

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

George Crile, Jr.

GEORGE CRILE, JR.

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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George Crile, Jr.

CHRONOLOGY

1907	Born in Cleveland, November 7
1929	Yale University, Ph.B.
1933	Harvard University, M.D.
1933-1934	Barnes Hospital, St. Louis, Intern
1934-1937	Cleveland Clinic, Resident surgeon
1937-	Cleveland Clinic, Member surgical staff
1942-1945	U.S. Naval Reserves
1951-1955	Honorary Civilian Consultant to the Surgeon General
1956-1969	Cleveland Clinic, Head, Department of General Surgery
1969-1972	Cleveland Clinic, Department of Surgery, Senior Consultant
1972-	Cleveland Clinic, Department of Surgery, Emeritus Consultant

MEMBERSHIPS & AFFILIATIONS

American College of Surgeons, Fellow

American Surgical Association

American Thyroid Association

Central Surgical Association

Southern Surgical Association

Royal College of Surgeons, Honorary

BOOKS

Hospital Care of the Surgical Patient (with Frank Shively), 1943

Practical Aspects of Thyroid Disease, 1949

Treasure Diving Holidays (with Jane Crile), 1954

Cancer and Common Sense, 1955

More Than Booty, 1966

A Biological Consideration of the Treatment of Breast Cancer, 1967

A Naturalistic View of Man, 1969

To Act as a Unit: The Story of the Cleveland Clinic (with A.T. Bunts), 1970

Above and Below (with Helga Sandburg), 1970

What Women Should Know About the Breast Cancer Controversy, 1973

Surgery: Your Choices and Alternatives, 1978

WEEKS:

Dr. Crile, it's a pleasure to be here. I'd like to have you talk about your life. I know you were born in Cleveland about 1907. But maybe you would like to take it from there, if you want to talk about your family or your schooling or your internship or....

CRILE:

I was born down on Euclid Avenue, not such a glorious place to be born today, but it was all right then. I lived there until I was about six years old and then the family, just about the time of World War I, moved up to Cleveland Heights, where we have lived ever since.

World War I, I remember, because my mother was doing research work with one of my father's research people in our house during that period. My father was away for six months at the beginning of the war and then he returned; that is before the United States got into the war, he was with the English. Then he returned to the war, the first unit of any official American army unit to reach France. They were there for the duration.

Then he came home. Of course, our house was an enormous house. It was built some years before by a railway magnate, Mr. Calhoun, who lost all of his money in one of the ups and downs of the market. So we got it from the bank.

On the first floor, as you come in, there was a court yard. The house was shaped like a U, open towards the back. There were several acres of wooded property facing on Derbyshire Road.

First, you would come into this gigantic hall with two circular staircases going up to the second floor, then on the right, as you came in, there was a large living room and then a large dining room and then there was a kitchen and servants' dining rooms and whatever they had out there, a butler's room in the basement. Then, on the left as you come in, there was a music room and a gigantic ballroom. And that was the first floor.

Then on the second floor, there were five bedrooms in one wing, and a secretary's office, a big hallway, and a library and then two more family bedrooms in the other wing and then the whole suite of maids' rooms, about five or six of them. The reason for that was, that at that time in the way of servants, and this all seems incredible today but it's absolutely true, we had not only the butler, but the cook and the kitchen maid and the serving maid, the downstairs girl and the upstairs girl, and the chauffeur and two gardeners, the secretary, a couple of laundresses. That would say nothing of our place in the country where we had a groom and a full-time couple that lived there all the time, in spite of the fact that we only went out weekends.

So, my mother needed a secretary, just to keep track of it all, because my father was an inveterate writer. He just wrote continuously.

Then on the third floor, of course, there were about six guest rooms. It was rare that we would have dinner alone during that immediate post-war period because my father was very famous and visitors were coming from all over the world. He would always ask everybody who came to visit him at the clinic home for dinner. So mother had the organization there to run a hotel, and she

did. We very often had two or three people living in the house too for protracted periods of time.

So, luxurious as it may seem, it wasn't absurd for the needs of that particular time. So that's where I was born and grew up.

But my father was a farm boy and he always liked to keep in touch with the reality of things. When I was about seven or eight years old, he sent me down, one whole summer--first it started off to be going down for two weeks, but I liked it so much that I begged them and they allowed me to stay there most of the summer--with my uncle, who had a farm near where my grandmother had her place and where my father came from. So I worked down there on the farm all that summer. I used to get paid 10¢ a week for setting up corn. The horse would drag the plow around the field to plow up the weeds and the big chunks of earth would fall now and then on the corn stalk. And that would crush it or deform it unless a little boy was following along behind and he would pick that up.

My cousin was a little older than I, he was probably around nineteen or twenty, and I found out that this corn machine was going round and round this hill and going back to the same place again. Not very far away, a couple of hundred yards away, was a nice bend of the creek with a swimming hole in it. I found that by working very fast on the corn, that I could stop every other row and go swimming and come back, or sometimes two or three rows, and still do it just as well. That infuriated my cousin, because he thought that was cheating, So we had a big inspection. The family came out and said that I was doing it okay.

So that was my first adventure in short-cuts.

I had a marvelous time down there that summer. I remember the ice cream,

when my week's savings would go for the ice cream at the Sunday church events that usually went on, Saturday nights or Sunday. It was a beautiful experience. Cherries ripening in the sun.

WEEKS:

I understand how you turned out to love nature. How about your father, did he inspire you to become a surgeon?

CRILE:

I never had any other thought.

WEEKS:

You just took it for granted this is what you were going to be.

CRILE:

I was the first boy, I had two older sisters and I have a younger brother. But it never occurred to me that I would be anything except a surgeon.

My father always brought me up with things called the weasel stories and they were adventures of a family of weasels who had the same name as our family. It was science fiction of the highest order. Very informing and very philosophical. We would listen to those, breathlessly, at breakfast every morning and then they would be continued the next day.

WEEKS:

Even though he was a busy man, he did have time to spend with you?

CRILE:

Well, he'd come rushing home at night, rather late. We all had dinner together, even when we had company--we children. I suppose when we were very small we didn't. But in my memory, since I was eight or ten, we always dressed up for dinner every night. My father wore a tuxedo every night. My

mother put on an evening gown every night for dinner. We all put on whatever was appropriate for our age and all sat down there, a little bit stiffly, I guess. But it was all right. We met lots of interesting people, always good conversation, and I think it was good for us.

The other thing was, that weekends were always ours because we had this place in the country where we had a stable of horses. Father was a great rider, he had been in the cavalry in the Spanish-American War in the old Troop A down here in Cleveland. It was a famous horseback troop. We went on these wild rides. He was a very dangerous rider. He had several bad falls, himself, broke ribs and sprained a wrist and did all sorts of things, but he survived them all and we all did. My sister broke an arm one time and that was about all that ever happened. We rode all over that whole area. We had, at that time, more than two thousand acres out in the country. We had trails through it. We used to ride it like mad.

Then we would go on vacations, usually that would be something in the country. When I was very small, we went down on vacation in Florida, on the West Coast there. There was some island off shore, I remember it very well, we went out to some sand dunes. Everything was always happening. The boat broke down on the way home, got completely shrouded in fog. Nobody could figure out where we were. Finally somebody rowed ashore and then another boat came out. By that time, the fog was so thick you couldn't see anything. By the time the other boat came out and fixed this boat, neither of them had a compass, they didn't know where shore was. All of a sudden a rooster crowed. My father said, "Never mind the compass, that's where we go." So that's where we went and we got home all right. I was about six then. I remember a man fell overboard that night.

Then we used to go on these long trips out West. Take a month vacation, go out and ride horseback all through the West, a four state trip, Colorado, Utah, New Mexico, through the Grand Canyon and all of that. Then we went up to Canada, too, and took canoes and camped out on islands and my father finally ended that by buying an island. Up on Lake Timayami, it was a beautiful little place. He had always sent me to camp there, as soon as I got old enough to go to camp. I used to spend the summer on these long canoe trips. So I was perfectly competent to take care of myself in the wild or anywhere.

