Note:

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Some examples of the kinds of errors to be found in the transcripts are provided below.

Filename	PDF Version Page	Error
jmf_int_transcript_Williams_2_2_1976.pdf	20	"Parkalnd"
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DR. FORDTRAN: INTERVIEW TRANSCRIPTION

?Could you tell me your position here and your institutional (role)?
Well, I'm Professor of Medicine and head of the division of Gastroenterology, and the research I'm involved in is primarily in those areas that I mentioned, namely things to do with diarrheal diseases, things to do with peptic ulcer, and things to do with abnormalities in calcium metabolism.
?So you teach in the medical school, too?
Right. I teach in the medical school, take care of the patients in Parkland, and do research.
?That's perfect, from my point of viewf, showing how all these interrelate. As long as we started on the CRC, what does that contribute to your research?
It's made it a lot easier to get it done, it's facilitated it in a great way, and to some extent it's made it possible to study patients we wouldn't have been able to study before. For example,a doctor called about a patient today who has very severe diarrhea, and she's not a resident of Dallas County, so she's not eligible to be admitted to the hospital unless she were a private patient.But she has very severe diarrhea and I'm interested f in her from a research standpoint, because we're interested in trying to find out better ways to diagnose and treat diarrheal disease, The CRC gives us a nice place to put her, at no expense to her, so that she can be brought here and put in the hospital and we can do our research. She can get good medical care at the same time, and she'll be a good patient for a lot of our students to see. So, in a sense, it serves a teaching purpose.
?What can you find out from patients in the CRC that you can't find out in other ways?
Well, you can put people there to do the tests and the experiments, and whereas if you didn't have the CRC you couldn't. In other words, who would finance it? There would be no way to finance it, for one thing, and, second, the bed situation is tight, so even if you could finance it, and

the patient could afford it, you might not be justified in putting the patient there, because you're preventing someone else from getting the bed.

?Is there any other way to carry out your research, though, without patients?

No, not my particular type of research, because my research is patient-oriented. A lot of people around here do research in animals, and they don't need patients. In fact patients play no role, except maybe in stimulating them with ideas, but my own research is directly patient-related.

?Are you publishing something now?

We work on a lot of original papers, right now I'm working on a new edition of this book, of which I'm co-editor. It's a book which we first put out in 1973, and I'm working on a second edition now. It's a textbook of Gastroenterology. That's what I'm working on right this minute, but most of my time writing is concerned with publishing original papers.

?What type of revisions does a basic textbook like that require?

It has to be brought up to date, because that book was published in 1973, which means that in 1971 and 1972, the latest references were in there. So that means that anything that's happened since '72, let's say, is not in that book. So we want to update it and revise it and make it as current as possible.

?You must have to be on top of every development.

You do, at least you have to organize so that somebody who's contributing chapters to the book has to be on top of it, that's true.

?Since you're involved in most of the areas, how do students move into these areas of research?

Students are involved in a lot of different ways, because, for example, I make attending rounds at Parkland three months of the year, and during that time there'll be six students attached with me, and so I'll make four times a week I'll make rounds with them, and teach and discuss cases with them, and so forth. In addition to that, on our gastrointestinal

service, GI service, where we see patients primarily with gastro-intestingl disease, students take electives, so that I see them that way. And several students have worked with us in research programs in the summer, and get involved in some of the research activities we have going on.

?Are these medical students, or are they graduate students as well?

Both. We have medical students as I've just described, and we have a large postgraduate program in gastroenterology, where we take from five to seven new fellows each year, and each usually stays two years, so at any one time in our whole group we probably have from 10 to 17 what we call fellows or trainees in gastroenterology. They're M.D.'s, occasionally we have a PH.D. doing strictly research, but most of the time our postgraduate training is for M.D.'s.

?Do you give any lectures in the basic science...

A few--they're what's called clinical correlation lectures mainly, and we come in in the basic sciences in the first two years and give a couple of lectures usually in several of the basic science courses. Most of our lecture series, though, is given to the third-year medical students.

?In fitting the CRC into the film, we're trying to show the special nature of the program...

I don't think that would be a special problem, because we have patients from all over the USA, really, including Canada who have diarrhea that the cause hasn't been able to be explained, and they'd be glad to talk to you.

?Terrific. The cause hasn't been able to be explained?

Well, in these patients, that's right. Just like in every field, there's unexplained symptoms, and sometimes they can be quite troublesome in diarrhea when it's persistent and large and severe, it's a really trouble-some problem. And very debilitating. And there are a number of causes, and you can run through a number of tests hat people can do and you sometimes don't come up with the answer and that's when we get them.

?I was talking to someone the other day about that--how you can make the test and then make the leap beyond the information, which can often give the same answers for a number of causes.

That's true, but on the other hand that's part of knowing how to make a diagnosis, is knowing how to put things together, and that's clinical judgment and experience, and sometimes you don't do it right, either, I mean, sometimes you add it up wrong.

?How do you teach that?

You mean, how do you teach experience? You don't, you have to get it, there's a lot to be learned, it isn't easy. Making a correct diagnosis is oftentimes very difficult. And many times you do the best you can, and many times you're right, and sometimes you're wrong, and the other thing you have to know about is when to stop trying to make a diagnosis. Sometimes you reach a point when you've done what's reasonable and the symptoms are not severe enough to make it mandatory to go on, because sometimes you might go an and hurt a patient with some of your diagnostic techniques, when the severity of the symptom wasn't bad enough to warrant that risk. So being a good doctor is hard. And you sometimes make the wrong decisions for an individual case, unfortunately.

