

Oral Memoirs
of
Robert W. Block, MD

An Interview
Conducted by
Clinton M. Thompson
February 11, 2016

Development of the Tulsa Medical College:
An Oral History Project

Schusterman Library, University of Oklahoma – Tulsa
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Interviewer: Clinton M. Thompson

Videographer: Alyssa Peterson

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The Development of the Tulsa Medical College Project was conducted by the Schusterman Library at the University of Oklahoma-Tulsa from January 2016 to June 2018. The project focused on the development of the Tulsa Medical College, which later became the OU-TU School of Community Medicine. The project consisted of 28 interviews with former and current employees of the University of Oklahoma-Tulsa.

Robert W. Block served as the Vice Chair, and later the Chair of the Department of Pediatrics.

Clinton M. Thompson was the first Director of the Tulsa Medical College Library and went on to become the Director of the Robert M. Bird Health Sciences Library at the University of Oklahoma Health Sciences Center.

Alyssa Peterson was a Medical Librarian at the Schusterman Library.

Marianne Myers was a Graduate Assistant at the Schusterman Library.

Hope Harder was a Library Tech at the Schusterman Library.

Robert W. Block, MD
Oral History Memoir
Interview Number 1

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February 11, 2016
Tulsa, Oklahoma

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THOMPSON: This is February 11, 2016. Would you like to introduce yourself?

BLOCK: I'd be happy to. I'm Dr. Robert Block—I go by Bob—and you'll learn all about me as this goes forward.

THOMPSON: Let's talk about your education first. Start at either high school or college, wherever you want to start and go to the end.

BLOCK: I'll do it. Actually I like to start at pre-school, only because my pre-school teacher was my mom, so I had a good foundation. I went to college at Wesleyan University in Middletown, Connecticut. Small college that at that time was an all men's school, surrounded by all women's schools. It was probably good for me that it was all men during the week because there were fewer distractions. I went from there to the University of South Dakota, School of Medicine in Vermillion, South Dakota. A little known school; it was only a two-year school, now a four-year school. The reason that happened is another story, for perhaps another day. It was a very good education because there were forty people in my class, much like the class here in Tulsa. So we got to know the professors very well, we got to know each other very well. The class cohesed [ed. note: non-existent verb form of cohesion] nicely. And I was recruited, actually from there—at the end of the second year medical schools from around the country would come looking for students to replace the ones who had failed in their first two years. And I wanted to go back to the East Coast because I was born and raised in the Midwest. Went back to the east coast at the University of Pennsylvania and received my MD degree two years later from there, and stayed in Philadelphia then for pediatric residency. We were at that point just moved from an internship base(??) to three years of residency. So, I did all three years of residency at the children's hospital in Philadelphia.

THOMPSON: And that was the end of your education?

BLOCK: That was the end of my education. There were no fellowships after that.

THOMPSON: All right. You want to do your career? And then we'll come back and talk about Tulsa extensively, but just do the whole career.

BLOCK: Okay. Well, it was a short career before Tulsa. I remember writing a letter to a fellow by the name of Dr. Daniel Plunket, who was a colonel in the U.S. Army and was a consultant to the Surgeon General for pediatrics. And normally that person is located at the Pentagon, but Dan was in Denver at Fitzsimons Army Medical Center. And so I wrote him this letter that essentially said, you know, I'm finishing residency at this esteemed program and I'm just better than sliced bread and I'd really like to come work at your institution. And we didn't know each other, so he wrote me back and said, well, we usually reserve places at our teaching hospitals for those who have done their education in the military system, so I suggest you look elsewhere. But he did give me a suggestion that I talk to one of the people at the Pentagon. And we were in Philadelphia at the time, so it was easy to go talk with them. And they said, you know, would you like to go back to the Midwest, somewhere close to family because my wife's family lives in South Dakota and mine was still in Iowa. I said, yeah, that would be good. And so he gave me two choices, one at Fort Leavenworth, Kansas, and the other at Fort Riley, Kansas. We picked Fort Leavenworth mainly because of location, not knowing that it was a smart choice because Fort Riley was this huge post, it was a troop post, and it turned out there were a lot of young families there with young children and lots of problems. Fort Leavenworth on the other hand was a post that was all officers, and all the officers were there either because that was their duty post or because they were going to the Command and General Staff College where they learned how to be generals and a lot of them were coming back—this was in 1972, so Vietnam was winding down. Most of these people had been in Vietnam for two or three tours, there were lots of stories to tell about that. But I had a two-year commitment because I had the Berry Plan at the time, which allowed you to finish your residency rather than being drafted and then you would commit to two years of service after that. And I had such a good time that I eventually stayed for a third year.

The story behind that is, about six months into my tour at Fort Leavenworth, I was a pediatrician, one of three. We had a great practice; it was like a suburban practice. All the moms had master's degrees and were involved in some business or profession of their own, very well educated, small community, an excellent hospital. It was a primary care hospital, so if a kid got really sick, Kansas City was about thirty minutes away, so it was easy for us to transfer. But about six months into my tour, I got word that one of our consultants was coming through and this was a consultant in hematology and oncology; and he would come to the post hospitals about once or twice a year to see if he or she could be of any value to us and talking about patients that were ill. So, lo and behold the hematology/oncology colonel who was coming was Daniel Plunket. So, I got my uniform all spiffed up and made sure everything was okay and went out to the airport to greet him and hoped he had forgotten about my letter. So, the airplane lands, it was a small army

plane, and out comes this guy in a rumpled uniform, his insignia aren't in the right place, he didn't have his hat on, I didn't know what—do you salute in this situation or—he's looking sort of casual. So, I saluted and he just came over and shook my hand. There's a long story to follow that, but we became very good friends very quickly during that stay and then beyond. And I thought I was going to go into practice when I was finishing my military career. So, I stayed that third year, and one day I get a call from Dr. Plunket and he tried for about twenty minutes to convince me that I should stay in the Army. I was chief of the clinics then, as well as chief of pediatrics—small post—I was enjoying the administrative part, the clinic part was great. And he said you should continue to do that. And I said, well, you know, I don't know, you're retiring from the military and I'm just not sure what's ahead for pediatrics or the military, army medicine. So, I'm sort of looking for a practice, and after saying about three times or four times to me, are you sure, are you sure? I said, yes, sir I am definitely sure. He said, well then, Bob, what would you think about coming to Tulsa and working for me? It took me about a second and half, which was a deep breath, to say yes. So, we changed our plans completely and that led to my coming here because he had just been selected to be the first chair at the Department of Pediatrics.

THOMPSON: So, you were his first hire?

BLOCK: I was his first hire. So, my whole career before Tulsa was just those three years in the army following residency.

THOMPSON: And you stayed here?

BLOCK: It's the only job I've ever had.

THOMPSON: All right.

BLOCK: It may be that no one else wanted me.

THOMPSON: I don't think, sir, I don't think that.

BLOCK: So, I have to tell you about my interview here. So, Dan invited me for an interview. He said we need to meet the Dean, and he needs to talk with you. So, the Dean, Martin Fitzpatrick, was to interview me, and Dan said—we came to town, we stayed here at a hotel—and he called me and said we're going to do the interview at my home. And I said, oh, okay. So, my wife and I drove over to his home, and my wife spent the evening with Mrs. Plunket learning about Petty's Grocery Store. And Barri Plunket was pretty much a down-to-earth lady, and she was amazed by the fact that when you went to Petty's at Utica Square to buy groceries, you had to get dressed up, and she said women even wear white gloves. So, it turns out that when we went back to Fort

Leavenworth after accepting the job that our friends there, as we were leaving, gave Sharon a pair of white gloves with blue denim cuffs that went up to her elbow just to wear at the grocery store. But I had my interview in Dr. Plunket's living room; Dr. Fitzpatrick was sitting in a comfortable chair with a short sleeve sports shirt, tennis shorts, and shoes with no socks. And we just chatted about what was going to be developed here in Tulsa and that was it. So, it was a very informal setting and I thought that was pretty cool, so that led to coming here.

THOMPSON: What do you remember about those early days in the Department of Pediatrics?

BLOCK: Well, the earliest days there were only two of us. I wrote a letter to my dad who is a pediatrician who was practicing at the time, just finishing up his practice, and I wrote a letter to him, I said hey dad guess what, I've got this great job, I'm the vice chairman of the Department of Pediatrics at this new medical school. I didn't tell him I was also the only other faculty person in addition to the chair and that I was sort of the chief resident and intern and everything all at the same time. Although we did have a small residency program that we inherited when we got here. So, the earliest memories are—we had to develop some bases for teaching program. We had the hospitals and at that time we had residents in all of the three hospitals—St. John, Hillcrest, and St. Francis. So, the residency was really dispersed. We didn't have an outpatient site, so we developed a relationship with what was then the Moton Health Center, now the Morton Health Center in Tulsa. They had a pediatric department, but no physicians. They had a wonderful, wonderful nurse who was famous for not taking grief from anybody, including patients and doctors working with her. And we developed a great relationship; about three days a week we'd have a clinic there and a couple of days a week we'd have clinics at one of the city-county health departments, and that's where we took our residents and eventually the students would come there as well as the wards and that's where they got their outpatient treatment.

That went on for about a year before Mike Lapolla and I got together. Mike was, his role then was developing clinics. He'd already developed the family practice clinic and had been involved in that. So, he and I got together and we designed a pediatric clinic, which was located on 21st Street, kitty-corner to St. John Hospital where there is a restaurant and bar now. So, I had, actually I had, my very first office here was in the Ranch Acres Medical—Office Complex, it wasn't just medical, Office Complex. So, I had that office as an administrative office and a clinical office in the new pediatric clinic. We called it TAPC, it stood for Tulsa Ambulatory Pediatric Center and it combined the outpatient clinics for Hillcrest and St. John. At that time, St. Francis did not have an outpatient clinic, but they did participate though TMEF in supporting our clinic there. And that went on pretty much unchanged for quite a while. We gradually added a couple of faculty so that we had another faculty person working more continuously at, again then Moton Health Center. And our residents sometime would work there, but mostly would come work in the clinic. That pattern, although the geography has changed several times since, but that pattern of having a freestanding pediatric clinic was the order of the day until we moved to this

campus [the Schusterman Center Campus]. Then the pediatric clinic became part of the overall clinic.

But in the early days it was a matter of adding a few faculty. The most important part to me was that we had tremendous support from the practicing pediatric community. Without them this would not have been a success because we couldn't be three or four places at one time with two people, and the pediatricians in town took turns doing attending duties at the hospitals and they'd round with the residents and we would alternate with them. So, both Dr. Plunket and I would be making rounds in the rotation, but the practicing pediatricians would give up two weeks of morning maybe twice a year each one of them and spend that time with the residents in the hospitals. And we maintained our three hospitals that way. The pediatricians in town were also really, really generous in allowing residents to come spend time in their offices, and students as well, but primarily residents. And what they got in return for that was some of the residents became interested in joining their practices. So, back in those days, all the pediatricians in town were the ones who had been here or recruiting into their practices as opposed to today, I don't know what the percent is, but I bet it's 75 or 80 percent of pediatricians in town are people we trained over the years. A few have been imported from other places and many of our residents went elsewhere, but many of them stayed and make up the bulk of the pediatricians now. So back then, the biggest change was when we just couldn't recruit and didn't think it was ethical to recruit the number of residents it would take to cover all three hospitals. So, we went to TMEF, and we said, well, we're going to have to make this a smaller program. And TMEF and none of the hospitals wanted to relinquish their residents, so they came up with a plan where every three months we'd be in two of the three hospitals and then we'd change. So, for three months we'd be at Hillcrest and St. John, next three months we'd be at St. John and St. Francis, next three months we'd be at St. Francis and Hillcrest, and we'd rotate round. And that just, it didn't work at all, but we managed to keep it together for about a year and we finally said, you know, the only way to deal with this is to reduce the program to one hospital. And it was pretty obvious at that time that that hospital was going to be St. Francis.

