

John C. Liebeskind History of Pain Collection

**Oral History Interview
with
Wilbert E. Fordyce**

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Biographical Sketch

Wilbert Fordyce was born in Sunnyside, Washington, in 1923. He began his education at Washington State University. Following service in World War II, he studied psychology at the University of Washington, receiving a B.S. in 1948 and a Ph.D. in 1953. From 1954-59 he held staff positions in clinical psychology at the St. Paul and Seattle Veterans Administration (VA) Hospitals. In 1959, Dr. Fordyce was appointed Assistant Professor of Clinical Psychology in the Department of Rehabilitation Medicine at the University of Washington, where he remained throughout his career until retiring as Professor Emeritus in 1988. He is best known for his application of behavioral medicine methods to the rehabilitation of pain patients, which he first described in a 1968 article written with Roy Fowler, Jr, and Barbara DeLateur. Shortly thereafter, Dr. Fordyce was asked by John J. Bonica to join Bonica's multidisciplinary pain clinic. He was a founding member of the International Association for the Study of Pain (IASP) and the American Pain Society (APS) and served as President of APS in 1985-86. From 1989-93 he chaired the IASP Task Force on Pain in the Workplace.

Interview History

Dr. Fordyce was interviewed at his home in Seattle by John Liebeskind on July 10, 1993. The interview lasted approximately 2.5 hours. The transcript was audit-edited by Marcia Meldrum and reviewed by Dr. Fordyce prior to its accession by the History of Pain Collection. The tape and transcript are in the public domain, by agreement with the oral author. The original recording, consisting of two (2) 90-minute audiotapes, is in the Library holdings and is available under the regulations governing the use of permanent noncurrent records. Records relating to the interview are located in the offices of the History & Special Collections Division.

Topical Outline (Scope and Content Note)

The interview is organized chronologically and then topically, beginning with Fordyce's childhood, education, and graduate training; his work in Minnesota and encounters with Paul Meehl and Starke Hathaway; his return to Seattle and the development of the behavioral modification program for pain patients; the Bonica pain clinic and the 1973 Issaquah meeting; and work of the IASP Pain in the Workplace task force. Fordyce then discusses the key concepts of his approach to pain and some problems of the pain field. Major topics include the relationships of psychology to psychiatry, and of anesthesiology and orthopedics to the pain field; the field of rehabilitation medicine; Alf Nachemson and the Boeing study (1980-81); Rick Deyo and the Back Outcome Assessment Team (BOAT); acute disease models v. chronic management models in clinical medicine; and health care delivery problems and the difficulty of attitudinal change.

Access to the Interview

This oral history interview, in its audio and transcript forms, is held by the History & Special Collections Division. Those wishing to use the printed transcript (which is available through Interlibrary Loan) or the audiocassette version (which is available by appointment only) should contact: History & Special Collections Division, Louise M. Darling Biomedical Library, UCLA, Los Angeles, California 90095-1798. Phone: (310) 825-6940.

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Citation Information

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Related Materials in the *John C. Liebeskind History of Pain Collection*

The reader is referred to the following related materials: interviews with John Bonica, Martin Grabois, Richard Sternbach, and Judith Turner; "Pain Clinic" files in the John J. Bonica Papers (Ms. Coll. no. 118); and American Pain Society Records (Ms. Coll. no. 123).

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Wilbert E. Fordyce, PhD

Psychologist

WILBERT E. FORDYCE INTERVIEW

TAPE ONE, SIDE ONE

JOHN LIEBESKIND: I would like to note for the sake of the tape that it is ten o'clock in the morning, that it is July 10th, and that we are at the home of Dr. Wilbert Fordyce, and we are just beginning our interview. Bill, I've got a whole bunch of questions here.

WILBERT FORDYCE: Please, John, proceed in whatever way you wish.

LIEBESKIND: Some of them, you'll see, are kind of overlapping. And depending on what you answer to number one, it might make number two irrelevant, or whatever, but we'll stumble through them and see how it goes. You'll see that the last question I'm going to ask you, if we get that far, if we don't die of old age before then, is to ask you what you think of these questions and whether they are useful and whether you could help me devise better ones for subsequent interviews. Anyway, I want to start at the beginning and ask you to talk to me about the factors, the influences, early in life, that prepared you or steered you toward a career in pain management. How did you happen to come into the field of pain? What early on might have influenced you in this direction?

FORDYCE: I guess a number of things -- it's hard to know which route to follow down, but I was working as a clinical psychologist in medical rehabilitation at the medical school here at the University. My graduate training was very much what then was a traditional psychodynamic, Neo-Freudian, whatever.

LIEBESKIND: Where was that? Where did you do that?

FORDYCE: I did that here at the University of Washington.

LIEBESKIND: Oh did you?

FORDYCE: I did part of my undergraduate work at Washington State University -- "Wazoo" as they say -- and then went into the service during World War II and came back to the University, finished up here and went right into graduate school here.

LIEBESKIND: So for the standpoint of biography, were you from this area? You were born here and so forth?

FORDYCE: My father was a physician in eastern Washington, in the Yakima Valley. He came out from the middle west in 1905. I'm the youngest of a second marriage -- his first wife died and then he married my mother and from that second marriage I have a full brother. There was a half-brother and a half-sister from the first marriage. So I grew up in the state of Washington. He died during the middle of the Depression, so things were kind of tough. I remember I worked my way through school and did my graduate work here. I'm sure that -- he was a physician and

my mother was a nurse -- in those days, when people had surgery, the anesthetist was usually a nurse. That's what my mother did, she was an anesthetist.

LIEBESKIND: There wasn't the field of anesthesiology then, was there?

FORDYCE: I don't think there was -- I'm not sure about that history of it, but in any event she was -- [The practice of anesthesia was dominated in the early 1900s in the US by nurse-anesthetists, but a small group of physicians were already campaigning for a medical specialty of anesthesiology. Ralph Waters at Wisconsin and Emery Rovenstine at Bellevue were two of the leaders of the pre-WWII era.]

LIEBESKIND: Did John Bonica invent the field of anesthesiology?

FORDYCE: I think so. So anyway, I'm sure that influenced me, and my father's brother-in-law was also a physician and his daughters all married physicians and so on. So there was a lot of medically related influence, which I'm sure shaped things in a lot of ways. After my father died and our immediate family fortunes fell to the bottom, after I got out of high school, my uncle said to me, "Look, if you want to go to medical school, I'll take care of that, I'll pay that." And at the time I didn't want to do that. It's not where I was, and so I went on through graduate school and into psychology.

LIEBESKIND: What was there about it that you didn't want to do? Was it the blood and guts?

FORDYCE: No, I don't think so. It probably reflected the magnitude of the loss of my father. He was a small-town family practitioner, general practitioner as they say in those days, who made home visits and so forth, and it was a seven-day-a-week, 24-hour-a-day job. I had what, as I look back on it, was almost a superstition that somehow all of that had killed him.

LIEBESKIND: He worked so hard --

FORDYCE: That's right. And so I thought that's not the kind of life I want to lead. So I went in a slightly different direction. But when I got out of graduate school -- and in those days I was a member of the first group of clinical psychologists, to go through the graduate school here, and I remind you that, until the end of World War II, there was really no clinical psychology. There were all kinds of retreat psychologists in the service. And so we were outsiders. That had a beneficial effect. I think it sort of mobilized us to work harder and so forth. We did well collectively.

LIEBESKIND: Was there a clinical faculty here that you could get your training from?

FORDYCE: They brought in this marvelous, marvelous man who ultimately was my thesis sponsor, Chuck Strother -- Charles R. Strother -- who was a combination clinician and speech pathologist, and he used to be senior person in the Iowa speech pathology program as well as psychology. And he came and headed it and Sid Bijou [Sidney W. Bijou (1908-) an early leader in behavior modification), whose name you'll recognize, came with him and two or three other people. So they came when we came. We all started together. They saw us through the battles.

It was fun, as I say, because it was sort of us against them, with them being the rest of the graduate students, who looked at us as somehow deficient.

LIEBESKIND: All the hard-nosed, experimental types.