WEEKS:

You grew up in Cleveland and went to school here until you went away?

CRILE:

To University School here in Cleveland until I finished my sophomore year and then the standards of those Eastern prep schools, at that time, were somewhat higher in certain areas, like Latin and all, than ours were, so I repeated the sophomore year when I went to Hotchkiss. I thought that was a pretty disastrous school. I never liked it, but they did have good scholastic standards. I was always in athletics. I played football and I was on the track team. That prepared me for Yale, where I went to college. I did the same things, I was on the Yale football and track teams. I went there with friends and associates.

WEEKS:

Well, it's the natural place to go after Hotchkiss, and you went to medical school at Harvard.

CRILE:

That's right. I was never a particularly good student in prep school. I

got very ordinary marks. I think I got third honors, finally in my senior year. But prior to that I never really had anything. In college, I was not particularly interested in most of the things I studied. Although, I must say that I did begin to like the sciences. We had a marvelous course in social science, the science of society. Old Dr. Keller was teaching it. He was a practical old cynic. It was how the origins of all human customs come about. Very philosophical course, and I loved that. I got about second honors in college. But I was never particularly bright.

But in medical school, everything was dead easy for me because I had been, by that time, working summers in the clinic. I had been working in research by the time I went to medical school. You know, you just learn the language of science. I think one of the hardest things for youngsters when they come from college and they have not lived in medical families, they suddenly come in contact with all this new language and they just don't understand it completely. Well, that was almost part of my nature, I had been born to it. I heard the conversation at dinner every night, I heard it in working the summers at the clinic. So it was no problem at all in medical school. I was graduated summa cum laude from Harvard, and never had any problems.

WEEKS:

Your experience, let's see, you went to Barnes in St. Louis?

CRILE:

Yes, Barnes Hospital in St. Louis, which was a marvelous thing. It was just like black and white after Harvard. Harvard was so stuffy and so unspecialized. It was just the time that Elliot Cutler had come there as Chief of Surgery. I remember Elliot Cutler doing his first clinic where medical students were going to watch him operate. He said, "A surgeon must be

able to do everything." He said, "This morning I'm going to do first of all a brain tumor and then a hysterectomy." If I ever saw two disasters, that was it. The patient with the brain tumor died on the table and with the woman with the hysterectomy he got all mixed up and removed most of the vagina, and she bled and it was just a disaster.

I had seen enough surgery by that time that I knew that he was all mixed up. Boston was mostly that way. The medical departments were very good, but surgery was extremely poor, compared with more specialized institutions.

Then when I went out to Barnes Hospital, Everts Graham had just recently done the first pneumonectomy for cancer of the lung and they were beginning to develop pulmonary surgery as a specialty. Barrett Brown and Blair were at the peak of their careers in plastic surgery. They did marvelous plastic work. And it was not just facelifting surgery, this was cancer of the head and neck, cancer anywhere on the surface of the body, and the plastic repairs that go with it. They were just fascinating.

Orthopedics was highly specialized. Keyes was in charge of that. GU had a couple of great men, they were leaders in the field of transurethral resection of the prostate. Neurosurgery had Saks, an absolutely tremendous leader in this field. Gynecology had Crossen, a writer of many of the current textbooks and all. It was, by far, the best surgical service in the world at that time. And I had a year there. I never regretted it, I just thought it was a wonderful year.

WEEKS:

Then you came back to....

CRILE:

Then I came back to Cleveland Clinic and had my residency in surgery at

the clinic. In those days, it only took two years after internship.

My father was still active, but the main, dominant surgeon at the Cleveland Clinic at that time was Dr. Tom Jones, who, again, was an absolutely superlative technical surgeon. Tom could do a combined abdominal/perineal resection, front stage and back, opening to closure in thirty-five to forty minutes. I've never seen anybody as good. The whole team, all the people in the operating room were just trained to turn the patient over and go right on with the procedure, you know, to do the posterior part of it. He was just as good in all abdominal surgery.

Dr. Dinsmore was there too. He was a great philosopher and widely acclaimed by surgeons everywhere, for what I don't know, because he was not a good technical surgeon. But he was a good surgical philosopher and wrote a lot about things like that. He ended up by being president of the American Surgical Association, of all things.

WEEKS:

It seems that sometimes men serve a different purpose from what you think they would, and do it well.

CRILE:

We were in a bad situation because by the time I got through, the market crash came in 1929 when I was a senior in college. Then as you remember, the market kept on going down so it hit its bottom really and the worst of the depression was in 1932 and 1933, just about the time I was graduating from medical school.

Well, at the same time the clinic blew up. We had the big clinic disaster, with a hundred ten or twenty deaths. Everything had to start all over again after that. Didn't even use the same building, they built a new

building. They continued to use the building for other purposes, but there was a sort of stigma attached to it for a while.

Those were very hard times and my father should have retired at that time, but he couldn't, because he was bringing in the money that kept the Cleveland Clinic going. Tom Jones was not nationally established at that time and the clinic was my father. Surgery was the main source of income and it was mainly thyroidectomies.

In 1927, we did more than 2,000 thyroidectomies at the Cleveland Clinic, about 2,500. Now we're doing about 25 a year because we have learned to treat almost all thyroid disease except malignant disease in other ways. Malignant disease, now we don't have to operate on unless it's truly malignant because we do routine needle biopsies. So we'll never build a clinic from thyroids again.

But during that time, my father lost his eyesight as a result of cataracts. He had an operation. He had glaucoma first, for which he had an operation and then he had some cataracts. So he lost one eye altogether and had very poor vision in the other and was doing his operations largely by hand, by touch. Thyroids and adrenal denervations which he did for hypertension. He was a little overenthusiastic about the results of his denervations., I think, at that time. The tension of all of this and trying to keep up in the face of his handicaps was a very bad thing for him.

So for several years, after I first came to the clinic, while I was resident, he was still operating. By the time I got on the staff, he pretty much turned it over to me, and so I inherited what thyroid practice he had.

WEEKS:

Yes, I was wondering. In reading about it, I noticed that you had the

same specialities that he did.

CRILE:

To begin with, I had an interest in the thyroid, yes, but I've had many others during the years. I never remained in any special field.

WEEKS:

I haven't read your father's autobiography, but in what little I have read, it seems he was a very dynamic man. He must have had a tremendous amount of energy.

CRILE:

Tremendous. No question. That whole shelf contains the books that he wrote.

WEEKS:

You sometimes wonder how a man can accomplish as much, how he can find the time, have a family....

CRILE:

He had a wife who was absolutely devoted to him and she had a secretary at home to help him and at the clinic he had excellent secretarial and other kinds of help. His chief helper was Miss Rowland, who was a college graduate from Bryn Mawr, or some place like that, Vassar, I don't know. But she was an absolutely magnificent woman. She could run any business in the world. Extraordinarily intelligent, and helpful.

WEEKS:

Would you like to talk about the three or four men who started this clinic and how they happened to work together?

CRILE:

What happened was that my father came up from down on the farm and he went

to work with Dr. Reed. Dr. Reed was a general surgeon who was working in town here. He had a big practice, quite a bit of it industrial. There were a lot of industrial accidents in those days. Many more than now because then nobody fussed about the machinery being dangerous.

So he came in, after his graduation from medical school, such as it was. I think they only went to school for a couple of years after high school at that time. No college or anything. So he was a young man. He went in and Dr. Bunts was working there too. Dr. Bunts was a little senior to my father, but they became very good friends, worked together very well. The business increased and they then sent for Dr. Lower, who was my father's first cousin, from the farm. Dr. Lower was a little younger than Dr. Crile.

So that was Bunts, Crile and Lower. Then all of a sudden, Dr. Reed died. So Drs. Bunts, Crile, and Lower took over Reed's practice. They had their offices together and worked together down in the old Osborn building. My father after a while became the head of the surgical department and professor of surgery at Western Reserve operated down at the old Lakeside Hospital.

