

DONALD WAYNE SELDIN, MD: a conversation with the editor

An institution is the lengthened shadow of one man.

—RALPH WALDO EMERSON (*Self-Reliance*)

Dr. Donald Wayne Seldin (Figure 1) was born in New York City on October 24, 1920, and grew up there. In 1940, he received a bachelor's degree from New York University and in December 1943, a medical degree from Yale University School of Medicine. His medical internship and 2-year residency were at New Haven Hospital of the Yale University School of Medicine. He then spent 2 years in the Medical Corps of the US Army as chief of the Department of Medicine at a military hospital in Munich, Germany. He returned to the USA in 1948 and joined the Department of Internal Medicine at Yale. In 1951, he came to Dallas as an associate professor in the Department of Medicine of the University of Texas Southwestern Medical School. Within a year he was professor and chairman of the department, and he served in that position until 1987. In 1969, he was named the William Buchanan Professor of Internal Medicine, and in 1988 he became the University of Texas System Professor of Internal Medicine in the same department.

During his 37 years as chairman, Dr. Seldin built one of the 3 or 4 strongest departments of medicine in the world. When Seldin became chairman of the Department of Medicine at the University of Texas Southwestern Medical School in January 1952, he was its only full-time member. When he stepped down in 1987, the medical faculty was 125 times larger. At the same time, he was a highly productive researcher and one of the world's finest medical statesmen.

He has been a member of the advisory committees or board of trustees of numerous organizations. He has been president of 7 learned societies: the Central Society for Clinical Research, the Southern Society of Clinical Investigation, the American Society for Clinical Investigation, the American Society of Nephrology, the Association of Professors of Medicine, the As-



Figure 1. Donald W. Seldin, MD, during the interview.

sociation of American Physicians, and the International Society of Nephrology. He has received 6 honorary doctorate degrees, including one from his alma mater, Yale University. His awards are too numerous to list but include the Kober Medal from the Association of American Physicians; the John P. Peters Award from the American Society of Nephrology; the David M. Hume Award from the National Kidney Foundation; the Distinguished Teacher Award from the American College of Physicians; the Robert H. Williams Distinguished Chairman of Medicine Award from the Association of Professors of Medicine; and the Volhard Medal of the German Society of Nephrology.

The influence at his medical center has extended far beyond his own department. In 1966, when Dr. Seldin was offered the prestigious Herman Blumgart chair at Harvard Medical School, he convinced the board of regents of the University of Texas that the only way to build a first-rate medical school was to have first-rate basic science departments. When the board agreed to supply the necessary resources to do that, he decided to stay in Dallas. He asked nothing for his own department! He has been persuasive in spreading his high standards to all areas of his medical center. The University of Texas Southwestern Medical School truly represents the lengthened shadow of Dr. Donald Wayne Seldin.

Seldin has always had a strong commitment to research. That conducted by him in collaboration with many associates reflects his interest in the physiologic regulatory mechanisms controlling acid-base and potassium balance, the osmolarity and volume of body fluids, and the impact of disease on these regulatory processes. He has studied acid-base homeostasis, the regulation of ammonia production, the mechanisms of tubular acidification, the counter-current system, the control of tubular transport by adrenal steroids, the heterogeneity of tubular transport, and the mechanism of action of diuretics, among other diverse topics.

Those who know Seldin, as Floyd C. Rector, Jr., has so eloquently expressed, are most inspired by his "unique personal qualities: his fascination with the fruits of the human intellect in all its dimensions, his admiration for those who strive tena-

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ciously for excellence, his own continual search for knowledge. . . . He was intolerant of the illogical or poorly informed argument, the disorganized lecture, pedestrian research, indifferent patient care. . . . He was lavish in his praise of the clever or novel idea, the ingenious experiment, the scholarly lecture, the extraordinary effort expended in the care of a seriously ill patient."

His chief residents during his tenure as department chairman put together in 1987 a collection of letters expressing their gratitude to him. Many of the letters included some of Seldin's more frequent sayings during teaching sessions:

"Here's a dime. Go call your mother. She will know the answer to my question. Tell her that you are coming home."

"Good care is not good enough. It must be great care."

"The greatest crime is to do the right thing for the wrong reason."

"The difference between mediocre and ideal management is only about 15%, but at Parkland we expect the best."

"Your patient could have received better care at J. C. Penney."

"A good medical education leaves much to be desired."

"Education is what you have left after you have forgotten the facts."

"Education does not change personalities—it simply makes them more difficult to deal with."

"One of the dangers of a medical education is that it leads to graduation from medical school."

"For every problem there is a simple direct answer—wrong."

"Mobilize your resources. Of course you know. What is the treatment? Why is that the treatment?"

"Develop an intellectual curiosity!"

"What are you going to be when you grow up?"

About surgery: "Does your mother know that you are cutting other people for a living?"

"Treat all patients with respect and dignity and with equal value."

"This is a beautiful example of therapeutic frenzy combined with abysmal ignorance."

"Chicken soup has 3 times the sodium and 5 times the potassium of your formula."

Some of his commonly used words and phrases: "elliptic, crisp, terse, unambiguous, dope, boy, mute" and "milk-drinking Texan, inglorious Milton, ineluctably conjoined, a Cromwell guiltless of his country's blood."

As many of his colleagues have stressed, Seldin's profound eloquence stirs the minds and souls of students, residents, and staff and has established him as a teacher without equal. He renders the most complex subjects readily understandable. His greatest attribute may not lay in his teachings but in his exaltation of the learning process. His greatest satisfaction may have come from watching his students' progress and from exhorting his colleagues as they collected and assembled information and created new knowledge.

Seldin is a complex, multitalented, and charming man. He can be formal and abrasive but also warm and caring. He is as comfortable in the humanities (literature, art, philosophy, politics, economics, architecture, music) as he is in the sciences. His scholarship in the broad spectrum of medicine, his magnificent teaching abilities, his "taste" for picking the right faculty, and his standards for patient care and research made him a unique



Figure 2. As an infant.

departmental chairman, and his grasp of the entire medical school and hospital arenas allowed him to propagate his teaching, research, and patient care standards over the entire medical center.

How would the University of Texas at Southwestern Medical Center have developed had Seldin not come to Dallas? It would be hard to imagine the medical center's producing 4 Nobel Prize winners and 10 members of the Institute of Medicine or the National Academy of Sciences without his enormous impact. Thousands of medical students have graduated from that medical school in the past 50 years, and a number of them are now connected to Baylor. There is no medical person who has had the impact on this community in the last 50 years as Seldin has had.

Seldin and his first wife, Muriel Goldberg, who died in 1994, had 3 offspring. In 1998 he married Dr. Ellen Taylor, whose interview follows this one.

William Clifford Roberts, MD (hereafter, WCR): *Dr. Seldin, it's an honor to talk to you, and I appreciate your willingness to speak to me and therefore to the readers of Baylor University Medical Center Proceedings. Could we start by your talking about some of your earliest memories, what it was like growing up in New York, and your parents and siblings?*

Donald Wayne Seldin, MD (hereafter, DWS): I was born in Coney Island on October 24, 1920 (Figure 2). It was a pretty rough place at that time, actually sort of a slum appended to Seagate Garden, which was walled off. Seagate Garden was at the tip of Coney Island facing the Atlantic Ocean, but the barrier between the two was striking, not only because of the large fence, but also because Seagate Garden was a sumptuous place with very wealthy inhabitants, whereas Coney Island was impoverished. It was the seat of some very extensive amusement parks. Luna Park and Steeplechase were centered there and, of course, there was Nathan's Hot Dogs and the like.

I went to public school (PS 188). I was a rather mediocre student. I was more concerned with gangs and running around than I was with anything of an academic nature. My father was,

by contrast, a rather scholarly person. He was an immigrant from Bessarabia, which at that time was part of Romania and subsequently was taken over by the Soviet Union. My mother came from Vienna. My father was in full command of Hebrew, Latin, and Greek and was very anxious for me to follow along scholarly lines. I was a mess in this regard and a big disappointment to him. He arranged for me to have violin lessons, but I practiced not at all. He wanted me to learn Hebrew, but at that time I was taken up with a notion that religious activities were a way to enslave the masses. Although I was enrolled in Hebrew School, I never attended classes. His interest in my going to Hebrew school was not primarily for religious reasons, but rather because he thought it was an important cultural experience. My own interest was to distinguish myself in a gang and play football and baseball. I followed very carefully the fate of the Brooklyn Dodgers, housed in Ebbets Field.

WCR: *When you say "followed a gang," that just means you hung out with boys your age?*

DWS: Yes. I hung out with boys my age whose purpose in life was to get into fights with other gangs, especially rivals from Seagate Garden. These individuals were of a wealthier group, poised against the Coney Island lower classes, and from time to time there were fights.

After I graduated from elementary school, I went to Seth Low Junior High School, located in the Bay Ridge area of Brooklyn. Subsequent to that I entered James Madison High School, which was also in the same area. I was on the basketball team and track team there and became moderately interested in academic work. I wouldn't say I was distinguished. I graduated fairly high in the class, but I was by no means an outstanding student. I graduated very young, in 1936, when 16 years old.

WCR: *Did you skip grades?*

DWS: I skipped several grades in public school, and junior high was an accelerated program. The net effect was that I saved about 2 years from the ordinary course of public school education.

WCR: *What did you do in track?*

DWS: I ran the 100-yard dash.

WCR: *You were pretty fast?*

DWS: Yes. My time was okay, but it wasn't the best. I don't remember much detail. I remember more of the basketball team because in high school we were a championship team in Brooklyn.

WCR: *You were a starter in basketball?*

DWS: Yes, but I was not one of the major figures on the team. There were better players.

WCR: *How tall were you in high school?*

DWS: I don't remember. I'm now about 6'. I imagine I must have been about 5'9" or 5'10".

WCR: *Did you play forward?*

DWS: Yes.

WCR: *Did your parents come out and watch you play sports?*

DWS: No. They had no interest whatsoever in those activities. That was sort of my world outside of their world.

WCR: *You mentioned that in high school learning became more of an interest to you.*

DWS: Yes. In high school I became interested in various social and cultural activities. I began to read extensively. I spent a lot of time in the New York Public Library. I developed an in-

terest in literary works, economics, political science, and some interest in philosophy. By the time I graduated from college, I was heavily immersed in the academic world. After high school, I never again did anything in the way of athletics. That stopped abruptly, and I became interested more in intellectual activities.

WCR: *What do you think turned you to academic pursuits?*

DWS: I don't know. There weren't any role models that I can remember in high school. Most people speak of intellectual influences of one type or another. I just remember that when I was at James Madison High School, I became increasingly interested in literature, poetry, political science, and things like that. I read a lot on my own. There was a fabulous bookshop in New York called the "Wheye Book Shop," which used to have all sorts of interesting art books. I spent a fair amount of time looking at them. I became very much interested in things outside the classroom. They weren't necessarily items that had to do with current courses I was taking.

WCR: *Did you visit the Metropolitan Museum of Art?*

DWS: Yes.

WCR: *Did your father or mother do that?*

DWS: No. We never went as a family.

WCR: *Which poets did you enjoy reading?*

DWS: In high school I was interested mainly in the romantic poets—Keats, Shelley, Byron, and Wordsworth.

WCR: *What was home like in Coney Island?*

DWS: My father was a dentist. He was rather successful until the depression in 1929 when Wall Street crashed. Before the crash he had invested in an instrumentality called "City Services," which collapsed, and the net effect was that he was rendered bankrupt. He became persuaded that professional men were of no value, that in this country what you had to do was to be a businessman. Having started out with a reverential attitude toward academic pursuits and learning, he became an embittered man who felt that all of those activities led to nothing. He was now impoverished. He'd lost all his money, and his practice was minimal because this was deep in the depression. The New York depression was a terrible time.

All through junior high and high school I worked. I was a delivery boy for a grocery store and a fruit store. We were very poor, and we had to find some way of generating money. In looking at the *New York Times*, a nondescript ad indicated that opportunities existed for activities for anybody interested in open opportunities. It was hard to tell what it involved. When I came to the specified area, there must have been 100 to 200 people in line. When I ultimately came to the interviewer, it turned out that the job was selling oneself—one who was going to college and needed money—and in appreciation of that support we would send some magazines. We were all assigned to specified areas and went from door to door. I found the whole activity embarrassing and humiliating. I quit after about a week. I wasn't very successful, either. I felt very awkward even though we had this prepared speech when knocking on the door.

Later on in high school, I used to go to the Catskill Mountains to a place called Grossingers, where I was a bellhop for 2 months during the summer.

WCR: *How did you get the job?*

DWS: I applied, again after seeing an advertisement in the *New York Times*. There was no salary, but the tips were good. The

net effect was that I made a fair amount of money for those times. I also taught dancing at Grossingers. They had a ballroom dancing program under the auspices of Arthur Murray. I was one of the instructors during the summer.

Thereafter, there was an advertisement in the *New York Times* regarding a position as usher at the New York Paramount. When arriving, there was a line around the block, from Broadway to 8th Avenue. The line eventually advanced into the lobby of the Paramount where about 30 to 40 people would line up. The chief usher would walk along the line and pick 1 or 2 to be interviewed further, and then the rest were dismissed. The line was rapidly processed and about 20 to 30 people remained. I was one of them.

There, my purpose was to persuade people entering the movie house to go to the balcony so that the person outside the theater, who was talking about the seats available, could say that there were still seats in the orchestra. I worked for a number of months as an usher and also in the role of selling seats in the balcony. At that time, the movie alternated with a stage show. Frank Sinatra was there, and the young girls screamed and collapsed. There were a number of outstanding shows and some of the movies were just loaded. I remember one where Martha Raye was singing and acting and the place was just a mad house. There was Phil Spitalny and his All Girl Orchestra, which was quite unusual then. The big comedians were there—Milton Berle, Eddie Cantor.

WCR: *You were quite young?*

DWS: When I worked at the New York Paramount, I was about 15, but I looked older.

WCR: *It was quite safe to ride the subway to Manhattan at that time?*

DWS: Yes. Safety wasn't a problem, and this job was fabulous. Remember that in 1935 and 1936, the country was in a deep depression. To get a job at that time was hard.

WCR: *Your father was born and died when?*

DWS: He was born about 1880 and died in 1955.

WCR: *Your mother?*

DWS: She was born around 1900 and died in 1970.

WCR: *Your mother was a first-generation American; your father was an immigrant. How did he get to dental school?*

DWS: He went to a proprietary dental school in the USA. At that time it was not elaborate.

