got them right in front of you. It created a lot of anxiety at the time, but when people who have taken the orals get together many years later, the main topic that comes up among a group of friends is the oral, “My oral was…” and “Who did this to me…” and this, that and the other. I think it did have a very meaningful and important effect in the long run.

DR. STRAIN: We all remember who our examiners were.

DR. DAESCHNER: That’s right. I had Bill Nelson and Ralph Platou. I was scared to death of Dr. Platou because I heard so many terrible stories about him. [Laughs] He turned out to be a real nice guy and I enjoyed it. The cardiologist, Hugh McCulloch, was editor [of the journal Pediatrics]. I was scared of him, too, but I knew him a little bit because I had known him in St Louis. I knew he wasn’t nearly as mean as he appeared to be. My fourth one
was Charlie [Charles F.] McKhann, whose history was sad. He's a fine guy, but he got some bad colleagues and made some bad mistakes. He was sort of wiped out.

DR. STRAIN: I see.

DR. DAESCHNER: But those 4 guys were important people to me for many years thereafter. In the long run, Bill [Nelson] and I became very close friends, although he was never my direct teacher. I always had the feeling he was one of the people who had a lot of influence on my life through ideas he expressed—and through his hard-headedness and arguing. He could argue with a wooden post. [Laughs]

DR. STRAIN: Now, you were on the pediatric Residency Review Committee from 1969 to 1976. Anything about that experience you want to comment on?

DR. DAESCHNER: I think it’s a well-run organization, if it keeps the program honest. There is an awful lot of nonsense that people report about their program that you discover isn’t true, or it isn’t a central theme when you visit there. I think it makes an awful lot of programs re-examine at regular intervals what they’re doing. It’s not perfect, but I think it maintains a much higher quality educational environment for young people who are going into pediatrics than if we didn’t have it. That’s one of the few things that is unique in this country and in Canada. We have that; nobody else has it.

DR. STRAIN: Did you ever have occasion to disapprove a program?

DR. DAESCHNER: Oh, yes. Yes, lots of programs. That’s always hard because you not only hurt the program, but you hurt the people who have been trained in that program. You also hurt the people who are in training in that program, indirectly. But yes, many times. As a matter of fact, I had the occasion to help put out of business the medical school in Tulsa that the minister created—Oral Roberts University. I’m always been embarrassed to say he was a Methodist minister. He was.

DR. STRAIN: And some [schools] were reinstated after they revised their programs?

DR. DAESCHNER: Yes. Sometimes the revisions were quite extensive. Sometimes that was the means by which they could get their due from the administration. Too often in big institutions, the departments of medicine and surgery call all the shots because they are numerically large and they bring in lot of money. I think the RRC is the best friend to most chairmen of
pediatrics in seeing to it that they are given a reasonable chance to succeed. I think the RRC was important and still is important.

DR. STRAIN: What do you think about the matching program?

DR. DAESCHNER: I think it is a tremendous help. At the same time, it started out very pure, but it’s so badly abridged now that an awful lot of people have reduced its effectiveness. It has made it very difficult for young people trying to get a job to be objective about what they’re getting. If you can get extra money and a commitment ahead of time, an awful lot of people are going to take a job that isn’t as good as they should have or as good as they want, simply because it’s a sure thing. I think that program has been badly undermined. But I guess that’s human nature. You know, you make a law and then the lawyers start finding ways to get around it. We’ve got an awful lot of lawyers in medicine. [Laughs]

DR. STRAIN: Now Bill, you were chairman of AMSPDC [Association of Medical School Pediatric Department Chairs]. Did anything exciting happen during your term of office?

DR. DAESCHNER: Well, I was one of the organizers of AMSPDC, indirectly. I would spend time with Charlie Janeway whenever I went to all the research meetings. One time he said, “You know, we need to get all the chairmen together once a year and just have a good time.” I thought that was a great idea, but at that time just having a good time wasn’t enough. As Charlie said, at Oxford the most important educational component they had was the beer cellars. That’s when the students got together in the evening and argued significant problems. It wasn’t the classrooms where they learned so much. It was there. Well, I was still too young to really appreciate that, but in the long run I think he was probably right.