THOMPSON: So, you ended up just at St. Francis then?

BLOCK: Yeah, so the program moved just to St. Francis. We did consults—Dan was a hematologist/oncologist and I was an evolving—without the benefit of fellowship—a developmental behavioral pediatrician. Also, we sort of framed me as a diagnostician, so I occasionally would get consults from the local pediatricians for a problematic case, and it was great fun because I was young enough then I still remembered what I was trained and what I had learned. I could come in—I remember the very first case was actually a child that was at the Doctors' Hospital and one of the pediatricians in town, one of the older pediatricians, had a child there, he was admitted to that hospital as well, and had a child who had what [was] called a fever of unknown origin. He just had a fever and no one could figure out what was wrong with him.

He'd been in the hospital for a couple of days and they couldn't find a cause, so they asked me if I'd look at him. I thought okay, this is sort of fun, I'll see what I can figure out. Well, when I was a resident, one of the older pediatricians at the children's hospital taught me that one of the places that infections hide are in teeth, when you get tooth abscesses. And the way you can find that without—back in those days we didn't have fancy x-rays—is a trick that he taught me, you put a tongue depressor on the tooth and then tap on it with your reflex hammer. If there's an infection there, the kid is going to jump out of the bed because it really creates a sensation. So, I did my routine physical, didn't find anything else, took out my tongue blade and tapped on it and lo and behold the kid jumped out of bed, almost literally into my arms. I apologize profusely to him and to his parents, but now I know what's wrong and we were able to get him some treatment. I felt that was sort of a neat introduction to the community—pure luck that I'd even learned that little trick and remembered to think of it. But I'm telling that because it sort of emphasizes how we were scattered around the community and then eventually made that shift to stay at St. Francis.

THOMPSON: Faculty that you remember in the department that stand out to you in those early years?

BLOCK: We had some really interesting faculty, all of them were—many of them have moved on—but all of them were superb in their own area. There was a fellow by the name of Tom Charbonnel, who Dan also had known from the military that we recruited to do some of the Morton Health Center work, along with a young man from Australia, Damian Marsden. Damian was married to a young lady he met in California, by the name of Susie. I have to tell you this story. Damian and Susie, along with the rest of us, the small faculty, one evening went to a party at Steve and Ellen Adelson's house. And Steve was one of the senior pediatricians, even at that time in Tulsa, headed up the group that is now Utica Park Clinic, but it was a private group. Very nice guy and very giving to the medical school and to our department, so they decided to have sort of a cocktail party. Well, Steve and Ellen lived in a beautiful, beautiful home in Midtown. Ellen's parents were part of the wealthy Tulsa oil families. Not the one's with foundations now that you hear about every day, but they had done very well. Ellen, I think, was either an only child, or one of only a couple kids. So, Steve and Ellen lived in this elegant, elegant house, and it just so happened that Sharon and I arrived at the same time that Damian and Susie did. And we parked our cars together and we were walking up to this house and Susie's eyes just got real big. Ellen opened the door, and we walked in the home and it was a very classical black and white tiled entry hallway—it was as big as my house, just the entryway—and Susie's eyes got even bigger and she said, "Oh, Damian, someday we'll be able to live like this." And I said no, Susie, this isn't the pediatric house, this is the oil house.

But Steve was a great example of faculty who helped us. Damian was a great asset. Tom Charbonnel was an asset. And then we began to collect other folks. Tim Miller was our faulty

member who came to do adolescent medicine for us; he was trained in adolescent medicine. Unfortunately, he had also done an outside of medicine type fellowship in healthcare business and management and two or three of the people he met in that group and Tim developed their own company. And at the time it was when hospitals were beginning to sell to conglomerates, so they formed their own conglomerate and Tim left us to run the conglomerate because they were buying hospitals all across the country. I don't know what happened to him, but I suspect he's fabulously wealthy because they bought these hospitals at rock bottom prices and right after that along came the HCAs and the big companies and bought the hospitals from them at a hugely escalated price. So, that was one of them. Tom Riley was a pediatric neurologist who came. Tom was really funny. One day I had some neurologic problems—I had some anesthesia in my facial muscles, I couldn't quite feel some things and there was another—I don't even remember what the complaint was. So I said, "Tom take a look at me, see what you think is going on." And so he did, and he looked at me, and he said, "Bob, I think you might have multiple sclerosis." Well, that sort of took the wind out of my sails for a little while. Well, about twenty years later Tom had left and he came back for sort of a reunion party at Dr. Plunket's house and he took me aside and said I owe you an apology. And I said, "First let me tell you I don't have multiple sclerosis." And he said, "I know, I know. I never should [have] said that." He said, "I went home and I agonized over having done that." And I said, "Well, you know, it did make me think about what might be possibly going on." He was very embarrassed about that, but he was a great neurologist and he knew all these strange connections and he helped us out a lot with children who had unusual neurological problems. So, he's one of the persons I remember. I remember Gwen Gibson who was a resident with us. Gwen was, I believe, the first African American resident that we had. And Gwen I remember particularly because when she finished her residency, I was at that time doing a lot of child abuse work, which is another story, but I talked her into staying with me and letting me continue to train her in child abuse work and then she for several years stayed with me as we developed the Justice Center and had our own child abuse program. She's still in the community, she went into private practice, actually joined Dr. Adelson's practice initially as he was retiring and recruiting new people, and then went out a little bit on her own, and I think now she's working in minor emergency at urgent care centers. So, there's a few of the faculty.

THOMPSON: Do you remember any of the students that stand out in your mind?

BLOCK: Well, there have been a surprising number, but one or two, but they're recent. Tom Trion was one. Tom is now the head of ambulatory clinics for Children's Mercy Hospital in Kansas City. And Tom is very active with the American Academy of Pediatrics and wanted—we just went through nationally, we went through a CEO change. Dr. Errol Alden, another army person, retired after many, many years with the academy and there were four finalists for the CEO position and Tom was one of those. Eventually [Tom] did not get that, but he and I spent a lot of time talking about that and talking about the Academy. But the other part of that story is

his daughter—about three years ago now, graduated from here as a medical student and went to the University of South Dakota for residency. So, things just sort of came around in a circle. So, I remember Tom really well, as well as Gwen as a student. I have to tell you that I don't remember a student I didn't like. Now one of the students I had was David Nierenberg. Dr. David Nierenberg is now my internist, although I didn't know him from pediatrics, but he was a student here. You know all the students regardless of where they ended up had to rotate through pediatrics. David knew I think at the time that he was going to be an internist, but we taught him well. He's an excellent internist. He was offered a job at one of the hospitals to move up as a semi-administrative job, but he said no, he wanted to stay in clinical medicine. And I've run into, for one medical reason or another over the years, several of the people that were either students or residents here.

THOMPSON: Any residents that stand out in your mind?

BLOCK: Well, Gwen is certainly one. And any of the residents, many of them, _____ (??) Bowling, who is an instrumental faculty person on our faculty now was one of our residents. One of our hospitalists was a former resident. So, we try and keep, whenever there's a job opening, if we have a resident who wants to do that we try to incorporate them. So, we had some family faculty that came out of the residency. Again, I don't, we had one resident, I won't talk about that, but we only had one resident in all the years that I can remember that was not appropriate in his approach to medicine. He did graduate from the program, we had many counseling sessions, he did okay, went to a small town here in Oklahoma and did not only pediatrics, which is strange now for a pediatrician, but he did—what do you call it when you're working with—workman's comp, he did a lot of workman's comp. Matter of fact, he even set up a separate area of his office for an emergency room and sort of an adult medicine clinic, made a ton of money and at least for that period of time behaved himself. He subsequently did not and the story tails off from there. But I think that's the only instance with all the residents that we had that we had not a successful outcome.

THOMPSON: A story I remember about you all, and I don't know whether you'd make comments or not, was if I remember correctly you were the first department to take an osteopathic student in residency. Can you talk a little—at least as I remember it—that was a pretty hot topic at that time.

BLOCK: It was. You know when I came here we were still at the point when MD and DO were, even though better than the distant past, were still, was left over—you know, that the DOs were closer to chiropractors than MDs. And their training was very different, but it began to morph. And at one point actually, California I believe was the first state that offered all DOs an MD degree and the DOs rejected that because they're proud of their heritage and their profession, as well they should be. But we were pretty good friends, Stan Grogg was one of the great DOs in

the community at the time who was very active and we worked together quite a bit. So, over time as their training shifted a little bit and our ego became more centric it was time to take some osteopathic students into our residency. Ted Koltenbach(??) was the first and he did a superb job. He has been in practice in Tulsa, I'm not quite sure he still is, but he was an excellent pediatrician. And because of his success we then started raiding the OSU School of Osteopathic Medicine and took, as best we could, their top students in our residency. We had a bit of an advantage because many of them wanted to go on to pediatric subspecialties and in order to get a fellowship you had to have three years of ACGME [Accreditation Council for Graduate Medical Education] accredited pediatric training. So, they couldn't do that because the DO residency was two years and it wasn't ACGME accredited. So, a lot of them that wanted the subspecialty would come and do residency with us, or some in other MD programs. The country eventually morphed into almost all programs that contained DOs were MD/DO combined programs and they had faculty from both. And the DOs had their little special that they wanted, it was usually an elective by this time, for manipulation and that kind of thing. And I probably shouldn't say this on tape because I'm not quite sure, but I think there's only four osteopathic pediatric programs in the country that are separate. And ours—OSU's is one of those. And because of the success with Ted and the people who followed him, we now have had probably in the last several years an equal number of DOs and MD students come into the residency and everybody performs equally. That's no longer the issue it used to be.

THOMPSON: Other questions about students and residents in those early days. To get the students, you had to get them out of Oklahoma City and, of course, you were recruiting residents, you already discussed that a little bit. Can you talk a little bit about encouraging the students from Oklahoma City to come here and where you obtained the majority of your resident candidates?

BLOCK: Sure. The student recruitment was interesting because Oklahoma City acknowledged that we were here, they weren't entirely supportive and we know for a fact that students were counseled not to come to Tulsa, that they should stay on the traditional track and get involved in research and end up being super-subspecialists someday. But there was always a contingent of students who wanted to be primary care, especially, or use that as a base for a subspecialty career. They liked the idea of being in a small class. Some years we were more successful than others in finding them and letting them know that their education here would be equal to Oklahoma City, different, but equal. And actually our best recruiters were the Tulsa students who would tell the Oklahoma City students, hey, you know, I came to Tulsa, I'm having a great time, it's a lot of fun, I'm learning. So, most of the students in the early and middle years who came here didn't come because we went down and did a great job recruiting. They came because of the students who were here. So, we spent a lot of time I think, talking with the students here about what made them, what made up their mind to come here, how could we do that with the current students. The other thing we did, is we went to every week to the pods that they have all

the pods that they have all the students in Oklahoma City—they call them something else I don't remember what they're called—but they're groups, smaller groups of students that now are used here—

THOMPSON: Modules.

BLOCK: Huh?

THOMPSON: Modules.