FORDYCE: That's right. When we would perform as well as they did academically in various courses, why, that was a great source of gratification.

LIEBESKIND: Did you have experiences in the service that molded you in this direction at all?

FORDYCE: I don't think of anything in particular. I can remember one conversation I had when I was in the service up in Alaska. A fellow asked me, "What are you going to do afterwards?" and I said, "Gee, I don't know. Psychology somehow appeals to me." I didn't really know what that meant. I knew how to spell it and that was about it. But I almost drifted into it at first. When I got out of the service and returned to school, I started off in sociology. I have enough credits to get a doctorate in sociology -- I have a lot of that -- and then somewhere along junior year, something of that sort, as an undergraduate, I decided, no, I wanted to go into psychology. It seemed evident that one could hardly make a living in sociology and, I remind you, this was in the context of having gone through the Depression, and so having something to do --

LIEBESKIND: And being pinched by the Depression because your father had died and there wasn't a lot of money.

FORDYCE: That's right. It intensified things, so that it was particularly important in sorting out the options to have, well, this is something that will bring in a living for the family and what not. But I also discovered that, tactically within the workings of a university, if you major in one field, then that gives you greater latitude to select your courses in a second field. You could sort of free-lance. And so I had somewhat more latitude in selecting my undergraduate work. You still had to meet certain requirements. So I didn't make the formal transfer until my senior year. But then we went into the clinical and that was a very heavy experience. In those days --

LIEBESKIND: You just stayed on -- you finished your undergraduate here -- when was that, what year was that?

FORDYCE: I got my undergraduate degree in '48.

LIEBESKIND: In '48 -- and then just stayed right on and continued in graduate.

FORDYCE: Well, once you applied for graduate school -- and the graduate schools in those days were just damn packed because of the three-, four-, five-year backlog of people who had been in the service.

LIEBESKIND: Oh, yes, the GI bill [the "G.I. Bill" paid for the college education of returning U.S. servicemen after World War II], and so forth.

FORDYCE: That's right. We all descended upon the university at the same time. I took a statistics course from Alan Edwards. I took several, but I'll never forget that course -- I can't imagine any academic course of, say thirty students, which is about what it was -- [INTERRUPTION]

I tell you, John, I can't believe there was any collection of people brighter than that thirty people. I was the 29th or 30th, I swear, in that.

LIEBESKIND: Statistics has a way of doing that to people. It makes them feel inferior.

FORDYCE: I tell you! So anyway, I went on into graduate school. I got my undergraduate degree -- they had decided to accept five people into this one track in graduate school. And I came out competitively number six. So I was going to go out and sell neckties or whatever one does -- teach school, something -- One of the fellows, Bill Clemmons, then decided to go to the Educational Testing Service in Princeton instead. So he vacated his slot and I got it. So that's how I got into graduate school.

LIEBESKIND: Opened an opportunity. I was an alternate in going to graduate school -- I didn't get in at first and then I was accepted -- we share that.

FORDYCE: When I finished in the graduate program, they didn't have internships and so forth. Most everybody became VA [Veterans Administration Hospital] trainees -- I don't know if you're familiar with that term. So what we did as graduate students was to work. We had the GI bill -- probably my GI bill had been exhausted then, I don't remember exactly -- but at any rate we worked for the VA as clinical hands. By the time I finished graduate school, which was just under five years, I had the equivalent of two years' full-time clinical experience.

LIEBESKIND: Probably all the licensing and so forth must have been very different in those days. The machinery wasn't set up.

FORDYCE: There wasn't any.

LIEBESKIND: There wasn't any at all?

FORDYCE: When I graduated, nationally there were two jobs, one in Houston and one in Minneapolis -- that I was qualified for and I was pretty sure I could get. So we decided on sociological grounds that we preferred to live in Minneapolis to Texas. My wife had relatives in the Twin Cities.

LIEBESKIND: You were already married at that time.

FORDYCE: Yes, we got married in '46. By that time, my number one son was born in '49, so that was while I was still in graduate school -- we have two sons -- number two was born in '52, just a year before I finished. So we had two young children. So we made our way to Minneapolis-St. Paul with the VA, and I had a joint appointment in the University, both in the graduate school of social work and also in clinical faculty of psychology. I was back there a year.

LIEBESKIND: That was probably even then a very distinguished department, right? Wasn't that [Kenneth] MacCorquodale and [Paul] Meehl (1920-) and Rich and those people?

FORDYCE: That's right. It was an enormously rich experience. My training had been very traditionally psychodynamic, Neo-Freudian, whatever. I was giving Rorschachs like anybody and all that funny stuff. When I got back there it was just like going into a different world, you know.

LIEBESKIND: The MMPI! [Minnesota Multiphasic Personality Inventory] [developed at Minnesota in the 1930s, the MMPI remains the best-known and most commonly used scale for assessment of personality disorders in psychology.]

FORDYCE: Oh, you can't cross the Minnesota border, you know; a state patrolman hands one to you if you drive over the line. Particularly Meehl and Hathaway [Starke R. Hathaway 1903-86, co-developer of the MMPI] and [William] Schofield were the principal clinical domain people that I interfaced with and they would come out, each of them would come out every week to where we were at Fort Snelling [the VA facility in Minneapolis]. So that was a fascinating experience.

LIEBESKIND: Out to the VA? They were consultants?

FORDYCE: That was at the VA. Once I got into that I look back with sheer luck that I had the whatever it takes to listen to such a different perspective and take it in. It gets so easy to [think] -- well, they don't know what they're talking about sort of thing.

LIEBESKIND: Let me pause on that point. That's a very interesting point you make, and I'm sure it does take a certain something to listen, as you say -- how did you experience that, do you recall? Was it antithetical to your views, or was it something that you were prepared somehow to accept, this other point of view? Were you having misgivings about the analytic approach, or was it a tough pill to swallow. How did you react?

FORDYCE: That's an interesting question, John. Obviously I haven't thought back and really sorted that out altogether. In response to what you say, what I find myself thinking is that a number of factors, I think, converged to help with that -- in the first place, a couple of fellows I was working with were really very great, nice people, really good people -- Sherman Nelson and Charles Halbower, and we related very easily. Chuck, after he finished up -- he was an advanced graduate student, Sherm had finished -- and Chuck went on into Arthur B. Little, isn't that it, the consulting -- so he became a consulting type, working out of the New England area, Boston or whatever -- haven't seen Chuck for years.

LIEBESKIND: They had an influence there. They were nice guys.

FORDYCE: I didn't feel like I was some sort of foreigner. And then Meehl was at his absolute peak.

LIEBESKIND: He was considered a brilliant man, was he not?

FORDYCE: I'll tell you, John, I've never seen anybody who comes even close. He was absolutely dazzlingly bright and eloquent and a delightful person.

LIEBESKIND: Never laid eyes on him. I've heard stories.

FORDYCE: He's about my age -- I think he's probably a year or two older, something like that -- but Paul would have his ups and downs. Sometimes he'd get down and he was down. But when he was a little bit up, which is what he was when I was there, it was a dazzling display. Not dazzling in the sense of a show-off or anything, not that -- it was like you were looking into the sun -- such an incredibly bright man. His book, *Clinical vs. Statistical Prediction*, which of course is a landmark for everybody, was at that point in mimeograph form, being sort of circulated around, and everybody was reading it. It didn't come out formally for about two years. So that was tremendously impressive. They had one fellow on the faculty -- they were feeling a little bit guilty that they were getting too inbred, and so they brought in Ephraim Rosen, who was a Rorschach expert. Ef was a nice man -- and so Ef and I were practically -- it was us against them -- not in an animosity sense, but we were so different from all of the rest of them that we found each other and shared a lot of experiences. Ef has been dead many years now -- he died quite young.