What he wanted was a very informal group. He didn’t want us to have a president; just a party each year and someone to convene the meeting next year. And that’s what we did for several years. Then, as is inevitable with humans, we began to formalize it. By the time I was president, there was a definite structure. We had a secretary and a treasurer, things like that. It was still a fairly informal group. The main thing I tried to do was to encourage AMSPDC to give support to new departments, to new chairmen, and to people just getting started in this business so each one didn’t reinvent the wheel as they came in. An outgrowth of that were the new chairmen’s meetings that we used to hold annually in Hugh [A.] Carither’s hometown of Jacksonville, Florida. They were a lot of fun. So, I can’t say that I did that, but I got the ball rolling in that direction. In my presidential address I had a number of suggestions to make, most of which were too grand for a group that met informally once a year. I doubt that many of those ideas survived—maybe in the minutes, but that’s the only place. [Laughs]
DR. STRAIN: Now, AMSPDC had something to do with the young
scientist awards [Pediatric Physician Scientist Program Award].

DR. DAESCHNER: Yes, that was a number of years later. I think probably
Ralph [D.] Feigin gets a lot of credit for that. He and 2 or 3 other people who
were members at that time and who pushed the idea of developing that. I
think it is very good. It was something they could do, and I think they did it
well. I sense that it has not been as successful as they had hoped. Somehow
or another, the complexity and weight of it is so great that the majority of
people who have gone into it have not finished. But maybe it should be all
you could expect is that only 1 in 4 or 1 in 5 should accomplish what the
program wants. It’s a voluntary thing. It may be that it is doing what it
needs to do.

DR. STRAIN: This was focused on clinical research, as I recall.

DR. DAESCHNER: Yes, in the beginning. It drifted off into basic research
pretty fast. But at the beginning, it was focused on clinical research. The
problem with clinical research is that the money isn’t there. I hate to say
this, and it may sound a little sour, but what happens is that chairmen
discover that their performance is judged by how much money the
department brings into the school. If the school is infinitely hungry for
money—and I haven’t seen one yet that couldn’t spend all the money that
they could come across—to get that money they will use almost any
technique that is acceptable, and some that probably are marginally
acceptable. So, an awful lot of poor research—research they knew shouldn’t
be done—gets supported. But it brings in money. Many researchers and
many people in the institutions discover that their personal existence depends
on the amount of money they bring in. I think that is a problem.

DR. STRAIN: Now, your career actually has been focused on medical
education at all levels. I wonder, were you part of that pediatric education task
force that met back in the late 1970s [1978 Task Force on the Future of Pediatric
Education]. I think [C.] Henry Kempe was involved with that.

DR. DAESCHNER: Yes, he was chairman and I was deputy chairman.
Henry, as you know, was sick at that time. So, I would step in whenever he
wasn’t there. Then, when he was out in Hawaii and was too sick to come
home, he resigned and I took over. But he stuck with it until the final report
was written. That final report has much more of his ideas and emphasis than
mine. I can’t take much credit for it.

DR. STRAIN: What were the high points of that?
DR. DAESCHNER: We looked at the total needs of the pediatrician to do his job, and tried to see how the residency program needed to be revamped and revised to provide that. It could have happened lots of other ways. Henry was a very stimulating leader. Like old Bill Nelson, he could be pretty hardheaded. But he was always, always right when he was hardheaded. He was incredibly imaginative—he could see things nobody else could see. I think it was an important step. It wasn’t the first step. There was an older report, where Bob [Robert E.] Cooke was chairman. It had been out 20 years at the time that we undertook this, and we took a somewhat different approach to it. But the whole idea was to make sure our educational programs were focused on what the trainee needed. To some extent pediatrics had changed a lot between the 2 reports, and we attempted to focus on those things that were relatively new to pediatrics.