Dr. Lower, I think, was head of surgery at one of the west side hospitals. Bunts was always, more or less, a private person. He never had a very large practice. My father always said that they put Dr. Lower in for economy because Dr. Lower was a real pinch-penny, went around turning out the lights all the time. They put Dr. Bunts in for the face of it because he was such a handsome, nice looking man and never did anything wrong. So Bunts was their face, and Crile and Lower were really the driving force behind the whole team.

I heard the story differently from different people, I can't attest to the

veracity of this, but as I understand it, there was a chief of surgery at Lakeside who was not very effective and my father wanted that position. He knew all the trustees, he had operated on them all and was good friends with them.

He said, "Don't you think we ought to pass a law that we should have a retirement age of 60. (This man was about 58 or 59.)"

They said, "Sure."

So, they passed that law. That was just fine, until my father got to be 59, at which time he wasn't going to go back on the principle he had started so he started the Cleveland Clinic and pretty well put Lakeside out of business. Then that's when Dr. Philips joined them too. Dr. Philips, in medicine, was from Lakeside Hospital, and the University.

WEEKS:

They did, for a while, take their patients to Lakeside and the other hospitals in town, didn't they, until you built your own hospital?

CRILE:

No, we built the hospital at pretty much the same time.

WEEKS:

Oh, I see. This goes back to '21 or '22?

CRILE:

1921. They built some hospital beds. There were no laws at that time against things like this, they used to have the Oxley nursing homes over there. They were little tinderboxes, they were fire traps, but nothing ever happened. Up and down on 93rd street. They just converted those from residences into little wards and rooms and patients would stay there and be brought across the street on stretchers for operations and then brought back.

WEEKS;

I suppose there have been many hospitals in this country start that way from a mansion or a residence of some kind. I can think of two or three of them that did.

From the very beginning, did the four men, and the people they hired later, work on a salary basis?

CRILE:

No, they had their independent practices, when they were down in the old Osborn building.

You see, the war had another impact on them too. Three of these men were in the war together and they worked together. They were used, then, to working on salaries and they liked that idea. So from the time the Cleveland Clinic started, it was always salary.

WEEKS:

Then it was shortly after that that they formed the foundation, the Cleveland Clinic Foundation?

CRILE:

Each one of them had a certain amount of stock in this Cleveland Clinic Foundation. And then as soon as it got started they all gave all the stock back to the Foundation.

WEEKS:

This meant quite a contribution on their parts. They put in a great deal of their own money and actually gave it up. So then when they started working on a salary basis, anything the clinic earned beyond expenses went back into the clinic?

CRILE:

Went to research or expansion.

WEEKS:

This is a very unusual situation, even today. When you consider fifty or sixty years ago, it's quite an unusual thing.

CRILE:

Well, these men were wealthy, they had huge practices, and money did not mean all that to them. They had no problem about money. I mean, I was literally born with a silver spoon. I never wanted for anything. Even in the Depression, somehow or other, my mother had some independent wealth of her own, too. Even with the clinic blowing up that didn't affect that. We never ran out of money.

WEEKS:

So the money in itself didn't mean anything, but nevertheless it was an unusual gesture on their part to do this.

So the four men continued to run the clinic foundation for some time. Do you want to talk about the disaster?

CRILE:

I was a senior in college when the clinic disaster hit the headlines. I remember very clearly it said, "Dr. Crile went through the holocaust." Well, I didn't know what the heck a holocaust was. I thought it was something like a laundry chute. Well I found out what a holocaust was and it certainly was a holocaust. A hundred ten or a hundred and twenty people died. It was not a fire, this was all due to films, nobody knows for sure how they were set afire, but there was a workman who had been in the film room. In those days films were flammable, although this hazard, the gas hazard, was not known. They were in a special room which complied with fire department regulations

but somehow it had access to a ventilating shaft. When this film fire was started, whether by an electric light lying on a film or whether from the man in there smoking or using some kind of tools for something, anyway it started. In no time, the entire clinic was filled with highly lethal carbon monoxide and nitrogen dioxide. Nitrogen dioxide, as soon as it hits water, turns into nitric acid and this burns out the lungs. So these people died of pulmonary edema, if not within hours, they sometimes died three or four days later. It was a very disastrous thing.

WEEKS:

There were many, many people who are prominent in the clinic?

CRILE:

Dr. Philips, himself, died. He was one of the founders. He died in the disaster. We lost one or two others, we lost a neurosurgeon. Dr. McCullagh and Dr. Rudeman, both of them were seriously gassed, but recovered.

WEEKS:

This occurred, as you say, just before the Depression or just as the Depression was beginning and the rebuilding must have been quite difficult to finance.

CRILE:

They had plans already go ahead. My father was a genius, nothing ever would stop him. He had the full support of everyone in Cleveland.

You know, Cleveland at that time was one of the most booming and finest towns in the country. It was the fifth largest city. We had a very rich group of very public-spirited people who gave to all the good things, the cultural things. We had a beautiful art museum, natural history museum, opera, the symphony. All of that, all of those good things about Cleveland

were started back in that period or before. The same people who sponsored those would give my father assurance that they would support him in loans and so forth to get started again on the clinic. There was very widespread support for the clinic's next stage of development.

Just at that time, there was an old friend of my father's, Mrs. Lyman, with whom he had boarded. She and Mr. Lyman had a house on the west side and when Dr. Crile first came to town working for Dr. Webb, he was living, boarding, at her house. She had a great influence on him. She was a school teacher and later the headmistress and founder of Laurel School, which is the main girl's school in this city, and remains so to this day. She was an extraordinary woman, and they were best friends. She had just moved out from the old Laurel School which used to be there, into a new one which they were building up the street a way. There was a vacancy there, a dormitory and everything, so they just moved the clinic across the street, and never stopped seeing patients.

WEEKS:

It had to have community support in order to come back with that kind of resilience.

CRILE:

Of course the hospital wasn't affected at all, this was a different building.

WEEKS:

There was a research building also, wasn't there?

CRILE:

The research building was there at the time of the disaster.

WEEKS:

I've been wondering about the hospital itself. Was this staffed only by your people from the clinic?

CRILE:

Yes, we always had a closed-staff hospital.

WEEKS:

I've been wondering about how patients were admitted. I know that with your type of operation, probably most of your patients come from a distance, referral patients or people who come here because of the reputation of the clinic, the same as they go to Mayo.

CRILE:

Probably, we don't draw from as far a distance as Mayo although we were getting more and more foreigners in our cardiac department. Mayo draws pretty much from all over the country. I'd say we draw, perhaps, 30% from greater Cleveland. The rest comes, maybe 80%, from within two or three hundred miles driving distance and the others from anywhere.

WEEKS:

We've noticed in Ann Arbor that the University Hospital, as an example, which used to pull from all over the state, now doesn't have quite as large a service area because there are other medical centers in the state that may not be as good, but they have many of the services that the University hospital has.

CRILE:

That is true, it's becoming much more competitive.

WEEKS:

If a person decided on his own that he wanted the services of the Cleveland Clinic and he came here, would he be screened? For instance, if a

man comes and says I have a pain here, or whatever, and he doesn't know what sort of specialist he needs, how would he be processed?

CRILE:

I suppose they just go to the front desk and say I've got a pain in my belly and would be seen by general surgery or somebody if they thought it was an emergency. There is an emergency room, too.

Most everybody, though, comes in with some kind of an idea about what they want to see. People aren't very naive these days. Most people are pretty well up on everything.

WEEKS:

I think this is one point that you've made somewhere in your writing, that people should question what's being done to them or what's being proposed for them. I sometimes think when you look at some of these TV shows, medical shows, the surgeon is immediately a miracle man and even if it isn't his specialty, he can do anything. I think this has been a distorted picture that some people have gotten of the medical profession today and unfortunately it is that way.

Another thing I've been wondering about the clinic...I noticed that in reading about it, when you said you wanted to open a certain new department or new division, the clinic would go out and hire somebody from Johns Hopkins or some noted person. You were able to go out and hire the best, let us say.

CRILE:

Not necessarily. We don't necessarily hire people who are famous at all. We prefer to find a young person who we have confidence in.