So I soon came to -- within the first few months I realized that my experience in Minneapolis-St. Paul was a once-in-a-lifetime opportunity, and I have always been curious -- I have fun learning. Just to learn something new, that's fun. I really love that. So here I was, just gobbling it up as best I could. But I had, for all those years in graduate school -- one does not live in Seattle and then move away very easily. It's a nice place to live, and my wife was raised in this area, so we always thought, well, we'll come back to Seattle. But I thought, I don't want to come back in one year, for heaven's sake -- I want to take at least three years to soak up more of Minnesota. But along about two-thirds, three-fourths of the way through that year, a friend here in Seattle with the VA, a psychologist, called me -- Bill Cogen, Bill and Kay Cogen -- you may recognize the name Kay Cogen -- Bill called me and said to me that a position was opening up in the VA in Seattle. At that time there was no University Hospital. The University Medical School was using the VA and Children's and the County Hospital and so on. I don't know when I began to feel that what I want to do was wind up in the University Medical School; I'm sure that has all kinds of implications with my background and so on. But anyway, this call came and it was obvious that if I didn't take it, it might be "never again", who knows.

So with great ambivalence, we worked things around so we were in Minneapolis just one year, and then we came back. Then I was marking time at the VA Hospital, which is over on the hill over there, for the next five years until the University Hospital -- it was already blueprinted -- until it was finished, and sure enough --

LIEBESKIND: You already had an appointment at the University, but you were placed at the VA?

FORDYCE: I was clinical -- all VA psychologists and psychiatrists and whatnot -- were clinical, because we were part of the University Hospital system. But the University Hospital opened in spring of '59, which was my fifth year at the VA Hospital, and sometime a few months before then I was approached both by the chair of psychiatry, Herb [Herbert S.] Ripley [chair until 1972], and by the chair of rehab medicine, Justus [F.] Lehmann [founding chair of the Department 1961-72, retired in 1986]. And they asked me if I would be interested in joining the faculty there. So I was in that unusual and delightful position of having a choice which I want[ed], and my interests were such that I chose the rehabilitation medicine -- they called it physical medicine and rehab then.

LIEBESKIND: I'd like to hear a little bit more about that choice, but before we go down that line, I want to go back to Minnesota again for just a minute, because maybe you're presuming I know more about clinical psychology than I do. How would you characterize the Minnesota experience? Was it testing-oriented? Would you say it was behavioristic, as opposed to analytic?

FORDYCE: Starke Hathaway was an experimental/physiological psychologist who sort of got grandfathered in -- I'm not even sure if that's the right term -- at any rate, circumstances put him into the position of exercising things clinical. He was a very wise man and a very bright man. He was -- I'll tell you a funny story. I arrived in Minneapolis, and the consultants, Hathaway and Meehl and Schofield would each come out one-half day a week to spend time with us. The first time Hathaway had been on a sabbatical at Palo Alto. So I had been in Minneapolis, I don't know, a month maybe, something like that, when he returned. So they had sort of a coffee klatsch to welcome Hathaway back. That meant that there were the five or six psychologists within the mental hygiene clinic, where I was working, and another four or five, Manfred Myer and several others from the VA Hospital, which was just a couple of miles away. We all came into this room to have coffee with Hathaway.

So they brought me in to introduce the latest member of the troop. Hathaway was seated at this sort of bench-like affair in this room and I walked in, scared stiff. I had heard about the rigors of Hathaway, didn't know what to expect, and he sat there and I stood before him and I was introduced. He sat there and he started at my shoes and he looked up, all the way up. So I began to think, my God, is my fly unzipped or something, you know. He shook hands and he was cordial but not warm, just sort of businesslike. And I thought, oh, this is tough. So that was a heavy day for me. [they laugh]

LIEBESKIND: That was your introduction to Hathaway.

FORDYCE: But I want you to know that as the years passed -- no, only the months passed there -- I didn't really get to know Hathaway so well there -- I got to know him, but not as well. Then, in subsequent years my thesis sponsor here, Chuck Strother, who is one of the world's really marvelous, beautiful people -- Chuck probably qualifies as the world's number one fly-fisherman. He can lay that fly out there within a two-inch square. And Hathaway was a fly-fisherman. They had discovered each other down through the years, and so they would spend vacations together fly-fishing, and what would usually happen is Hathaway and his wife would come out to spend time with June and Chuck, and in the course of these, a number of times my

wife and I went to dinner with them. So I got to know him much better in a very different way. Then, in his last years, we spent quite a little bit of time together. Marvelous man, just a marvelous man.

LIEBESKIND: But again, from the standpoint of the concepts back there -- this was a brand new thing for you, is that right, or relatively new, this whole approach?

FORDYCE: Well, John, the clinical program, in terms of eyeball-to-eyeball interacting, relationship-based, talking therapy kinds of things, which made up so much of clinical, particularly in those days -- the clinical program in that sense at Minnesota was not strong -- the testing and the research and so forth -- but the clinical was not strong. So actually I found myself, though I was an absolute novice with the MMPI stuff -- I was better trained than most of them were about the other things, which made me feel more comfortable. I felt like I could give something that was useful and appreciated. So I didn't learn very much about the clinical orientation, but what I learned, I think, a lot more than I had learned in graduate school, was to sort out data better and be a little more tough-minded. I'm still not tough-minded, but after a year in Minnesota, I was an awful lot more tough-minded than I had been before.

The other thing was that Meehl takes you beyond where you are conceptually, and that was just a dazzling experience. I remember soon after we got back here with the VA and Meehl's book came out, Bill Cogen and I put together a seminar for the psychiatry residents and the graduate students in psychology on that. I worked very, very hard to present that -- I'm sure that ten years later, I could have presented it more effectively, but I worked very hard on that. They didn't know what we were talking about. It was a different world. But of course, as the years have passed, it was the right horse to bet on, as it were. So I came away from Minnesota with the feeling I had learned and as I look back on it, I feel I had learned very important things that have been very helpful to me. It was a marvelous experience.

LIEBESKIND: Now you're here; and after five years you have these two possibilities -- of going into psychiatry or into rehabilitation. What mediated that decision?

FORDYCE: Well, I have to take you back also to the issues of -- here was clinical psychology, a new field, trying to establish itself not only within psychology, but even more pointedly within the mental health/mental illness domain. The warfare, open and otherwise, with psychiatry was profound.

LIEBESKIND: I've heard stories from others about that period. It went on for quite a while -- it's still going on to some degree.

FORDYCE: It still goes on. The Puget Sound Psychological Association, which is the local entity, and the local Psychiatric Association, set up a joint committee, an interprofessional relations committee, I'm not even sure that's what we called it. I was a member of that, as was my friend Art, who lived next door, and a couple of others -- there were three or four of us -- Irwin Sarason [University of Washington Department of Psychology] was a member for a while, and somebody else. We met, I suppose, once a month, something like that, to try to sort out who we are and where we are going and how we might relate.

There was one of the psychiatrists was a fellow who had his doctorate in clinical psychology, then went on to medical school and got his boards in psychiatry. He at one meeting said -- he was a practicing analyst -- he said to us, "You know, the situation we're in is this - we, psychiatry, own an apartment building and you want to rent a unit, and we're just not at all sure we want to bother renting it to you." [they laugh] Now that was a very impressive statement -- even with my hearing loss I heard that -- so it is very vivid to this day, I still have that mental image of that room and where he was sitting when he said it. So all of that colored our feeling.

All through graduate school we were sort of outsiders trying to get a foothold, not only in the professional community, but just to get access to a patient. When I was a VA trainee, the patient would come into the mental hygiene clinic for therapy, never mind the merits of the therapy -- they would come in for therapy and the pecking order was very clear, that if there were any patients left over after the psychiatrists were satisfied that they had made their choices and would be suitably entertained for the balance of the time, then the psychologists could get in line and take what was left. So I had and still have a lot of scars from all of that.

And the chairman of psychiatry then, who was a very kind man and a very mellow man -- he would probably qualify as a Dianetic "clear" [a reference to Scientology] -- if I can say that, and a very nice father figure, but he also was in an interesting way very rigid. He could not take in new information. The way we used to put it was that he'd had his last idea somewhere during the first part of his residency program, and then the doors had been shut and he hadn't had any new ones since. So when he came to me, it was more of a familiar turf that he was talking about, but it was also one in which I felt that it was highly unlikely that I would be much more than a second-class citizen. So I took the other choice.