DR. STRAIN: I think the emphasis, as you read the report, was on the need for outpatient instruction, number 1. Adolescent medicine was number 2.

DR. DAESCHNER: Yes, those were the 2 that had a great deal of emphasis. There were others, but they were all sort of along those same lines—that pediatricians were doing something different today than they were 40 years ago. For one thing, pediatric practitioners weren’t acting as consultants as exclusively as they once had. Therefore, their skills and the broad general responsibilities of a pediatrician were greater.

DR. STRAIN: I see. What do you think about the new report [Task Force on the Future of Pediatric Medical Education II]?

DR. DAESCHNER: I'm kind of biased there, because Jimmy [L.] Simon [MD] had a big role...

DR. STRAIN: He was the chief, wasn’t he?

DR. DAESCHNER: Yes, he was chairman. I think it is well done, and I think it has carried on the tradition of looking at how pediatrics has changed and what programs need to do to [respond to] those changes. I confess that I haven’t studied it closely, as I was so far removed from responsibility at that time that I just scanned it and read it here and there. But I feel that it is a real step forward.

I think each of the reports through the years represented real steps forward. It’s like everything else, it shouldn’t be necessary. On the other hand, it is necessary. I think it is a necessary evil that a lot of people don’t like. They don’t want to be bothered with it. There are an awful lot of people who don’t need it. There are probably a lot of people who get worried about recertification who have no reason whatsoever to worry, because they’ve always practiced good pediatrics and they’ve always stayed ahead of the
game. But I think there are a handful who don’t, and they’re not ever going to be recertified. One of the first questions the public asks is whether you’re certified or not.

There’s a brilliant young pediatrician in Austin named Karen [W.] Teel. You may have met her. She was an examiner for the boards and she is a product of Martha Yow's training. Anyway, Karen said to me one day, “I had some people come in the other day, and they said, ‘We’re looking for a pediatrician for our child, and we’d like to know what your qualifications are.’” All these years in practice—she’s had fellowships in infectious diseases and everything else, and she’s a brilliant, personable person to begin with—yet that is the first time that anybody ever cared. I could have been straight out of medical school, and if they liked my looks and my manner they were going to be happy with me. That’s the majority. But she said, “These people, I just love them!” [Laughter]

DR. STRAIN: So, you think recertification is here to stay. Of course, it has been revised recently.

DR. DAESCHNER: It’s like any other system. It needs continuous revision. It needs a lot of thought put into it to make it effective. It can’t be just a mechanical, routine thing. The licensing boards that the states use were, for many years, very static, very poor, and did not accomplish their true purpose. I think, gradually, they’ve all gotten under the leadership of the National Boards and used National Boards for the exam. National Boards have always taken their responsibilities very seriously. That was John Hubbard's basic attitude.

DR. STRAIN: Do you think the recertification encourages more attendance at meetings and keeping up to speed on the literature?

DR. DAESCHNER: Oh, yes. I think it increased that by 3- or 4-fold. As it should. Too often the ones who go to the meetings regularly are the ones who don’t need it the most. Those who need it the most rarely have time to go. They’re too busy grinding out money.

DR. STRAIN: This is a long question. How do you think undergraduate, graduate, and residency education can be improved? What are your overall thoughts on that? Particularly at the graduate and residency level, do you see any way it can be improved over what has existed up until now?

DR. DAESCHNER: I think we’re continuing, with these various reports and things, to try to reexamine what we’re doing in light of today’s problems. As long as we keep on doing that, we’re going to keep it up. It’s a little bit like the automobile. The Model A and the car we’re in today are radically different vehicles. But one is really the product of an improved Model A.
It’s not a radically different thing. It’s still a Ford. I think that a characteristic of our approach, which is sometimes clumsy and slow, is continuous reexamination of ourselves carried out as critically and objectively as we can. I think that’s what we’re doing. I’m kind of proud of us.

DR. STRAIN: The American Academy of Pediatrics has continuing education as its primary goal. Do you see any way that can be improved? If you were to develop something beyond what we do now…can you think of anything more that we ought to be doing that we’re not doing now?