WEEKS:

But the point I was bringing up was that you can choose the person you

want to add to your staff rather than in a general hospital, where a physician might apply for staff membership and privileges.

CRILE:

Nobody applies to the Clinic. Nobody comes there unless we ask them to.

WEEKS:

Well, if a person comes here for training, then you might observe talent in that way and say we'd like to retain this man or this woman. This person seems to have a lot of talent. So then the first thing to do is to try to get a residency here, if possible.

How about a nursing school, have you ever had a nursing school?

CRILE:

I don't think so, we never had a school but we, from time to time and I think still do, take nurses from the established Cleveland State Nursing School, and they come out here for a certain part of their clinical training.

WEEKS:

My observation of nurses in hospitals is that quite often a hospital has to do a lot of inservice training in order to teach the nurse as to how this particular hospital handles a certain situation. For instance, one hospital may allow a nurse to do a certain amount of things and another might not.

You are very much interested, of course, in quality of care. I wondered what you have thought of the various peer review procedures. What does Cleveland Clinic do?

CRILE:

We never had any, I don't think, because we're too close. We are all looking right over one another's shoulder all the time.

WEEKS:

Are decisions made independently by the various physicians?

CRILE:

Well, if somebody is doing a lousy job, everybody knows it, he'd be fired. That's happened often.

WEEKS:

You don't have any requirement of second opinion or this sort of thing?

CRILE:

You see there's no problem about this because all of us are salaried, it makes no difference to us who does what. If there are any questions in our minds or in the patient's mind, we automatically ask for a second opinion. Then there's no charge for the second opinion or anything, because we just want a backup on this. We do that all the time, we're working together.

WEEKS;

Since there is no fee-for-service here, how are fees set?

CRILE:

Oh, no. There's fee-for-service, but it doesn't go to the physician.

WEEKS:

That's what I mean, there is no fee-for-service for the physician but how is the fee schedule set up for the patient?

CRILE:

Just the way it is in any other hospital.

WEEKS:

You have a fee schedule for a certain kind of surgery.

CRILE:

The ticket is marked. I think that this is subject to upward slants with inflation but, a followup visit is \$10, and office call is \$15, consultation

\$20, limited physical examination--that would be like a new patient coming in with a thyroid problem--is \$25.

WEEKS:

Have you had trouble working with Blue Cross and with Medicare and so forth?

CRILE:

I don't know of any.

WEEKS:

We haven't talked about your educational unit yet, but I wondering if any of that expense could be charged through the hospital to Blue Cross or Medicare? There's been a great deal of argument about what allowable costs are. Residency training programs are fairly simple, they can be charged fairly well, but there are some fringe areas where Blue Cross and particularly Medicare won't allow certain costs. I was wondering what experience you had had with that.

Do you know George Bugbee, who was here in Cleveland at one time at City Hospital? It was back in the thirties that he was here. He later went on to become head of the American Hospital Association. He told me about the time when the American College of Surgeons had originally had some kind of an inspection program for hospitals and it got to the point where, this would be in about the forties I think, that it got to the point where the College didn't have enough money to pay for the expanded services they wanted to do and they were at the point of giving it up when the American Hospital Association and I think the AMA and the American College of Surgeons and American College of Physicians and maybe a Canadian medical association at that time, set up the Joint Commission.

Have you had any observations of the effectiveness of the Joint Commission?

CRILE:

I know every now and then we get inspected for something or other....records and things. But I don't think we've had any trouble with them.

WEEKS:

Do you have any opinion as to the effectiveness of these programs in providing better care? Of course, from what I have read of the Clinic, this has been one of your tenets anyway, is to provide the best possible care.

CRILE:

I think that we don't suffer from the same problems that the ordinary hospital has, because our men are hand-picked. If they don't perform, we fire them. So we don't really have to worry too much about what they do, because we have confidence in them.

WEEKS:

Once in a while you read something about some hospital or board of trustees that's been sued by a physician whose privileges have been taken away. Would that be conceivable to happen at Cleveland Clinic?

CRILE:

It never has, as far as I know. But this isn't a question of privileges, this is a job. If you do a lousy job, we've got a right to fire you. You see the ordinary hospital grants these privileges on the basis that the man is qualified to have them, and we don't. We don't have to accept anybody. You come into a hospital and say, I'm fully qualified and everything, they more or less have to give you privileges. But we don't, because it's a private thing.

WEEKS:

I assume then that you have some method of evaluating these people before you hire them.

CRILE:

Well, their reputation, what we can find out about them and so forth. They are screened as carefully as we can. We've made mistakes and we've gotten some that haven't worked out. We've given them plenty of notice. They're better in the long run to move on.

WEEKS:

Will you talk about your ideas of fee-for-service payment to the regular physicians, not connected with a salaried post? I think I told you I read a statement by you in Harper's many years ago, that was when I first recognized your interest in this. For the record, would you like to talk a little bit about it?

CRILE:

Well, it's nothing. Except I don't think that a thing as important as a decision regarding a surgical operation, which is not like a medical treatment--most medical treatments you can try for a while and then stop and try something else--a surgical operation is a one way street. You commit yourself. After you've taken out a breast or a lung or a stomach or something like that, that's the end, you can't put it back. There's mortality involved. I don't think that there should be any financial considerations involved in this.

The average person only goes through surgery a couple of times, perhaps, in his life. So a little inconvenience, for example, perhaps having to wait for appointments, is not the fundamental thing. In your daily experience with an internist, if you have go to in to see him once a week for some disease for

the rest of your life, you want him to see you promptly and to be polite to you and be nice and everything. That is a continuing relationship and it's better harvested by fee-for-service. He's more polite to you and more prompt.

But on surgery, no, I don't think so. I think... The surgeon likes to operate. That's pleasure for him. I think that a lot of internal medicine, a lot of office work, can be fairly boring after many years of it. Seeing the same old person, you more or less have to be paid to do it. But surgeons would almost pay to operate. It's fun, like playing the piano or playing golf--and it's a skill.

So I really think that to add to that a financial incentive where you get paid nothing if you say that an operation is not necessary or you get paid five to ten times as much if you do a big one instead of a small one, I just think it's wrong.

WEEKS:

There's no question about that. You used the word and I'll Anglicize it "functionlust", I assume that was from the German originally. The joy of doing things. Then there's another angle too, that I think enters into it possibly, I don't know whether you agree or not, but if you're trained as a surgeon, you see your solutions in terms of surgery.

CRILE:

Exactly. It's no different than if you are looking for a car. You're not going to go into a Buick agency and have them say, oh, no the kind of car you want is down the street with Chrysler. They just don't work that way. They'll give you another General Motors product. The same way with Ford. They're not dishonest at all.

Neither is a surgeon dishonest because he thinks that his way of treating

this is good. But you're not going to have a surgeon, if you come in with a little lump in your breast, you're not going to have him say, "All you need is a lumpectomy and radiation. We have this wonderful radiation therapist down there. The results will be just as good as if I did a modified radical mastectomy." They don't say that because they don't believe it.

WEEKS:

But then the point comes, who makes the decision as to what treatment.?

CRILE:

The patient.

WEEKS:

But as you said, the patient has to be educated.

CRILE:

You're darn right.

WEEKS:

To me this is a very important situation and I don't think we've ever found an answer to it. I don't know whether you have an answer to it or not. Take cigarette smoking, we ban advertising from television and radio, we have a warning on every package of cigarettes, and yet there are millions and millions of Americans smoking although they may have complications from cancer or heart but they are saying that won't happen to me of course, or something to that effect. I enjoy what I'm doing, if I live a year or two less...All kinds of answers.

Today, when I was coming out here, I saw a couple of kids in the airport, playing with the doors. They stopped, they weren't over ten or twelve, got out some cigarettes and started smoking. Why were they doing that? How do you convince them not to?

CRILE:

I think if we spent the same amount of money, going absolutely all out, and banishing cigarettes, making it a disapproved thing, I think we could do it...in a short time. I think we'd save many more lives and much more health than a lot of the money we spend on other so-called health things.