LIEBESKIND: It must have been very unusual for rehabilitation to be involved with psychologists at that time.

FORDYCE: That's right.

LIEBESKIND: I assume you were one of the pioneers in that.

FORDYCE: I was one of the -- well, that's true.

LIEBESKIND: Was there a particularly enlightened chairman in rehabilitation medicine there, who saw the value of psychology and wanted that?

FORDYCE: Yes, the chairman, Justus Lehmann. He had been in the Luftwaffe in World War II in Germany, had grown up in the Frankfurt area, and he and his wife had been terribly disillusioned by all of that, and were not at all sympathizers of Hitler. So they got out as soon as they could, which wasn't until about 1950, and came over here to Mayo [the Mayo Clinic in Rochester, Minnesota] and took his residency with Frank Krusen in rehab medicine [Frank H. Krusen (1898-1973) was one of the leaders in establishing Physical Medicine and Rehabilitation as a medical specialty]. That imbued him -- both -- the combination, in a formal sense -- Krusen taught this as really a multidisciplinary process and in a less formal sense, Justus, as a person

from a different culture, didn't have the same kinds of commitments to how to look at things as others did.

And the dean of our medical school then, George Aagaard [George N. Aagaard (1913-97) was dean of the University of Washington Medical School 1954-64] --, who is one of the world's really marvelous people, was strongly committed to not only setting up a rehab medicine program -- there were only about three in the whole country -- it's a new field too, it began to emerge about the same time as clinical psychology -- but also to set it up in a way that, I guess I'll say was broad-gauge. The perspective and the scope of it and the intent were from the beginning to move in a lot of directions. And I would say, and I think this is a fair statement, not just a bias, it has probably been for the most of these thirty-plus years, the strongest medical rehab program in the world.

LIEBESKIND: The one here?

FORDYCE: Here. It really had some marvelously talented people that have been very productive and had roles of leadership, so all I did was I just got along -- I hopped a fast train.

LIEBESKIND: You made the right choice.

FORDYCE: That's right. And came along for the ride, with the added benefit that if one from the University of Washington medical school said something, people would listen, and then within the rehab domain, if you were from rehab medicine within that, then they'd really listen. So it was a marvelous opportunity.

LIEBESKIND: You know, just, you're talking now, and all of a sudden I realized we have been speaking for 35 minutes and there is a four-letter word we haven't used yet. Beginning with a P. [they laugh]

FORDYCE: Now let's see, what could that be?

LIEBESKIND: Where does pain come in? Here you are, you are now five years back here, you are now accepting an appointment in rehab medicine. Are you interested in pain yet?

FORDYCE: Not particularly. What I was interested in -- I was fortunate enough to have had several courses from Guthrie [Edwin R. Guthrie 1886-1959, learning theorist] as an undergraduate. He too was a marvelous, marvelous man. So here I had this sort of Gutherian foundation and then superimposed over that the psychodynamic graduate training, and then superimposed on that the Minnesota experience, so I felt, as a matter of style, I have always been intellectually restless -- I want to try to think, I get bored very easily and I want to try something else. It quickly became apparent to me and a lot of other people that the traditional psychological perspective on what one might be doing with a person who has recently become paraplegic, for example, is relevant, but it's not very helpful. Other things need doing. So I had in those first several years become increasingly dissatisfied with trying to play a traditional, wear a traditional clinical hat, and began to cast around for -- not quite sure what to do and how to do it. In those days I would remind you that the idea of using contingency management or

“operative conditioning” -- the procedures, tools, with human problems was – Ogden [R.] Lindsley [1922-2004] had started some things with schizophrenics and a few things had been done with [R.] Emmers and Sid Bijou.

LIEBESKIND: Lindsley was at Harvard, wasn't he?

FORDYCE: Yes.

LIEBESKIND: Wasn't he a student of Skinner's? I knew him.

FORDYCE: That's right. And he started doing things with chronic schizophrenics, tokens and token economies and things like that. So this was all just -- the technology was reasonably well known, though not fleshed out. But the application had been very limited. And here we were -- and another thing that happened was that in the LBJ years, the feds poured lots of money into social and health care programs. So we came down, our department came down with a huge grant. We were a research and training center grant, and that included the lecture fund. So each Friday, practically year-round, we'd have the money to bring somebody in to lecture. Finally I got my piece of that pie too and so I got Jack Michael. Jack Michael would qualify, I guess, as a radical behaviorist, and at that time he was at Arizona State with Lee Myerson and he has now for many years been [Professor of Psychology] at Kalamazoo at [the University of] Western Michigan.

But we got Jack in as a lecturer. This was how it all started: On a Thursday we had had on our ward a chemist with rheumatoid arthritis, disease in remission, the sed rate was down; but there was a lot of residual immobilization. He had been referred to rehab for reactivation. He had been there for a couple of weeks, whatever. On Thursday he announced with great feeling to the nurses and everyone else that the pain was so great that he could not even tolerate the touch of his sleeve on his arm, and that he could not get out of bed to go exercise. That was on Thursday. I was on the ward at that time, in those days, with Justus Lehmann, the chairman of the department, and Barbara DeLateur, his senior resident [now Professor of Physical Medicine and Rehabilitation at Johns Hopkins]. We'd make walking rounds each day. Friday Jack Michael came, gave his lecture and pointed out what seems so obvious now but didn't seem so obvious then, that social feedback has a lot of influence potentially.

The following Monday -- now our chemist friend had been in bed Thursday and Friday and Saturday and Sunday -- the following Monday we came walking around the ward and came to his room on ward rounds. I don't know where the idea came -- I got this harebrained idea. “What do you say, if he says anything about pain, let's look out the window.” It was crass, it was cold, it was whatever. But we did it. We walked into the room --

LIEBESKIND: You planned this ahead of time with the others?

FORDYCE: We just had a little caucus outside the door and I laid this proposal on my colleagues and they said, okay. They looked at me sort of funny, but why not. So we went in there and began talking with him at the bedside. He was lying in bed and immediately he began to tell us how bad his pain was. So all three of us looked out the window, turned our heads

ninety degrees or whatever it was. It was just crude. And he stopped. So then we turned back to him and he stated talking about pain again -- looked out the window again. We went through this little charade two minutes, three minutes, something like that, not long, and then left. The darnedest thing happened. He got up and got dressed. He hadn't been out of bed since Thursday, except to go to the bathroom, I guess. He got up and got dressed and went to PT and OT and did his exercises. He never missed another session of treatment. The second afternoon - - this was a Monday morning we had done this --and Tuesday morning we came around again. On Tuesday afternoon he said to the nurses, "I know what those SOB's are doing. Every time I say anything about pain they look out the window." But it didn't make any difference.

LIEBESKIND: He understood it, but it didn't --

FORDYCE: I was just flabbergasted. As Al Roberts would have said, this was strictly a data-driven -- we didn't set up and think up some theoretical framework for all of this, we weren't testing some hypothesis, it was just a harebrained idea, which had an unexpected effect, we can't even claim cause and effect. We can only say that this was the sequence. So then when that happened, Roy Fowler, who was one of my psychology colleagues, Roy S. Fowler, Jr., who deserves a lot of credit for all of this -- Roy and I sat down and I don't think we took more than an hour of coffee conversation, to say, well, gee, if that had this effect, what do you suppose would happen if -- and we asked ourselves, now how could we handle the issue of exercise. We had already addressed the issue of social feedback, namely ignore the patient, not necessarily look out the window, but don't flap about it -- how could we handle exercise. And so we came up with the working to quota system and how can we handle the medications, which were so common then, analgesics, and we came up with the time-contingent pain-cocktail gambit if you will. Then having breadboarded this, we said now we've got to find someone to try it out on.

LIEBESKIND: So you literally had both of those, that set of ideas, in one hour-long conversation.

FORDYCE: Yeah. But look at it the other way -- if you ask yourself, what is it that they do during the day and what kinds of things might be done to influence that? and medication and rest and exercise were the obvious ones.