WCR: *Right after high school he enrolled in dental school?*

DWS: Yes. When he arrived in the USA he had graduated from high school and had a certain command of classical languages and Hebrew.

WCR: *You never met either his parents or your mother's parents?*

DWS: Correct.

WCR: *Was your mother an educated person?*

DWS: Not as well as my father. She was reasonably intelligent, but not especially educated.

WCR: *Did she go to college?*

DWS: She never went past high school.

WCR: *When did they get married?*

DWS: I was born in 1920; they married about 1917.

WCR: *What was your father like?*

DWS: He was an interesting man. He was very thoughtful and scholarly. He tried to educate himself in various lines. He read extensively. He was a great admirer of Sinclair Lewis and

read his novels. He was inclined to isolate himself. The collapse of the stock market in 1929 and his own failure in the USA embittered him a great deal. He was not a happy man.

WCR: *Did you and your father get along well?*

DWS: We weren't intimate, but we got along well. I admired his academic impulses, his tendency to educate himself, his interest in literature and social problems.

WCR: *Were there many books around the house?*

DWS: A fair number.

WCR: *He was the reader in your family?*

DWS: Yes.

WCR: *Did your mother read much?*

DWS: No.

WCR: *What was your mother like?*

DWS: She was a rather pleasant housewife mainly concerned with family matters, less with intellectual or artistic issues.

WCR: *Were there siblings?*

DWS: I had 1 sister, Marion. She was born in 1925 and died in 1952 of multiple sclerosis.

WCR: *What was your house like? Was dinner a major happening each day in your house?*

DWS: No. The family was not a very tightly knit one. My father became increasingly more embittered as the years went by. There was tension between my father and mother. The family life was pretty fragmented. Dinner was never an occasion.

WCR: *Do you think some of your stimulus to always have a job was that it got you out of the home?*

DWS: It may have been in part, but I wasn't rooted to the household in any way. I was off by myself mostly.

WCR: *It sounds like you were quite an independent kid from very early on?*

DWS: Yes, I was.

WCR: *Did your father talk to you much? You mentioned that he became relatively antiprofessional and wanted you to go into business.*

DWS: His idea was that a professional man in the USA was bound to be a failure. The only thing he appreciated was financial success. Consequently, the only sensible track for an individual, in his view, was to become a businessman. In college, I finally decided to apply to medical school, and he thought that was terrible. Again, when I decided to join the medical school faculty in Dallas and not go into private practice, he thought that was a disaster. He was appalled later that I turned down a prestigious offer at Harvard. He thought I always was a flop, never amounted to anything, and this was the ultimate proof.

WCR: *As a youngster you seem to have had a great deal of confidence and belief in yourself. Did your father or mother compliment you a lot?*

DWS: I don't think so. When I grew up I was sort of spinning by myself. I was working. I was developing various interests. The linkage with family life was weak.

WCR: *How did it come about that you went to Washington Square College? Is that New York University?*

DWS: Yes. It was called Washington Square. New York University had 2 campuses at that time: one was uptown and one was downtown. The one I applied to was the downtown campus in Greenwich Village.

WCR: *Did your father or mother recommend this to you?*

DWS: No.

WCR: *Did you have a scholarship to college?*

DWS: Yes.

WCR: *Did you live at home?*

DWS: Yes. I took the subway in each day.

WCR: *What did you major in?*

DWS: Let me describe a little about the college. Washington Square College is in a very (at that time) active area. It was right in the heart of Greenwich Village. The abstract impressionists were all over the place. In its cafeteria was a fabulous art gallery with paintings provided by the art collector Gallatin. I became very interested in courses like philosophy, art history, economics, and political science. I turned out to be a fairly good student, even though I didn't attend a lot of classes. Washington Square College was one of those places where you had daily, weekly, and monthly examinations and then final examinations. I was pretty good at taking exams. I would sometimes cram for 2 or 3 days to pass an exam because I had not attended many classes. Nevertheless, I did very well. I graduated with almost a straight A average. I can't say that I really mastered any of the courses in which I got good marks. I was just skillful in coping with the exams.

My main interests and reading were outside the courses. I had very stimulating teachers. Sidney Hook, Albert Hofstadter, and James Burnham were on the faculty. It was an exciting atmosphere. Also, I began to develop a cadre of friends who were taking these various courses, and I became immersed in a rather stimulating atmosphere.

At that time, I was majoring in literature and wanted to go into either poetry or philosophy. But the time was deep in the depression, and it would have been impossible really to make a living from those disciplines. My friends at that time were in these areas, and they could not get jobs. I felt I couldn't continue to get a bachelor's degree of a nonspecific type where I would wind up with a major in literature or philosophy because that would lead nowhere. I decided I would go into medicine. It wasn't my first choice. The last year of college I took a number of courses in biology and chemistry, which allowed me to qualify for application to medical school. I applied to various medical schools and was accepted at New York University. Painfully, I paid the \$50 acceptance fee. Then, to my surprise, a month or so later I was accepted at Yale.

WCR: *Why did you decide to go to Yale?*

DWS: Yale seemed to me to be a much better medical school. I wouldn't say that my analysis was the most sophisticated in the world, but my inquiries led me to that conclusion.

WCR: *How many medical schools did you apply to?*

DWS: I must have applied to 20 or 30. I was on the waiting list at Harvard when I was accepted at Yale. Many years later when I was offered a chair at Harvard, an acquaintance, who knew a chairperson at Harvard, wrote a letter to him indicating that although I was offered a chair at Harvard, I was not accepted there as a medical student.

WCR: *Was your father interested in what you were studying in college?*

DWS: By the time I entered college, my father and mother had separated. I lived with my mother and sister and visited my



Figure 3. With first wife, Muriel, on their wedding day, 1943.

father from time to time. He had an office and his own little apartment. I saw him probably only once a week.

WCR: *Did he ask you what you were studying in college?*

DWS: Yes, but there was no intimate interchange. It was rather remote by this time. There was a certain amount of affection, a certain amount of warmth, but there was no tight interaction.

WCR: *You said that your father became essentially bitter or maybe even depressed.*

DWS: He was an embittered man by this time. He may have been somewhat depressed, but mainly embittered, isolated. He never really overcame the setback that occurred with the crash.

WCR: *Did your mother survive all right?*

DWS: My mother ultimately developed what amounts to a schizophrenic state and was hospitalized and institutionalized.

WCR: *Did either parent drink alcohol?*

DWS: None at all.

WCR: *Smoke?*

DWS: My father smoked.

WCR: *As you were growing up, did your family go to synagogue?*

DWS: No.

WCR: *Were you dating by this time?*

DWS: Yes. I met my first wife, Muriel Goldberg, in college.

WCR: *What was she studying in college?*

DWS: She was studying music. She had been at Juilliard.

WCR: *What were the characteristics in her that appealed to you?*

DWS: She was a very attractive woman. She was physically lovely with long black hair framing an aquiline face. At the same time, she was intelligent and charming. We got along very well. We had mutual interests of various kinds. Things worked out fairly well together.



Figure 4. Dissecting while a medical student at Yale, 1940.

WCR: Was she as much of a reader as you were?

DWS: I don't think so. She was more involved with music. While she read things, she wasn't as deeply involved in intellectual matters as I was.

WCR: When you went off to medical school at Yale in New Haven, Muriel was still back at New York University.

DWS: Yes.

WCR: On weekends you spent a good bit of time coming back on the train to New York?

DWS: Or she would come to New Haven.

WCR: You dated throughout your medical school?

DWS: Until we were married. We were married on April 1, 1943 (Figure 3), and I graduated in December 1943.

WCR: Did you get a scholarship to Yale Medical School?

DWS: Yes.

WCR: You worked during medical school?

DWS: Yes. There was some sort of government-sponsored program where you were reimbursed for doing work for a faculty member. I worked for C. N. H. Long. He was writing a review of metabolism and endocrinology, and I did a lot of work assembling the bibliography and summarizing the articles.

WCR: Did that appeal to you?

DWS: Yes, it did.

WCR: That was your first insight into medical publishing?

DWS: Yes.

WCR: You mentioned when you were in Washington Square College that you were tested all the time: daily, weekly, monthly. When you went to Yale and started medical school, you were away from home for the first time in your life in a very sophisticated place. What struck you about medical school? What were some early surprises that you encountered?

DWS: In the orientation session, a faculty member named Ralph Meader assembled the class of 39 students and indicated that at Yale they had a tutorial system of such a type where attendance at classes was never required. If you had something better to do, you should do it. There was a very close tutorial relation between the faculty and the students. The faculty was



Figure 5. As a medical student at Yale.

more numerous by far than the students. No texts were assigned. They encouraged reading, but they didn't require any specific reading. And no examinations were given until after 2 years, when a comprehensive exam lasting 4 or 5 days covering the entire 2-year curriculum was given. At the beginning, this nonstructured, rather informal, atmosphere struck me as somewhat disorienting compared with my previous experience where assignments were very definite and where exams were continuous.

WCR: At medical school did you go to classes regularly those first 2 years?

DWS: I went to class but I wasn't faithful (Figures 4 and 5). I missed a whole series of sessions. I developed interests there that went along with required courses but were somewhat different. I remember becoming very interested in Fritz Lippman's work on high-energy phosphate. It was just coming out and I began to read it. Then I spent a lot of time studying issues outside of the curriculum. The Institute of Human Relations was there. A great deal of sophisticated work was being done in psychology. I remember particularly the studies of Clark Hull. I spent a lot of time reading them.

WCR: What struck you about that?

DWS: It had to do with the theory of explanation and how that applied to psychological systems.

WCR: If indeed you did skip a lecture or class in medical school, it wasn't that you were sleeping. You were just studying something else that you thought was more beneficial than that particular class.

DWS: Yes. More interesting. Then, of course, there's always the time of reckoning, for after 2 years you had to pass a very comprehensive exam. Just before that time, I began to really work through the subject matters that I'd neglected.

WCR: Did anybody at Yale influence you those first 2 years?

DWS: I enjoyed working for C. N. H. Long. I interacted well with him, but I didn't find the experience inspiring in any way.



Figure 6. Dr. Seldin's mentor, Dr. John Punnett Peters, 1956.

It was nothing like the experience I had subsequently when I encountered Peters in medicine.

WCR: *When you finished your basic science work and started in medicine, you encountered Dr. John Peters rather quickly.*

DWS: Yes. It was on the clinical medicine program.

WCR: *How did he strike you initially?*

DWS: I was impressed by his learning, scholarship, and dedication to medicine, all integrated together. On the one hand, he was a meticulous physician. On the other hand, he was a man of enormous learning. He applied himself with rigor. Everything he did I found very impressive (Figure 6). For example, he was writing the second edition of Peters and Van Slyke, a huge book at the time I encountered him. At the same time, someone might ask him to give a talk to the housestaff or to the students. He would never brush that request aside, and he would present something in a very formal way. You would think he would just present something off the cuff, but he never did. It was very carefully done. He always acceded to all of these requests despite the fact that he was obviously tremendously busy.

WCR: *Did he use notes when he gave lectures?*

DWS: Yes. His lectures were terrible. You could hardly hear him. However, if you read them, they amounted to something. I found Dr. Peters a very inspiring figure. He anchored me in the direction of medicine. I became very interested in not just commanding the subject matter but becoming genuinely involved in clinical medicine.

WCR: *When you first characterized Dr. Peters, you mentioned his honesty and integrity. What did he do that allowed you to draw that conclusion?*

DWS: In the first place, he was a very conscientious clinician. He took care of his patients meticulously. He made rounds 3 times a week throughout the entire hospital, wherever meta-

bolic patients were located. He followed them carefully, called them at home, treated them with the highest dignity, and, at the same time, applied to them the finest kind of biomedical knowledge that was available at the time. He was an extremely conscientious teacher, continuously available for teaching and for clinical work. He sponsored academic work and research so that the metabolic division became the rallying point for anybody who was interested in academic medicine and research. It was a very exciting intellectual atmosphere. At the same time, he was a very knowledgeable and learned man. He was not what I would call, in the superficial sense, "a brilliant clinician." He didn't see a patient and quickly make a dazzling diagnosis, but he was a painfully careful clinician. He would be interested in all aspects of a patient's problems, from varicose veins to piles.

WCR: *Did he have private patients?*

DWS: Yes. He had a private practice, but the income of the private practice at Yale did not go to the physician.

WCR: *Were all of the faculty in internal medicine full-time at that point (1940–1943)?*

DWS: Yes. It was a full-time faculty system.

WCR: *Did you have any contact with physicians in junior high school, high school, or college? Was there anybody in your family who had ever been a physician?*

DWS: No. I had no contact whatsoever with physicians.

WCR: *When you met Dr. Peters, all of a sudden you saw medicine in a different light. Medicine wasn't just hanging up your shingle and waiting for patients to start coming.*

DWS: Correct. That was never my image of medicine. In some vague sense, I always thought about medicine as a kind of academic pursuit. This was very striking with Peters. On the one hand, he had a deep appreciation of medical science; on the other hand, this was rooted to a meticulous care of patients. The two together turned out to be a very exciting thing. It wasn't contrived. It wasn't a question of I do science and I see a patient. Or I see a patient as an instrument to do experiments.

WCR: *Your phrase "clinical scholar" was beautifully applicable in John Peters.*

DWS: He was the epitome of a clinical scholar.

WCR: *In medical school, you rotated through obstetrics/gynecology, surgery, and the other specialties. Did any of them strike you as a potential scholarly pursuit? Did surgery appeal to you at all?*

DWS: No. I wasn't interested in surgery. We had a very good pediatrics department. Grover Powers was chairman; Daniel Darrow was a member of it. They had a very good program. But I was never interested in going into pediatrics.

WCR: *Clinically, nobody else was quite on a level with Dr. Peters?*

DWS: As a clinical scholar, that is right.

WCR: *You decided pretty quickly that this was the endeavor you wanted to be in?*

DWS: Yes. I was in the army while in medical school. I was in uniform and we marched. Exactly how this would play out was a matter of great uncertainty. This was during World War II. I graduated from medical school in December 1943 because of the abbreviated program.

WCR: *You were going to medical school 12 months of the year.*

DWS: Yes. After graduation, I then started a straight medicine internship at Yale. They had the "999 program" during the



Figure 7. In the US Army Medical Corps in Germany.

war. It was an abbreviated program of training that lasted 27 months—a 9-month period of internship followed by two 9-month periods of residency. When I finished my housestaff training program, I was activated. Initially, at the end of 1945, I was sent to San Antonio, Texas, for basic training for 1 month just as the war was ending. Thereafter, I was sent to the 98th General Hospital in Munich, Germany (Figure 7).