BLOCK: Yeah, yeah. Modules. And the modules would do problem based learning together and that kind of thing. But we would go over and work—each one of us became a faculty member for one of the modules. So, I remember Dan Duffy and Dan Plunket and I went over, went of the family practice docs went over, and we'd all pile in a car and drive over there for the afternoon and spend the afternoon with our modules and come back. That helped us a lot because the students got to see us. Of course, students in my module would talk to the students in Dr. Plunket's module and find out that maybe Tulsa's okay. That was a lot of fun, except for the one day we were all coming back and Dan Plunket was driving and he gets pulled over for speeding. So, we had a discussion in the car about whether we should all split up the fine in equal portions or just leave it with Dan, and we voted to leave it with Dan. But we had a lot of fun and that was good faculty bonding time because you're in a car for two hours. When we first started doing that the speed limit on I-44 was fifty-five miles an hour, so it took a while to get to Oklahoma City. We tried to talk the dean, and I don't remember which dean it was then, we tried to talk him into getting a limousine, under the guise that we could all drive in this limousine, we could black out the windows, and we could all do work. Way before cell phones, way before computers, so we thought we'd have little lap desks and we could all do work, about four or five hours of work that the faculty could get done. He didn't buy it. But we planned to have a little bar underneath the desk. (laughs) But I think that helped us a lot with recruiting from Oklahoma City. It's still difficult but I think the biggest change, obviously, is the fact that students can now come here right from the beginning and do four years here and pick a track that makes some sense. The scholarships that the Kaiser Foundation helped us with, starting a few years ago, also was helpful in bringing students here. It's word of mouth I think more than anything else, and the student has to make up their mind. Oklahoma City, of course, has grown immensely since those days and it's a huge traditional medical center now, and I think an excellent one. A great choice for a medical student, but I think this is an alternative choice, and Gerry Clancy and Dan Duffy and others among us developed it as a community medical school, something I'm a little worried about sustaining. But as we did that, students who are interested in that are the ones who came here and so they came with interest and that helped us a lot.

THOMPSON: The resident portion of it? Were most of them out of the students here? You've already talked about using OSU as a place. Did you recruit other places?

BLOCK: We did recruit from other places, but in the early years it was very, very difficult. Now there's about a hundred percent match in pediatrics, so that helps the school and the program. Back then the match was about 75 to 80 percent and the rest of the slots went unfilled. And we quite often did not fill. We had a fair number of international, then called foreign medical graduates, almost all of who did very, very well. There were one or two who maybe had been doing something else between their formal medical school training and getting here for residency because they had to go through immigrant status and in India they had to work in the UK for a year before they could come over here from India. But some of our better residents, many of whom, well, some of whom stayed here as faculty came from the foreign medical graduate pool. It was very difficult to get students to come, even if they were interviewing in Oklahoma City, to come over here, spend an extra half-day and come interview with us. Over the years it gradually improved, and I think the fact that there are more students, for reasons I'm delighted with but can't explain, wanting to do primary care and pediatrics than there are residency positions, so we're filling easier—more easily than before. But it was hard in the early days, and the residents, when they were working with less than a full class; they really loaded up the schedule for them and had to work hard. And they did, they were very successful, having residents do well. We did have some struggle with the educational, academic part. We had some residents, not necessarily just the foreign graduates, but we had residents who had difficulty with their board exam. So we, over the years, developed more formal approaches to academic afternoons and resident education where we sat them down and said this is a book. Today I guess it's a computer, but.

And I think one of the reasons, quite frankly—this is a back in the day story. Back in the day when we would make rounds at the children's hospital, we had an attending by the name of Dr. Frank Ostey. Frank went on to be chair of Johns Hopkins, but Frank was—he was brilliant. He would make rounds with us, and every day on purpose he would tell us one thing that was wrong. And it was always something that wouldn't jeopardize a patient's healthcare if you acted on what he said. It usually a diagnostic thing or a test or something, and he didn't tell us what he had said that was wrong. So, our job was by the next morning we had to be able to tell him what he said that was wrong. Well as a librarian, you will appreciate the fact that we went to the hospital library and we spent hours in there because everything was in the bound journals in the stacks. We were roaming through the stacks in the middle of the night and looking up things that didn't sound quite right or didn't match up. And there were usually three or four different a-ha moments and we'd present those to Frank, he'd say no, what I told you about that was right, you don't have the right answer and then we'd finally come up with the right answer for him. And that was sort of neat because it was fun and it forced us to go look up things, and back in those days what you were held accountable for was if you found an article that proved your point you had to also find the references in that article that were around that point and read those as well. I

think the ready access to information now on your phone, even during rounds, has made—residents don't need to know as much. You know, some days we're going to have Watson, right? They won't need to know anything, they can come out of first grade and be a doctor and just ask Watson their questions. That perhaps is overstated because there are clinical skills, but I think that residents don't learn the same way now as they learned before. On the other hand, there is so much more to learn and eventually we may talk about—when we talk about medical education I have some thoughts about that time and this side as well.

THOMPSON: I wanted—before I forget to do it because I'm making notes of questions to ask you—but because we can't interview him and he was always a special person to me, are there any things you want to say about Dr. Plunket?

BLOCK: You got like two or three hours?

THOMPSON: Well, I understand that. But I think it's important. You're the closest, you know, to reflecting who he was and what he meant to the school and what kind of a gentleman he really was. So I'll ask you that question now before I forget.

BLOCK: Dan was a special person. His approach to pediatrics, to medicine in general was informal. He was very open and collegial, not only with faculty and residents and students, but with patients as well. He was extraordinarily caring. I think a lot of our residents, as well as some of our early faculty like me, learned a lot about how to conduct yourself as a pediatrician from Dan. He was very, very smart. You wouldn't know that because he didn't talk about it a lot. You just watched him and you knew he was very bright. And he actually became a doctor very early, so when he got here after thirty years in the army, he was still relatively young because he started with his training in the army and then had all those years. He taught—well first of all he was one of the best general pediatricians of any pediatric specialist that I've ever known. That proved over the years when we switched jobs, instead of me working for Dan, Dan was working for me, when I was chair and he came back on the faculty. He was one of the best teachers in the clinic. He knew how to ask all the right questions and it wasn't just about hematology or oncology, he had a wide array of knowledge areas. He was a very kind guy. He was very supportive, and he and I got to be very, very close, as I did with Barri. As a matter of fact, I painted his swimming pool one summer, and in return for that I got to [go] swimming in the pool with my two young daughters any time I wanted to. But Dan was thoughtful, he was extraordinarily kind, and I really learned a lot from him about bedside manner. You know, he was telling people horrible diagnoses, and back in that day a lot of children who would survive their disease today would die at that point in time. Including the son of one of the people you and I know well. He was actually one of the first patients with leukemia that I took care of alongside Dan—Dan did all the work I just hung in there. He's now alive and well and doing great. But that was a tough time in

pediatric oncology, still is, but now children are surviving with a 95 percent success rate diseases that would have been the end many years ago.

Dan was very approachable. He got called at home all the time. I remember when he went on sabbatical. Guess who the only pediatric hematology oncologist was in Tulsa? It was him, he was gone. So as he left, his parting words were, “Bob, you’re now the hematology oncologist.” Really? And I was. And I did that work. I got a lot of support from Oklahoma City, and there were patients we referred there. But, you know, patients with serious illnesses don’t want to stray far from home unless they have to, so we did a lot of telephone work and I have to hand it to the hematology people in Oklahoma City, they really did support me. But I’ll give you an example of what I learned from Dan. I saw a young boy at St. John’s who had pain in his shoulder and they took an x-ray and told him that he had a muscle strain; and the pain was progressing and one of the—I think the primary care docs saw him first and said, you know, I just think we need to get a couple other people to take a look at him. So he called me, we were friends and he just said, I know you’re not an oncologist, but I think there’s something going on here. Well, long story short, he was right, there was. I took a look at the x-ray and what they had not found was a big hole in the scapula, which was an osteosarcoma, which was in those days a fatal type of cancer. He received treatment for maybe three or four years. He came from an African American family, lived up in North Tulsa, his daddy worked for American Airlines; his mom worked in the early childhood programs in Tulsa after graduating from being a house cleaner in her earlier days. Delightful, delightful family. They had about a million kids. And he was, he may have been the oldest, I’m not 100 percent sure of that. And we became very close as a family because I was emulating what Dan Plunket taught me, which is—we became friends. I have a wonderful picture that I prize. Petey and his mom were visiting my wife and I at our house. And they came over and our invitation said, come on over we’ll have milk and cookies and have a nice evening. He was doing pretty well at the time. And so I was sitting in the chair like this on our back porch and he came walking by and he was a big kid, about twelve, and I grabbed him and put him on my lap and Sharon knew I was going to do that and took a picture. So here I’ve got him on my lap and he’s going like this. So I tell that as a way of saying that’s what Dan taught me is to have interpersonal relationships. It’s not just oh, I don’t want to get involved because it’s too hard. He eventually had metastases and we knew he was going to die. We made arrangements with his family for him to die at home, which was not done very often back then. I called a medical examiner and told him what the plan was because otherwise there would be a police investigation. One evening his mom called me and said I think this is going to be his last night, so I went over there; she was right. Dan was back by that time and had seen him and met with them with his usual Plunket magic in terms of relationships. Nothing could be done for the disease. But I remember when we went to that funeral; it was very hard for me. Dan was very comforting for me as well as for the family. And that is sort of my way of putting a lot of things about Dan Plunket into perspective.

He was a super teacher; students loved him. He was funny. He would take me with him to American Academy of Pediatrics national meetings, literally with him because we were too cheap to get two rooms, so we'd stay in the same room. Let me tell you, he snored. But he made a point—Dan knew everybody because when he was at Fitzsimons he made a point of inviting all the famous pediatricians from around the county to come down grand rounds and spend a day or two at Fitzsimons. Took great pride in knowing all these people. So, during the time I was with him and we would go to these meetings, he knew every president of the American Academy of Pediatrics and he would make a point of introducing me to that person and other influential persons. Which, a very interesting end point to that, which unfortunately Dan didn't get to live to see, which is a big regret that I have. Wonderful guy, I could talk about him all day.

THOMPSON: Very good. I knew that you would be the one to do that. I think he's very special. He probably served as the acting dean more than any other person on this campus, and I used to love it because I would ask him why he'd do it. And he said, well, because I know a lot when I go back to being chair of pediatrics.

BLOCK: You know the unfortunate thing for Dan was that he was in that acting dean position when we had the research issue that came up. And I remember he called me, and it happened to be, I was taking a couple days off because I have a friend who's a wood carver and he had agreed to come to Tulsa and teach a small class on wood carving—that's my hobby. So my friend and I were in this room doing some wood carving with other people and I got a call from Dan that said, Bob you ought to come meet me. Where we met was at McGill's restaurant, which is where our first clinic, TAPC, used to be. He said meet me over there, but you have to do it now. And dress up. So, here I was, I was in jeans and a t-shirt and wood chips all over the place. What the hell's going on? So, I went over and he told me what had happened—that that morning he came to work, the dean's door was locked and he was escorted out of the building. The dean was still here; Dan was like an associate dean or something at the time. And he was acting without any training or background or real solid information as the head of the Tulsa IRB [Institutional Review Board]. No one bothered to really teach him what an IRB is all about or what his responsibilities were or how people _____ (??) what a reporting area was. So, he told me what happened and that he was being asked to leave. And I said, well if you leave, I leave. He thought about that for a minute and said, absolutely not, I forbid it. So, then I remember we had an all school auditorium meeting that afternoon, and Dean Andrews came over and David Boren came over and they were up on the stage with me. I was supposed to be the glue that kept them together, got the Tulsa campus through this tragedy really. But Dan, Dan came back. And came back as a faculty member in pediatrics. And that's when he worked for me. I teased him about that. Never once I don't think did I get to tell him what to do. But the two happiest days of my life are when he came back from sabbatical to take over that job and when he came back on to the faculty after having the troubles with the administrative stuff.