LIEBESKIND: Well you know, I'm just sort of reflecting on what we've talked about so far, and it's wonderful, because the question I asked really was the appropriate one, wasn't it. I mean, what prepared you to enter this field? We hear about these different experiences that you've had and the different kinds of training, and all of a sudden it comes together in one hour, isn't that right. And here is the prepared mind, ready to seize a moment and to have an idea.

FORDYCE: Well, and a whole bunch of coincidences occurred. I can't say exactly, but probably within a day or two of that conversation, I got a telephone call from a psychiatrist I knew downtown, saying he had this patient who had chronic pain and said, "I think rehabilitation might be helpful." He was thinking rehabilitation, he wasn't thinking about any kind of pain management, but just rehabilitation -- "and so would you take him on?" So I said, "I'm sure we can get a bed;" so we got a bed and we brought him in and tried out our working to quota and the pain cocktail bit. We didn't call it pain cocktail until about a week later, one of the residents in

rehab medicine, Bruce Masock [A. J. Masock, 1928-2000], said, “This ought to be called the pain cocktail.” So that was how that came about.

LIEBESKIND: Why “pain cocktail”? I mean, it’s time-contingency. Where does the cocktail come in?

FORDYCE: It’s just a smart remark by a resident. He was almost making fun of us when he said it. But the name stuck.

LIEBESKIND: I’m still not understanding “cocktail.” I mean, why “cocktail”?

FORDYCE: Because they take it orally.

LIEBESKIND: I see. Not pain cocktail in the sense of the Brompton mixture, which was a mixture, a mixed drink, of drugs. This is just a cocktail in the sense that it was something you pour in.

FORDYCE: This was the active ingredient plus a color- and taste-masking vehicle, usually cherry syrup. So that was the pain cocktail.

LIEBESKIND: So you could titrate the dose without the patient knowing it.

FORDYCE: That’s right. So we did it. And we brought this patient in and he did fabulously well. A man that -- he hadn’t worked for two years and he went back to his business and it was physically vigorous, arduous work and he did it.

LIEBESKIND: Was it back pain?

FORDYCE: Back pain. He’d been working -- he had one of these jobs where you take wrecked autos and disassemble them and then sell the parts and so forth -- an auto wrecking outfit. He had been under a car and the jack broke and the car fell down on him and gave him his pain problem, a couple of surgeries and whatnot. He came in with canes and addiction and walked out whistling. And hell, our eyes bugged and we thought, well gee, let’s try it again. So we tried a second one and that worked and then tried a third one and she set all kinds of records, so that by the time we got to the third one -- hey, we’ve got something here. We were opportunistic enough, Roy and I, we wanted to establish ourselves academically -- so we’re going to write this up, right now. So the next week or so that’s all I did was to write that first paper, which wound up in [Hans J. Eysenck (1916-97)] Eysenck’s journal .

LIEBESKIND: Oh, yes, so this is a very famous paper now, this is sort of the beginning of Fordyce and the behavioral approach. And when did that come out?

FORDYCE: ‘68. ‘67, ‘68. I think ‘68 [Fordyce, Fowler, and DeLateur. An application of behavior modification technique to a problem of chronic pain. *Behavioral Research and Therapy* 6(1968): 105-07].

LIEBESKIND: And this was Fordyce and Fowler?

FORDYCE: Fordyce, Fowler, Lehmann, and DeLateur. You know, in a rehab medicine program, one always brings as coauthors people you have worked with. And that cuts both ways.

LIEBESKIND: So this came out in Eysenck's journal. What was that called? I don't remember.

FORDYCE: *Behavior, Research and Therapy*. Then -- I can't quite remember the impetus for this -- there was a second article. The first one was a case history. That was the Eysenck article. Then the second one was the *Journal of Chronic Diseases*. [Fordyce, Fowler, Lehmann and DeLateur. Some implications of learning in problems of chronic pain. *Journal of Chronic Diseases* 21 (1968): 179-190]. And we put in a series of three -- a big series.

LIEBESKIND: Three cases?

FORDYCE: Yeah, three cases. I might add that it's very difficult, particularly in a setting like that, to accrue much data. There's no way you can get a control group random assignment -- that was not an option. More than that, the department had other fish to fry besides chronic pain -- they were working with paraplegics, quadriplegics, stroke, etc. I was given access to up to three beds out of thirty.

LIEBESKIND: It would be tough to build up an N.

FORDYCE: That's right. So it was three or four years.

WILBERT E. FORDYCE INTERVIEW

TAPE ONE, SIDE TWO

LIEBESKIND: This fellow Fowler now, Ray Fowler?

FORDYCE: Roy S. Fowler, Jr.

LIEBESKIND: He was what, a colleague?

FORDYCE: He was a psychologist.

LIEBESKIND: A contemporary of yours?

FORDYCE: Well, he was -- Roy must be at least ten years younger than I. He'd come on -- when I came to the medical school I was one of three psychologists, the only one in rehab. Gradually as the years went by and our roles expanded, we added, and Roy was one of those we wound up -- eventually at one point we had five or six, seven, something like that. So Roy came on in the early or middle '60's, I guess, something like that.

LIEBESKIND: So you and he kind of played these ideas off one another and so forth.

FORDYCE: That's right. Roy was with the University until about ten years ago, when the federal largesse was cut back considerably, so he went into private practice. He is over in eastern Washington, Walla Walla, in the Tri Cities. So we published. We went about the business of accumulating data at a slow pace.

About that time the third patient we had worked with, one who has had all kinds of "records" -- she did such startling things. She taught us more about this than anybody else had. And I will tell you this too -- we'd made these walking rounds on the ward, and one of the things that our chronic pain patients would be doing would be to walk laps to quotas and gradually increment the quotas. She decided on her own to walk those laps on the ward. When she came to us, I am not exaggerating, she was reclining, by her own records and her husband's agreement, 22 to 23 hours a day and had been for quite some time. When we started her walking and got her going and she started walking these laps around the ward, she got great pleasure out of seeing people's eyes bug as she walked. A way of doing that, to call more attention to herself, was to walk faster and faster. It was just marvelous. So she would roar around the ward. We'd be coming down the corridor with these wheeled carts in which the charts are contained, and she would sort of, "Get out of my way! Get out of my way!"

LIEBESKIND: She just bought into this.

FORDYCE: On her first pass -- she hadn't been able to visit her parents 90 miles away -- she got her husband to get on the freeway and at that point she had reached 1.1 miles on her walking, so she told her husband to stop the car, she was hurting -- stop the car, pull over -- freeway, mind

you -- she got out and she said, "Now drive up 1.1 miles and wait for me." She walked the shoulder of the freeway after getting out of this car. Things like this -- we didn't think of anything like that -- as I say, she taught us all kinds of tricks.

LIEBESKIND: She was obviously reinforcing herself with this, walking was reinforcing to her.

FORDYCE: She was, unbelievably, and us. And of course the more she reinforced us the more we'd reinforce her, and so it goes. That lady had gone through John Bonica's pain clinic some years before. And I would remind you that the Pain Clinic initially was basically a diagnostic mechanism [that] brought together professionals bearing perspectives to analyze a pain problem and make recommendations about what might be done. But they didn't do it. If blocks were going to be done, John would do that. If it was something else, on the other hand -- and so on.

We were busting our britches with all that we had been able to do. So I went down to John and said, "We have this lady who came through your clinic three or four years ago, and then in the course of events she came to us, and we have done some things with her and we would like very much to have you have a chance to see what's happened." We wanted to brag and show off and all that. So he said yes. We set up one of the conferences to be a case presentation. We presented this case. Eyebrows went up. So then he asked if I would be willing to join this pain clinic group.

LIEBESKIND: What year was this now?

FORDYCE: This would have been probably about '68, '69, right along in there. So then, for the next number of years, I would participate. The pain clinic group would take in two patients a week. Those patients, depending on the problem, would be circulated around various consultants. But I would see them routinely, almost all of them, because I would arrange for an MMPI and I was learning how to do what I choose to call a behavioral analysis of pain interview and I would do that with patient and spouse. Then when the Friday conference would come, the case would be presented and I too would present. That went on for several years. That's where John Loeser [Professor Emeritus of Neurosurgery at Washington, IASP President 1993-1996] and I first became acquainted. He was a resident and sat in on those conferences. And it went from there.