WCR: *The army didn't pay for your medical school. You had a scholarship. But the army was paying you something?*

DWS: The army paid a small amount of money. I've forgotten exactly how much.

WCR: *What did you do in Munich?*

DWS: The US Army then had 2 major base general hospitals in Germany: the 97th General Hospital in Frankfurt and the 98th General Hospital in Munich. Both were large hospitals. The Munich one previously had been the Schwabinger Krankenhaus, which was taken over by the US Army, remodeled, and re-equipped.

WCR: *What did you do there?*

DWS: Initially, I was a member of the medical service; shortly after arriving, the chief of the medical service left, and for much of my time there I was in charge of the medical service. The war had just ended, and many medical officers were returning to the USA.

WCR: *You were born in 1920. Thus, you were only 26 years old when you became chief of the medical service. How many beds did the medical service have in this hospital?*

DWS: There must have been at least 200 beds.

WCR: *How many internists or physicians were on the medical service there?*

DWS: I guess about 10.

WCR: *You were busy?*

DWS: Yes. I also ran the laboratory. Although when I arrived in Munich I was assigned to the medical service, I was asked to set up a variety of clinical methods for standard laboratory determinations. At Yale I had done a research thesis in medicine under Dr. Peters, and there I had learned the methods of the department. It didn't matter what research problem you worked on in Peters' lab, you had to learn all the routine laboratory methods. I tried to set up these clinical methods in the 98th General Hospital. The army had its own protocol. I tried to make sure the methods were accurate. For example, the army did the determination of serum proteins using the copper sulfate method. I tried to institute the Kjeldahl determination. It was the classical method at the time. The copper sulfate method that the army was using was very poor. I had to get the new equipment in the German market, and I bought it with my own money. When we were inspected, a question was raised as to how we were doing proteins, and I was criticized for not using the copper sulfate method. I tried to point out that the copper sulfate method was poor, but that didn't carry much weight. Standard protocol was insisted upon. Nevertheless, we were finally permitted to continue.

It was shortly after setting up the laboratory that I was asked to run the medical service. Among other things at that time, I had to testify at a trial of Nazi physicians at Dachau.

WCR: *How were you asked to be an expert witness there?*

DWS: As head of the medical service in 1947, I was called as an expert witness in the military trial of a Nazi physician accused of being associated with the deaths of some 40 or so inmates following liver biopsies for hepatitis. The trial had been going on for some time before I was asked to testify. It had been established before my appearance that the Nazi physician had performed the liver biopsies. The 3 general officers serving as judges had decided before I came that if the liver biopsies had been done with a therapeutic intent, the deaths, however tragic, would not have been considered murder. But, if the biopsies were done without informed consent for experimental purposes or even for torture, then the physician would be convicted of murder. The question I was summoned to answer essentially was, "What was the status of liver biopsy?" I was asked not because I was an expert on liver biopsy, but because at that time, I was probably one of the major medical officers remaining in Europe following the return of many officers to the USA at the end of the war.

The physician who was accused was very smart and was acting as his own attorney. He was fluent in English and had had a fellowship at the Rockefeller Institute before the war. When he examined me, his first approach was to challenge my competence by quizzing me extensively on methods of liver function. If you are an expert on liver, you ought to know how to do liver tests. He didn't know anything about me, and I didn't know anything about him. He had the Peters and Van Slyke book right in front of him. He asked me, How do you fractionate the serum proteins? How do you do this? How do you do that? These were things, fortuitously, that I had at my fingertips. I learned them at Yale in Peters' laboratory, and I had just set up the laboratory in Munich. I had no trouble answering his questions. He was smart and tough. He would have the book open and would ask me very

specific questions that would ordinarily be difficult for anybody to answer, but I was in a particularly good position to handle them because of my previous training. Finally, he asked, "What did you know about liver biopsy in Germany in 1943–1944?" I said, "I don't know anything about it." He asked, "What do you know about liver biopsy in Hungary? How can you make a judgment about liver biopsy in Germany when you don't know anything about the status of liver biopsy in Germany?" I said, "Liver biopsy had been developed in the USA by Kark, Pirani, and others. They used the Vim Silverman needle. I notice that you have that needle on the table." The USA was far ahead of anybody else in liver biopsy at the time.

I presumed that what was known about the liver biopsy in the USA was in the forefront; liver biopsy had no therapeutic role. At that time, there was no way to treat infectious hepatitis. It didn't matter therapeutically what was found on liver biopsy. We went back and forth on this. I pointed out that they were using the Vim Silverman needle, which was an American needle. Whatever the purpose of liver biopsy, it couldn't be used to direct therapy. This went on for 2 or 3 days. Finally, the court terminated the interrogation. The court was very fair. (Military courts are under discussion these days for other reasons, but I thought the Munich Tribunal was very fair.) They decided that this was not a procedure that was done remotely in the interests of patients. Forty patients dying following liver biopsy pointed to medical inhumanity, not medical therapy. He was convicted and appropriately sentenced.

WCR: *You were 27 years old at this time?*

DWS: Yes.

WCR: *How old was the guilty physician at the time?*

DWS: He looked to me to be about 40 or 45.

WCR: *Your experience at the Munich General Hospital was a nice preamble to your directing the department at Southwestern just 4 years later.*

DWS: I wouldn't say that. In the army we were inundated by wards of patients with infectious hepatitis, which was epidemic at that time. There was a lot of alcoholism. There were army routines. The army required that you have a note on the chart every day. Patients would be in the hospital for 3 months waiting for a boat to take them back to the USA. The patients were often healthy, but having had hepatitis the regulations were such that they would have to be evacuated to the USA. That might take 3 months. The notes on the charts would read "condition unchanged" and then there would be marks, just hyphens, page after page after page. These were acceptable. If you really wrote a progress note with a careful history and physical examination, etc., once a week on such a patient, that was unacceptable because you hadn't filled in a note every single day, even though those notes were completely contrived. There was an extensive requirement for routine and often senseless documentation specific to the military environment that almost dominated the scene.

I didn't know what I was going to do when I returned to the USA. I'd been away for over 2 years. The last day I was in Munich, in a hotel downtown awaiting assignment to a ship to return to the USA, I went to the hospital to check my mail. To my surprise, there was a letter from Yale. This was the first communication I had received from Yale since I'd left a little more

than 2 years earlier. The letter went like this: "Dear Don: I would like to offer you a position as instructor of medicine at a salary to begin at \$2500 a year. Why haven't you written? Sincerely yours, Jack."

WCR: *This was John Peters?*

DWS: Yes. He signed his name "Jack." I never called him Jack. That was one of the most moving letters I'd ever received. I didn't know that I would have a position at Yale. Nothing had been guaranteed when I left. The first inkling that I might return to Yale was this letter I received.

WCR: *Where were you going in the USA had you not received this letter?*

DWS: I was not sure. I thought I would call Dr. Peters after arriving back in the USA. I thought I might go into practice or take a fellowship. I didn't know what I was going to do. I was still in the army. I was offered a position at a much higher rank to stay in the army, but I didn't want an army career. I was really uncertain as to what I would do. Peters' letter was a very defining moment, and it was out of the blue.

WCR: *You took the ship back and went directly to New Haven?*

DWS: Yes.

WCR: *Muriel had had a baby by that time?*

DWS: We had a baby who died in Germany. When Muriel and I went to New Haven there were just the 2 of us.

WCR: *After full term?*

DWS: Yes.

WCR: *How did the baby die?*

DWS: From *Escherichia coli* septicemia: Winkelman's syndrome.

WCR: *You joined the faculty at Yale in 1948 as an instructor in medicine?*

DWS: Yes.

WCR: *What happened back at Yale? You're now on the faculty.*

DWS: I made rounds on the general medical wards and attended medical clinic. I developed a little research program. I had a wonderful time. Yale was absolutely thrilling from both medical and academic points of view. We became involved in an academic circle. It was easy to do at Yale. They may have had more talent in the aggregate in New York City, but in New York everybody was scattered. At Yale, the faculty tended to live in the same concentrated area. There was a group who lived together in a certain new development. It consisted of towering figures, including Carl Hempel, professor of philosophy and logic; Robert Lopez, professor of medieval history; his wife, Claude Lopez, who had written a number of seminal works on Benjamin Franklin; Bernard Brodie, a military strategist and a social scientist; his wife, Fawn Brodie, who first developed the theory that Thomas Jefferson had fathered children with his slave Sally Hemings; Ed Lindblom, professor of economics; and Robert Dahl, professor of political science. These were some of the best people in their fields. All of them were, so to speak, "a single circle" of which we were sort of members. At the same time, the music school was fabulous. Paul Hindemith, the composer, was director. My wife took music lessons there. We interacted with various members of the music faculty. It was a very exciting intellectual atmosphere.

In 1948, there was a whole group of really outstanding people in the metabolic section that Peters ran, including Lou Welt, Bud

Relman, Frank Epstein, Paul Laviertes, Alex Winkler, Ted Danowski, Russ Elkinton, William Engstrom, and Ethan Allen Hitchcock Sims. Pauline Hold supervised the clinical laboratory. Evelyn Man worked on endocrine determinations, particularly thyroid hormone. It was a very exciting place, medically, intellectually, and culturally, and we were right in the middle of it. In many ways, that period was as great a time as I've ever had.

WCR: *You were there 3 years?*

DWS: Yes, until January 1951.

WCR: *You started publishing for the first time there. How did that hit you to have a publication in a medical journal? To do research seeking new knowledge?*

DWS: The whole atmosphere was stimulating. I was trying to develop a research program of my own. It was difficult at Yale. You had to do all your own work. Peters didn't allow any technicians. It was hard to do balance studies because there were no metabolic wards. Peters himself almost never did experimental work on animals. His studies were on patients and were in the nature of informed observations. They weren't manipulations. He always felt that it was a moral responsibility to study patients so as to take advantage of experiments of nature and to make meaningful clinical observations. But members of his department, like myself, were also interested in experimental studies. When I did a study on diabetic acidosis, it was very difficult because not only did we have to care for the patients, but we also had to simultaneously do the analytical work ourselves.

WCR: *Why didn't he allow technicians?*

DWS: He didn't believe in them. He thought that everybody should do their own lab work. Not only that, you had to calibrate the burettes, pipettes, etc. You had to do everything as if there was nothing available.

WCR: *How many members were there on the faculty in the metabolic department?*

DWS: I would guess about 8 to 10. For all intents and purposes it was very large because the rest of the Department of Medicine was so small. The metabolic division dominated the Department of Medicine. It was a crowded section. Peters was not chairman of the department. Blake was chairman.

WCR: *How did it come about that you came to Dallas?*

DWS: These decisions are always complicated. Let me describe the climate at the time. This was 1950, and there were very few medical schools in the USA of academic caliber. There was Harvard, Yale, Michigan, Stanford, Johns Hopkins, and a few others. At that time, most medical institutions in the USA were just beginning. The Department of Medicine at Yale was a very crowded department in the area I was working in. It was highly developed and very competent. What future was there for me at Yale in the long run? At that time, Chuck Burnett, who was in Boston at the time, had accepted the position as chairman of the Department of Medicine at Southwestern. He had asked me to come to Dallas and set up a metabolic unit of my own.

WCR: *How did you know each other?*



Figure 8. Southwestern Medical School when Dr. Seldin joined its faculty in 1951.

DWS: Through various meetings and interactions. I didn't know him very well. He had never been at Yale. He knew Bud Relman, who was in Boston at that time. He'd talked to Relman about me.

I never visited Dallas prior to accepting the position. It's incredible. These days nobody ever accepts a job until after several visits and major offers. I thought about it for a long time. I was very happy at Yale. It was just a question of what I would do in the long run. What opportunities would I have by remaining in New Haven? In contrast, what opportunities would I have in a new institution where there were very few academic faculty? After all, Burnett was going to Dallas, and the only other member of the faculty was Tom Farmer, a neurologist. The Southwestern internal medicine faculty when I came consisted of Drs. Burnett, Farmer, and a fellow, Mac Walser. With much trepidation and uncertainty, I decided to come to Dallas.

WCR: *You must have talked to Dr. Peters about it.*

DWS: Yes. He thought it was a terrible decision.

WCR: *He advised you to stay at Yale?*

DWS: In discussing the position in Dallas, Peters said that he thought undoubtedly that Southwestern would have competent clinicians. He didn't doubt that people would be medically responsible in Dallas. He also thought that there would probably be a good teaching program. He couldn't believe, though, that they would value my interest in research. He thought it would be virtually impossible for me to develop an academic program in Dallas and, therefore, he thought that coming to Dallas was a very bad choice.

WCR: *But you parted friends?*

DWS: Oh, yes. He gave me a warm departing party. I arrived in Dallas on January 8, 1951. At the corner of Maple Avenue and Oak Lawn was a filling station. My wife, daughter, and I had driven from New Haven. I wanted to see the medical school before we settled anywhere. I asked the filling station attendant where the medical school was. He gestured in the direction of the railroad tracks down the street. I drove the car there. I looked around and saw nothing. I came back and told the attendant that I had not seen a medical school, only shacks and garbage. "That's it," he said (Figure 8).

Dr. Charles Burnett came here in October 1950, 3 months before I arrived. In April 1951, I went into Chuck's office to tell him that an abstract of mine had been accepted for presentation at the main program in Atlantic City. (In those days that was a tremendous achievement. There were no specialty societies of any importance in 1951. The main program at Atlantic City was a highlight of academic medicine. The abstract summarized work that I had done at Yale.) He congratulated me and said, "By the way, I have just received an offer to be chairman of the Department of Medicine at North Carolina." By June 1951 he was gone. He had been chairman of the Department of Medicine only about 8 months. With him went Tom Farmer, the neurologist. I was the only remaining member of the Department of Medicine. Within the next 1 or 2 years, every full-time chairman of clinical departments had left—William Mengert, who was chairman of obstetrics and gynecology, left for the University of Illinois; Gil Forbes, chairman of pediatrics, left for Rochester; Carl Moyer, chairman of surgery and dean, left for Washington University of St. Louis. The net effect was that there was no full-time chairman of any clinical department. I was appointed chairman of medicine at the end of 1951. The appointment was probably officially sanctioned in 1952 by the board of regents.