WEEKS:

I think somewhere you said that you recommend starting in the early school age to change habits because adults are pretty well set in our habits. Somebody who tries to change one's habits by an argument is going to find it very difficult. It is difficult for us to listen to logic when we are emotional about what we are doing.

CRILE:

It is a peculiar thing, I don't know if you have noticed it, but in physicians' meeting now or in many of the social meetings you go to today, people will simply not light up cigarettes.

WEEKS:

I think there is much less smoking among physicians, although a couple of years ago, I spent three days at a meeting of the deans of medical schools founded since 1960. I was surprised at how much smoking there was going on.

CRILE:

But they are not clinicians. Really, in clinical meetings, and among their wives too, it's very rare that you see, in the evening with cocktails and all, it's very rare that you see any smoking now. It's been that way in England for quite a long while.

WEEKS:

I've noticed something, too, in more recent years, that people will object

to someone smoking in their presence such as in a public place. We know of the segregated sections in the airplanes and the restaurants and so on. It's taking hold, but can we convince the young people coming up? Why is it smart to smoke?

CRILE:

The same with drugs.

WEEKS:

I don't know how we can do it, but I agree with you that something has to be done.

One thing that you have been interested in here, at the Clinic, is not only medical education in the sense of residency, but what other things have you done? Have you had extended education?

CRILE:

Oh, yes, we have about fifty postgraduate courses a year here. They each last two or three days.

WEEKS:

Are these open to anybody but your own people?

CRILE:

They are open to everybody. In every specialty.

WEEKS:

I imagine this has helped your relationships with the other hospitals, since you have a closed staff. I imagine there's a certain amount of feeling of being left out a little bit because they don't have any privileges at your hospital.

CRILE:

I don't think many of the people from other hospitals in Cleveland

would ever bother to come. In other groups, there is too much, I don't like to call it jealousy, too much competition, so I don't think anybody from any other group would ever come to our meetings any more than we'd go to theirs.

WEEKS:

You wouldn't go to theirs if you were invited personally?

CRILE:

Oh, to speak, sure, but I wouldn't go to listen.

WEEKS:

Well, you and Mayo and others, if there are others as well known as you two, receive a great number of visitors. I noticed that you also work the other way, that you have traveling fellowships, so that you can send some of your people to observe procedures that are being done other places?

CRILE:

Yes, we have those in I don't know how many departments. I know we have in general surgery and some other departments. They go, sometimes abroad and sometimes in this country, depending on where the interest is.

WEEKS:

You've done some of this yourself, haven't you? Traveling for that purpose and other purposes. I know you're a great traveler.

CRILE:

Oh, yes and whenever I travel, I always look in on the medical facilities.

WEEKS:

I was impressed somewhere in something you wrote about the condition of little children in India or somewhere, while at the same time some very sophisticated procedures were tying up the hospital.

CRILE:

Actually, the most dramatic one was in Haiti, where they were doing all these adrenalectomies....these little old ladies dying of breast cancer. Paying no attention at all to the children who were dying. These women were over eighty years of age, having adrenalectomies. These little children, their toes and fingers dropped off from drinking bush tea!

WEEKS:

Recently, we've had a lot of publicity on some of the news programs about the baby formula versus human milk in Africa and places of this sort. I've known some of these companies that make some of these things and I've had a pretty good regard for them. You've got one right here in Cleveland or Columbus. Similac, owned by Abbott Laboratories. What I can't understand is why we, ourselves, take all the blame or blame is all pointed to the Americans when there must be somebody down there buying this stuff, there must be somebody who is responsible for poor water supply and all these things.

CRILE:

I don't know much about that. I've got a pretty strong feeling that we've got enough problems of our own that we don't have to go all the way out to foreign places to look for problems. There are problems enough in our schools and what you were speaking about--the cigarette problem--until we solve that, I don't think we have to worry about what babies eat in India.

WEEKS:

Quite often when we read about the draft of World War I or World War II we read about the poor condition of health of these draftees or people who registered, at least. We still haven't made a great deal of improvement, we've made some I'm sure, but I look about me and I see people and I wonder isn't there a better way to live. Couldn't they do better?

CRILE:

I am fundamentally a clinician and always have been. In the years before World War II, I was quite conventional. I was just trying to establish a surgical practice, and the competition was pretty brisk. There was Tom Jones, who was, as I say, a superlative abdominal surgeon and Bob Dinsmore, he did thyroidectomies. He had a big reputation for that. I was just trying to do anything I could.

I never did much of anything original before World War II. Then all of a sudden, I got thrown out on New Zealand, where we had the casualties from Guadalcanal and all of the island warfare as well as those things that happen at a big Marine base. After that, I went back to San Diego, which was the largest hospital that the world has ever seen, some 25,000 or something beds in it. The skipper of the hospital never would discharge anybody who could build. Any carpenter, any brickmason or anything. He wanted to have the biggest hospital that was ever built. So they just stayed there and built. They didn't mind, it was better than going out and getting shot.

So the hospital kept getting bigger and bigger. It was a good thing, too, because that was where all our Navy and Marines were based, out there on the Pacific.

So we would see eight and ten or more acute appendices every day. Just an enormous experience and all that ordinary things which I, having spent my life in places like the Cleveland Clinic, never had seen before, at all.

We got some new ideas about pilonidal sinuses and cysts, for example, and all of that. I had always done them like everybody else, but all of a sudden I began to look at them because I saw them in this volume and it's obviously just ingrown hairs, so what's the use of cutting it all out. No use, you

don't have to, all you have to do is pull the hairs out and they heal right up. Then you keep the hairs from growing back in. The cysts, you just put in a little catheter with a little thing on the end of it so it doesn't fall out and leave it in for a couple of weeks and then pull it out and the whole thing heals right up and there is no problem.

All that was purely unnecessary. Appendicitis, we could treat it--they were operating at that time--the corpsmen, totally untrained to do surgery were doing appendectomies in people on submarines, getting great acclaim. I thought that was absurd.

So we ran the first large series of ruptured appendices treated with penicillin, there were fifty cases, with proven ruptured appendices. This was a continuous series and there was only one who had any fatal complications. That wasn't due to the failure of the treatment, it was due to a mesenteric thrombosis which just went up all through the liver and everywhere. But the peritonitis never killed him, just the vascular complication.

So we established the fact that appendicitis could be controlled this way.

There were just a lot of things that I figured out that were different from the way I'd been taught. So I said, perhaps everything is different from the way I've been taught. I came home and tried to look at everything then as though each problem I'd never seen before, and didn't know an answer, and asked myself what is the logical thing to do. So that was great fun.

That was all clinical research. It wasn't until very much later that I got really interested for the first time in laboratory research. I had done some under my father's direction, as a medical student, as I mentioned before, but nothing really on my own.

In 1950, I began to become interested. I wrote a book called Cancer and

Common Sense. I was interested in the problems of cancer and thought I'd like to do some research in cancer. So I got working with mice. This is where the clinic is wonderful because they have all the facilities there. They have a place to keep the mice, and operating rooms for mice and the whole works. They'll let you have a technician.

It so happened at the time, that I had a young woman that was in the house here...no that was later....my first technicians were different. They were full-time regular technicians. They worked with me and I would spend about two half days a week in the laboratory and I would do all the technical work myself, and all the final results of the experiments I'd do myself, and read the results myself, and do the autopsies.

We put the tumors on the hind feet of these mice. You could watch them grow and of course they metastasized to the popliteal nodes, inguinal nodes and so forth and to the lungs, depending on the type of tumor that you had. It was a marvelous location for it because they could be treated easily by either surgery or radiation or by combinations, and so forth. We worked a lot with radiation.

Then we began to work with heat and radiation. Some very dramatic things. I had a marvelous period of about ten years in there when we worked. About half way through that period, my wife, Jane, had cancer of the breast. She had a simple mastectomy and she never had any more trouble locally but five years later she died with cerebral metastasis, metastasis of the brain.

In the meantime, however, she worked with me in the laboratory. She was very much interested as a result of her problem. So she was an ideal companion as well as technician working in the laboratory together. We published a number of papers.