DR. DAESCHNER: There might be, but I don’t know of any. I think the standard course [Pediatrics Review and Education Program], despite its shortcomings, is still about the best we can do. The man in practice can’t take a lot of time off for training. He can’t spend a lot of his office time doing things that relate to learning. So how do we bring all of these disparate functions together to make a better product? We all recognize those problems, and I think we’re trying to do something about it.

DR. STRAIN: This is a controversy that kind of wavers from time to time, and I’d like your views on this, Bill. With regard to subspecialists, do you think we have too many or too few in pediatrics?

DR. DAESCHNER: I think it’s about right. The reason is that when we discover we have too many subspecialists, they do something else. They’re all prepared as generalists to begin with, so some subspecialists don’t do much subspecialty. Some are overworked and do nothing but their subspecialty. But I think in a free system like the one we have, it pretty well balances itself out. Much like the democratic principle. We complain about our legislators, “They’re not doing their job,” and this, that, and the other thing. But in the long run, the bad legislation is either not used or eliminated, and the good legislation grows and improves. I’m a great believer in the democracy that guides us.

DR. STRAIN: Do you think there is a supply and demand issue here?

DR. DAESCHNER: Yes. We sometimes create a demand that isn’t real. But that is part of the come-and-go and the up-and down.

DR. STRAIN: What do you see the future to be of general pediatrics? I’m asking this in view of the fact that, on the one hand, we have a number of allied health professions, both nurses and physician assistants, who do quite a lot of pediatrics and do it well. On the other hand, we have a number of subspecialists who really need to be there to take care of the seriously ill child. Where do you see general pediatrics going? We have a very different system in this country
versus what they have in England and even what they have now in Canada. What do you think?

DR. DAESCHNER: My feeling would be that we are going to trend toward the English- and Canadian-type systems. To some extent, we have already, in that we treat our better subspecialists much like they do in England. They practice strictly within a hospital. Our better practitioners don’t try to take care of subspecialty problems. So, I think that by a very slow evolution, we are going to have a system—in principle, at least—like the English and Canadian systems. I’ve always been a great admirer of the Canadian system, particularly. I think they are a first-rate group of people.

DR. STRAIN: Would that, then, result in fewer general pediatricians being trained? We now have more than 55,000 general pediatricians in this country. By moving toward the English or Canadian system, wouldn’t we need far fewer than we have right now?

DR. DAESCHNER: I think that may be true. I’m reluctant to voice much of an opinion on that because I’m out of the loop now and have been for about 10 years. I just have a feeling that the supply and demand will change that. If the more general-type person—particularly the nurse practitioner and the like—they do such a good job in some cases that you’ve got to reexamine what they’re doing. Sometimes I think the pediatrician is overtrained for what he needs to be able to do best and, as a result, doesn’t do for the average patient as much as he could do. It’s kind of a clumsy way to express it, but it’s sort of like putting a person with a college degree into a certain job next to somebody who is in the same job, but who had earned the position by working their way up from a high school education. That person who worked their way up from a high school education has certain skills and abilities that the college-trained person may not have. By contrast, I think there are certain skills and abilities that the college-trained person has the potential to have that the other person doesn’t. You ask a very complicated question, and to give a very categorical answer would not be in keeping with my habits.

DR. STRAIN: Going back to medical students… You haven’t been in a teaching position very recently, but what do you think about the present medical students coming into medical school, aside from pediatrics? The quality and the kind of person who goes into medicine now, compared to when you and I trained? How do they differ?

DR. DAESCHNER: I think that the basic education is so much more extensive, that they are extremely well prepared to deal with the more technical and the more complicated aspects of medical practice. So, I think in some respects they are better prepared to become a better doctor. On the other hand, what worries me some is that they have been raised in such a
commercial, dog-eat-dog world—and they have come to believe that is the norm. Therefore, many of the subtle qualities that make for fine doctor-patient relationships are missing. They just don’t have them. Whether they are going to get that in medical school and residency, I don’t know.