As you may have gathered from the fact that Burnett departed so quickly, this was a very difficult place. Parkland Hospital was an old building behind the shacks. (It was subsequently called Woodlawn when the new Parkland Hospital was developed.) It was a decaying hospital. Medical students called it "the black hole of Calcutta." There was a lot of tension at the school just before I became chairman. There were certain factions representing different groups pitted against one another. For example, Moyer, chairman of surgery, was not head of surgery at Parkland Hospital. The hospital had a separate chairman of surgery. Referrals were a problem that agitated the community. What would a referral be? Could you keep the money? How long would you keep the patient? Ironically, the debate went on when there were hardly any faculty members. Much of the discussion was theoretical.

When Burnett left, I was the only remaining member of the Department of Medicine. I had a number of offers. I could go back to Yale; I could go to North Carolina with Burnett; I had an offer from Harvard; I could stay in Dallas. Initially, I was asked to be chairman shortly after Burnett left, and I refused. I just thought it was hopeless, and I was considering returning to Yale. I had an offer from Peters and Paul Beeson, then the chairman of the Department of Medicine at Yale. Peters was never chairman of the Department of Medicine, but the letter came from both Peters and Beeson. I told Peters that I was going to return, and my wife went to New Haven to look for an apartment. We gave up our own apartment here in Dallas, and she was in the northeast and I was living with Sam Shelburne, a physician at Baylor and good friend of mine.

I was then offered the chairmanship of medicine a second time. By this time, certain interesting things had happened. In the first place, the new Parkland Hospital, which had been on the books for 20 years without money being appropriated by the county to build it, was suddenly being discussed again. The medical school was in shacks, and whether we would ever have a new medical school wasn't clear. The governor, Allen Shivers, had

not up to then made any commitment. There was no dean, since Carl Moyer, the chairman of surgery and dean, had left for Washington University of St. Louis.

To my surprise, these issues were suddenly resolved. George Aagard, a person of great integrity, was appointed dean. At the same time, Governor Shivers, at a special session, decided to furnish money for the first building of the medical school. The county appropriated money through a bond issue for the new Parkland Hospital. All of these were very promising, and as a consequence I decided to stay.

WCR: *Your wife was still up in New Haven?*

DWS: I called her and told her not to sign a lease, because now I had decided to stay in Dallas.

WCR: *How did your wife react when you first told her of your interest in coming to Dallas?*

DWS: She wasn't happy about it, but she would go along with what I thought was appropriate for a professional career. But she had her roots in the northeast and always did. In Dallas she taught art history and French at Greenhill School. She did a fabulous job. She was also very active in the symphony. I think, by and large, that she gradually found life in Dallas quite rewarding and would not have been very happy to return to the northeast after a few years here. We had an active musical life here. In New York, for example, there may have been better musicians, but you never saw any of them. Here we knew many musicians in the symphony, and they would come over to the house and play in ensembles. There were young architects who were talented, good, lively, and became good friends of ours, like E. G. Hamilton and James Pratt, as well as others. Although superficially the kind of cultural activities available in Dallas would be less extensive than in New York City or New Haven, nevertheless, there were various features that were equally rewarding.

WCR: *You were 31 years old when you became chairman of the Department of Medicine. How did it develop? What was the state of affairs at the school?*

DWS: I was left as the only full-time medical faculty member. The school was placed on probation.

WCR: *Probation from the national accrediting agency of the American Medical Association?*

DWS: Yes.

WCR: *You were the only full-time member of the Department of Medicine. You were dependent on getting practitioners from Dallas to come in and make ward rounds and participate extensively in the teaching. What happened? Where was your office when you became chairman?*

DWS: In the shacks. The whole medical school was there. Let me give you some portrayal of the various components of the medical service then. Very few resources were available. The support for the department by the University of Texas was trivial.

WCR: *Southwestern in 1951 had already been incorporated within the University of Texas system?*

DWS: That had occurred in 1949. Southwestern then was renamed Southwestern Medical School of the University of Texas. Previous to that time it had been essentially a proprietary school.

WCR: *At that time, there was the medical school in Galveston and Baylor in Houston, making Southwestern the third medical school in Texas?*

DWS: Yes. The medical service was centered in Parkland Hospital, and we had 2 ancillary services at the Veterans Administration (VA) hospitals. One was in McKinney, Texas, and one was in its present location in Lisbon. I made rounds in Parkland and also went to McKinney and Lisbon. The 100 students per class were distributed to those services. A very small cadre of students was sent to St. Paul's and another small cadre to Baylor Hospital. The major rotation through the Department of Medicine was in the third year, and the clinical clerkship lasted about 7 months. This has changed drastically over the years, but at that time the clinical clerkship was a long service on medicine. Half of the time or more was spent in Parkland.

The teaching program at Parkland was conducted mainly by clinical practitioners and the chairman. The lecture program was somewhat in disarray. There was no real control of the teaching program in the Department of Medicine. There were lectures in orthopaedics, urology, and surgery for long periods of time during the medical rotation. Students spent enormous amounts of time in lectures. The ward services were conducted by practitioners who gave their time, free of charge, to the medical school. They were very competent and extremely loyal. They didn't house their own patients at Parkland, so they received no remuneration either directly or indirectly by virtue of being clinical teachers at Parkland, but there was a very good spirit and a very warm dedication to the medical school. That dedication was surprising when you consider that the medical school was a minor institution at the time and that the private patients were essentially housed at Baylor, St. Paul's, and other private hospitals.

I wanted to institute a block system. That meant that the students on the medical service were under the control of the Department of Medicine. The miscellaneous lectures would be conducted at other times when students rotated on other services. The students had too many lectures, and there was not a tight articulation between the lectures and the clinical experience on the wards. I rearranged the program so that when the students were on medicine, the whole program was designed by the Department of Medicine. This meant that a number of physicians, both internists and surgeons, who had given lectures generously and loyally were evicted, and that move created a crisis, as you might imagine. Great prestige was associated with lecturing to the medical students. When I decided to cancel the lectures in 1952, say by the orthopaedists, urologists, and various general surgeons, there was a huge protest. I tried to develop and defend the block system and instituted a program where the students would have a clinical clerkship on medicine during the period they were assigned to medicine, and one afternoon a week only (Wednesday, as it turned out) would be devoted to lectures. The lectures were to serve orientation purposes and were designed to develop a feeling for medicine—not cover everything but try to give a sense of where medicine was going.

WCR: *These were lectures only in medicine, not in orthopaedics or surgery. You won on that?*

DWS: Yes. It created a sort of a crisis. It wasn't only a crisis between medicine and surgery or orthopaedics. The reorganization of the teaching program also created a crisis within medicine. For example, in redesigning the lecture program, it wasn't only that lectures from outside the Department of Medicine were eliminated. In addition, the entire lecture system within the

Department of Medicine was changed in 2 ways. Many individuals were giving random lectures on scattered topics of their own interest. I decided that the lecture program should be presented in a coherent way and dominated by whatever full-time faculty we had. Initially, I gave most of the lectures. In addition, the lecture program was changed so that certain lectures were eliminated.

Among the casualties in this regard was dermatology. In Dallas, dermatology was very powerful. Bedford Shelmire was a distinguished dermatologist. Arthur Shock was nationally known as a dermatologist and syphilologist. There were others. The dermatology lectures were drastically reduced. I wanted the students to have a limited number of lectures and, in the case of dermatology, I thought many of those lectures could best be transposed to a postgraduate level. A delegation of dermatologists came to me protesting this change. They pointed out that almost every patient who came to a doctor's office had a dermatologic problem. Obviously, if athlete's foot is considered a dermatologic problem, which it is, then nearly every patient did have a dermatologic problem. They pointed out that since dermatology involved so many patients, it ought to receive a prominent position in the lecture program in contrast to porphyria, which I had installed, which is a rare disease relative to many dermatological conditions. I tried to point out that the reason I put porphyria in was because it typified a kind of derangement that was important for teaching purposes so that students got a sense of how disease processes operated. Its orientation wasn't designed to reflect the incidence of porphyria in the general population. Dermatology may be very widespread, but it doesn't follow that we have the conceptual system to permit an analysis of dermatology in a coherent fashion. It was a more empirical discipline. They were all sorts of problems of that kind.

WCR: *Both Drs. Shelmire and Shock also had been very loyal to the medical school for many years. You were the new, young (31-year-old) chairman, and the previous chairman of medicine had left after only a few months. Could they count on your being in Dallas over a long period of time?*

DWS: The tension evolved from several facts. First, I was from the northeast, Yale. Starting something new and overturning a system that had been operative for a long time posed difficulties. Also, the notion of a full-time system was rather strange in Dallas. Tinsley Harrison, who had been here in Dallas as chairman of medicine, was a very distinguished figure, nationally as well as locally, but he had not developed much of a faculty. He was the whole department. When I came to Dallas, the question of the status of a full-time faculty physician and the development of a full-time system constituted a problem. The system here had been dominated by practitioners who were very loyal and highly competent, but who weren't full-time members of the faculty. The fact that I was young, that I was from a different area of the country, that I was trying to develop a program that involved reducing the power and status of many private practitioners, and that I wanted to develop a full-time system all served to generate a lot of tension.

WCR: *You are Jewish?*

DWS: Yes.

WCR: *Did that come into play?*

DWS: As far as I could tell, there was very little overt anti-Semitism here. In actuality, there was less than in New Haven

or New York. There are lots of things that you have to recognize about the way social forces manifest themselves. Let me give you an example. At Yale, before desegregation, allegedly there was no segregation. But it turns out that all the black patients were in the back of the ward and were never assigned to the 1- or 2-bed rooms that the service had. When I was on the housestaff at Yale, I talked to the chief resident and asked, "Listen, why don't we assign patients to beds at random without any particular sequestration." He said, "I don't think that would be very good." I said, "Well, this doesn't seem to be fair." His response to the notion that we should have a colorblind assignment of patients to rooms was, "Would you want your sister to marry a black man?" I said, "Look, I would try to point out that that creates certain social turmoil, but this is a free country and after pointing that out, she could do exactly as she wished. If it were foolish or wonderful, that would be her responsibility. After all, she is a free citizen."

In Dallas, we actually had a softer social scene in this respect. For example, when I wanted to build a research unit (we didn't have the clinical research centers at that time), I went to the administrator and asked him about that possibility. I was able to make arrangements to have a 4-bed unit assigned for clinical studies. Since we had many black patients at Parkland and the unit was to be small with 1 nurse and 1 small kitchen, the question was raised as to where the black and white patients would be assigned. The administrator said, "Well, just admit them and don't make a formal issue of it, and I don't think there will be any problems." And there weren't. This isn't to say that there weren't many problems here as well as elsewhere, but I never observed the kind of subtle prejudice against blacks that I saw more prominently in the northeast.

There are other aspects of this that are more complicated. I'm sure that there was some concern about the fact that I was Jewish. I venture to guess that there was less prejudice here than there was in New Haven. When I left Yale, there wasn't a single Jewish chairman of any department in the medical school! I was young, and I was appointed the chairman here—and that was much more daring or striking than my experience at Yale. At Yale, there were all sorts of subtle social distinctions. For example, when I graduated from medical school in 1943, I graduated first in the class. The president of Yale University, Charles Seymour, called Dr. Peters (Dr. Peters told me this later) and said, "Doctor, I understand one of your students is getting the Campbell Gold Medal [the highest honor of the graduating class]." Dr. Peters said, "Yes." Dr. Seymour said, "I assume the recipient, Mr. Seldin, comes from a family that has attended Yale for many years?" Dr. Peters said no. "I assume then that they went to other schools like Harvard or Dartmouth." Peters said no. (This may have been embroidered by Peters. I don't know.) "Well, probably the family has been in this country for many years, many generations." Peters said no. After all this, there was a pause and Peters said, "Look, I should tell you that his parents are immigrants. They never went to college here. He is the first member of his family to be in an American university."

WCR: *What was the response? You got the medal?*

DWS: Yes. When he called Peters, Dr. Seymour was preparing his speech. In our graduation, he was the one who gave the graduation address. What he was doing was simply orienting

himself to say something when he presented the Campbell Gold Medal. This was the conversation that transpired.

WCR: *When you were in medical school at Yale, you mentioned there were 39 students in your class. Were there many Jews among those 39? Were you the only Jew?*

DWS: I can't say that. There might have been 1 or 2 others.

WCR: *That was a very small class.*

DWS: Very small, and very few were from New York. Being from New York wasn't an asset.

WCR: *What religious faith was Dr. Peters?*

DWS: He was Presbyterian. His family came here on the Mayflower or something close to it. His father was a distinguished minister and archeologist. He was from a very old family.

WCR: *Where did he grow up?*

DWS: I think mainly in New York, but I'm not sure. I don't know his biography very well. His family was very distinguished in religious circles.

WCR: *Did he not get the chairmanship of medicine at Yale because he didn't want it or because it was never offered to him?*

DWS: He wanted very much to be a chairman at Yale and at other places also. After I became chairman in Dallas, he came to visit on several occasions. He stayed with us at our house. One evening when we were visiting together he remarked, "You know, I've given my whole life to academic medicine. I've sacrificed my wife, my children. I've never earned any money. And I've never had the opportunity to be a chairman." But Peters was an abrasive man. People were afraid of him. He was very critical of everything. It was perfectly obvious that the reason he didn't have the chairmanship was because of these personal characteristics. From an academic point of view, he was a massive figure. When Blake retired, Peters had perhaps 2 years to go before his own retirement. There was an obligatory retirement age at Yale at the time. They didn't appoint him as acting chairman and, of course, they didn't make him permanent chairman. Paul Beeson was appointed chairman following the retirement of Blake. Peters was absolutely dedicated to academic medicine but never had the opportunity to become chairman. I did, but he didn't. Ironic.

I instituted the block system, and it created a lot of fuss. I also tried to gather together the resources for the department. Previously, private practitioners had been given a small stipend (\$100) for giving lectures. I stopped that because I needed the money, even though it wasn't a significant amount. Again, that caused a certain amount of fuss, not because people were so dependent on the money, but because it reduced their status. All of this—the full-time system, the reorganization of the medical service, the change of the lecture system—posed problems. Also, I'm no rose. I would hardly describe myself as an easy person in certain ways. Also, the background wasn't so attractive for individuals who were rooted in another culture. All of this served to generate a lot of hostility.