THOMPSON: Anything else you want to say about the development of the pediatric clinic?

BLOCK: Well, you know, only it started out as a pretty traditional—it was a lot of fun, and I had the opportunity not only to teach the residents there, but also to see the patients there doing this developmental and behavioral stuff and that's how I got involved in the Tulsa community in two areas: one was teenage pregnancy. That was something I was involved with my wife. And also the learning disabilities and kids who had attention deficit problems. We didn't call it that then, but that's what it was. And I had taught to see those kids in the clinic, so we would go through the regular 8:00 to 5:00 day and then I would make private patient appointments from about 4:30 to 6:30 and see two or three kids. That was a really nice time.

The array of patients we saw back then was all the way from a whole lot of well babies and well children to some really sick kids with diseases that we don't have today because of the success of vaccinations, in spite of what the anti-vaxxers say. Even though we have that to contend with, the vaccines have been very, very successful. We always had one or two cases of H-flu, meningitis, in the hospital at any given time. It's gone. Every once and a while a case pops up in one of the anti-vax families who gets exposed to somebody who may have brought it over from overseas. That's what happened with measles recently. So, it was really a nice. We owned that clinic, we ran that clinic the way we wanted to. That was really fun for me. And when we moved from there to the Sheridan Campus it was the same thing. We were in a building with other clinics now, but each clinic belonged to the medical director and the chair and the administrator of the clinic. When we came here [the Schusterman Center Campus] we had to fit it into an entirely different system where we weren't in charge of the system of our own clinic.

And then of course along came the computers. The year we changed from paper charts to computers, our patient volume, because of how many we could or couldn't see, fell by 50 percent. Along with the 50 percent in patient volume goes 50 percent reduction in revenue. Those were difficult times. We sort of got into it a little bit better, and I remember Dan Plunket was the one, bless his heart, who when computers first hit the scene, he talked me into going with him to a computer programming class. We went somewhere, I don't even know where it was, and we learned how to program basic. That was so basic back then, it doesn't compare to anything now. The residents used to laugh at me—oh yeah, I can do basic. But Dan predicted that computers were going to be more and more a part of everything, including medicine, and we have to at least have some idea of how they work. And that was back in the time when shortly after that Mike Lapolla bought one of the first Apple computers, the Mac whatever they called it then. And we had these interesting conversations, and I thought well that's just sort of Mickey Mouse because you know, real computers you program them, pretend play computers you're just rubbing your finger on something. The move here, the move to computers, and now just as I was I guess really just observing from afar over the last three or four years, the overwhelming

dominance of administrative and financial incentives versus clinical medicine is a big concern that I have. Not just for here, eventually we're going to talk about that, for all of medicine. I was really lucky, my dad probably practiced pediatrics in the best of all times. Individual pediatricians that own their practicing group whatever they wanted, any way they wanted to do that. They saw patients in the hospital, in the office, they had subspecialty sometimes. We were in Cedar Rapids, and Iowa City was only twenty-five minutes away, so there were some specialists. That was a golden time. Patients paid. He made house calls. I grew up in his car because after supper in the evening he would make house calls, and I'd go with him so I could see him. Couldn't go in the homes, so when he was in the homes I would do my homework. And then he'd come out and we'd chat as we went to the next place after. I sort of came through the tarnished golden age. It was still really, really good. Now all the gold is gone as far as I'm concerned. I still encourage people to go into medicine, I think it's an honorable field, but you have to be very, very careful about why you're there, why you're choosing your subspecialty area, how's it going to work out financially for you, who's going to drive that train. And I worry that in all medical centers right now, the train is being driven by the guy that does the books, not by the faculty who teach medicine. So, we'll see where that is twenty years from now when somebody is watching this tape.

THOMPSON: That's the reason for the tape. Administrators that you remember in those early days?

BLOCK: I can't remember all the names. I've lost the name of our first dean who wasn't a doctor, well wasn't a medical doctor.

THOMPSON: Dr. Lewis.

BLOCK: Dr. Lewis. Yeah, the geographer.

THOMPSON: Right.

BLOCK: I really thought he was a very interesting guy and we got along really well. And I was pretty close to our first dean, Dr. Fitzpatrick, because there were only three or four of us—we could have faculty meetings in a phone booth. And I bet you Dan Duffy talked about this, but we used to have regular faculty meetings over at the old Harvard Club, which doesn't exist anymore. And we could get the entire faculty around a table for dinner. We'd have a meeting and then we'd have dinner. It was great. Everybody knew everybody. There weren't that many of us. Family practice probably had the biggest contingency. Internal medicine and pediatrics came next. Surgery had maybe two. Our most famous dinner by the way at the Harvard Club was that day instead of a faculty meeting we'd had a CPR class for the faculty. The Red Cross people came over and taught us CPR, including the newly discovered Heimlich Maneuver. This is a true

story. So, we all sort of joked around and practiced the Heimlich Maneuver. We're sitting around having dinner, all the sudden Dan Plunket, who had a habit of talking while he was eating, Dan Plunket stops talking and he goes and gets up just like we'd been taught that the person choking is going to be embarrassed and is going to leave, and [Dan] starts leaving the room. Silvie Alfonso, who was one of the family practice faculty, recognized immediately what he'd just been taught and went over to Dan, grabbed him, did the Heimlich, steak went flying across the room, saved his life. Which was brilliant. It was the same day—it was like two hours after we'd been taught that.

So, I remember Silvie because we had a poker group—Dr. Good, the family practice doctor; Leeland Alexander; Dr. Plunket; myself; oh shoot, I've forgotten the name, one of the other family practice docs. We got together about once a month to play poker. Well, the first time I showed up the group had—I was added to the group, they'd already had several poker nights. It was all in fun, but we played for a little bit of money. So, they told me well bring \$15, \$20 or something. So, my wife spent an evening cutting up pieces of newspaper the size of a dollar bill. And on the outside of that, we rolled them all up and I put a \$10 bill around that roll. I showed up and I reached into my pocket and I said, do you think this will be enough money? I never lived that down with the group. Did you bring your roll today? So, but those were good people and some died too soon.

And then you mentioned Dan Duffy. Dan and I worked very closely together. I remember we wrote a grant to put—have special training for internal medicine residents and pediatric residents, this was before med-peds. We wrote the grant on a word processor, and you don't know what that is [ed. note: directed to camera woman, Alyssa Peterson], but you do [ed. note: directed at interviewer, Marty Thompson]. But a word processor, we had this word processor and we just thought this was amazing that it could do this work. We wrote up the grant, which we received, and the deal was to put an internal medicine doctor and a pediatric doctor together in the community to sort of bring a—you know, a different level of expertise to both children and adults than they might have from a little country family practice doc, which my father-in-law was, so I say that with a certain reservation that we were a little bit too ego focused. We were never able to do that because med-peds came on board right after that, but we did bring in June Holmes as our educator. I believe Dan and June and I worked for quite a while on developing the curriculum. It still would have some value I think today if we could update it.

THOMPSON: You mentioned Dr. Good.

BLOCK: Roger was a great guy. I really liked him. He was one of our poker buddies, but he was also a great chair, I thought, in the Department of Family Medicine. Died way too soon. I remember I knew him, I knew his wife; I knew at least one of his kids pretty well. But Roger was very integrated with the other departments and wanted his family practice residents to learn as

much as they could about what our particular specialty was all about. And I think a lot of his residents went on and stayed in Oklahoma. He put a major focus on them to try and stay here in the state, and I think he was successful with that. He had a good sense of humor. He could be a little—I don't know what the right word is—forceful at times. Can't we all? But he was one of the people along with Silvie in other departments—and by the way, George Prothro worked with their department. And George was the head of the [Tulsa] City-County Health Department for a million years. And only died a couple years ago. And worked with the county medical society, and worked here at the school, and contributed a lot through the Department of Family Medicine and Internal Medicine, even though George was a pediatrician. Great guy, and a good example of the adjunct faculty that we had here over the years, who contributed a lot to the school and to the education of students and residents.

THOMPSON: Are there any other of the local, community physicians—you mentioned a couple—are there any others you want to mention?

BLOCK: Oh gosh, there are several. I mentioned Steve Adelson. One of the others that deserves mention is Bob Endres. Bob Endres is about to be ninety-three years old I think. He was the first person to take care of kids with diabetes in Tulsa County. He was not a trained endocrinologist. Matter of fact, he recruited one, Donnie Wilson, who came for several years to work with Bob. And then Donnie and Bob recruited Dr. Jelley. And Dave Jelley came, he was one of our students, was one of our residents, went away for fellowship and came back and joined Donny and Bob. Bob, then retired from his pediatric and diabetes practice, came as a volunteer to work with us in the clinic. He'd already been doing that, he'd come over one or two days a month and was a revered teacher. So, I hired him when, during the time I was chair. I said, come on and work for me full time, you can come in a little bit late, leave a little bit early. So, there went the teaching awards because they all went to Bob. (laughs) Super guy. I still see him from time to time and he's doing great. He recently had a stroke, but he's recovering pretty well. Although he did tell me, he said, "Bob, you know, you can't put on your damn pants if your left hand doesn't work." So, I tried that one day and he's absolutely right. But Bob has, he's a wonderful, wonderful guy. Every summer he'd go up for two or three weeks to a camp that his father actually had established up in Minnesota on a lake, it was diabetes camp. And students, like Dave Jelley when he was a student and a resident, would go up there, and others would as well and were the camp doctors for a week or two weeks. So, I think that Bob deserves a great deal of recognition. We have a lot of people in the retired community now that contributed to the program.

Some of the younger pediatricians, or the middle group of pediatricians now, particularly those who came through the program, there are too many to name, but they remain supportive to the school, but not in the old way. Because all the pediatricians, as well as the other docs that we talked about, selling their practices to the hospital group or to Utica Park or to whoever, the first

thing they were told at the end of every year was, you're postings are not as high as they're supposed to be, you're going to have to see more patients. You know, I notice that you give a half a day a month to teach at the medical school, you're going to have to cut that out because you can see twelve or fourteen patients during that half day and we need that revenue. Not do we need that patient care, we need that revenue. So, our modus operandi from having a lot of experienced pediatricians come into the clinic and share that knowledge with residents dissipated and we hired more general pediatricians of our own to work at the clinic. But that as well as that as the separation of the hospitals, which worked very well together under TMEF, Tulsa Medical Education Foundation, and with the school, sort of broke apart.

And I experienced that when I was chair, trying to organize grand rounds. Because grand rounds was, in the olden days, once a week, hugely attended because everybody came together from the different practices around the community, and that was a time we could chat out in the hall, have a cup of coffee before the lecture, a little bit of time after the lecture. Everybody came. And then the grand rounds, it really, really took a nosedive in terms of attendance, and is still at that lower level. We still have students, we still have residents, and there still are two or three of the retired pediatricians. Rick Cohen is one. He hasn't missed a grand rounds ever. Rick was recruited by us for residency. He had gone to medical school in Guadalajara. His father had been in the military, met a Japanese lady in Japan, brought her over here and they did an oriental trading company thing, where they brought things in, and did fairly well, not magnificently, but did fairly well, and retired in Guadalajara, Mexico. And one of my first invitations as a visiting professor was to Guadalajara that Rick had arranged through the school. And they took me under their wing while I was there and they said on the first night we're going to go out to dinner. And I thought, oh great a nice Mexican dinner in Guadalajara—we went to a Japanese restaurant, which by the way was outstanding. But Rick graduated from the residency, went into practice, is still in practice. He's actually approaching retirement age now. I shudder a little bit. (laughs) But he's also, as a faculty member; he still comes to the clinic. Will Barnes in Claremore, Will Barnes is a general pediatrician in Claremore. He's been there forever. Will, until very recently, would religiously come a half-day every week, I mean every month, and work in the clinic. He brought a wealth of knowledge about small town pediatrics—and well, this is how we'd approach it in Claremore because we don't have this machine or that test or whatever. So, he's somebody that should be recognized. And then there's many, many more. I've got to tell you that I could probably count on at these three fingers pediatricians in the community I didn't really get along with, of course it was all their fault. (laughs) But almost everybody has been very cooperative, very supportive, and continues to be supportive, even after my retirement from school in terms of personal things that I've been able to do.