I guess a lot of people used think of becoming a doctor was sort of like being anointed to the priesthood or the clergy. They were taught to go out there and take care of people. Earning a living was a secondary phenomenon. I get the feeling that now they’re thinking, “Boy, I’m going to go out there to make a lot of money.” That worries me. Now, that’s a traditional view from the older generation versus the younger generation. I may be way off base. I’m not close enough now to know. Individual students I meet now from time to time seem to be some of the finest people I’ve run across in a long time. Others are like, “Gee, I wish they hadn’t gone into medicine.” I don’t really know what the balance is. Looking back on it, there are some of my classmates and friends I wasn’t too proud of at the time. Looking back 50 years, I’m still not too proud of them! [Laughs]

DR. STRAIN: Do you think, in general, that they are better prepared for medical school from the point of view of undergraduate education?

DR. DAESCHNER: Yes, they have knowledge. No doubt about that.

DR. STRAIN: What do you think about the number of women going into medicine, and particularly in pediatrics. How will that affect the specialty?

DR. DAESCHNER: I think it was inevitable. Joe St. Geme [Jr.] said to me one day as we were walking, “You know, Bill, my residency group this year will be 50 percent women.” I said, “We’re pretty close to that, too.” He said, “In a few years, I wouldn’t be surprised if it were 100 percent.” Of course, as handsome as he was, you can understand that! [Laughs] Seriously, I think that he was right. Pediatrics is an ideal profession for women. There’s a certain sensitivity, and there is a certain trust that children have of women. It wouldn’t bother me at all if it became 100 percent women. Over the years, I was amazed at how often we would choose a chief resident from among our group, and I’d say 3 out of 4 times it was a woman. I’ve had marvelous chief residents. I received a picture yesterday of a group of them that had gotten together someplace. Three of them were men, all whom I greatly admire. But I thought, even in their class, 15 to 20 years ago, half of them were women.

I do worry about the frequency with which we are drafting in foreign medical graduates and pretending that they have the same background or that their ability to pass that examination has admitted them to exactly the same situation. Because I don’t think they are the same. Those schools that they’re in are, too often, poor schools. I wish it weren’t that way. Many of
them are very fine people. But I think that we have let the pressure for more bodies decide the issue. This new legislation they are creating now to reduce the workweek is a good idea, but it is sure going to put the press on to let more foreigners in. They are going to need more bodies to cover the hours. That’s not good. You see that in the orals, sometimes. A fellow can answer all the questions; he can read every page in the textbook to you from memory. But when you ask him a question that involves a moral or ethical issue, he doesn’t have any idea what to say. That was not something that had entered into his thinking. I know of a few residents who I’ve worried about who have done some really poor things in practice. We should have seen that when they were residents. They didn’t have those ethical and moral values instilled into them for a long time. It isn’t any particular country. Some students from the Middle East, India, and places like that are very fine, moral people. But we don’t have the same skill at judging them as we do the people who were raised in the same environment we were. We’re not as good at it.

DR. STRAIN: Well, Bill, you’ve seen pediatrics over a period of 50 years. What are the major changes you’ve seen in pediatrics over the years?

DR. DAESCHNER: We’ve gone from a more specific, disease-oriented activity to becoming more counselors and supporters of families. I like that. People have moved away from the central family, where now they live all over the United States. It used to be that most people had a few relatives in town or a few close, longtime friends they could relate to. Now they’re all living far away from anybody they feel close to or for whom they have moral respect. The pediatrician has had to play a bigger role in doing that. I don’t know whether they do or not. I know many of them undoubtedly do. I’m sure that you do. I’m sure [A.] Lane Mitchell did, and I can think of dozens of others I’ve known personally who did that. I hope most of them give that kind of support to families. Because they don’t know—a young woman and a young man who hardly knew how babies were made get married and have a baby right off. It’s kind of a weird animal in the house. If they’re mature, basically they adapt to it. But a lot of them don’t, so then they’re divorcing and now she’s a single mother. So, she farms her baby out to a domestic of some sort and she goes to work to earn a living. That, to me, is not a healthy way for us to build the next generation of people.