LIEBESKIND: Tell me a little bit about Bonica now -- had you known him? How well did you know him?

FORDYCE: I didn't know the man. He came, actually I believe it's true that he came to the medical school a few months after I did. I think I recall his saying that he came in '60 from Tacoma. I'm not sure of that.

LIEBESKIND: I'm sure that date came up in my interview with him, but I don't recall. It was around that time.

FORDYCE: I'm not sure. That's probably not at all an important point. The thing is, he was in one department and I was in another and it's a big place.

LIEBESKIND: You weren't interested in pain at that moment anyway.

FORDYCE: So I'm sure I knew him when I saw him, but we were not, you know, didn't have a working relationship.

LIEBESKIND: So when you had this case, this woman, this third case of yours, you approached him because you knew about his clinic, but you didn't really know him very well, had just met him, and so --

FORDYCE: That's right.

LIEBESKIND: So that was the beginning of your relationship with him and with that clinic.

FORDYCE: That's right. So then we got to work all of this out and flesh it out, if you will, by the conferences themselves. They became -- they were very interesting. Pretty soon we had to get a bigger room. They got to be very interesting. So, and that went on for a number of years. Then when John stepped down as chairman, when he turned 65, that was an institutional requirement, he stepped down as chairman, the medical school recognized that here were these two pain programs. There was the pain clinic and then in the rehab medicine, the so-called operant program. I want to emphasize that we started off using the term operant conditioning, but that was mostly because we didn't know what else to use in the way of a term. It's really better thought of as a metaphor than it is a descriptor. There are contingency management elements to it, but there are other things as well.

So here were these two programs. So the medical school set up a task force, they set up a committee, to see what might be done to unify these. That was in 1980, maybe. They set up a paper amalgamation, but it was just that, and Terry Murphy [Terence M. Murphy, died 1996, Professor of Anesthesiology at the University of Washington] was given the responsibility of trying to run that. Terry was in an impossible situation. The institution hadn't really made the changes that would permit it to be viable. So for three years, Terry had to suffer through that, and it was obvious that that wasn't enough, and there was a change in the deanery and whatnot. So then, actually in '82, the change was made.

[INTERRUPTION]

FORDYCE: John Loeser was asked to take over [the pain program] and he set two conditions. One was the two enclaves would be united into one, and the other was that my clinical time would be full-time pain service. So that's how we put together -- then he and Judy [Judith A. Turner, now Blake Professor of Health Psychology at the University of Washington, and well-known specialist on low back pain] and I and others breadboarded the current program.

LIEBESKIND: So before that, then, during the years that John Bonica was running it, you were sort of straddling the two, is that right?

FORDYCE: I was the bridge between the two.

LIEBESKIND: You were running the operant program in rehabilitation, but you were consulting.

FORDYCE: That's right, I was a consultant evaluator for the pain service. And as time went on, it became ever more evident that a lot of the patients who were being processed through the pain clinic really needed the reactivation sort of thing. So an increasing number of patients were being referred to the rehab program. And the beds that anesthesiology was operating were basically detox beds, and they'd do a few other things, but that was mostly it.

LIEBESKIND: Well, let me look at my list of questions here and see where we are. I think we've definitely covered number two and all that, what your educational experiences were that influenced you in the field, were there other people or ideas to which you were exposed early in your career that have greatly influenced the direction you took -- I think we've done that. What steps did you actually take to enter your career -- I think we've covered that. That's all come out. The next question is, tell me about the Issaquah meeting, moving ahead a few years, or back, wherever we ended up.

FORDYCE: Did you attend those meetings?

LIEBESKIND: Yes I did.

FORDYCE: Okay.

LIEBESKIND: In fact, I recently had an opportunity to reminisce because I had a form letter from [Ulf] Lindblom [Professor of Psychology at the Karolinska Institute, Stockholm; IASP President 1990-93], who said he's going to do his presidential address on the 20th anniversary, so he wanted to mention that, and he wanted some bibulous reminiscences from me. So I wrote him a couple of pages of what I recalled. But you were part of that --

FORDYCE: I don't know that I can really say very much, add very much. I can tell you that the meetings occurred at a time that we were caught up in the reconstruction of this house, and so I did not stay at Issaquah overnight. I commuted because we had subcontractors and contractors we were hassling with and on and on, and working with and so forth. So some of the socializing byplay, if you will, I had some of it, but not as much as many others.

LIEBESKIND: Were you aware ahead of time -- obviously you knew of Bonica's plan and he announced this and so forth. Were you in any way working with him and planning it, or did he kind of do that pretty much on his own?

FORDYCE: The best I can do, John, in responding to that question is to say that I am sure I participated in some informal conversations and so forth with various people, including John, and maybe some others, Ray Fink [B. Raymond Fink (1914-2000), Professor of Anesthesiology at the University of Washington 1964-84, and a long-time Bonica collaborator] and a few others -- about the idea, but I don't have any recollection of my having participated in any systematic

way. I did, when they had this sort of organizing meeting in that one room one evening, I was in on that.

LIEBESKIND: That was during the conference?

FORDYCE: During the conference.

LIEBESKIND: Yes, I remember a meeting like that. That was to talk about creating an IASP [International Association for the Study of Pain].

FORDYCE: That's right. But I -- John Bonica could answer this better than I, and I'm sure he has, but my recollection is that it sort of sprung forth mainly from John and his ideas about what ought to happen.

LIEBESKIND: Did you have a sense at that time, a sense of excitement or a sense of moment, that this was a coming together of a nascent field? Did you feel that at all, or was it just the meeting?

FORDYCE: I don't think so, but I think it's probably to my discredit that I didn't. As I reflect back on it, I think that I thought that it would be extremely difficult to get people from such diverse backgrounds and diverse perspectives to come together in a working way. So I knew it was an important thing to do and a useful thing to do, and I thought it ought to happen, and I wanted to not only support it, but figure out how I might make some kind of a contribution to it. But I think I was pessimistic.

LIEBESKIND: Well, probably that was conditioned by your own adversarial experiences vis-à-vis psychiatry and being a psychologist in a medical world was not the most comfortable place to be, and could have conditioned some pessimism on your part.

FORDYCE: That's right, very much so. That was a "turf battle" -- and I don't mean that it was blood was flowing all over the place, nothing of that sort, but as a psychologist in a medical setting, I was very often sensitive to, is what I'm saying being accepted and am I listening -- this sort of thing. There was conflict. So that was an issue.

LIEBESKIND: Tell me, in a very broad -- my next question is a very broad one, Bill -- how has your work in the field of pain affected your personal life -- how has your career affected your personal life, would you say? Has it been an onerous duty, your work, has it been great pleasure -- how have the two halves of you interacted in that sense -- the work half and the private man?

FORDYCE: John, I have been absolutely blessed with a wife who could not have been more supportive. One thinks, well, what would have happened if it hadn't been that way and I don't know -- she is just a marvelous, marvelous woman. What happened to me was that I got caught up in a process in which I had something to say that other people wanted to listen to. I was more than ready -- my dynamic in major ways is having something to say that other people are going to listen to. Never mind what it is. And so I've been on the road more than I've been at home,

as it were, for the last twenty years. But it gave me a lot more sense of self-confidence and self-fulfillment and so forth. I'm not sure what else to say about it.

LIEBESKIND: I mean, about the time -- let me see if I can reconstruct here a little second. About the time that your career really took off in the sense of fame and so forth, it was here in, what --

FORDYCE: Say 1970, '68, '70, along in there.

LIEBESKIND: When this first article out, with Fowler and so forth, and that's when you really tied into something that was novel and you were the first person really to apply these behavioral techniques to the field of pain and so forth. The field of pain itself a few years later started really growing, out of the Issaquah meeting and so forth, and there was a lot of currency within psychology and within the pain world for this. And by that time, if I can reconstruct, you're sort of mid-career here.