THOMPSON: Okay. One of the questions that I've asked is—what change from medical school to now, what changes and issues have you seen? You've talked about a couple of them, but put it in a concise point, what have you seen change in medicine over that period of time?

BLOCK: Let me start out with sort of the negative. One of the problems is that it hasn't changed enough. We're still teaching medical students medicine that we practiced and that doesn't make any sense. We need to figure out how to teach them medicine they're going to practice. I'll use the example of immunization. You need to know about it, but you don't need to understand measles _____ (??), measles, you don't need to know _____ (??) meningitis. But there are new things on the horizon. We're discovering a lot now about neurobiology and relationship of just, and this is a big issue for me because it's my interest area, but looking at the environment that children are being raised in at home, in the community, at school, children who have adversity in their lives, which part of the adversity is created by their family or their neighborhood, have actual biologic changes that affect their DNA expression and it affects the way their brain functions. And that brain function, because the brain is part of the body—I hate the term mental health by the way because it assumes that the brain is somehow different than the rest of the body, and all that does is create stigma for patients and an excuse for the insurance company not to pay for what should be called brain health issues—but we're discovering that heart disease, lung disease, liver disease, cancer, you name it, are tied in some way, and sometimes in a huge—playing a huge role—in early adversity, in stress, in the reaction to stress in kids. So, it's really true that pediatric medicine is the basis for adulthood. Now there are adults who had wonderful lives, don't have a lot of adversity, and still get heart disease or liver disease, so it's not 100 percent correlation, but we have to begin to include that kind of thing in medical school education, which is one of the things I think the School of Community Medicine can do. I know Gerry Clancy is responsible, along with Dan [Duffy], for putting that idea to work here at the school. We need to pay more attention to that.

I think that the other thing that has changed, and probably for the good, although when you look back at it, you know, I worked every other night, not entirely for three years, but for good chunks of those three years. So, my training probably was at least, maybe 50 percent to 60 percent more time spent learning than we have now. The reason for making the change was fatigue, and fatigue causing mistakes. Other than in truck drivers, that's not been ever proved. And the studies that have looked at it in medicine show that it's actually the opposite because now we have these handoffs, okay. I can't see your care through to the morning because I have to leave or else the program gets dinged if I don't walk out. You could be dying, and I'm going to say, hey, see ya, Marty, because I have to get out of here. If I stay, which would the human reaction to stay with you, then the program gets dinged. That rule came about because of a lawsuit, and most people know the history of that. It should be revisited. I don't think people should work every other night, but I do think there should be more flexibility, so if they're in the middle of a case and need to see the results of a decision that they made, they can see those results and learn from those results. And hopefully there's somebody around, like there was during my training, to watch over and make sure that you're okay. I think that's a big change.

I think the fact that medical school following college costs as much as it does keeps a lot of people out of medicine who would do a good job. Many of them end up in either nursing, and become nurse practitioners, or they end up in PA [physician assistant] programs, which are very honorable and necessary. But I think the economic burden, and the other thing it does, is that when you're a student and you're looking at a two- to three-hundred thousand dollar debt coming out of school, are you going to pick family medicine or pediatrics or are you going to pick sports medicine, orthopedic surgery? Now, a lot of orthopedists that I know do orthopedic surgery because they love to do orthopedic surgery, there are a few scattered around the county that picked surgery because they can make a lot of money. And they make a lot of money. They somehow along the way may have lost some of their patient skills and that kind of thing. I don't want to cast dispersions [sic] on anybody, but I think that's changing—the financial part is really changing the way medicine is taught, the way it's practiced, and it then leads to something we didn't have to worry about, which is the legal part of it. Medical malpractice now and covering your rear so you don't get sued, and spending a lot of patients' money, insurance companies' money, on testing you don't need to do. That was a big issue. We never once worried about that. I remember my father had one lawsuit in his entire thirty-five years of practice, and it was for a baby who received some oxygen, born prematurely and ended up with some eye problems, and low oxygen was partially responsible. He, it turned out, it was the patient of one of his other pediatricians, and they covered each other on weekends, and he had a note on the patient's chart that he had been in and examined the baby that day, didn't make any diagnostic decisions one way or the other, so he was being sued. So, he wrote a letter to the parent, and he said I really don't think this is fair. And the parent called him up and said, you're absolutely right, it's not fair, my lawyer said we should name all the doctors, so I'm going to take your name off because they're still his patient. That doesn't happen anywhere today. So, we have to teach, right, we have to teach how to protect yourself, how do you avoid malpractice? That's a big part of continuing medical education. I worry about that. I can't say it shouldn't—isn't necessary. It's just a shame that it's necessary. It subtracts from the amount of time you could spend paying attention to perhaps brain health issues and developmental issues and looking at what we're discovering between the linkages we're discovering between what's happening. You watch and see what happens a generation from now with the children who are now immigrants and are trying to move from their devastated homes to foreign countries and some of them are dying in the oceans. I hate to say this, they may be the lucky ones because these other kids through that adversity that they're experiencing and the stress, even though they're being protected by their parents mostly, is going to lead to a lot of illness that before [we] had never understood the cause of. I think that's a major change. Learning how to use technology is a major change. And teaching patients that they're not going to have, as much as I wish this weren't true, they're not going to have the close communication and personal relationship with their physicians they used to have. You go in the hospital and the doctor that takes care of you Monday is not the same as the doctor that takes care of you Tuesday is not the same as the doctor who takes care of you Wednesday, and none of those three is your doctor that you went to who admitted you in the first

place. The medicine may be more focused, but being a behaviorist, I'm a big believer that the interpersonal relationship is a healing relationship and losing that is a shame.

THOMPSON: You've mentioned some, but do you want to list your mentors? Or talk about others that you might not have yet mentioned that you consider to be mentors?

BLOCK: Well, I mentioned Dr. Ostey, and he was monumental. There's another pediatrician who was teaching when I was a student and a resident by the name of Lou Barness. And Lou lived into his early nineties and passed away a couple years ago. Lou was funny. And he was an expert on milk feeding of babies. It was at a time when we were moving from—the drug companies were manufacturing Similac and Enfamil and artificial formulas—and the war started between the breastfeeding advocates and the formula people. Lou did a lot of research in that area, but he was a marvelous teacher as well. And he had a sense of humor that was, if you didn't know him you'd think it was caustic, but it was really kind hearted. So, my Lou Barness story is when making rounds one day, I'm a medical student, and he asked me a question. I was too dumb to say I don't know, so I made up some answer I stumbled over. And he goes Blockhead, that's the stupidest thing I've ever heard. And he takes out of his pocket—you could never do this today—takes out a syringe filled with water and squirts me. Well, I felt honored; I'd been squirted by Lou Barness. And it was all in fun, it was all in jest, it was perfect. He'd be thrown off the faculty if he did something like that today. Well, to finish the Blockhead story, he never referred to me as anything other than that. So, fast forward from 197—well this was as a student, so 1965, '67 through '69, somewhere in there, to 2010 and I had just been elected as president-elect of the American Academy of Pediatrics, and I wanted to share that with Lou. He was retired and living in Florida at the time. I called him from my cell phone, I'd never called him from my cell phone; he could have no idea who was on the phone. And he answered the phone, and I said, "Is this Dr. Louis Barness, the famous pediatrician?" And he goes, "Blockhead, how the hell are you?" Now Lou Barness knew every pediatrician in the world and how he did that is way beyond me. Now he had written a letter, and I still have this letter, that he wrote to Dr. Plunket when I was named chair and Dan stepped down. And he writes to Dan, he said, "Dear Dan, I always knew Blockhead would do good. Best wishes, Lou Barness." So he was definitely a memorable, memorable mentor and I got to interact with him a lot. He went from Pennsylvania to the University of South Florida and was chair there for a number of years. So he's a memorable one, too. There were several during residency.

And then you sort of change from mentee to mentor; although if you kept your head on straight, you keep learning from your colleagues. So, I would have to name just about every faculty member and many of the community pediatricians who I worked with while being here, as really contributing to my understanding of pediatrics, my understanding of education. Dan Duffy was not only a colleague, but a mentor, and hopefully a little bit the other direction as well. But I

definitely learned a lot from Dan. He was a true academician and continues to be. While I sit at home and wood carve, Dan is still doing medicine. So, I have to respect that.

THOMPSON: All right, can we talk about two of your personal interests—

BLOCK: Sure.

THOMPSON: —in this Tulsa community. One is the Justice Center. So can you talk a little bit about how it got where it got and how you got where you are involved in it?

BLOCK: Yeah, that's really an interesting story because that's what I am now is a child abuse pediatrician and people give me credit for championing the subspecialty, and I'll tell you that story. I trained during my residency, we saw some physical abuse, we never, ever knew there was such a thing as sexual abuse in children. It wasn't talked about. There was a mentor from afar, a judge, a juvenile judge by the name Lisa Richette, and I don't remember how to spell that. But she wrote a book called *The Throwaway Children*, a book about—in our library. Lisa wrote this book about the children in the juvenile justice system in Philadelphia and it was pretty rough because kids learned to be criminals when they were three and they improved those skills as life went on. But I was really fascinated by that book and I was worried about some of the kids that we were seeing were malnourished and maltreated and physically abused, so it sparked my interest.

When I came to Tulsa there was a program that had just started called the At Risk Program. Don Pfeifer and—shoot, I can see him and I forgot his name—two pediatricians in town sort of started that, along with Cathy Ayoub, who was a pediatric mental health nurse clinician. Don was a general pediatrician. Krenning. Dr. Krenning was a pediatric pulmonologist, started out as an internist at Harvard, as he went through his training got interested in pediatric diseases, particularly cystic fibrosis. But in spite of that, they both had an ear or an eye for these families that were in trouble and Cathy, who was working at Hillcrest, would identify mother-infant dyads where things just weren't right, and they were enrolled in this program. So, it was really an early program in child maltreatment prevention. Didn't receive a lot of national recognition, although we were on the *Today Show* once; I have a video clip that they did. That sort of got me going. And I worked in the At Risk Program as one of the pediatricians and delivered care to these kids that were part of the program.

Then one day, I was in the clinic, this is an absolutely true story. I was in the clinic and a social worker got a call from a DHS social worker saying that a young girl was claiming to have been sexually abused and needed a doctor to see her and she didn't know where to turn, was there somebody in the clinic who would maybe see this girl? She wasn't from Tulsa. So, Judy came to me and said, would you see her, and I have this congenital defect, I don't understand the word

no, so I said, well, yeah, I'll see her. And I did. And I examined her and stumbled through what I thought was an appropriate exam and fortunately most kids, younger kids, who are sexually abused don't have traumatic lesions from the, because it's not a violent rape like you would see in an older child or an adult. So, I thought her exam was pretty normal, and we got things squared away with DHS. And about a week later, her sibling said yeah, this has happened to me too. So, the social worker called Judy and she talked to me, and I said yes, I'll see her. Same story. Well, about three weeks went by, or somewhat, I'm not exactly sure of the time, and a social worker called me directly and she said, and I quote, "Dr. Block, I understand that you're the state's expert on child sexual abuse, would you see this case for me?" Of course I said yes, but that night I read the entire English literature on child sexual abuse, which consisted by the way of two articles and one book with pictures in it. That was it. That was all we knew about child sexual abuse. I love telling that story—oh, I read the whole world's literature. It was pretty easy to do. That really got me hooked and I started doing more and more child abuse work.