I guess your next question will need to be shorter because we only have 10 minutes left!

DR. STRAIN: Well, I’m wondering about that! There are 2 questions I’d like to ask. Would you recommend pediatrics to someone who came to you for advice? A son or a friend—what would you tell them about pediatrics?

[Recording interruption]
DR. STRAIN: You were telling me what you would tell somebody that has a career choice…

DR. DAESCHNER: Well I would tell them that they’re not looking for a soft easy future. That it’s hard work. That you have to put in a lot of hours. That you don’t make an awful lot of money for the hours you put in, compared to some of your colleagues. On the other hand, you do make enough money to live well. So, if you don’t compare too much and just look at the quality of your life, the income is okay. The additional factor is the richness of seeing children who you’ve had a hand in nurturing grow up, do well, and make you proud. You get pictures of them at college and at high school graduations and things like that. You get notes about how well so and so did and this, that, and the other thing. It just makes you feel like, ‘Gee I spent life doing something worthwhile.’

So, if you want to spend your life doing something worthwhile and you’re not fixed upon having yachts and things like that, you can be very happy in pediatrics. Children deserve a doctor who really likes doing what he’s doing. So, if you like doing it, good. On the other hand, if you don’t like what you’re doing, or if you are resentful that the guy in class who was not as smart as you is now making twice what you do, then don’t go into pediatrics. Because you’re going to resent your patients. If you resent them you are not going to treat them right. That’s what I’ve been telling residents for years and years and years (only I spent about 30 minutes each time doing it). [Laughs]. That’s what I told my granddaughter who was planning to go in pediatrics. I really think it’s a wonderful, wonderful world and I am deeply indebted to George Salmon, who started me along this path.

DR. STRAIN: You’ve received a lot of awards through your lifetime. What would you consider the most prestigious award you’ve received?

DR. DAESCHNER: Well, I don’t know, the word prestige always bothers me. But the one that I feel the warmest about is the one that I got just last year. The state pediatrics society [Texas Pediatric Society, the Texas Chapter of the American Academy of Pediatrics] created a new award, which was the highest award to be given by that society. They named it the Daeschner Award [The Charles W. Daeschner Jr., MD Lifetime Achievement Award]. I’ve never had anything like that. [Laughs]

DR. STRAIN: Very good. That was the Texas state chapter?

DR. DAESCHNER: Yes. [L.] Leighton Hill got it the first time. He was one of my first fellows and one of my trainees. Another trainee, Larry [Laurence N.] Nickey is getting it this year. I really feel good about that because the
way in which they defined the award—there’s a paragraph—including things that makes you put aside your modesty entirely and enjoy. [Laughs]

DR. STRAIN: Okay, one last question. You’ve served on a number of non-medical boards in your lifetime. Your church, the Galveston Planning Commission, Ronald McDonald House, Grand Ole Opry Advisory Board, United Way of Galveston. What role does that kind of civic activity play in your life?

DR. DAESCHNER: Well for me it’s a great pleasure. But also, I think it is part of the image you create for your trainees. For the last 20 years, I guess, almost half of the officers in the Texas Pediatric Society have been my former trainees. That’s not by chance. It’s because I used to put them all in the back of an old car and drive them to the meetings. Every year we put in as many as we could, and sometimes we would borrow a car and a bunch of us would go. I’ve done that all through the years because I believe they need to see that they have a responsibility for supporting the organization that supports the quality behind our operation. That’s the state pediatric society and the Academy and the other organizations. I think church is an essential part of anybody’s life. I don’t want to say that somebody should go to my church or this, that, or the other. But I do feel that my role in the church—I’ve been an officer in the church as long as I can remember and I’m still treasurer—is an important example of what a good doctor should be doing. He should be active in his community. He should be making contributions just beyond his own welfare.

DR. STRAIN: It’s now 4:00 PM and we have to conclude. This concludes the interview with Dr. Daeschner.

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