At the same time, I had people who were very strongly supportive. There was Al Harris. He had an enormous practice. He was absolutely dedicated to seeing that Southwestern emerged as a distinguished medical school. He got no remuneration. Nothing. He went out of his way to try to help the medical school. He spent a lot of time at the medical school. He arranged for one of his patients to establish a visiting lectureship here. We'd never had anything like that before. He used to call me up

at 3:00 AM. The phone would ring, "Hello, Don, can we talk?" That's the way he would start, and he would discuss things about the Department of Medicine, about how he might help in recruiting, etc.

WCR: *How old was he at that time?*

DWS: He must have been about 50.

WCR: *He was considerably older than you were.*

DWS: All of these people were much older than I was. Paul Thomas, who had his practice largely at Baylor, was very supportive and very warm. I used to see his patients all the time as a consultant. Sam Shelburne, I mentioned earlier, also was very supportive. There were a number of physicians who, without any personal gain whatsoever, were very supportive of the medical school and of me.

WCR: *You would go over to Baylor to see them?*

DWS: Oh, yes, and also to their homes. The ward rounds at Parkland were largely conducted by very loyal and highly competent clinical practitioners. These were absolutely outstanding clinical practitioners who contributed their time generously.

Very early I was then confronted with the responsibility, having reorganized to some extent the teaching program, of developing an academic research program in the Department of Medicine. I didn't have any money for fellows. I couldn't recruit from the outside. It seemed to me that the only source of fellows was the students. A student research program was instituted where largely third-year students would work in my laboratory in the shacks. The students turned out to be as good as any in the country. There was Norman Carter, Floyd Rector, Jean Wilson, Dan Foster, Norman Kaplan, Jere Mitchell, Dick Portwood, and many others. These were all medical students who eventually became internists. There were other student fellows who subsequently left for other departments. Paul McDonald became chairman of our Department of Obstetrics and Gynecology later on. Peggy Whalley was professor of obstetrics and gynecology. We had 4 or 5 student fellows almost all the time working in my laboratory.

WCR: *What was your laboratory doing at that time?*

DWS: It was centered on electrolyte metabolism. We were working on adrenal steroid hormones and various electrolyte problems centered on sodium, potassium, and acid-base balance. To back up a bit, I tried early to recruit faculty from outside, but the resources were very limited; nevertheless, a few faculty members were recruited mainly from local institutions: Leonard Madison came from our local VA hospital; William Miller in pulmonary disease came from the same institution; and Al Shapiro, with a principal interest in psychosomatic medicine, also joined the department. I was able to persuade Marvin Siperstein to come here from the National Institutes of Health (NIH). He could have gone to many places, so it was very fortunate that he came to Southwestern. He was an outstanding person.

WCR: *What was the budget of your Department of Medicine in 1951 when you became chairman?*

DWS: Probably about \$20,000 a year.

WCR: *Where did you get the money to pay your recruits?*

DWS: We had grants from the NIH. The salaries were very small. I was paid maybe \$20,000 a year. The new faculty recruits may have gotten \$7000 or \$8000 a year salary. What started out as a departmental budget of maybe \$20,000 might have risen to \$30,000 because of the elimination of the lecture stipends. The

students who worked in my lab were sent to the NIH for training with the hope that they would return.

WCR: *These were the ones who as medical students or house-officers you picked out to work in your laboratory?*

DWS: Yes. Most of these were medical students during my first 5 to 10 years in Dallas, but some were from our housestaff. John Fordtran was a houseofficer. He had graduated from Tulane Medical School. Since he was very gifted, I wanted to arrange for his postgraduate training with the understanding that he would return to Dallas as a faculty member. Since we needed a gastroenterologist, I talked to Franz Ingelfinger. I had served on an NIH study section with him. I had previously asked him if he could send one of his young fellows to Dallas to develop gastroenterology. Franz's response was that he didn't know of anybody who was good in gastroenterology. You have to know Dr. Ingelfinger to understand that somewhat sarcastic remark. But, he added, if I would send him a fellow, he would accept him for training. I arranged for Fordtran to go there. Fordtran never had any special knowledge of gastroenterology before that. Nevertheless, he was willing to embark on a long-range program. That was how we developed our gastroenterology program. The model that was being developed was a Department of Medicine organized as a series of specialty subsections, where the individuals would develop research and clinical programs in the specialty area and at the same time participate in general internal medicine.

WCR: *Coming back to Fordtran, he was with Ingelfinger for 2 years and then came back?*

DWS: He also had an obligation to fulfill military service. After his training and military service, he came back and established the gastroenterology program. Jean Wilson and Dan Foster returned from the NIH in metabolism and endocrinology. Norman Kaplan came back. Initially, he had worked on adrenal steroids, but ultimately he devoted himself to hypertension. Jere Mitchell returned in cardiology. Floyd Rector, who also went to the NIH, came back in kidney and electrolyte metabolism. We gradually were able through our own students to populate the department. It was inexpensive and efficient, because the students were loyal and dedicated. The net effect was that we could get people who were very young and who ultimately proved to be among the best in the world.

Over the years, I also tried to recruit faculty from outside in critical areas. Cardiology was always a big focus in Dallas. Tinsley Harrison was a great cardiologist, and people expected a cardiology program at the medical school to flourish. Carleton Chapman came here and headed cardiology and ultimately was elected president of the American Heart Association. I wanted someone in infectious disease. This was not a big specialty at that time. I was able to get Abe Braude from the University of Michigan to come here in that capacity. For hematology and oncology, Gene Frenkel was recruited from the outside. Burt Combs came here in liver disease. John Dietschy joined Fordtran in gastroenterology. Gradually the department became filled.

WCR: *This took about 10 years?*

DWS: Yes. I should also mention that Joe Goldstein was a medical student here, and at that time we were anxious to develop a program in genetics. There was almost no clinical genetics in the USA at that time. Joe was sent away with the thought that he would obtain genetic training and ultimately return. He

went for a year of internship and a year of residency at the Massachusetts General Hospital. Then he spent 2 or 3 years with Marshall Nirenberg at the NIH. Then he went for several years with Arno Motulsky at the University of Seattle for genetics training. After a period of 7 or 8 years, he came back. He was quite loyal in the sense that by the time he finished his training, he had innumerable offers because he'd done a great deal of outstanding work. Nevertheless, he came back and established a program here.

At the same time, Joe used to organize dinners at Atlantic City and would have me come to the dinner that included many houseofficers from Harvard. I met, among others, Mike Brown. He and Joe were houseofficers together at the Massachusetts General Hospital. Mike went to the NIH and then went into gastroenterology. He also had very sophisticated training with Earl Stadtman in enzymology. I offered him a position. He came here and, without going into details, he gave up a very promising career as an endoscopist to work in genetics and ultimately shared the Nobel Prize with Joe.

Over a 10-year period the department largely was filled with former students, houseofficers, and fellows who were sent away and came back. Some of the fellows, like John Dietschy, ultimately became faculty members. Dr. Dietschy was appointed chief of gastroenterology after John Fordtran left to go to Baylor. Gradually, over a period of years, the core of the department was assembled.

The recruitment of full-time positions was not necessarily popular among the clinical faculty. They were regarded as threatening. The question was raised as to whether the people who were subsidized by state tax funds would compete with unfair advantages with private practitioners. The full-time faculty was small, so it wasn't a problem, but it was nevertheless perceived as one. Gradually, the value of the full-time faculty came to be appreciated, and cordial relations were established. The dermatologists, the group that was upset about the teaching program early on, was also upset 10 years later about the fact that there were full-time faculty in many subsections but not in dermatology. They came to see me asking, "Why don't we have a full-time dermatologist?" Times had changed. We did develop a full-time program in dermatology. The dermatology section developed really in a marvelous fashion under the direction of Jim Gilliam, who had been a houseofficer of mine. He had had a fellowship with Morris Ziff.

WCR: *Dermatology was a part of the Department of Medicine?*

DWS: Yes, initially. Ultimately, it became a separate department. The same thing was true of neurology. All of the subsections initially were part of the Department of Medicine. In the case of neurology, I recruited a young man from Sweden, Sven Eliason, to head the section of neurology. There were problems. The neurology accrediting board wanted beds assigned to neurology, and I didn't want that. I wanted neurology maintained as part of medicine. That was contrary to the policy of the accrediting group. In addition, they controlled not only accreditation but also training grants. If separate beds and a separate Department of Neurology were not established, we were not likely to be accredited or approved for training grants. The net effect was that ultimately we established a separate Department of Neurology.

One of the major individuals recruited from outside the medical school was Morris Ziff, then at New York University and a very distinguished rheumatologist. He came to Southwestern to establish a program in rheumatology. It's interesting how that emerged. There was a group of private citizens—not physicians—who constituted a core of support for rheumatology and rheumatic diseases. Many prominent Dallas citizens were in that group. They were persuaded by the national rheumatology association that the way to develop rheumatology was to obtain what they called the "mobile unit": a car with a nurse who would visit patients with rheumatic diseases and provide physiotherapy and various other forms of treatment. I tried to argue that this was not the optimum way to allocate meager funds. The value that would stem from a mobile unit was minor compared with what could be achieved if we could develop a rheumatology program at the medical school that would train physicians and develop clinical and research programs. Howard Coggeshal, a practitioner and major rheumatologist, was very supportive. I finally persuaded the group to use the money to help recruit a rheumatologist. I succeeded in persuading Morris Ziff to come here. He developed a program that became world famous. He received almost every award at the time.

Jim Gilliam, after finishing a fellowship in rheumatology, became interested in dermatology and, ultimately, we set up a section of dermatology under his direction. As time went on, however, he wanted a separate department, and the school agreed to set up a Department of Dermatology. How this came about is of some interest too. A new medical school was being established in Houston, and a dermatology department was being formed. Jim Gilliam was offered the position as chairman. At that time dermatology here was a part of the Department of Medicine. I couldn't understand if the University of Texas wanted to allocate such enormous reserves to attract Gilliam to Houston why they didn't support him here where he was established and recruit someone from outside. We were confronted with the possibility that he would leave for Houston unless he had a separate department. A separate department was established for him, and it worked out very well. We've had a very distinguished department under Jim and then under his successor, Paul Bergstresser.

Let me just say a few other things about the philosophic background behind the way the department evolved. I wanted everybody to be comfortable in general internal medicine no matter what their specialties were. In addition, all were expected to be involved in a specialty area and, finally, all were required to do research. Research, teaching, and specialty areas were the 3 domains that were the model. For many years, we didn't have a separate section of general medicine or family medicine or emergency medicine. All of these activities were undertaken by the full-time faculty. It was expected that they would make ward rounds on the general medical service, that they would make rounds in their specialty area, and that they would conduct a research program. The faculty was rotated through the medical wards, through the emergency room, and through the clinics. The faculty manned the general medical clinic as well as the specialty clinics. For many years, clinical faculty members were alternated with full-time faculty in ward rounds and in the clinics. By and large, I think the system worked out very well. This plan allowed us to keep in touch with the local medical com-

munity. The students gained by having contact with both the best practitioners as well as with the full-time faculty.

This model didn't last forever. It was obvious that with increased specialization and increased clinical research commitments, we had to divide responsibilities so as to meet increasing service and academic responsibilities. The original model required that everybody in the Department of Medicine would be a physician-scientist or clinical scholar. As time went on, it became apparent that there were certain very gifted nonphysicians who could contribute a great deal. As long as the general spirit of the department was anchored in the concept of the clinical scholar, it wasn't an important violation. Dennis McGary, PhD, for example, was made a member of the faculty and contributed enormously to the department.

Gradually, it became apparent that there was a splay of talent: some people were better clinicians; some were better teachers; some were better investigators. This all seemed to be rather healthy, but in the long run it turned out that the requirements for patient care and for teaching became so overwhelming that it would be necessary to appoint certain individuals whose main activity was clinical care. Nevertheless, I always tried to stress the fact that all members of the department should have academic roots and should try to develop clinical research programs.

As years went by, I was able to persuade Parkland Hospital to provide space for a clinical research center. The NIH established the clinical research center under the direction of Charlie Pack, whom we recruited here from the NIH.

There were problems and failures as the years went by. I'll mention some. I wanted the VA hospital to be on the medical school-Parkland campus. It had been so arranged before I became chairman. That move had been accepted by the board of regents, by Parkland Hospital, and by the federal government. It seemed to me that a VA hospital here would give a great deal of resources to the school and enormously increase our patient base. This was ultimately changed. The administrator felt that the salary of VA employees would be greater than that of Parkland employees and that that discrepancy would generate financial problems, so that it would be better if the VA hospital were located elsewhere. The net effect was that the permission to develop the hospital on this campus was withdrawn and, when plans for the new VA hospital were developed, it was to remain in Lisbon, a suburb about a half-hour drive from Dallas. I thought and I still think that was a grave mistake.

There was a big fight over air-conditioning the new Parkland Hospital. At that time (about 1953) some private hospitals in Dallas were not air-conditioned. That a public hospital would be air-conditioned offended some sensibilities. It always seemed to me unreasonable to develop a hospital that was obsolete from the start. If the argument was advanced that it was too costly, we could at least have built the ducts so that we could later put in the air-conditioning. That view was defeated. The new Parkland Hospital was built without air-conditioning, which resulted in problems over the years, including heat stroke on the general medical wards. Ultimately, the hospital was air-conditioned at a much greater cost.

There were a lot of tensions early regarding the assignment of faculty and students to peripheral hospitals. I tried to keep the faculty centered at Parkland. I was under great pressure to assign



Figure 9. In 1958.

faculty members to other hospitals. I didn't want to do that because I felt that doing so would compromise the character of the training program and disrupt its academic structure. We were able to prevent the dissemination of the faculty, but only after formidable confrontations.

Over the years the department flourished. Some faculty became very distinguished. The department produced its fair share of first-rate practitioners as well as academic scholars.

When I was chairman, in addition to making rounds, we had a number of clinical and research conferences. I read the manuscripts, initially anyway, of almost everyone in the department, independent of which section they were in—endocrinology, cardiology.

WCR: *They all had to pass by you?*

DWS: At that time I tried very hard to make sure that the department was moving in a healthy academic direction. We had rehearsals for every national meeting. If someone had a paper to give, the whole department assembled to criticize the papers and make sure that they were presented in the best possible way. We also had regular department meetings for research, for clinical developments, and the like.