WEEKS:

Talking about writing a book on cancer, you have written many books, haven't you?

CRILE:

About twelve.

WEEKS:

I know what that means, having been through it a little bit myself. Many of these books have been for the general public.

CRILE:

No, most of them are technical. About half and half, I guess.

WEEKS:

I was wondering about the titles. I was thinking particularly about this last book, it is certainly written for the public. The Alternatives of Surgery. You wrote a book on cancer....

CRILE:

Cancer and Common Sense and then I wrote, on medical subjects, What Women Should Know About the Breast Cancer Controversy. And then this last one, Surgery, Your Choices, Your Alternatives. Then I wrote some other things like on travel and underwater. I've always been interested in diving. Treasure Diving Holidays, that was the most successful book I ever wrote. It hit the best sellers list for the Herald Tribune and was translated into Russian and German and Japanese.

WEEKS:

I only had one foreign translation, that was Portuguese. It must be a thrill to have it in several languages. More than Booty was a beautiful book. I picked it up at the city library the other day, I read it and I

handed it to my wife and she's been reading it. She was very well taken with it and she wanted me to be sure to tell you how much she's enjoyed it.

You've been busy in your travels and in your writing. What are you going to do now?

CRILE:

I still see patients three days a week. There is a lot of office work. I'm sort of the distributing center.

You see, during the years, if you have an interest in breast and thyroid, your patients don't die very fast. If you are a specialist in cancer of the pancreas, for example, you'll never have a very busy office practice because your patients are all dead in a year. The same is true of cancer in many other organs. I think these pulmonary specialists don't ever build up a very large following.

But most of the breast cancer people die very slowly, if at all, and the thyroid ones practically never die. So you get this ever increasing number of people that want to see you. They like to see the person who has taken care of them through the years, and I like to see them again, and see the follow-ups. Then there also the people who hear about you for one reason or another, this breast business. See we've been doing simple breast operations and saving the breast in 10 to 15% of all cases in breast cancer with operable breast cancer since 1955. Which makes us about the first people in this country to do a local operation. So this reputation gets around, so we have people from all over the country that come in here for opinions about breast cancer. They like to see me, because they've heard about me.

And I can do the ordinary office work because all it is is the fine needle biopsy of the breast, same with the thyroid. All that is is an 18 gauge

biopsy of every thyroid nodule. This is why we are able to absolutely eliminate all of this unnecessary thyroid surgery. We're down to 25 a year. Before we did routine biopsies, we used to do more than 300 a year. In my father's day, of course, they also operated on Grave's disease. Now we don't operate on Grave's disease, we don't operate on thyroiditis, there's a medical treatment for all of that. We recognize every type of tumor that there is by biopsy and treat it appropriately, and that's all we do. More than half of our patients operated on now are operated on for malignancy. Whereas, it used to be only a small percentage.

WEEKS:

There's no question that procedures change as cause of death has changed certainly over the years. I read these tables of what happened in say 1920 versus what happens in 1980 and it's amazing the change there is.

The reason I asked what you were going to do now, is because I think you asked me something of a similar question.

CRILE:

Well, I still do that and then I travel. We're going to go to China again in April. I have medical friends all over the world and I enjoy seeing them again. I enjoy keeping up on what's going on and I enjoy the travel part.

We have a hobby which is a nice one. We make movies and they are pretty close to professional type movies. Some of them have been shown on BBC television and on national television in this country. I've been doing it for many years. Helga, is of course, not only Carl Sandburg's daughter, but also she is the niece of Steichen, the great photographer. She inherits all of these abilities. She makes beautiful films. Travel films of all kinds and adventure films. We used to make a lot of underwater films. So that keeps us

busy. Every year we have a film festival here at Christmas time which lasts three days a week for three weeks, between 4 and 7. We have about 125 people a night come through and see the movies. We have the house all fixed up.

WEEKS:

Somewhere I read about your scuba diving. Was it in Crete that you were looking at the lost city?

CRILE:

Yes.

WEEKS:

I was wondering if you developed any particular interest in following through on something of this sort or if you just happened to be there?

CRILE:

It's very difficult abroad. They are very strict about you exploring any antiquities. You just can't get permission. You can go exploring for it but once you find it, you can't work the wreck. You've got to have all the authorities with you and everything.

So we've always just been in the exploratory stage.

WEEKS:

Will you please talk about your opinion of HMOs?

CRILE:

I wrote someplace one time that I thought that we ought to continue to try to develop HMOs to the point they were taking care of about half of the patients in the country. Then I think we should let them go and fend for themselves. I think if we had about half of the people in HMOs and half of them on fee-for-service, it would be about right. Because, HMOs, their incentive is to cut down service and not give any service at all. They get

more wealthy the less they do, and the opposite is true of these others. In fee-for-service, the more they do the wealthier they get. From a financial standpoint, the ideal balance should 50-50 and let people go back and forth between these two, which is a good way of keeping both of them in line, because HMOs are going to give better service if they find themselves being run out of business.

Kaiser has been here in Cleveland for a long time and I respect them very much. I think their patients get excellent service. But quite a few of their people still come to us for consultations and sometimes even for operations, when they are not completely satisfied. But I can't say there's any scientific reason for their dissatisfaction. The Kaiser people have given them very good service, as far as I can see.

WEEKS:

This has been my impression. In Michigan, we are having a little controversy going on now about Medicaid patients. The state is trying to enroll them in HMOs where they are available, and they're getting some resistance to this. But if they could enroll every patient, as an example, they could save a hundred million dollars a year, and the people would probably be getting adequate medical care. It would seem to me that particularly where the public has to pay for the care of people, it seems like a normal way to go about it.

CRILE:

The thing that bothers me the most today is the fact that there is this absolutely constantly expanding medical technology. Take thyroid, for example, we see patients come in with a little nodule on the thyroid. They will have had five or six expensive blood tests, all sorts of antibodies and

all sorts of thises and thats and thyroid function tests and then they will have had ultrasound and they would have had a scan, all to find out about this nodule. Now, all of these things are going to show nothing. The scan is going to show it's a cold nodule, 95% of them are, ultrasound is going to show that it's a mixed cystic thing, most of them are. Then where are you around to? You're no further on than you were to begin with and the needle will tell you the whole story. One little needle prick in the office and you have the whole story, you don't need any of that. And it costs, what? We charge the patient, perhaps, \$25.

WEEKS:

How much of this is defensive medicine?

CRILE:

Well, I don't know what defense you could have with these silly things. I don't know that that gives you any defense.

WEEKS:

Against malpractice. Statistically, they could say that we did all these things, I suppose that's their defense.

What do you do at the Clinic for your people? Do you protect them with their malpractice.

CRILE:

Sure.

WEEKS:

So they're working on a good salary and they have the protection of malpractice. Do you do all their paper work for them?

CRILE:

We don't have to worry about anything.

WEEKS:

It seems to me that this is an ideal way for a physician to work.

CRILE:

It is. Our hospital and clinic and everything are right there together.

WEEKS:

Wilbur Cohen, former Secretary of HEW--one of his pet ideas is that if he would like to have the federal government someday take care of the doctors' malpractice insurance. With a surgeon, it must run very high.

CRILE:

They are going to have to change the law. You see there is no other country under British law which allows for the lawyer to take a contingency fee. They are thrown in jail, the lawyers are, if they take a contingency fee in England. This is the same as fee-for-service does for medicine. The lawyer works on percentage because he gets more if he gets a bigger settlement. That shouldn't be allowed.

WEEKS:

It's the old ambulance chaser idea that we used to have and we still have it on a higher level, that's all.

CRILE:

Exactly.

WEEKS:

You didn't tell me about your consulting. Aren't you a civilian consultant to the Surgeon General?

CRILE:

Oh, for a while after the war, I went on one trip with him. I went out to Hawaii and then out around the islands, ended up....had an interesting time,

saw the Naval hospitals, visited Japan.

My first experience with Japanese endoscopy started there. I immediately wrote back to the Cleveland Clinic and said, for God sakes, get us a flexible endoscope.