FORDYCE: Oh yeah.

LIEBESKIND: I mean, you're not a beginning assistant professor struggling for survival.

FORDYCE: I had children, my two boys, and I was in my middle forties.

LIEBESKIND: Your two boys must have been fairly grown already by that time, is that right?

FORDYCE: That's right.

LIEBESKIND: They were not chicks in the nest.

FORDYCE: If we use 1970 as a benchmark, one son was 21 and the other 18.

LIEBESKIND: So when you started hitting the road and really getting out there, you had the home situation was quite stable from that standpoint. You weren't abandoning a struggling wife and infant children.

FORDYCE: No, no. I'm not quite sure why this comes into my mind now, but it's a bit of a digression. But let me mention, at least because it's important to me and I think it may reflect on some things we can get to. In 1964, the American Rehabilitation Foundation, which was really money out of the Sister Kenny Institute in Minneapolis, set up two committees, a medical expert committee and a psychology expert committee. [The American Rehabilitation Foundation was actually the parent company of the Sister Kenny Institute, a Minneapolis physical therapy and rehabilitation center established by polio nurse Elizabeth Kenny (1880-1952). It has since been renamed the Sister Kenny Foundation.] The purpose of those committees, since rehabilitation was itself a growing and emerging field, the purpose of those committees was to prepare a nucleus of people who had information about social and political and economic, etc., etc., issues which relate to rehabilitation. Paul Elwood [trained as a pediatric neurologist, Elwood has been a campaigner for healthcare reform since the 1960s] is one of Hillary Clinton's key people --

he's a key member of this Jackson Hole group now that's writing health policy [Hillary Clinton, as First Lady, 1992-95, led an initiative to reform the US health care system, which ultimately failed] -- he and Alain Enthoven, or something like that, the economist from Palo Alto [Enthoven is Professor Emeritus of Public and Private Management at Stanford] -- Paul was head of this Sister Kenny Foundation at that point. He set up this committee. So I was a member -- there were about ten of us.

LIEBESKIND: You were a member of the psychology --

FORDYCE: Of the psychology -- we called it [the] vocational/ psychology expert committee. We met -- it existed for six years with generous funding, so we could get together in Washington D.C. three or four times a year, bringing in all kinds of experts. The purpose of this in this context was that it exposed me in a much more systematic way to some of these social, political and economic dimensions to health care and rehabilitation and so forth. And that has been -- it's why I came to you a few years ago and told you that I wanted to work on some things about management of disability -- those were part of the roots of that. So then when we got involved in various pain-related organizational things, I brought to that a set of interests and some knowledge -- mostly a smattering of ignorance, but some knowledge about some of these issues that influence where we're going.

LIEBESKIND: This comment makes me realize that maybe we haven't given enough attention to the idea that this emerging field of rehabilitation medicine is both very much shaped by you, but also shaped you because it -- I mean, psychology was an important part of it, it sounds like almost from the start, and there was a recognition of a physical medicine aspect but also a behavioral or psychological aspect. I mean, if this committee, this Sister Kenny thing, and so forth...

FORDYCE: Really gave strength to that.

LIEBESKIND: Gave strength to that -- here are these two committees and so forth. This was back in, what, you said the early '60's, that was.

FORDYCE: That's right. It seems to me I've felt for years that comprehensive rehabilitation, which is the key term, comprehensive rehabilitation, and that should be sort of distinguished from physical medicine -- it includes but goes beyond physical medicine -- comprehensive rehabilitation is doing and has been for twenty, thirty years, what the rest of the health care system should have been doing all along, and only now is it beginning to catch up. So we were - - and with the ARF committee particularly, we were in a position of being able to sort of break ground, not just for rehab, narrowly defined, and pain, but in a broader sense help to put footprints on where the health care system should go. And we were blessed with this marvelous dean who supported this greatly.

LIEBESKIND: I'm starting to get more of a feel for that now. This is fascinating to hear this, because you feel that these currents are very important in terms of what's happening today in the health field and in terms of care of patients and so forth, and we are kind of getting at what are some of the roots of these things.

FORDYCE: But you don't find it in the blueprint anywhere. It's things that happen and come together.

LIEBESKIND: Yeah. It's fascinating. You know, I mean, I don't know what's going to come of these interviews. There will be tapes, there will be transcripts of tapes, they will be archivally stored through the American Pain Society, the IASP and so forth. People will make what use of them they will. I have the idea, most grandiosely, maybe someday myself to do a kind of an intellectual history of the field of pain, and this would be one of the really key ideas, it seems to me, which was why I wanted to talk to you so much, and it's just interesting to see the background. I'm sure you could trace these things back further and where all that came from.

FORDYCE: That makes me think of another root that I think should be touched on. You know Alf Nachemson [Professor of Orthopedics at G^{te}teborg], who is a fascinating man and you may well want to --

LIEBESKIND: I'd love to talk to him sometime. I just got a little glimpse of him.

FORDYCE: Well, he's a real dynamo. Incidentally, he and John Loeser now communicate a great deal and I'm sure you could get more about Alf through John. But Alf -- there's a placard on the wall in Alf's office that his secretary put up years ago -- I don't know if it's still there -- that said: "God is everywhere. Alf Nachemson is everywhere but G^{te}teborg." [Both laugh] He's on the road. He'd laugh. So anyway, Alf, on one of his numerous sabbaticals, came to Seattle because he had been interested -- Alf has been one of the -- if it's not control group prospective random assignment, it doesn't count. It isn't there. There isn't anybody tougher about that than he is. So Alf and the then head of orthopedics here, Vic Frankel [now President Emeritus of the Hospital for Joint Diseases Orthopaedic Institute at New York University and Founder of the Occupational and Industrial Orthopaedic Center there -- they had known each other -- and Alf prevailed upon Vic to begin to hustle Boeing [the Boeing Company of Seattle, airplane manufacturers], and then Alf got his sabbatical.

LIEBESKIND: What year was this?

FORDYCE: Well, he got here in '80, probably summer of '80 - I sort of forget. And the idea was that they had already done a lot of pump priming. And they thought that during his year here they would be able to set up and start to carry out the Boeing study, which has had a lot of impact. But when he got here he found that life is never simple, and all kinds of the Boeing bureaucracy were not ready to go this way. Some wanted to, but others didn't. So we spent the whole year struggling to set that up. But during that year we got acquainted. He had read something about the stuff we had been doing with pain and so forth and it just wound up that Alf and I enjoy each other and share a lot of interests. So we got acquainted and I joined the Boeing group -- I didn't help set up the project -- Alf and Vic Frankel did that, and to some extent Stan Bigos [Professor of Orthopedic Surgery at the University of Washington] did. But then we finally got it set up and under way in the summer of '81. So having access to the orthopedic community which is, I remind you -- here you've got IASP and APS [American Pain Society], all that pain stuff, and across the street over here you have the orthopedists.

LIEBESKIND: That's a problem.

FORDYCE: Well, no, not a problem, but they've got volumes of efforts and task forces and books and everything on pain. And these two domains have in past years talked to each other very little. So here I was -- I needed three legs, anesthesiology, rehab medicine and orthopedics. At one point I was voted an honorary member of AAOS [American Academy of Orthopedic Surgeons].

LIEBESKIND: Is that right?

FORDYCE: Yes.

LIEBESKIND: That's the orthopedic society?

FORDYCE: Yeah, American Academy of Orthopedic Surgery. I think it was a paper tiger; I've never seen anything on paper, but that's what they told me.

LIEBESKIND: Well you would think a lot of what you would have to say to them would be very -- would anger them a lot, just as you were saying in the car coming over here.

FORDYCE: That's right. We can come back to that.

LIEBESKIND: Well, you would think that that -- it's cutting at their economic heart.

FORDYCE: But Alf with his connections, and then he got involved with us -- that's how I got involved with this Volvo [Swedish automobile manufacturer] study. The first Volvo study was basically a replication of a study that subsequently -- Alf was here in '80 and '81, and we set up, in '82-'83, an NIH-funded prospective random assignment [trial], comparing traditional with behavioral methods, with back pain. That proved to be a very productive effort.