WCR: *How long had you been chairman here before you clearly decided that you had made the right decision to stay here?*

DWS: These things can be associated with various offers I've had. As the years went by I had a number of offers to leave Dallas. I didn't look at most of them, but I looked at some. One position I looked at was Harvard. I was offered a chair at Harvard, and I looked into it very carefully. I honestly thought that Southwestern offered more in terms of academic potential than I could gain at Harvard (Figure 9).

WCR: *What year was that?*

DWS: It must have been about 1963. The last offer I looked at seriously was Columbia, about 1976. I come from New York and I love the city. Columbia is a great medical school, but there

were many difficulties, especially on the clinical level. I was offered a chair there and ultimately I decided to stay in Dallas.

WCR: *Dr. Seldin, could you give a flavor of what a day was like when you were just beginning development of this department—let's say 1953 or 1954? You mentioned that Dr. Al Harris would call you freely at 3:00 AM. You must have been enormously busy. What time would you get to the hospital back then? What time would you leave? What time would you go to bed?*

DWS: We started with what the housestaff called “sunshine rounds” at 6:00 AM. I met with the housestaff and discussed various clinical issues and problems.

WCR: *Would this be like morning report?*

DWS: Initially, it consisted of a lecture or a clinical conference. In addition to that, there was morning report, which was a discussion of the patients admitted the previous day. It was a combination of those two. That conference was largely directed to the housestaff. I made rounds at various places. I might go to a VA hospital 2 or 3 times a week (to McKinney or to Lisbon). Sometimes it would be in the mornings; sometimes, afternoons. I made rounds at Parkland, and I worked with student fellows doing research. Some early papers from the lab were based on work done with Floyd Rector, Norman Carter, and Jean Wilson, who were medical students at the time. I met with the faculty, practitioners, and others. I saw patients on a consultation basis. The major physicians with whom I worked were Al Harris, Paul Thomas, and Sam Shelburne.

WCR: *They would ask you to see some of their patients?*

DWS: Yes, for consultation. I didn't have a practice. The question of what defined a referral was a burning issue for a time. It seemed so unrealistic because there were so few faculty members. Practitioners were nevertheless very concerned. A referral was defined as a request by a private practitioner to see his or her patient, after which the patient was referred back to the practitioner. The patient could be seen a number of times if required, but ultimately the patient would be referred back to the physician. There would be no long-range care of a patient independent of the private physician. That was the initial model.

WCR: *You had to wake up in the morning by 5:00 AM to get here at 6:00. What time would you leave the hospital back then?*

DWS: We used to make rounds sometimes at 6:00, 7:00, or 8:00 PM. I'd get home pretty late, at 7:00, 8:00, or 9:00 PM. It was not the same every night.

WCR: *What about on Saturday and Sunday?*

DWS: We made rounds on Saturday. We had a conference Saturday morning. We still have it. Everybody came in on Saturdays then.

WCR: *Was that primarily a research conference on Saturday?*

DWS: No, it was a clinical conference. It was set up in such a manner that a houseofficer would present a case and discuss it, and then it was open for general discussion. We would have 2 such presentations. That's evolved over the years in various forms but we still have it. Now it's at 8:30 AM.

WCR: *You remind me so much of Gene Braunwald. You are very much alike. I couldn't imagine your being at an institution over a long period of time unless you were chief. The same with Braunwald. He was number 1 in his class at New York University. You were at Yale. He said he was the last one in because of the Jewish quota. You both had the New York quota problem.*

DWS: Yes. Coming from New York was a major disadvantage in getting into Yale. Admission policy at Yale was in part designed to take students from all over the country and indeed over the world. To be from New York and Jewish was a disadvantage.

WCR: *Could you talk a little bit more about your concept of clinical scholar? That was your focus from the very beginning.*

DWS: You can start by imagining what criteria a university would establish for a faculty member in a clinical department. If you were in a basic science department, the orientation would be entirely toward the search for new knowledge and its transmission. In a clinical department, you have a responsibility for taking care of patients and transmitting knowledge concerning disease. Any time you take responsibility for the care of a patient, this must, for moral reasons, have priority. On the other hand, if you were only a good clinician, you wouldn't fulfill the university requirements for the search for new knowledge and for its transmission to others. A clinical scholar, therefore, has a complicated requirement. He or she is required not only to be interested and concerned with clinical medicine but also to do research and to teach students and colleagues.

Research and clinical medicine are sometimes almost unified in the sense that the critical observation and analysis of disease contributes both to good medical care and new knowledge. When I was starting medicine, if you were in nephrology and did an inulin clearance as part of a reasonable research project, the paper had a good chance of being accepted in the *Journal of Clinical Investigation*. But that research technology also helped you as a clinician because the determination of inulin clearance, that is, the study of filtration rate, also imparted a great deal of understanding of how the kidney functioned. As medical science has developed, however, the two activities have tended to diverge. This exploded with the development of molecular biology and genetics. The highly specialized technology and sophisticated conceptual systems involved in research don't very easily carry over to clinical competence.

A university is not a research institute. In a research institute, the principal requirement is good research. The whole purpose of the NIH is to advance medical science. Everything else is ancillary. A university is different. In a clinical department, we have the responsibility of educating students and making sure that the educational process does full dignity to clinical responsibilities. To populate the Department of Medicine with individuals just for the sake of turning out research seems somewhat hypocritical to me. The culture that is now emerging is not cordial to the model of the clinical scholar. The evaluation of medical practice, the financing of medical education, and the emergence of highly sophisticated science all work against the medical model.

Today we have the problem of money generation. The department is often required to see as many patients as possible for the purpose of money generation, not only to defray the salary of the faculty member but also to furnish financial reserves to the department. The early Flexner model of clinical responsibilities delimited by the requirements of teaching and research is here disrupted. It was never perfect. You couldn't perfectly match the requirements of teaching and research and clinical care, but in a rough sort of way the Flexner model argued for a certain de-

limitation of clinical responsibilities to allow for the development of academic work. Now, we are asking people to see as many patients as possible, way beyond the requirements of teaching and research, specifically for the generation of money.

This problem of balancing research, patient care, and teaching is present in all medical schools, but this school has coped with it better than most. We have support from the state. We have the VA hospital, which is supported by the federal government. Parkland Hospital is supported by the citizenry of Dallas County. There has been an attempt (and it is hard) to keep the model of the clinical scholar intact. But the model has been loosened. We have individuals now whose principal focus is clinical medicine. We hope that they can contribute to academic learning, and there are special tracks set up to acknowledge their performance as clinicians. This has worked out well. If the university wants people to see many patients and do it with high competence, these physicians ought to be appropriately rewarded. Southwestern has done that rather well. But the clinical scholar, the academic core of the department, is an individual who advances first-rate clinical science and at the same time is competent in clinical medicine and in teaching. If most people in the department fulfill that model, the department is healthy. If you tear that model apart, you get into problems.

WCR: *Who were the outstanding chairmen of departments of medicine in the USA during the last 50 years of the twentieth century?*

DWS: It's difficult to make a judgment of that sort because there have been a number who have been outstanding. Among the elite I would mention Eugene Stead, Eugene Braunwald, Carl Moore, Holly Smith, Robert Williams, and Robert Schrier.

WCR: *What characteristics of these former chairmen allowed you to put them in the elite category?*

DWS: They all developed an academic program characterized, on the one hand, by outstanding clinical medicine infused with humane concern for patients, and biomedical science was built into it as a key ingredient. In addition, and this is very important, they assembled a faculty of high distinction. They had good taste. It's hard to identify a department as first rate if you look only at the chairman without appreciating the entire academic program. These chairmen had the ability to select individuals of great potential, encourage them, and develop them to a very high caliber.

WCR: *As far as you know, you were the first to use the phrase "clinical scholar"?*

DWS: I don't know. The phrase appeals to me. These days most people talk about "physician-scientists," and I do too.

WCR: *You have talked about and written that medical schools are really not in the business of providing clinical care across the board in a community.*

DWS: I must clarify that. The primary purpose of a medical school is different from that of a public utility. Medical schools are not designed primarily to provide care for an indefinite number of people. Nevertheless, medical schools are in a certain sense impure institutions. They are not just institutions of learning. When you take responsibility for sick human beings, this must, for moral reasons, assume a priority. The fit between an institution of learning with the necessary requirements of teaching and research on the one hand and patient care on the other hand is

never perfect. After all, we have private hospitals. We have outpatient clinics. We have city/county hospitals. These have their own logic and their own structure. Ideally, the responsibility for patient care on the part of the clinical faculty should be somewhat limited by the requirements of teaching and research. Without this limitation, the faculty would have its energies dissipated in a whole set of different directions which, however socially valuable, would compromise the capacity to fulfill academic functions. Since the responsibilities to a community are complicated and demands are placed on the medical school that must be fulfilled, various devices have been deployed to protect academic functions and still discharge broad clinical responsibilities. Special kinds of departments, like family medicine and general internal medicine, have been developed, which, by and large, fulfill a very good function and, moreover, have encouraged the development of specialized academic skills. So long as the central core function of the school and the department is maintained, I think academic functions can be fulfilled in a dignified way. Nevertheless, the conflicting pressures remain.

WCR: *When you encountered John Peters and were essentially immediately turned on by clinical medicine, nephrology and metabolism were probably the most intellectual specialties of internal medicine. Yet, in recent decades, dialysis and renal transplantation have entered the scene and now nephrology is no longer attracting the elite like it used to. Is that fair?*

DWS: When I entered the third year of medical school and encountered Dr. Peters, nephrology wasn't a well-defined discipline. The section he headed was the metabolic division. One component of it had to do with electrolyte metabolism. Equally, the section was immersed in endocrinology, cardiology via heart failure, salt retention, and metabolic disorders, with all diabetic patients also being taken care of by the metabolic service. Nephrology wasn't a separate discipline but simply a part of the metabolic division, at least at Yale. Subsequently, and particularly with the growth of specialized therapeutic modalities like dialysis and transplantation, nephrology came to be a separate discipline. Originally, nephrology consisted of what might be called renal physiology. Subsequently, other disciplines became parts of nephrology, such as renal endocrinology (parathyroid hormone) and immunonephrology. As a consequence, nephrology became a very broad discipline. Whether the initial base was more intellectual than others, I don't know. Certainly, the component of transport was a very sophisticated discipline.

WCR: *Dr. Seldin, you were enormously productive once you came back to Yale as an instructor in the metabolism division. In those 3 years there, you did some seminal work. When you came to Dallas, your productivity in these 5 decades has continued. There are not many chairmen of medicine who maintain their own academic productivity such as you have. That's been an enormous stimulus for others in your department to follow your leadership. I'm sure that wasn't easy. How did you do it?*

DWS: The atmosphere here was a very healthy one. Initially, the department was very small. The department also was well focused. It was confined to Parkland Hospital and the VA and little else. That cohesiveness was, incidentally, not easy to maintain. There were always demands that we send faculty and students and housestaff to other institutions in the community. That was something I tried to prevent. I thought it was healthy and



Figure 10. Receiving an honorary doctorate from Yale University (second row, second from left). Paul Newman (first row, left) also received an honorary degree.

in a way stimulating if the students had contact with the full-time faculty as their mentors. Because the department was small and the student body was 100 per class, not the 200 per class we now have, we were able to have effective and frequent contact with the students and housestaff. The research programs I developed were largely those that involved students, housestaff, and junior colleagues. Most of the junior colleagues had been previous students or houseofficers—Floyd Rector, Norman Carter, Jean Wilson, and others were fellows and houseofficers who later joined the department. The academic climate made for mutual interests and collaborative work.

WCR: From your publication list, it looks like you never piggy-backed on any of your faculty's work. It seems to me that they were incredibly appreciative to you about that. Maybe that was one of the factors producing the great loyalty to you through the years. The number of faculty you have lost was relatively small despite the fact that institutions such as Harvard and Yale tried to recruit some of your faculty.

DWS: We were a very stable department.

WCR: You've received a number of honors through the years. You've been president of 7 learned societies. You've received 6 honorary doctorate degrees, including one from your alma mater, Yale. Of all the honors you have received, which one or ones do you prize the most?

DWS: I've never tried to evaluate one against the other to see which was most moving to me. Naturally, to receive an honorary degree from Yale, where I graduated, was very moving (Figure 10), but so was the Kober Medal.

WCR: When Brown and Goldstein were awarded the Nobel Prize in 1985, that must have caused your heart rate to jump up a bit. Here was Joe Goldstein, whom you brought along yourself. You had him in your laboratory as a medical student. You had gotten him into genetics. It looks to me like their winning the Nobel Prize was the personification of what you had been trying to accomplish during the 35 years that you had been chairman of the department. Is that appropriate?

DWS: Naturally, it was thrilling when they both won the Nobel Prize. That event needs to be put into context. Some people think a department of medicine is an institution to de-

velop academic scholars who contribute important new knowledge. I feel somewhat otherwise. At least at the level of the medical student—and I'm talking about the medical school where education of the medical student terminates in an MD degree—I think the function of a department of medicine is to educate students in the best possible way in medicine. If some of them go into private practice and turn out to be fine practitioners, I think that's healthy. If others use their medical knowledge to go into academic medicine, that's also tremendous. Still others may become medical leaders and administrators. I don't think that the defining feature of a department of medicine is necessarily to develop medical investigators. This is not to say that it isn't a thrilling accomplishment. It is. For someone to win a Nobel Prize or to be

elected to the National Academy of Sciences or to the Institute of Medicine (Jean Wilson, Roger Unger, Mike Brown, and Joe Goldstein all are members of the National Academy of Sciences, and we have a number of departmental members who are in the Institute of Medicine) engenders a great deal of pride. But, at the same time, we do our fair share in graduating a number of individuals who are outstanding physicians in the state of Texas and elsewhere. That also is a matter of some pride.

WCR: Dr. Seldin, is it a requirement to step down from the chairmanship of the Department of Medicine at this institution once one reaches a certain age?

DWS: No. Not any longer. At one time there may have been an age limit. I'm not aware of any age requirement to step down.

WCR: When you stepped down in 1987, that was your decision.

DWS: Yes.

WCR: Why did you decide to step down?

DWS: I thought that I had done just about everything I could in the Department of Medicine (Figure 11). I thought that I had developed it to a point where my underlying philosophy had been translated into the department, and I thought it might be a good time for someone else to take over. I always enjoyed being chairman. It wasn't a problem. These days, people often avoid chairmanships of departments of medicine, feeling that the administrative and financial responsibilities are overwhelming. When I was chairman, I didn't feel that way. I always enjoyed the clinical teaching, investigative, and academic responsibilities of the department and thought that they far outweighed the administrative difficulties.