WEEKS:

Well, there's no question that you must have been able to observe many things that at least made you think of your own situation back here and what you could do. Maybe you wouldn't copy what you saw in every case.

CRILE:

Oh, no! The reason we got a head start in vascular surgery was because I was in England at the time that they were just starting to do the very first vein graftings. So I came right home and we really didn't have much confidence in it, so we took an orthopedic surgeon because we figured we'd have to cut off the legs after we fooled around with these vessels. So we made a vascular surgeon out of him, Al Humphreys. He was one of the first vascular surgeons in this country.

WEEKS:

I can't help but admire the English. I think that the national health service of England is good for Englishmen. I think most of them are quite happy with it. In fact, we had an English Fellow over here at the University of Michigan for a year and he had his wife over here, and his family. The faculty really made it pleasant for them and tried to do everything they could to help them see America and realize how we lived over here. And, of course, the wife liked our cake mixes and all these prepared foods that we have.

My wife and I went to a tea that they gave just before they left. I remember my wife talking to this woman and saying, "We're going to miss you."

Wouldn't you really like to stay here?"

The woman said, "Truthfully, I've enjoyed it here. Our children have been in the University schools (at that time we did have University elementary and high schools,) and I've learned to drive a car, but," she said, "I miss the national health insurance, the security of it. The feeling that's it's always there." This would draw her back to England over everything else.

Is there anything that you would like to talk about for the record that we haven't talked about?

CRILE:

Let me see.

I was trying to remember the things which I thought were worthwhile that I had done. Although, I am a great enthusiast, I throw myself into things at first and then I often find that they are not any damn good at all and just back right out of them.

For example, in 1947, I did what is about the fourth successful radical resection of the cancer of the head of the pancreas, a disastrous operation. I wrote a number of very enthusiastic articles about that. But then, about fifteen years later, when I still hadn't had anybody who was ever cured by a radical operation for cancer of the pancreas, I was one of the first, if not the first, to say that I didn't think that the operation is justified as a routine treatment of that condition, because the risk of the operation, which is as high as 30% in the average hands. What do you call that institution at Ann Arbor? The one that keeps track of all the mortality rates.

WEEKS:

CPHA? The Commission on Professional and Hospital Activities. Their system is called PAS, Professional Activities Study.

CRILE:

They say that the average mortality rate is 30%. Well, now you don't gain very much when you only cure 1% of the people. Most of these people are sixty-five years of age. In terms of years of life, you're losing, if you are operated on for a cancer of the pancreas.

One of the important things that I've emphasized in recent years and is the enormous difference in the mortality rates and the success of operations, depending upon who does them--whether you have a specialized group or just anybody. Now this isn't true of hysterectomy and maybe gallstones or ordinary things, because everybody gets a lot of experience in them. But the more rare operations, cancer of the pancreas and so forth, this will vary anywhere from 5 to 10 to 1. Some people can do cancer of the pancreas with mortality rates of 5%, some of them have a 50% mortality rate. The average is 30%.

I seized on vagotomy. I was the first person to follow Dragstedt--and we immediately had a big series. That's the wonderful thing about working at a place like the Clinic. If they find you are interested in something, you get all the cases and you can get a big series right away. I started doing pyloroplasty. I was the first one to use pyloroplasty to forward drainage after vagotomy. Then I continued on with this developmentation then thyroid and moved in the treatment of hyperthyroidism completely to the use of radioactive iodine, so that was no longer surgical and I moved into the field of papillary carcinoma. They were advising very radical operations. I had a long-standing fight with Memorial Hospital in New York and all of their advocates of radical surgery, because they did these very deforming operations on these young girls with papillary carcinoma of the thyroid. It was disastrous, and they didn't do any better than we did with the small operation

and giving suppressive doses of thyroid, which, again, we found inhibited the growth of thyroid cancer in a high proportion of the cases. That was discovered here.

The treatment of thyroiditis, the use of thyroid in the treatment of Hashimoto's disease was first reported by me. Although thyroiditis, sub-acute thyroiditis, had been treated by cortisone in Scandinavia, we were the first to report it in this country.

Vagotomy and gastroenterostomy or pyloroplasty, I've mentioned that.

In 1948, pilonidal cysts and sinuses, I mentioned that, the surgical treatment of that. I was a strong backer of I¹³¹ in hyperthyroidism, about the first person to go overboard, saying there's no excuse to operate any more. Ligation of esophageal varices.....

A surgeon in Amsterdam simultaneously, but unknown to me, was doing this same kind of ligation. It's funny how those things happen. Somebody out in another part of the world has thought of the same thing. I published on the ligation of esophageal varices simultaneously as he did.

That is for the big bleeding varices. They were doing very radical operations but it can be done very simply. Not for the ones with cirrhosis, but the ones that have congenital abnormalities. You can cure them very well by just ligating them. Esophageal diverticula can be treated by inversion. In surgery of the colon I started using colectomy for acute ulcerative colitis. There was a new type of ileostomy which I developed with Turnbull. Dragstedt had the old type of ileostomy called the skin grafted ileostomy. We called ours the mucosal grafted ileostomy, turning the mucosa inside out. It works very well.

Needle biopsy. I was the first one to use this in thyroid, in office

practice. I was a great advocate of that.

Those were in the immediate postwar years to about 1953. I came home from the war with the fixed thought that what I had been taught prior was wrong. Everything I touched I wanted to find something new.

WEEKS:

It seems that we are overcome by new drugs and new treatments, but then the next year it is something different.

CRILE:

That's right. It keeps changing.

WEEKS:

It must be difficult to keep a balance with all the change that's taking place.

CRILE:

During this period I had a wonderful time working in the laboratory on heat. We used a lot of big animals. We used dogs and other creatures. I had a close working relationship with the veterinarians of the town. Whenever they had dogs with cancers they could not cure--people had given up on them--we would take them over and try various forms of heat on them. (If they had deformities, people would never take them back.)

WEEKS:

I suppose there are extremes in attitudes of persons toward pets. Some would take them under any condition and some would not. Sometimes I think older people are more attached to pets than others might be. They build their whole lives around a pet.

CRILE:

The breast battle was a very long and interesting one. I became impressed

about 1950 with McWhirter's work. It was between 1950 and 1955, about 1955 that McWhirter in Edinburgh, Scotland first published his long series of patients who were treated by simple mastectomy and radiation. He compared that with the previous experience of radical mastectomy and it was favorable.

I was beginning to be interested in immunology at that time. I met Deborah Doniach the most marvelous immunologist, in London, England. She came and visited us here, and she introduced me to the immunological literature. I read extensively in this. It's incredible to think that we didn't have an idea about tumor immunology before 1950. Nobody talked about it.

So, I was the first here to work in it with mice. We had the little nodule of the tumor on the foot.

Then we began to be impressed with the McWhirter's work in the breast. We said that if simple mastectomy is OK with radiation, what about the simple mastectomy alone? Then in the event the tumor does recur after a time, could it still be radiated? I asked the radiation therapist and he thought they could. So we started a series in which my colleagues continued to do the radical and I did the simple, usually without radiation, unless nodes were involved, in which case I did the modified radical. But now no radicals at all, we stopped doing that in 1955.

As time went by it became obvious that the patients were doing just as well if we didn't treat them prophylactically by axillary dissection as they did if we did. You could wait until nodes appeared in the axilla, then operate and radiate. You would get just as good results as if you had done the whole thing right off at once.

Then we began more and more to do partial mastectomies. We got up to about 15% partial mastectomies where the breast was saved and reconstructed.

That was for small peripheral lesions. Then patients began coming to us, for we were saving the breasts. That brought a certain amount of selectivity into it so people with small peripheral tumors would tend to come to us. So we got a higher proportion of these. At the last reckoning, Dr. Esselstyn, who is my associate--I don't operate anymore--is doing most of the breast surgery. He said in the last year's series of operable breast cancers they did only 15% mastectomies. Everybody else was treated by preserving the breast, one way or another with or without radiation, and by various types of surgery.