It wasn't too long after that that the state established a program called the Chief Child Abuse Examiner, along with a Board of Child Abuse Examination. The purpose was to try and connect cases around the state and get training for physicians and good care for kids. And I was appointed and first child abuse examiner and held that position until 2011 when I had to retire from that because of Academy of Pediatrics work. But about twenty-two years ago now, we were seeing these kids in our clinic and there were just more and more of them that were coming and police were bringing kids, ungodly number of kids in this community all treated.

By that time I'd done a lot of self-study and I'd worked with some other people who were doing sexual abuse, particularly a lady by name of Astrid Hagars, a pediatrician in California who taught me a lot. And we wanted to do something; we didn't know what to do. Along comes, I mention, Spencer Wood, this guy that was working for a company called the Yurac Company. And they made some sort of health tonic. Long story behind that. I tried it once, it tasted like tar and I didn't get any healthier after drinking it. But they approached Dr. Plunket and said we want to do something for the Tulsa community as a foundation, and we were thinking about maybe providing a corporate jet to fly children where they wanted to go. And Dan said, well in the first place most kids can get the care they need right here in Tulsa, and second if we never need a corporate jet, hey this is Tulsa, not a problem. So, Spencer said, well what else could we do for you? So, Dan talked to me and I said for starters—this was right at the time Gwen Gibson was finishing her residency—you can give me as much money as you care to give me so I can afford to hire Gwen to do child abuse work. Spencer and his wife and the company behind them went—uh, child abuse, we don't _____ (??). And then they started thinking about it. Well, what area could we have that would do greater good. So, they gave me some money to help hire Gwen, a little bit of money. But then they decided after discussions with us, we needed a separate place to do this work, and it needed to be a place where we could coordinate and have law enforcement, the district attorney, DHS, and physicians all working together in one place. So from that, they

decided to fund that. The University owned the Sheridan campus by that time; the peds clinic and one other clinic were there. So we, the University, deeded them the space for a new building for a dollar, which allowed them to build the building without having to worry about state construction rules for state property. So, they built the Justice Center and we were the first place in the country that collocated all those people. There were others, three or four others, that collated everybody but the doctors, and the kids would have to go to a different place to see the doctors, but we were the first in the country to have everybody in one place so they could get their forensic interview, the police could do whatever work they needed to do, the DAs were there so they could talk with the police about charges, whether to file charges. Social workers were there and the medical team was there. So, I had an office there, Gwen had an office there, subsequently others had as well. And we were even able to develop a fellowship there. The fellowship came about because child abuse was not a recognized sub-boarded specialty. We had a group, a national group, called the Halfer Society. That's h-a-l-f-e-r. And Ray Halfer was a pediatrician who taught in Michigan who along, was one of the first two or three pediatricians really dealing with child abuse. He worked with Henry Kemp who was in Denver. Henry Kemp wrote the famous book *The Battered Child* and wrote a paper that was published in the journal of the AMA in I think 1960. It's either 1962 '65, somewhere in there. So we named the society after Ray because a lot of things were already named after Dr. Kemp. And we met as a small group. I think our first meeting was twelve people and then we got to maybe thirty or forty. And we decided it was time to develop the next wave of child abuse pediatricians. This was becoming—we were learning more about it, not only detection and treatment, but also prevention. So, a couple of the members went to the American Board of Pediatrics and petitioned to become a subspecialty. We were turned down. But we learned a lot from the rejection about what they expected if we were going to be a subspecialty. So, we worked on that, as a group we were working on that. One day we had a big meeting to decide, okay, how are we going to move this forward? And you know at meetings you drink a lot of coffee, or I did back then. I drank about eighteen cups of coffee and I just had to go the bathroom, so I excused myself and went to the bathroom. When I came back I was named the person to go to the American Board of Pediatrics to present our petition for a new subspecialty. It didn't hurt that the CEO of the American Board at that time was a pediatrician who trained with me; we did our residency together. So, we became a recognized subspecialty, developed what's called a sub-board, which is a group of people who write the examination because to be sub-boarded, just like being boarded, you have to take a board exam. Spent many happy years doing that. And the neatest part about that is that because we wrote the exam we didn't have to take the exam. And the other really neat thing that I'm very proud of is, because I was the first chair of the sub-board, when we did the certificates for the sub-board, I have certificate number one in child abuse pediatrics and that's hanging on my wall. So all that meshed with what was happening here at the Justice Center and evolved into really a career for me over the last probably fifteen, twenty years of my practice.

THOMPSON: Is there anything else you want to say about the Justice Center?

BLOCK: Well, only, I'd say about the Justice Center that the nice thing is that it is now a training place. We have two faculty right now, both of whom were residents in our program. Interestingly, because you asked before, they are both DOs, came into our residency program one behind the other, finished the residency program, did their fellowship with us in child abuse pediatrics, and now they co-share being medical director of the Justice Center. And one of our residents who graduated six months ago and waited six months as an interim faculty member for our approval of our fellowship, again, we had to get it reapproved, now is reapproved and she is now our first new fellow. So, we now have subspecialty faculty and we have a fellow in training who hopefully will stay on board as faculty. We're still struggling for funding, child abuse does not generate revenue, as you might imagine. We've been very fortunate to have some funding from the Schusterman Family here in Tulsa. The hospitals have participated in the past, and St. Francis just announced they're going to help us with the fellowship. So, hopefully we'll have more stable funding because in this era where you have to feed the money machine, you can't do that and take care of child abuse patients, you've got to have outside funding. So, I hope we'll be successful with that. And I keep saying we, I'm not part of that anymore. But it's still good.

THOMPSON: Is it the only one? I mean is there one in Oklahoma City, or are you it?

BLOCK: There's an advocacy center in Oklahoma City, but politically they didn't get along well with the medical center, so the doctors are still working out—primarily—out of the emergency department at the children's hospital. The rest of the team, the other people that I mentioned, are in the Advocacy Center. They're a little bit closer now than they were; they're working towards coming together. It just was a little bit different. But no there is one there. And there are about seventeen advocacy centers scattered around the state that are just places where the teams can meet. Children are not necessarily seen there, they are seen sometimes. One of the big parts of the medical examiner program, the Board Medical Examinations under the Chief Child Abuse Examiner is that we did training for pediatricians and family docs, mostly in smaller communities, which is a pain in the rear for somebody to have to take a child in a police car to our advocacy center. You don't want to have to do that. Or even for the parent. The parent couldn't take them if the parent might be the perpetrator or Uncle Jimmy or somebody. So, the doctors locally would train. We had a system in place, we don't use it as much, we don't need it as much anymore where they could actually do some video recording of findings and send them to us and we could review their findings, either here or the docs in Oklahoma City and make some comments so the child didn't have to move back and forth if they needed another opinion. We've come a long way with that, the state has evolved nicely. Like other things it's really going to take some hits now through Medicaid cuts. We're going to see more kids because as the income gap continues to really suppress people at a working level or just below we're going to have a lot of kids who have no access to care and we're going to be less and less able to afford to

provide that care if there's not a reimbursement system. One of the things people don't know is that half of the children in Oklahoma live at or below twice the federal poverty level. Yeah. In the United States of American that just doesn't add up. We're twenty-eighth in the world among developed countries with the percentage of children living in poverty. Twenty-eighth in the United States? So, maybe the presidential candidates—by the way you haven't heard the word child in any of the presidential debates yet.

THOMPSON: Well, that's an interesting observation.

BLOCK: I think it's true. I haven't heard all of them, can't really get through all three hours of people calling each other names, but nobody has said anything about children or child care or child health. And nobody has said anything, because they don't know, about the linkage between what we talked about earlier, childhood and adversity and adult disease. In the political arena, we have been unable—through the Academy—we're always trying to talk to the White House and to Congress about children's needs and it's very, very difficult for anybody to focus on children because nobody can understand—there's a different timeline in politics. And my timeline is from conception through maybe twenty-one. What happens along that time? Politicians' timeline is what happen between now and the next election. That's very true. You know, when I was president of the Academy, I asked a staffer for the Senate, the US Senate, whose job it was to bring Senate bills to the congressional budget office, why can't we get things passed in the Senate that affect children and then save money on the other end? There's a huge saving, we know that. There's Nobel Prize-winning economist in Chicago, Jim Heckman, who's proved that, won a Nobel Prize for his theory about early investment and return on that investment. And her answer was we can never do that. And I said why not? And she said because the congressional budget office can't score something that goes from early childhood to adults and takes ten, twelve, fifteen years to manifest itself. They only look at things from three to six years. That's it. So we're stuck. Now I'm starting to become an advocate here, but I think that's important when people are watching this in years to come to see which directions, if that's been corrected, because if it's not we're doomed. We really are.

Right now we're beginning to get businesses interested in what we're talking about because they can't find a work force. And the work force they have—I learned a new term. It's called presenteeism. And what presenteeism, or present-ism, some form of that, is that a worker is there working, but there's real family strife at home, just beating up their wife if it's a guy or vice versa, or beat up their kid or something, or somebody's really, really sick and they can't afford the care. So, they're at work because they can't afford not to be, but they're not there. Their head is somewhere else. So, that's presenteeism. I'm counted, I'm here. So, it's different than absenteeism. And actually absenteeism would be better because if their kid is sick and they're worried about them, they should be with the child and the employer ought to recognize that. But more importantly they can't find people to come into the job. One of the reasons they can't is

because those 50 percent of kids who know nothing but poverty, or at least relative poverty, and another whole bunch of kids who have all this adversity whether they're impoverished or not. And they don't do well in school. Good quiz question. In what grade between kindergarten and twelfth grade, are most children expelled? The answer is kindergarten. The reason for that is kids come to kindergarten, or maybe pre-k, if they live like in Oklahoma where we have pre-k programs, but they come totally unprepared for being with a group of kids. Their life is traumatic. Their answer to everything is to fight. They don't understand. They've been abused. The child hits the teacher, it isn't because he's mad at the teacher it's because he's been hit so many times he thinks that's what you're supposed to do when you're fighting with somebody, arguing with someone. So, what do we do? Instead of understanding the adversity that the child is living with and try to do something about it, we kick them out of school, which then pretty much assigns them to the street, where he'll learn to get better and better at being a criminal. And then we wonder why Oklahoma has more people in prison than any other state in the entire world? So, hopefully someday the thinking that I have been able to develop with the help of a lot of other people and absorb is going to be more recognized. This isn't a pediatrician talking, this is a humanist talking. We've got to understand that, not all, but many, many people are who they are because of what happened to them as a child.