WCR: It sounds to me like you are a good businessman too, that you handled that arena of the department pretty efficiently.

DWS: I don't think so. I did the best I could, but I wouldn't regard myself as someone who is very astute on a business level or even enormously efficient on an administrative level. Over the years, I spent a lot of time on administrative and financial matters, which could have been more efficiently done if they had been delegated to an administrative assistant. I always thought that the defining feature of a chairman should be academic lead-



Figure 11. In 1986 when he stepped down as chairman of the Department of Medicine.

ership. Of course, you can't go bankrupt. There has to be a sensible direction along financial administrative lines, and I tried to do the best I could, but I wouldn't regard that as something I did brilliantly.

WCR: *Dr. Seldin, your contributions to this medical center and to national and international medicine have gone far beyond your duties as chairman of the Department of Medicine. Could you comment a bit about how you influenced who was selected for other chairmanships in other departments in this medical center? I understand, for example, that Austin had planned various buildings in this medical center so each department would have a separate building and that was already signed, sealed, and delivered, when that concept was brought to your attention. You convinced the powers that be, however, that that was an inappropriate way to build a medical center. Would you comment?*

DWS: At one time a committee was formed (I was chairman of the committee) to help design the architectural structure of the medical campus. It ultimately turned out that there were forces beyond the committee that wanted to have separate buildings all over the campus for various functions, somewhat in the manner of the pavilion-style medical campuses in some European countries. It always seemed to me that the more important function was to integrate the campus. While architecture doesn't do everything, it certainly helps. I thought it was very important that the campus, instead of being spread out and scattered, should be continuous, that we have buildings so designed that it would be possible to go from the farthest reaches of Parkland Hospital to the Hughes without leaving the floor. This would encourage interactions among the various units so that people could talk and aggregate. Ultimately, that's what we did. We have a very integrated campus.

A similar problem arose when the Zale Lipshy Hospital was planned. Originally, some people wanted it on a separate site. The advantage of that is that it allows for an architecturally unique presentation, somewhat as a piece of sculpture. It seemed to me that it would be very critical to integrate the new hospital into the rest of the campus. I argued for the hospital to be contiguous with the rest of the structures. Many people agreed, and ultimately we had the Charles Sprague Clinical Science Building, which connects Parkland Hospital with what was then the new Zale Lipshy University Hospital. The medical school has continued the policy of a unified campus. When the south campus property was filled up, additional property was purchased north of Harry Hines Boulevard. Buildings there were connected very efficiently with the south campus by a bridge. Again, we tried to maintain a unified structure.

WCR: *What was your role in building the basic science departments at the medical school?*

DWS: Early in the evolution of the school, a real question arose as to whether the basic science department should be given special support. I tried to do everything I could to make sure that we had strong basic science departments. Harry Ransom at that time was chancellor of the University of Texas. In conversations with him and with others, I argued the importance of having strong basic sciences and of providing money for those departments. I think that was a successful thrust.

WCR: *I suspect through the years that you were offered positions as dean, provost, or vice president for medical affairs in several medical schools. Did any of those positions ever appeal to you?*

DWS: I did have a number of those opportunities presented to me, but they never interested me. I always regarded them as disembodied leadership in the sense that one could develop broad programs that were critical for the institution but that were rather remote from direct contact with students, housestaff, and others. I always thought that a chairmanship of the Department of Medicine was really an ideal position for me in terms of my interests. I never was attracted to major administrative positions.

WCR: *Your activities as a consultant, as a visiting professor, as the president of these learned societies have required you to do a good bit of travel during your tenure as departmental chairman and subsequently. How have you integrated your traveling for these outside obligations into your day-to-day activities?*

DWS: When the department is solidly functioning, when people understand what their responsibilities are, it's not necessary that the individual who directs the operation be present all the time almost as a monitor. The important thing is to ensure that one's presence is felt even though one leaves for a time. We were able to develop a program that was, in a sense, self-sustaining. It worked out rather well. It's true that I was a visiting professor at many different medical schools. These trips took me away from time to time. And I spent a lot of time during a 4-year period on the National Commission for the Protection of Human Subjects. That's an ethical commission mandated by the Congress to report on biomedical ethics. During this period, however, I don't think that my absence (usually over weekends) created any problems.

WCR: *I understand that when you gave lectures or were a visiting professor, you did not use any notes.*

DWS: I never used notes. I made notes in advance when I was organizing the talk, but in presenting it I never wrote it out.

WCR: *You obviously knew the subjects so well that each thing fit into place.*

DWS: Yes. I had it logically organized in advance. It wasn't difficult to present it in a fashion that was deductively logical.

WCR: *For your own writing, do you write it out on a pad or do you dictate?*

DWS: I write it out in pen or pencil.

WCR: *I heard that a person who writes a manuscript with a pen is an optimist.*

DWS: I'm not optimistic.

WCR: *Your manuscripts go through a few drafts?*

DWS: Yes.

WCR: *Do you sleep much?*

DWS: Not too much, 4 hours or so, maybe 5.

WCR: *What time do you generally go to bed at night?*

DWS: By 2:00 AM.

WCR: *And you get up at what time?*

DWS: It varies, 6:00 AM or thereabouts.

WCR: *What do you eat for breakfast every day?*

DWS: I don't eat breakfast. Over the weekend, we might have cheese omelets, and I would make them.

WCR: *What do you eat for lunch as a rule?*

DWS: Lunch, for all intents and purposes, is a meal in the cafeteria here. I might have soup or a tuna fish sandwich or some Chinese fried rice. I don't eat very much for lunch, and very often I skip it.

WCR: *What about dinner? What's your favorite meal?*

DWS: Dinner is usually a more formal occasion either at home or at a restaurant. Most of the time we have dinner at home. My first wife, Muriel, was an excellent cook, and my current wife also is an excellent cook. My wife makes various forms of duck. She's playing around with a duck confit these days. I like Tarte Latin and soufflés as desserts. It's sometimes fun to have a rather elaborate meal, and from time to time we do. If we're pressed, of course, we have something simple.

WCR: *Do you drink wine at night?*

DWS: Not every night but, yes, we drink wine, and I have a wine cellar. As a matter of fact, the wine cellar I have was given to me as a present by the faculty of the Department of Medicine.

WCR: *How many bottles of wine do you have there?*

DWS: It was stocked by the department! There must have been several hundred. I mean it.

WCR: *What's your favorite kind of wine?*

DWS: My favorite wine would be a French Montrachet, a white wine. There are many different kinds of Montrachet. They are very expensive, but that kind of white wine is the kind I like best. As for red wines, I like cabernet sauvignon.

WCR: *Do you drink spirits?*

DWS: Not much, only occasionally, and then either gin or bourbon (Jack Daniels).

WCR: *Have you smoked cigarettes?*

DWS: Yes, I have. I smoked cigarettes rather heavily for about 20 years. I remember why I stopped smoking. It was in 1966 at a time when I had to write a chapter on renal tubular acidosis, and Waldenström was a visiting professor here. I had to spend time with him, I had to write this chapter, and I had to prepare to go

to Europe. I was up continuously for about 10 days and smoked about 3 packs of cigarettes each day. I could hardly speak at the end of this time. I decided to stop, and I've never smoked since.

WCR: *You have always been at ideal body weight?*

DWS: More or less. I've always had a reasonable body weight.

WCR: *How much do you weigh?*

DWS: Now I weigh about 155 lb. I have usually weighed about 147 or 148 lb.

WCR: *How tall are you?*

DWS: Six feet.

WCR: *You've always been at ideal body weight, and yet so many patients are overweight. How can we in the USA take more charge of our personal health?*

DWS: First, let me say something about body weight, the question you initially posed. Obviously, you're talking about a caloric balance. Body weight will be gained to the extent that caloric intake exceeds caloric output. Caloric output is largely a function of exercise. Everybody points out these days that in order to lose weight, or at least forestall weight gain, one should exercise to dissipate calories and control caloric intake by restraining the intake of food and high-caloric items containing a lot of fat. Exercise is very valuable in and of itself. It leads to conditioning such that muscle tone is better, the circulation is improved, and various reflex functions are more active and precise.

Above and beyond these admitted values of exercise, there is the question of exercise as a mechanism to dissipate calories. One should remember the arithmetic here. One of our cardiologists exercises religiously and uses various treadmills. Very often a treadmill is accompanied by a monitor that indicates how many calories he has dissipated after an hour of running. One thing that strikes him is the fact that when he gets off the treadmill, having exhausted himself, he learns that he's dissipated calories that are the equivalent of a candy bar. It's hard to lose a great many calories by moderate exercise. I'm not talking about a long-distance runner or a lumberjack, whose activity is associated with massive caloric loss. Ordinary activity, while invaluable to maintaining muscle tone and muscle reflexes and a brisk, responsive cardiovascular system, contributes only modestly to weight loss through dissipation of calories.

The critical determinant to lose body weight is to restrain food intake. Since everybody is sedentary these days and fastened to a television set, the temptation is to nibble various kinds of potato chips and the like endlessly. This is one of the problems in the American community. Above and beyond that, one should recognize that the various diets that are prescribed are not followed by people. They tend to follow their appetite and eat what pleases them. Moreover, there's very little doubt that a high food intake acts as a sedative and quiets people when they are anxious. My own feeling is that it's very hard to restrain food intake if one is sitting idly before a television set all day and nibbling on various kinds of junk food. The diets that are prescribed really don't satisfy most people because food intake is driven by taste and appetite. What I do is refrain from eating anything I don't like, eat about half of what I do like, and then partake of everything. That works rather well.

WCR: *You have commented that health food is not your thing. What you are saying is you don't waste calories. You don't put calories in your mouth unless they are pretty good.*

DWS: Yes. What I'm saying is that there are foods that I like. I eat them, but I don't eat endlessly. I eat about half of what I like. Foods that I don't like, I don't eat. In other words, I'm not driven by a huge rise in hunger.

WCR: *Do you think it's important for members of the medical community to present themselves in a healthful manner? You are walking around this hospital among medical students and houseofficers at ideal body weight. It seems to me that that must have an impact on them.*

DWS: I don't know how important that is. It's always a good idea if one can function as a role model in this respect. On the other hand, I'm not sure that patients, if that's the relationship you're describing, would be deterred from following a doctor's advice simply because the doctor is obese.

WCR: *What is your cholesterol level?*

DWS: My total cholesterol level is about 170 mg/dL.

WCR: *What is your blood pressure?*

DWS: About 130/75 mm Hg.

WCR: *You take no medicines for either of those?*

DWS: Correct. No medicines for either of those.

WCR: *Are you healthy?*

DWS: No. Not particularly. Not now. I'm troubled with a strange mixed immunodeficiency syndrome. Nobody knows quite what it is, but it results in leukopenia and reduced circulating antibodies. My total immunoglobulin G is low.

WCR: *Has that been going on a long time?*

DWS: Yes. About 5 or 6 years. It makes me vulnerable to infections, and I've had 3 episodes of pneumonia over the past 6 years.

WCR: *What happens when you go home at night? I'm not talking about just now, but through the years. Did you do much professional work after you got home at night?*

DWS: Yes, a fair amount of reading and studying. I always was fond of reading, not only on professional matters but also a broad variety of other things. Many nights were spent doing medical work, but also other things. Most of the work I did in the way of writing or planning was done at night. I was pretty busy during the day.

WCR: *Nighttime, through the years, was your thinking time?*

DWS: Yes. Also, I did some departmental work, such as budgets, and most of my own writing at home at night. There are, of course, different types of writing. Some writings are philosophical and educational; other writings are broad reviews. For many years, the technical writing was done partly at home and partly at the medical school. I used to meet with Floyd Rector in particular on Sundays or over the weekends, and we wrote a number of manuscripts together that way.

WCR: *When you would go home, you'd have dinner and after that, as a rule, you would be busy through the evening?*

DWS: Yes, more or less. We had a rather active social schedule. We often went to concerts and to operas.

WCR: *I understand your capacity for friendship is enormous—that parties and dinners at your house are spectacular. Are you a gourmet cook?*

DWS: During the years we often entertained the housestaff and the faculty, and we had other parties at our home. My contribution to gourmet cooking consisted of omelets, which I can

make, and also Pommes Anna, and that's it. The cooking is entirely done by my wife.

WCR: *You mentioned nonmedical reading. You, of course, have been called a "Renaissance man." I understand that one of your architecture friends was discussing something with you and he told another friend you know more about the history of architecture than he did. Your philosophical and literature reading endeavors have continued through the years. Is your home filled with books?*

DWS: Yes.

WCR: *How many books do you think you have?*

DWS: I don't know. It's overloaded. They are flowing everywhere.

WCR: *What is your favorite type of reading now?*

DWS: I read in rather broad areas, and I like to read in depth, with a certain density. I'm interested in philosophy and logic, art, paintings, architecture, literature, poetry, and in problems of history and political science. I get involved with a subject and then penetrate more or less deeply into it before I leave it and go on to something else.

WCR: *Do you buy the books? Do you get them from the library?*

DWS: Both. I buy a lot of books and a fair number I read in the library.

WCR: *Which library do you use now?*

DWS: I used to use the library downtown, but now I use the library in the neighborhood. Borders also has become very helpful. It's right next door and it affords an opportunity not only to see the latest books but also to scan and find out what's going on.

WCR: *What are you reading right now?*

DWS: I am now reading 2 books of sonnets that have just been published and 2 books that are critical studies of Shakespeare's sonnets—by Helen Vendler and Katherine Duncan-Jones. I am also reading a book on the foundation of Europe by R. I. Moore—*The First European Revolution c. 970–1215*.

WCR: *Have you written poems yourself?*

DWS: Yes, but not too much. I used to do it as a kid, but not now. The last poem I wrote was a tribute to Mike Brown on the occasion of his birthday. It's on the Web. It's just a joke.

WCR: *Why do you think poetry appeals to you? It's so different from science.*

DWS: Not all of human experience is embraced in the principles of rationality. There are moving experiences outside the rational calculus. Poetry is very moving to me because of the feelings it incorporates. The beauty of the language, the style of the poet—all of these have the effect of charging experience with emotional intensity.

WCR: *You have a phenomenal memory. When you read poems, do you remember the verses pretty well?*

DWS: I do if I read them over and over again. I can remember a great deal of poetry.

WCR: *Do you read much fiction?*

DWS: I used to. I read some now, but not as much as I did in the past.