?From my point of view the CRC seems to be such a compact unit, we're anxious to film there fairly soon. It seems to be more comprehensible than a number of other aspects we're trying to bring into this context....

How long will you be here? A year?

?The premier date is the spring meeting of the SW Foundation, so we'll be working on this from now through March, probably. It would be nice to have a year, but if you don't have that deadline, you could go on forever.

In fact I'd be curious if you could give me some help in understanding the medical school in any way, since you have a fairly broad experience....

The medical school is different to every person who works here--the health center. I'm sure it means a different thing to me than it means does to the policemen who work here, or the nurses who work in the hospital

and the people that work in administration, we all have our own, somewhat isolated concept of what it is and what it does. It's a place to work, and it's a place where medical students are trained, where research is done. Some basic research, which has almost nothing to do with patient care and patient well-being, at least at the present time. I mean, there's always the hope that it might be, and other stuff that is directly relevant to patient problems. Now, I'm a patient-oriented person. In other words, if I think of a research project to do, it's almost always in line with some problem related to a patient that I've, you know, some clinical problem that I see. Soo that's my orientation, and my prejudice is that we ought to have moee of that and less of some of the other things. Listen, there's an enormous amount of activity around here, there are television crews here, there's a police force here, there's....

?What does all of it together contribute to your work?

Well, it gives me a place to work. One thing that's fair to say is, it's probably the best place I know of to work I know of in the country. I mean, not that I think it's perfect, I sure don't, but considering other places I've seen, I think the environment here is better than any other place I've seen.....I like the relationship we have with Parkland. I like taking care of those kind of patients, rather than having a University hospital. I like taking care of the Parkland patients, it's an unusual type of person who comes to Parkland Hospital, and They're poor, they're indigent, they've got real problems, and they're often unsolvable. In fact many times they're unsolvable--maybe you can handle the medical aspects, maybe you can't, but even if you do, their social situations are such that... and yet those people put up with that, and they're good people, most of them, and so I really get a lot out of working with people at Parkland. And that's something that you definitely ought to portray, in my opinion, and that is the people that are involved over there. It's a really good thing, in my opinion, to take care of people who need it and who can't

afford it sort of on their own. And even if you gave them the money to, you probably couldn't find a doctor who'd want to treat most of those people.

?They're interesting to you from more than just...

They're interesting to me because of themselves, in other words, their personalities, their problems, and so forth. And the frustrations you see in them in realizing how there's no way of solving their problem unless you could suddenly make them smart, or give them a lot of money, or something like that, something you can't do.

?Do you have a good rapport with most of your patients?

I think sso. Even if you make mistakes with patients and make the wrong diagnosis, and so forth--in other words, what they think of you is not necessarily how brilliant you are as a physician, what they thinkof you is primarily determined by how nice you are to them, and how concerned you are about them.

?When you talked about your research a moment ago, you talked about when you think of a problem...

Yeah, seeing patiants and their problems makes you think of research ideas. So you see a problem in a patient and then it goes in the back of your mind, and then you're thinking of ways to solve it, and sometimes an idea clicks with something else and then you're off on a research project related to a patient problem.

?That's what I was curious about, that process of developing research ideas.

Let me give you an example, you see patients who vomit, and you're wondering what makes people, what determines vomiting in people. And suddenly you're thinking about gastric emptying and soon methods come to mind, and pretty soon you're off studying the way in which the stomach empties, and you're trying to bring it back to patients who, and so you devlop methods for studying gastric emptying, and you bring it back and apply those methods to studying patients with diseases.

?How do you develop the methods? I suppose there are a variety of ways. You always build on what's done before, you improvise, and it's not very difficult to, I mean, there are some things you can't do, but once you're into a field, like I am in gastroenterology, I feel like for measuring most things in the stomach and the small intestines, you can develop methods for accurately doing that in people.

?Is that sort of thing that led you to edit a textbook?

Yeah, being interested in patients, and not thinking there was a good textbook in gastroenterology, and then wanting to do one.

?how long did it take you?

Oh, we worked on that about two years.

?For some reason it seems surprising to me that a book that thick can be produced in two years.

You work hard on it, you work and you have other contributors, too. I didn't write every bit of that, I wrote a good portion of it, so did my co-editor, but a lot of that we would assign other people to write.

?Are you saying there must be an infinity of possible topics and chapters?

There are, but you organize it and decide the important areas that need to be covered and you allot certain spaces for certain things, and you, it fits in pretty well.

?I'm curious about something I've noticed in the lecures. Even in the freshman and sophomore classes, the students ask questions which are very basic.

That's true, but that's all they've heard until now, is sort of basic, fundamental physiological and biochemical things, and so that's where their questions are. As they go on, they get more and more interested in clinical problems, disease states, abnormalities, and they get that soon after the first year. The first year is to some extent oriented to basic physiological and biochemical problems.

?There must be a sort of relationship between the biochemical and physiological

processes and clinical...

Of course there is, sure there is. That's why you build from the bottom upd. You teach the normal physiology and biochemistry and anatomy and everything first, and when you begin to explain abnormalities, it all fits into place.