I was just absolutely condemned for this point of view about breast surgery in 1955 when we started writing about it. It gradually calmed down. Of course, now the government and the national cancer society have come right out and said there is no known difference (in results), and there isn't. They are now running a randomized study which they couldn't run if there were any known difference in survival. The American Cancer Society is saying this is an alternative, so now we are on respectable ground. But I am still hated: I am taking bread out of their (the surgeons') mouths.

WEEKS:

I realize your position. Are you a member of AMA?

CRILE:

No. I was until a few years ago. What happened was a very interesting interchange just about the time I retired. In fact, it was about two weeks before I retired. I wrote an article, which was a very frank article, about breast cancer. It came out in one of the scientific journals. Some newspaper people from the local newspaper came out and interviewed me. I said that, in my opinion, there was no longer under any circumstances an excuse for a radical mastectomy.

They said, "Some people still do it."

I said, "Yes, some people still do it because they are indoctrinated in it and they are not about to change their mind until they are shown. Also you have got to remember that Blue Cross pays more for that than it does for the other."

That hit the ceiling and they (the local medical society) reprimanded me. So, I told them that I refused to accept the reprimand because I was right. They said that the reason they reprimanded me was because I had said that there was no longer need for radical mastectomy and that would make patients who had had radical mastectomies critical of the people who had done them. Therefore, I was reprehensible.

A few years later when the NIH came out and said that this (my view) was right, I republished the whole thing, quoting them, everything, exactly as they (the society) had said. I threatened suit in a quiet sort of a way, never overtly, but I let it be known that I was ready to find a woman who had had a radical mastectomy and make a class suit against the members of ethics committee of the society because they had reprimanded me and that had stopped people like me from saying that the operation wasn't necessary. I despised the local bodies of the AMA. With the central body of the AMA I have never had the slightest difficulty. But I just reached retirement age and there is no use of being a member of AMA anymore.

WEEKS:

The American College of Surgeons to me seems to have a much more understanding attitude about problems.

CRILE:

The central body of the AMA is all right. It's only the local ones. The

local ones are all mixed up in money and competition and jealousies.

WEEKS:

They have always felt quite threatened. Going back to the days of World War I, the father of your colleague, Dr. Esselstyn, was also a famous doctor. Didn't he take a stand about Medicare and this sort of thing in his later life?

CRILE:

Oh, sure. We had a clinic; it was almost like an HMO. He was a very advanced thinker. Did you know Ess?

WEEKS:

I never met him. I read about him and heard about him, of course. There is another Ohio man, a contemporary of ours, Nelson Cruikshank, who did a lot of work in the health field. Do you know him?

CRILE:

Cruikshank? Where was he?

WEEKS:

He was with AFL-CIO. He was a graduate of Ohio Wesleyan.

CRILE:

I knew a Cruikshank at Yale one time.

WEEKS:

This must be a different man, but this Cruikshank was at New Haven at one time back around Roosevelt's time. Some of these men have told me about Esselstyn and how he opposed the AMA's stand on the government entering in any way into paying for medical care of the people of this country. This was because they were afraid that then the government would begin controlling the physician and he would no longer be able to practice the way he wanted to practice. But there were a few stalwart men of those days who stood up....

CRILE:

Well, Ess was one of them. He was very good. Then he went in Detroit for some sort of a labor group who had a health service.

WEEKS:

Oh, that probably was for the United Auto Workers.

CRILE:

Something like that.

WEEKS:

In fact, they still have their own HMO.

CRILE:

He was an effective writer and speaker. He was my football coach at Yale and I knew him all the way through medical school, more or less. Just by reputation and all. He was in New Haven at that time, I was at Harvard. Then his son married my daughter; Essy's my son-in-law.

WEEKS:

While you were at Yale, did you know I. S. Falk? He was one of the men who wrote the Social Security law. I interviewed him around Christmas time. He is now a man in his middle eighties. He was interested in epidemiology. I thought you might have met him.

CRILE:

No, I don't remember him.

In all my life, I have always been privileged to do whatever I wanted. I've never had any lack of money. I've never been rich, but I've always had enough money to travel, to do what I wanted to on vacations and so forth, to live comfortably, but not elegantly. I drive a little old car and I'll drive it until it falls to pieces. I don't have Cadillacs. I don't go out to

dinner, my wife always cooked too well. We don't spend money on anything except things that we really want. So we can afford things.

Now, all my life, I have always been interested in clinical surgery and in research and writing, but I've never had any interest whatsoever, to be nor has anybody else had any interest in having me be, an officer in anything. I'm the only person in the world who has never even been elected president of his class. I've never been president of anything. Because I always like to take a minority position and take a lost cause and work for that. So I was never elected to anything whatsoever.

WEEKS:

I imagine it's been for a much more exciting life, and probably more useful life, too.

CRILE:

Oh, it's much more exciting than to be the head or the president of something or other which you have to be conventional in.

I remember very well, we had a young man working here named Aussie Robinett, whom I had met in the Navy in World War II, and brought him out to Cleveland. He was a very attractive young man. It was just the time that McWhirter was beginning.

I said, "Robbie, you take the field of the breast and you go on over all of our experience here with the breast." My father did only one type of operation. He did modified radical. Tommy Jones did a radical. And they were at the same time and in the same institution and everything. "You see if there is any difference." I said, "You go on into that and you will have yourself a name in American medicine."

Well, he did. He wrote the initial paper but then he moved on, he didn't

stay at the Clinic. So I took it up where he left off.

WEEKS:

In general, outside of the official, local societies among your individual physician colleagues outside of the Clinic, you still have a good working relationship, I mean a friendship?

CRILE:

I've never had any problems. Even though they have disagreed with me, I've never had any problems. The sharpest disagreements I've had have been with people at Memorial Hospital in New York. See, these are all fee-for-service people, and those are big fees, too. The breast group at Memorial and the thyroid group, originally, were all fee-for-service in their hospitals. These people were the last to abandon those big operations. Now, they are gradually doing it. But I've had some bitter controversies with people like Jerry Urban. Sometimes they have gotten a little bit personal.

Outside of that, I don't think I've ever had any bad times. I've enjoyed my detractors rather than anything else.

WEEKS:

Did two of your daughters marry physicians?

CRILE:

Yes, Joan married another one. She's married to Dr. Roger Foster, He's in University of Vermont, associate professor. A very able young man who has done some excellent writing. He is very good at getting large surveys and masses of figures together. Essy is a very excellent technical surgeon.

WEEKS:

Well, it must give you a lot of satisfaction to see the next generation coming up who can carry on.

CRILE:

It is nice, yes.

WEEKS:

I don't know whether there's anything else you would like to talk about. One thing I noticed in the Unit book which I realize was written ten years ago, was the ratio, the term was used in Mr. Hardy's chapter, I think, the ratio of employees to patients. It seemed to me that it was very low. At that time he was quoting something less than three FTE ratio to patients. I was wondering how you were able to do so well?

CRILE:

Well, we've always had very good management. I don't know what it should be, but everything has gotten much worse.

WEEKS:

We have a lot of so-called para-professionals now with all the technicians of different kinds, doing work that nurses used to do. I'm not saying that they are not doing it better in some cases.

CRILE:

Nurses' salaries have increased more than 400% in seventeen years.

WEEKS:

Most of the nurses were underpaid. I noticed that the University Hospital just signed a contract with their nurses and I noticed that the average rate for a starting nurse is about the same as an automobile worker who works forty hours a week.

CRILE:

Number of employees per patient has increased from 1.8 per patient to nearly 2.5 per patient.

WEEKS:

I thought that was a remarkable good job, that you could staff that well.

CRILE:

2.5 per patient.

WEEKS:

Kaiser is reporting nearly four, not only in their own hospitals but as the national average. I was reading this the other day and I thought it was quite high.

CRILE:

Well, you see our hospital is all very closely controlled, the clinic hospital, the whole unit all being run by the same people. There are very few places like us--where we own and operate your own hospitals as well as your own whole unit.

WEEKS:

And as you say, you don't have a lot of the general cases that many would have. Thank you for the interview.

Interview in Cleveland Heights, Ohio

June 1, 1981

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