WCR: *I understand that John Dewey was one of your favorite authors early on?*

DWS: Yes. He was a philosopher at Columbia University. He wrote a whole series of books—*Logic, The Theory of Inquiry, Art as Experience, Human Nature of Conduct*. This was a form of pragmatism that I find very attractive.

WCR: You are also interested in economics and have read a good bit in that topic?

DWS: Yes.

WCR: What interests you there?

DWS: A number of issues represent a complicated interaction between moral decisions and resources in the health care system. For example, there is a complex interaction between economic resources on the one hand and various kinds of services that can be afforded people. To analyze these problems appropriately requires some insight into economic analysis, no less than into ethical issues. I've always been interested in problems of economic analysis, particularly as they bear on the health care system. It's not only that. The entire issue of economics is pertinent for intelligent interpretation of various political problems that beset the nation. I'm interested in those and try to view them with some insight derived from economic analysis. I've read and tried to study a whole variety of different economists. These days, the people who impress me a good deal are Robert Solow, James Tobin, Paul Krugman, Lawrence Summers, and, as a background, Schumpeter and John Maynard Keynes.

WCR: Do you follow the stock market?

DWS: No. I'm aware of what's going on, but I don't follow it in any detail.

WCR: Do you read a good bit about political history?

DWS: Yes, a certain amount.

WCR: Do you like biographies?

DWS: Not especially, but I read biographies when something of particular interest comes. I'm more interested in political analysis.

WCR: What would be an example of what you're reading in that arena?

DWS: There is currently a book that is not exactly a biography, but it's an interesting book called *Lincoln's Greatest Speech*. It's an analysis of the second inaugural address. I found it rather impressive. There is also a current book, *Six Days of War* by Michael Oren, that I'm looking at.

WCR: How does the present political arena in this country strike you?

DWS: It's somewhat depressing. I think the collapse of Enron and several other large companies and the likelihood that this kind of behavior infects a good deal of business is depressing because it's a violation of the concept of trust. The whole model of being rewarded for successful enterprise and being penalized for failures is being violated. We see people rewarded under circumstances where their various activities are colossal failures. When the capital markets become, to some extent, violated by various kinds of maneuvers—many of which may actually be legal but, nevertheless, from a moral point of view, are actually sleazy and deceitful—it is disturbing.

WCR: What about the political leadership in this nation?

DWS: I think the political leadership, in certain respects, has been rather successful. In other respects I think it's not been very good for the nation. The domestic policy involving tremendous tax cuts resulting in huge budget deficits and compromise of the



Figure 12. With wife, Muriel, and family, 1977. Photo: Gittings.

health care system and the Social Security system represents a questionable policy program. On the other hand, the capacity to crisply address the foreign policy issues posed by the terrorist attacks has been much more successful.

WCR: Traveling must have been a joy to you. As you were growing up, you never went out of New York City. Then you went to New Haven, San Antonio, and Munich. Did you travel widely in Europe while stationed in the army in Munich?

DWS: Yes. That's when I became acquainted firsthand with European art and architecture. When I was stationed in Munich for 2 years, we spent our leave time in France and Italy. That was a major experience. I studied in advance and planned out the trips so as to be knowledgeable. It was exciting. That background was very helpful when I returned to the USA. I had no idea that I would have opportunities to return, but as it happened over the years we've had a number of opportunities to go back to Europe.

WCR: When you returned to New Haven from Munich, you must have been a much broader person than when you left Yale to enter the army.

DWS: Before I left Yale, I had become very interested in the Renaissance and classical art and architecture. But I'd never seen anything. I'd studied art and architecture and I knew, for example, the classical work of Arthur Kingsley Porter, Meyer Shapiro, C. P. Morey, and other scholars. When I was sent to Europe, it wasn't as if I had never encountered this. I had been studying it for a long time.

WCR: You are also interested in music. Did your first wife, Muriel, have a major impact on your interest there?

DWS: I don't think so. She reinforced an interest I had. Her interests were quite independent of mine, but they meshed. She was a musician and I'm not. She played the piano and could read music. I can't read music.

WCR: I understand that when you were to be a visiting professor in Germany, you learned to speak the German language during the 3 months before you went.

DWS: No. I learned German when I was in high school. I became interested in German poetry in high school and began to read it, largely Heine and Hölderlein. When I went to Ger-



Figure 13. With family, about 1990.

many, I knew German modestly. I wouldn't say I was fluent, but I got along.

WCR: *What other languages do you speak?*

DWS: That's it. English and German.

WCR: *Do you have a pretty good ear for languages?*

DWS: I don't think so. I worked hard at German. I've given lectures in German. I was pretty proud of that. I can converse reasonably well.

WCR: *What is your favorite type of art?*

DWS: I wouldn't say any one thing. I'm very attracted to modern art (abstract expressionists). I like the classical modern painters (Picasso, Matisse, Mondrian, and the like). Also, I like very much classical art, Renaissance art. Recently, we were in Italy and saw the frescoes of Piero della Francesca in Arezzo and the Caravaggios in Rome.

WCR: *Could you talk about your interest in architecture?*

DWS: It's part and parcel of my general interest in art. I always thought that some of the modern architects were really transforming the scene. I was very interested in Mies van de Rohe, Frank Lloyd Wright, and others. I enjoy Greek and Renaissance architecture as well.

WCR: *Do you have a lot of art and sculpture in your home?*

DWS: We have some. We have several Frank Stellas, a George Segal sculpture, and some Picasso ceramics and drawings.

WCR: *What is your home like?*

DWS: It's a ranch-style house. It was designed by a student of Frank Lloyd Wright. It's rather attractive and largely of wood and stone. There's a nice integration of inside and outside materials forming a U shape, which embraces a broad terrace and then a lawn. The house is fairly large, and for many years we held our departmental parties there. When the department members and spouses exceeded 200, we transferred the departmental parties to the Faculty Club.

WCR: *Do you have a study at home?*

DWS: No. Not specially.

WCR: *You and your wife may be reading together in the living room. You are not isolated off?*

DWS: Correct. Our house is so designed that the kitchen forms the hinge of the house. Then on one wing is a den with 2

bedrooms that was the children's wing and the den was the play area. On the other side of the kitchen are a small study, living room, dining room, and a bedroom.

WCR: *Dr. Seldin, it's apparent that you have a number of interests and a variety of intellectual endeavors—art, architecture, music, philosophy, economics, and politics. I understand that you are a rabid Cowboys football fan. Is that appropriate?*

DWS: That's right. I don't know if it's appropriate, but it's true.

WCR: *Being a Cowboys fan means what to you? What does that entail?*

DWS: I used to faithfully attend the football games. I don't anymore. I particularly liked professional football. There are aspects of it that fascinate me. It's almost as if a game of chess were being played. It's not only the massive size of the players, it's the skill, speed, and the play making, the general design of the game, that interests me. I have over the years received a great deal of

pleasure following the professional football team. In addition to the character of the game, there develops a certain amount of loyalty.

WCR: *Now you watch the Cowboys on television?*

DWS: I do some, but not much. I watch very little television.

WCR: *Could I ask you about your family? You have 3 children by your first marriage?*

DWS: Yes.

WCR: *When were they born and how are they doing?*

DWS: My oldest child is my daughter Leslie. My second child is my son, Craig. My youngest child is my daughter Donna (Figures 12 and 13). Leslie lives in New York City. She's not married. She worked for a long time first at the Associated Press and then Reuters. Craig is a lawyer in Dallas. He too is single. Donna used to work as a curator at an art gallery called the Coe-Kerr Gallery, but since her marriage to Carroll Janis, who is director of the Janis Gallery, she has not done any gallery work, although she has written several important articles on John Singer Sargent, the painter. She lives in New York.

WCR: *Do they have children?*

DWS: They have 2 children.

WCR: *Your first wife died when?*

DWS: On September 13, 1994.

WCR: *Muriel was born when?*

DWS: In 1919.

WCR: *She was 1 year older than you. Her death must have been an enormous blow to you.*

DWS: Yes. She was very ill for a long time. She had cerebral amyloid angiitis, which caused recurrent hemorrhages over the last 10 to 15 years of her life.

WCR: *How did you handle the period after your first wife died before you met your current wife? The period when you were by yourself?*

DWS: Naturally, the death of my wife constituted both an emotional and a behavioral shock. I have a lot of interests. I read a great deal. I'm interested in music, plays, and a number of other things. I did fairly well by myself. I wasn't at a loss to do things. I get along fairly well when I'm completely alone.

WCR: *How did you meet your present wife?*



Figure 14. With Dr. Ellen Taylor on their wedding day, 1998.

DWS: I met Ellen Taylor Seldin when she was a student at Southwestern Medical School.

WCR: *She's a physician?*

DWS: Yes. I knew her as a student. She was a very good student. I tried to encourage her to enter medicine, but she decided to go into surgery instead. She went to the University of Colorado and was on the surgery faculty there. Then she went to Seattle, and finally she left general surgery and worked in emergency medicine. I didn't remember her or had only the vaguest recollection when one day she sent me a manuscript on Bach through the mail with a request that I criticize it.

WCR: *This was what year?*

DWS: It was in 1996.

WCR: *She was in Kentucky?*

DWS: Right. I hadn't seen her for years. I looked over the manuscript. As I told you, I don't read music. It seemed strange to me that she should send me the manuscript. If I had a manuscript on Bach, I'd send it to a Bach scholar. I put the manuscript aside. I was going on a trip to Canada where I was giving some talks. I was very busy at the time. I didn't do much with the manuscript. When I came back to Dallas, I was sick with pneumonia. The last thing in the world I remembered was the manuscript. Then I got a letter saying, "I know you're busy. Don't worry. Please send the manuscript back." I felt very guilty and I scurried around, looked at the manuscript, made some disjointed comments, and sent it back. I mentioned what I always say to students, that if they come back to Dallas I'd like to show them the campus and recount what has happened since they left the school. I said that in the letter to Ellen after I commented on the Bach manuscript. She sent me a letter subsequently indicating that she was going to a music conference in Houston. I invited her to stop in Dallas and I'd show her around. She did. I showed her the medical school and so forth. Ultimately, we started to correspond and visit. We subsequently went together and then got married.

WCR: *Beautiful story. When did you get married?*



Figure 15. With wife, Ellen, in May 2001.

DWS: May 4, 1998 (Figure 14).

WCR: *When did she graduate from medical school?*

DWS: I think it was 1972.

WCR: *What were the qualities of Dr. Taylor that attracted you to her?*

DWS: She's very lively, full of pep and verve.

WCR: *She sounds like a relatively scholarly lady also.*

DWS: She's very intelligent. I wouldn't say that intellectual matters are the center of her life, but she's an excellent musician. She loves to play the piano and participate in social activities.

WCR: *She has brought you a great deal of happiness?*

DWS: Yes (Figure 15).

WCR: *You've done an incredible amount of things in your professional life and outside of that. Of all of your accomplishments, which ones are you most proud of?*

DWS: I am very proud of my contributions to the development of this medical school and this Department of Medicine and the people who have emerged from the department. I think we've not only done justice by students, housestaff, and fellows, but we've assembled an academic group of very high quality.

WCR: *You have been incredibly productive, particularly early on. Would you have liked more time to do research?*

DWS: The most productive research period has been here in Dallas. My output of research papers at Yale was modest. I've had every opportunity in terms of time, facilities, and colleagues to do more or less what I could do. I don't think I would have done much better had I had much more time freed up. Obviously, productivity would be increased. There would be more opportunities to write up things. Sometimes the desk becomes filled with unpublished manuscripts. By and large, I think things went fairly well. My productivity was not enormously constrained, at least for long times, by virtue of academic responsibilities.

WCR: *What are your goals now?*

DWS: I would like to continue to contribute what I can to the department. I'd like to finish off some of the work I am doing with Gerhard Giebisch.



Figure 16. In his office at the time of the interview.

WCR: You come into work every day now?

DWS: Yes. On the whole, I get here between 8:30 and 9:00 AM and I leave about 4:00 PM (Figure 16).

WCR: Could you describe your general outlook on medical schools, medical education, and medical research?

DWS: The American medical system is structured in a very healthy way. First, there is the MD degree. The MD degree is not a license to practice. It simply certifies that an individual has completed mastery of the domain of learning, namely biomedical science and its application to sick human beings. You can't practice after that. You don't have a license. The MD degree symbolizes a general educational experience. Really, it's not a process that is designed, at the point where the degree is granted, to manufacture practitioners, investigators, faculty members, or teachers. It simply certifies mastery of the domain of learning. Sometimes, this more limited view of the medical school, that is, the MD degree, is criticized. Some view medical school as an instrumentality to produce investigators or to produce clinical practitioners or pathologists.

One can go in many different directions thereafter. There is a period of variable duration in which one applies the knowledge of biomedical science, the knowledge learned in medical school, in a specific way. Generally speaking, most people take housestaff training of one type or another pointing in specific directions—the practice of medicine, research, etc. And finally, there is more specific training beyond that in the nature of a fellowship, where the conceptual and technical basis of a discipline, be it basic science or clinical medicine, is learned.

At the level of the medical student, it's very important that the medical school establish a culture of excitement about medicine and establish biomedical science as the basis of medicine. There are many healers in society, but the only healer who brings to the patient medical science is the physician. A critical feature of medicine is the fact that in the past 50 years the explanatory power of medical science has become enormous. The

meaningful application and inculcation of medical science to medical students so that their clinical behavior is informed as the basis of medicine is very critical.

Medicine is not a disembodied discipline. When you deal with sick human beings, there are ethical and humane constraints, which are very important. Here too the medical school can play a role in bringing to bear the manner in which medicine is applied to patients. Those principles of interaction are incorporated in medical ethics. The growth of biomedical ethics as it is represented in certain of the texts like Beauchamp and Childress is a very healthy advance. The clinical scholar can play a vital part as a role model—incorporating a warm and humane interaction with patients with a comfortable command of medical knowledge.

WCR: If somebody asked you to describe yourself, what would you say?

DWS: Total loss. I would say an individual with a zest for learning, a broad interest in human experience, a broad interest in the cultivation of enlightenment principles—rationality, esthetic judgment, quality, and liberty—and their basis in rational human thought. All of this embraced in a notion that rationality, reason, esthetic experience, and ethics really are a very vital aspect of experience.

WCR: Dr. Seldin, on behalf of both the readers of Baylor University Medical Center Proceedings and myself, thank you for allowing all of us to get to know you better.

DWS: Thank you.

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