Now we talk about resilience just like we like to talk about child abuse prevention. We talk about trying to teach kids resilience, so that little boy who slaps the teacher, rather than kicking him out of school, need to have some of what's called, trauma-focused cognitive behavioral therapy. A great big word, but it really is therapy that can be delivered, doesn't have to be a psychiatrist, maybe a social worker who's trained in some brain health issues. A few sessions doing some time out things, there's a lot of things in society now, people are turning more to meditation and mindfulness. That's a really big thing, you can teach little kids that. My grandson, in kindergarten, his teacher taught the class, when you're frustrated here's how you do deep breathing. Instead of being frustrated, sit in your chair, you can raise your hand if you want to, so I know that you're having an issue, and just take ten deep breaths. They call it belly breathing. She taught them how to do that, and the incidence of trauma and confusion and negative stuff in the classroom went way down. And my grandson can show me how he belly breathes. Fortunately, there's not a great deal of adversity in his life, but then he was five in kindergarten and he's made it all the first grade. And he still will belly breathe when he gets upset. And he does it at our house sometimes because he didn't get his way, because Mimi and Papi have certain things that you can't do, like watch TV all night long. And gets sort of upset, and you say, time to belly breathe. He'll do that, and he'll say, "Okay, Papi, I'm better." So, I'm really hopeful this ties back into the medical education piece we talked about as well. I think that's a major issues, and there's probably something, but I've already forgotten the question that started this.

THOMPSON: I asked you about the Justice Center.

BLOCK: Oh, okay.

THOMPSON: Now one of the other areas that you have made a name for yourself is in learning disabilities. Do you want to talk about that arena that you've been in?

BLOCK: Yeah, and you know, that gives me a chance, too, to mention another faculty member, who's currently not a faculty member, is Don Hamilton. Dr. Hamilton practiced general pediatrics in this community for a long time, got really interested in learning disabilities and behavior issues for kids. We hired him on to the faculty to do that work and he had a clinic with us. We hired a psychologist who's still working for the University to see these kids and become a resource for the community. Don is a terrific guy. Really got emotionally stabbed when about five years ago the residency review committee came through. This was a group that reviews the residency program for accreditation. And they noted that we were teaching behavioral and developmental pediatrics, but we did not have a board certified behavioral developmental pediatrician. Well, Don Hamilton was as good as anybody who had been through the training just because he had all these years of experience and he was a great teacher. Well, but that hurt his feelings. So Don, I don't know quite what he said, but what he said was, you know, I'm going to go get that fellowship training. So at fifty-something he's now in Oklahoma City finishing up his third of three years of fellowship training in behavior and developmental pediatrics, learning what he already knew and I suspect a lot of other good things as well. Fortunately he's coming back to the community, I hear. Not to the University, but he will be here and we will be able to use him as an adjunct faculty person so that we can fix the residency program. The way they had to put a temporary fix on it is our residents had to go to Oklahoma City for rotations in behavioral pediatrics. They didn't have to stay there; they could go back and forth. But Don has, I mean that takes a lot hutzpah, if you will, to leave your job. You know, fellows don't make a whole lot of money. That's all they're paying him, as a fellow.

So, when I was working in the field learning disabilities were big, and we called it minimal brain dysfunction then before. Then it morphed into attention deficit disorder and attention deficit hyperactivity disorder. And I was just fortunate enough to be interested in that and to see a lot of kids that got involved in the state association, which is still active and helps parents. We were involved in getting special education meetings with parents and teachers, and special education plans that kids can have. And trying to make those work. There's a lot of kids, most of the kids can stay in regular classes, [and] they have to have some extra things going on around them in terms of support. And then other kids who are really struggling might, if they either have money or access to some money, can go to Town and Country School. I was the president of their Board of Directors for a number of years and working with them. They've expanded a little bit from just learning disabilities to include the ADHD and some other kids who, not the severely mentally challenged kids, but kids who have difficulty in school. And now that's coming with this whole understanding of adversity, too. Adversity doesn't cause learning disabilities and it

doesn't cause dyslexia where you can't read, but adversity does cause this kind of acting out stuff that gets you in trouble in regular school and then you end up in other places. I ran into a guy, I have to tell you, because this is a story I'm sure has happened to other doctors. I was sitting in an airport in Charlotte, I think, waiting for a plane, and a fellow came up to me that I didn't recognize at all. Dr. Block! Yes, but excuse me, I don't know who you are. I don't expect you to. You saw my five-year-old daughter thirty years ago. She was referred to you for having attention deficit, or whatever we called it then, and they were going to hold her back in kindergarten to give her more time to mature. And he said, you know, you spent two hours with her, we couldn't believe it. We thought we'd be there for a fifteen-minute appointment and a prescription. You spent two hours with her and you came out of the office and you said, not very delicately, there's no way in hell she has ADHD. She's bored. So, we had a psychologist test her. She had a superb IQ, she was extraordinarily gifted and skipped two or three grades on her way through high school, went to college, got a PhD, and is now working, very successfully, with a company doing something with management issues in Chicago. This isn't true, but he said, she's doing this because of you. No, she's doing that because of her and some very supportive parents and maybe a guy who's not afraid to say there's no way in hell she's got ADHD. But that's one of the things that happens to you now when you're my age and—I've seen a lot of people so I'm, I don't think people expect me to remember who they are. But they remember who I was and what I did. And I'm sure there are some who would just as soon shoot me. But I've met people now who say that was the result of the work that we did then has been successful and has helped their kids and their families. And I think most doctors will tell you that kind of story. There are people that that's happened to almost all of us, if we've done a job of making connections with the families. That part of me sort of disappeared when the child abuse stuff started building up and so I'll occasionally be asked for an opinion, but I don't see children anymore now for anything. I'll be asked sort of to review a situation. One of our residents went on into doing developmental pediatrics and passed away a couple of years ago. So, we have had some developmental work in town, but with Don coming back, you know, by the way our resident had a partner who trained in Kansas City, and she passed away way too young because of breast cancer. So we lost both of them, so there's a big hole there for Don to come back and fill in. So, hopefully that will happen.

THOMPSON: Well you can add my oldest one to that list as well.

BLOCK: That's right.

THOMPSON: Didn't get a PhD, but she got a master's in library science and works with kids now, so—

BLOCK: There's nothing more important than library science right?

THOMPSON: And it was you who got that and moved her along, so there is another successful story as well.

BLOCK: Glad to hear that.

THOMPSON: Your wife and teenage pregnancy—you want to mention any of that?

BLOCK: You bet.

THOMPSON: Because you all have been.

BLOCK: Yeah that was Sharon. Sharon is a nurse. When she finished nursing and we got married, she worked as a psychiatric nurse in Philadelphia while I was in residency. She always thought it was funny, she made more money than I did at that time. I said, oh, just wait, Honey, I'll try and pay you back. But when we came to Tulsa she got involved with the Margaret Hudson program and was an outreach nurse for Margaret Hudson. So she would go into schools, as many as would let her in, and either work with the girls whose pregnancy was becoming known, which in that day meant that you got kicked out of school, and explained to them about the Margaret Hudson program and continuing ed. But also then [she] was able to develop some teaching programs that really were sex education, in the Tulsa Public Schools if you can believe that. But she was most successful with groups outside of the schools, either in faith-based programs or with like the Girl Scouts. And I started working with her, and we would do classes together and we would go into churches and work with their youth groups and we had a rule that while we were teaching, except for the last two sessions, no other adult could be in the room. So, the kids had to, it's amazing what kids will tell you when you give them a chance. And if they didn't want to say it out loud, we had the "nothing to sneeze at" box, which was an empty Kleenex box and they could write questions on a piece of paper and put it in the box and we would read them the next day and answer them and nobody had to know who asked the question. But the neat thing was then after the last couple classes, usually the youth minister would come in and join us, and then we would leave after and he would continue classes for a while and integrate whatever faith beliefs or philosophies were important to the church and the children into the basics that we taught them. I remember our first two classes, we'd teach once a week, our first two weeks were on decision making. We were sex educators and we were talking about decisions. The kids were like, what? Decisions? I don't make decisions. Well, how many decisions have you made today? Let's list them. And then let's see the consequences. I remember it was at All Souls Unitarian Church, we were working with the youth group there, and one of the kids, we knew the kids there very well, and one of the kids after about the third session, we'd done decision making and now we were sort of morphing into a little bit of physiology and understanding some things. And wait a minute, wait a minute, we're in here talking about decisions. When are you going to show us how to put a condom on a banana? So,

we had this different view. But Sharon was great at that. And she was very successful at Town and Country.

Her career then took a right hand turn, and she became the first science teacher at TU, at the university school for gifted children. And she taught K through eighth grade there for probably a dozen years. Her degree was in psychology, which is why she started out as a psychiatric nurse, and it was a private school so you didn't need the same kind of education certification you do for public school. And she had a ball. And our house turned into a big laboratory, practicing different things that the kids would do. Her, the way she taught was, you did your homework and that's the only time you looked in the book. When you came to class we did experiments. The kids would design the experiments to sort of demonstrate what they learned in the book. Of course she was everybody's favorite teacher because—they did have tests—but they didn't have to do book stuff at school. And they didn't have to do a ton of it at home, just a modicum amount. These were gifted kids, so it was easy for them to get that done. But she had a really good time doing that. She retired into continuing motherhood, but she's, now her main job is in life is to make sure that things are going well for both of us and taking care of the two cats and two dogs. But we've been married for almost forty-seven years, so she needs a medal of some sort.

THOMPSON: Do you want to talk about being president of the American Academy of Pediatrics?

BLOCK: I'll never miss a chance to do that. You know, I never dreamed—back when Dr. Plunket was introducing me to presidents of the Academy—I never dreamed that that would be in my future at all. I did get to be—Bob Embers, as a matter of fact, talked me into being president of the state chapter; every state has a chapter of the Academy. Bob talked me into—he'd been—and talked me into doing that, so I did. And we had these really long terms, it was three years as vice-president, three years as president. But the neat thing is during those six years, once a year the Academy has, it's morphed in a huge meeting now, but it used to be a meeting of all the state presidents and vice-presidents. And they sat around and debated issues and things and then made recommendations to the board of directors. Proposals that the Academy ought to do this or ought to do that. And it was great fun. And I got to meet all sorts of Academy leadership. And then things sort of settled down for a while. I got involved with the Academy, they have committees that are appointed committees on different issues. There are about fifty of them. And I was appointed to the committee on child abuse and neglect. Eventually [I] became the chair, so you can serve for six years on the committee and then you're chair for a year, but you can be re-elected for four times, or re-appointed for four times. Spent ten years on that committee. And again during that time I got to meet a lot of influential people at the Academy. So one day back in about 2008, I was at a national meeting, and there's a nominating committee; one person from every district in the Academy; there's ten districts, is elected by the

district to be a nominating committee member. They then get together and pick out people to nominate for different offices. And I remember, we were in Washington, D.C., and she approached me for lunch ____ (??). And while we were having lunch she asked me if I'd run for president of the Academy because it's an elected position. And I was flabbergasted. So, but I remember I went home. I told her I'm going to have to think about this, talk to my wife, and I'll get back to you. At first I have to get over the shock. I went home and I said to Sharon, "You're not going to believe this, but A, they've asked me to run for president of the Academy, and B, I'm going to say no." Because I was chair here, and we were involved, there was some change occurring and there were some very important things going on and I thought that my allegiance first had to be here. And I knew that that level at the Academy, it's a full-time kind of thing. So I called her and I said, "I really don't know how to say this because it was the greatest honor I've ever had. I'm going to turn it down, I just can't do that." And she was very understanding. She said, "I know exactly what you're saying. We understand." So I went home and I told Sharon, I called her and said, "That's it that was a chance of a lifetime and I chose not to do it."

Well, next year they asked me again. I couldn't believe it. It actually was about a year and a half later. And things were, I was more settled in what I wanted to do here, which was get the hell out of here in a respectful manner over the next couple of years. There's a time when it's time to change because here I was, still with twelve years ago thinking, or in my case thirty years ago thinking, and we needed somebody who was more attuned with the current situation. So I told them, yes, I would run. Thinking, oh, that could lead to retirement, but first I have to get elected, right? So there's about seven people that were nominated and they bring us all together in Chicago. We have dinner together with the nominating committee and each other, and we all knew each other, and I was looking at the other six candidates and going, "Okay, we'll just go home and get out of the chairmanship another way." And then the next day they sequester all of us and one at a time you go into a room with the nominating committee. And [with] each one of them, you get to give a three-minute introductory talk, and then each one of them asks you a question. And then they shepherd you out the back door so you don't get to interact with the other candidates and whisk you away to the airport. And then they stay up all night debating the candidates and then they pick two and the next morning they call you and say thank you, but, or in my case, they said, "Bob, you're going to be one of our two candidates." And it was unbelievable. So, then it's really fun because you get to go, and there's two candidates, and I was running against a guy who's a general pediatrician, does a lot of school health pediatrics in the New York/New Jersey area, very affluent practice area, very connecting with practicing pediatricians, where I was being seen as an academic guy. But we travelled together to all these meetings and give talks and answer questions and things. And we got to be really good friends, and the wives got to be really good friends, too. And we knew one of us wasn't going to get the position, but vowed we would remain friends and have ever since. So, then they have a general election, and one of the few professional societies where everybody can vote. Most of them the

board of directors picks candidates and then picks the president. So, there's sixty-six thousand pediatricians, now not all of them vote, but among those who voted, we got to be president. So you'd be president-elect and then president and then past-president. It was wonderful because you sit with the Board of Directors, travel all over the world actually. I went to Myanmar; I went to Poland; I went to Chile; I went to England. It was fantastic. Plus going to all sorts of places around the country and you're invited everywhere to do grand rounds because they want the president of the Academy to do grand rounds. It was a great platform for me to talk about adversity and childhood experiences and brain health issues, all across the country. So, that was a wonderful, wonderful experience. Then you're past-president after you're president, and you're always a past president, and get called on to do things with the Academy as well. Great, great experience. Unfortunately, both Dan and my own dad were both dead by the time this happened, so they never got to know that, but maybe somehow they do.

THOMPSON: They do. I have a couple more questions that I want to ask you about. One, I want to ask about one of the former deans and your relationship with him. Just because he meant a lot to me, and that's Dr. Tomsovic.

BLOCK: Right.

THOMPSON: You want to talk to me about your interactions with him when he was here?

BLOCK: Sure do, thanks for the question. You know Ed was a good friend of Dan Plunket's. They were in the military together, so I got to meet Ed a little bit before he came as dean, but mainly when he was here as dean. He was very much like Dan. I thought he was well spoken, he was very empathetic with people. I thought at the time his ability to be an administrator was a fortunate time because things were pretty stable. I think partly they were stable because Ed was a pretty stable guy and moved things along that direction. He got along really well with the chairs. We had a different group of chairs then, even when Gerry Clancy came as dean, we had a similar group of chairs then, got along really well with each other. But Ed was a special guy, and unfortunately got sick and eventually died. But we were fortunate enough to have him and he really put his heart and soul [into his job]. He came here with no preconceived notions or ties except for what Dan had shared with him over the years about the medical college here. And he really put himself right in the midst of that and knew what was going on and got involved. I have a lot of respect for him.

THOMPSON: Very good. Now the other thing I want to come back to touch is personal. That's back to wood carving. When did you start that? How long have you been doing it? And then I assume from a comment you made a while ago, you're still doing it.

BLOCK: Still am. And it's great to have something like that when you're in semi-retirement because I never really got to do a lot of it before, and now I can actually finish a project. I got started probably about thirty-five, thirty-six years ago because there was a wood carving show here in Tulsa. Back in those days there was a club, still is and I'm still a member, but they would have their shows once a year in one of the shopping malls. So, Sharon and I, totally oblivious to that went out to Woodland Hills Mall to do some shopping and looking around, and there was this wood carving show. It was magnificent. I'd always liked wood because we learned how to refinish furniture when we were in the army. All the furniture in our house, almost all of it, is furniture that we bought at auctions in Kansas and re-finished ourselves. So, I was familiar with wood, but I'd never made anything. I think I made a cutting board in eighth grade shop. But I, so I hooked up with a couple of people at the show, and there was one guy who was from Nebraska, who was an art teacher in high school, who said we have this once a week rendezvous up in Nebraska, and why don't you come up and take my class and I'll teach you how to carve big things, not just little trinkets, but busts and stuff. So, I did that and then I took another class, a carver, a Greek guy, who came over, had been an apprentice carver in Greece and came over to become the head carver with apprentices to carve a lot of the work that are in the Greek Orthodox churches around Minnesota and the Midwest. Super guy. And the rest of it is self-taught, but I just love doing it. There's a book by a guy whose name I can't pronounce, but its Csikszentmihalyi or something like that called *Flow*. And his theory is that you get involved in something intensely and time disappears and other thoughts disappear and without me really thinking about it's really meditation because I can forget, I don't care if I'm mad at the dean or Sharon and I have had a spat, or one of the kids didn't do what they're supposed to do, or a medical student didn't show up on time, that all disappears when I'm carving. It's really a lot of fun. So, I've made a lot of carves, I've sold a bunch, not for a lot of money, but I sold it. And Tulsa County Medical Society now has, they call it Art Rx, and it's an art show, all the pieces in the show are made by Tulsa physicians or their spouses, and they're auctioned off and all the money goes to the free medical care program that County Medical supports, where you can see a primary care guy and then if you need a referral then the money from that account helps offset the cost of the subspecialist to then bring that patient in who would never be able to see them otherwise. So, I've had a couple pieces there, one was bought by one of the OB/GYN, it was a mother and child, sort of a Madonna like mother and child about that tall. And the last one was about that tall, was a girl sort of walking, in a walking pose, and one of the pediatricians, one of my former students slash residents bought that. So, that's a lot of fun to see that happen. So, I'm working on a giant piece of an eagle right now. I have a little shop, out back of where my garage is, and I go out there and listen to some music and do some wood carving and Sharon has to call me on the phone and say, hey it's time to come in. This flow thing really kicks in; you lose all track of time. And it's been really good. I recommend everybody find a hobby, start to develop it even though you're really busy and don't have a lot of time. Involve the kids, one of my daughters doesn't care for it at all, the other one does and she's done some carving. And both of my grandchildren love to come out in the shop and play with clay. So we make things out of

clay. So, I can get a little carving in while they're manufacturing stuff in clay. I took a couple of classes in sculpture here in Tulsa and have done a couple of clay things, but I'm not very good that. But the woodcarving is something that over the years I've developed a little bit of skill. The other fun part is going into the tool store and just buying a tool just because it's cool. So it's a lot of fun. Someday invite yourself, let me know when you're around and I'll take you out to the shop and show you. It's just a small room. I want to call it a studio, but it's way too messy, so it's just a shop. But it's a lot of fun. Unfortunately, along the way I haven't been able to see a piece of wood on the street, if a tree goes down, without putting it in my truck, so I now have to live to be 307-years-old in order to use up all the wood that I have. But I've quit looking for new wood. I finally drew the line, but it becomes almost like an addiction; oh this is going to be a great whatever, so now it's sitting around in piles in the back yard. So, if you ever need any firewood or something, I'm your guy.

THOMPSON: You don't remember, but my father was a wood carver.

BLOCK: No, I don't remember, Marty.

THOMPSON: He carved—

BLOCK: Now that you say that, now I do, yeah.

THOMPSON: He carved, and when he retired that's what he started doing. He did it nearly as many years as he worked, he carved. He carved up until almost the end. But he always loved it. I, like the one daughter, have no talent. My brother has the talent. And you'll have to one of these days when you're over in the library look, Stewart just put up a plaque in the library that my dad started when I first started to work up here that says Tulsa Medical College Library. But he never finished it, and when my brother was cleaning out his shop, he found it, and my brother finished it. And I gave it to Stewart and told him he could do whatever he wanted to. He hung it on the wall.

BLOCK: Oh, that's neat.

THOMPSON: Do you have any comments? Any additional things you want to say that I didn't probe you to say?

BLOCK: Well, you know, I thought about one thing in advance that I wanted to say, and I don't want to say this in terms of self-aggrandizement, but I think that there's a hesitancy for people to look at the school here and say wait a minute you're not Harvard or Hopkins or University of Pennsylvania, you're not even Oklahoma City. But there's a chance to evolve here as a faculty person. And to create a role at the state level, the national level. I know that the academy thing is

a great example of that. We've had three I think, or four maybe, master teachers, _____ (??) master teacher. I was fortunate enough to, I think _____ (??) Dan Duffy was the first from this campus, and then Ron Saizow, and I may be overlooking somebody, but that's a sign that the school is worthy of some recognition in the whole university complex. And I'm really proud of that for the school. So, I think that people who might be thinking in the future about, oh I want to do some academic medicine, but I don't want to lose touch with my clinical skills as a faculty person, I don't want to do research, I'm not a bench lab person, but I'm looking for a place, this could be a good place. And the proximity of the students and the residents to the faculty is really nice here, and there are faculty, Lou Barnes knew me as Blockhead, but probably for every one of him there are probably ten faculty who have no idea who I or any of the other students was because we didn't interact that way. But I think that's a major success story for the school. If we're able to fulfill our commitment to community medicine, that's going to be, this is a great breeding ground for prominent figures in community health. I say if because a lot of the community health is involved with does not generate revenue. So, we've got this revenue, teaching problem. But you know, students are looking ahead at what they should do, residents are looking ahead at what they should do, looking at faculty positions, not just here, but at some other of the smaller medical colleges. There's not, in my mind, any difference in what you learn and how you eventually practice, if you train here versus if you train at a super place. Unless you're going to be, I think research is a big difference. We're not going to teach a lot of bench research, we do some. And Kent and his team have been magnificent, but there's a real chance here, as it stands now, to create an edge. And Dan did that when he was here. I've been able to do that through the support of a lot of people. And I think that, my hope is that it will continue, and we can be a breeding ground for some really successful and interesting and interested persons in medicine and in all the other colleges that are associated with us, like nursing and social work and the PA program and the allied health kind of program, pharmacy program, which is probably not going to be here much longer, but there's a chance here to integrate with those programs, which you don't get very much in other schools. Someday we will have more students doing a combined MD/MPH which I think will really help us in my areas of interest because when you understand public health, you understand brain health as the center of that. So, that's my hope for the future.

THOMPSON: I would say that I was involved in the library program, and I thought it was a very astute observation by one of the sponsors in the first class that we had, and that is that whether you have created physicians in community medicine, what you have done is made them aware of things that they should be aware of in the communities where they practice, and that there are other things that they need to do other than just the paying patient that comes across, and that could be in itself, because as most of us know, physicians are great leaders.

BLOCK: I'm going to close out with something that I've learned and observed. The very first year with the summer institute, I was a driver and a group leader for a group of students and we

went up to North Tulsa, and we drove around and went to a couple of the emergency infant services and a couple other places up there and we were driving back to the campus and there was a girl in my car, who was one of our incoming freshman medical students started to cry. And she was sitting in the back and I said, "What's the matter?" She said, "I've lived here all my life, grew up here, went to high school, went to college in Oklahoma City, but I came back here all the time and now I'm thinking about coming back for medical school. I've never seen Tulsa from this angle, from this perspective before." And she said, "That's inexcusable." So, I thought that was, we're being successful, so we dried the tears and told her she can make a difference and it's her heart that will guide her in that direction and let me know if I can help.

THOMPSON: Well, we appreciate you doing this.

BLOCK: My pleasure.

THOMPSON: Thank you very much.

BLOCK: You're welcome.

End of interview.