LIEBESKIND: That was at Volvo?

FORDYCE: No, no, that was here. That was within the University -- we had four clinics, three within the University and one in a bedroom community. So then when those data were coming off the line about that time, and Alf wanted to do that -- he had a lot of clout with Volvo, the corporation -- they have their big plant in Gothenberg (Göteborg). So he prevailed upon them to set up what basically was a replication, and that's how I got over there to help them work that out. But one of the things that that did was, working with Alf, was to get exposure to a whole bunch of other groups who were working on different aspects of the pain problem, and it just brings tears to your eyes to see how much work is going on in orthopedics that IASP doesn't know about, and APS, and vice versa. It's fascinating.

LIEBESKIND: Is that changing?

FORDYCE: Yes. Although there are a handful -- John Frymoyer [John W. Frymoyer is Professor of Orthopedics and former dean of the medical school at the University of Vermont] and Alf Nachemson. [PAUSE] So I guess I was talking about the Volvo bit and just access to the orthopedists -- some of them are very pragmatic and very practical; many of them are openly hostile.

LIEBESKIND: Yes, I can imagine.

FORDYCE: But not all of them.

LIEBESKIND: And you'd think of the people that we know in the American Pain or the International Association who come from that background, who are orthopedists, there are relatively few.

FORDYCE: Very few. And they are by no means a random sample of orthopedists, at least insofar as I think I know.

LIEBESKIND: There's Alf -- I can think of Bob Addison [Robert G. Addison, of the Rehabilitation Institute of Chicago, APS president 1989-90].

FORDYCE: And Bob has been out of surgery for years. And Gordon Waddell [orthopedic surgeon at the Glasgow Nuffield Hospital in Scotland].

LIEBESKIND: Right. Not so many others.

FORDYCE: And Gordon, who is really moving it along as well or better than anybody in the world as far as I can see, he was sort of a protégée of Alf's and he and Stan Bigos [were] here with the Boeing study.

LIEBESKIND: Bigos is also an orthopedist?

FORDYCE: He's an orthopedist. But he's not in the -- he's not much of a joiner. He stays within his orthopedic culture and that's it.

LIEBESKIND: So that's going to be a tough nut to crack; I mean, that's coming slowly.

FORDYCE: Yes. I don't know if you want to go to this level yet -- I believe it to be the case that much of the problem, from a society's point of view about chronic pain, is basically an economic, political and emotional suffering problem, and it's not very much related to pain as a signal system and neurophysiological consideration and so forth. They are both important but they are somewhat different, and the orthopedists and much of the health care system is going to have a hard time.

LIEBESKIND: Switching over.

FORDYCE: Switching over.

LIEBESKIND: It's not an easy concept for them to understand. I read, I think, at that Dana Point meeting you had given me a few things to read. I know Mark Sullivan [Professor of Psychiatry and Behavioral Sciences at the University of Washington] sent me a few things, and there were a couple of things by you and there were a couple of things by Alf, some editorials, brief ones -- very clearly written, very beautifully written. There was one of yours that I liked particularly, that was kind of the questions that patients ask and how to reply to those and explain these concepts. But these concepts are not easy to get across. There's a lot of resistance to understanding them.

FORDYCE: That's right.

LIEBESKIND: I think maybe we're at the point now where we can just talk about this systematically, because my next question -- I had asked you before, how has your work in the field of pain affected your life in general, and it sounds like there has not been any negative impact -- it's been a rich, rewarding, very positive kind of thing. Now I want to ask the flip side of that question, which is, how has your career affected the world of pain? So I'm asking for kind of a self-appraisal here of what are the big Fordyce ideas that have had an impact? I have my own concept there, but if I can push you to be a bit immodest, would you yourself comment on this?

FORDYCE: I guess I'll say first that in all of this, my involvement with it, as I think I've made clear, it was not a situation in which I sat down with some theoretical idea and so forth. When we first began, I go to John Kenneth Galbraith's wonderful statement [John Kenneth Galbraith, b. 1908, is Professor Emeritus of Economics at Harvard University] that events and ideas used to explain them have ways of pursuing independent courses. [they laugh] So ever since we started doing this, I've been trying to figure out how to explain it. And that keeps changing, and I hope it keeps on changing. I'm not by any means committed to it being where it is. I think that what we did more than anything else was to break the mold -- that clinical pain was, this is what it is, and we came along and said, "No, it isn't." There's that in it, but there's a lot more to it than that, and what we used to rationalize the new mold had elements of truth in it and lots of baloney, and gradually I think we've gotten a better idea of what it is. So I think that that's been the impact mainly, of helping -- and this has occurred -- you see, you as an outsider to the clinical domain, you can say it and people say, this is a great scientist and I sure think he'd have stuff, but if he just knew what patients were really like -- and I come at it from the other direction, don't tell me what patients are like, I know what patients are like. And I know what the medical culture is like, and so on. So I had a different kind of listening type than perhaps others would. So that we have been able to help the system to shift its perspective. I think that's the real --

LIEBESKIND: Can we give some labels to two or three of the key concepts here? I'm sure we can. Give me some labels. Let's pull it apart now, what individual concepts here would you focus on as the key ideas here. You broke apart the mold, you say, there was one way of looking at it; now you've taken a fresh look and there's this aspect to it, there's this aspect to it. How would you label and briefly describe those key concepts?

FORDYCE: I have come to this in the last year and I don't know if I'll want to disown it in another six months or a year, but I'll tell you where I am. I may have mentioned this to you or maybe I lectured on this in Dana Point about intradermal/extradermal. There are a lot of ways -- I learned from Dick Lazarus [Professor of Psychology at University of California Berkeley] the other day, relationality would be another way of putting it. I think that the most important thing, I didn't think it up, is that illness and health are complex phenomena which include but are by no means restricted to what's inside the skin. Just the definition of "Do I feel pain or not, and if I feel pain or not, is that a problem or not, and if that's a problem or not, is it one that I go to the health care system for or not?" All of those have big pieces of the variance of what happens. So I think that's the --

LIEBESKIND: That's the key concept, you think.

FORDYCE: And it's not new to us. David Mechanic [René Dubos University Professor of Behavioral Sciences and Director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University in New Jersey] was saying this for years, and others before him.

LIEBESKIND: Well, in that sense there's nothing new under the sun. I know Loeser and many others that I've talked to, John Reeves [psychologist at Cedars-Sinai Hospital, Beverly Hills, California, president of the American Pain Society 1991-92], who I did, by the way, interview. He was really my first interview. I was practicing on my new machine, that was not this one, but my first little cheap machine, and the whole concept of doing these oral histories -- I asked him if he would submit for one. It was a fascinating experience because we found we were both very nervous about it and we didn't know how it was going to work out and we were kind of concerned. You know, we're very good friends, and as we talked, it was very uplifting and we didn't want to stop. It was a lot of fun.

But, I don't know, somehow this very brief characterization of intradermal/extradermal doesn't satisfy me as the measure of the Fordyce contribution. It's a broad concept, but there's a lot more. We could refine that -- I'm thinking like, here's a chapter in a book -- now, help me write my book, or write your book -- and here's a chapter and it's about the great ideas in the field of pain, and this chapter is all about Fordyce. Now we need some subheadings. And what would those subheadings be? You're going to write some pages on this and some pages on that, I mean, the behavioral approach, the reinforcement approach --

FORDYCE: Well, perhaps this is contributory. One of the aspects of all of this has been the idea that pain is not just a symptom, it's not just an arrow pointing to something else -- look at the low back or wherever. But pain is also -- pain behavior, really, would be a much better term, but in the clinical context, what a person brings to the system, I'll call that "pain" -- what the person brings to the health care system is a set of events that are influenced by a whole bunch of factors. So if you just think of it as a symptom, you miss that. That is, intradermal or extradermal is secondary in importance. Obviously it has to do also with past experience and expectations and all of those things.

LIEBESKIND: You know, as I commented in that little book, you've been full of these bon mots and aphoristic expressions and so forth -- there's one of them that caught in my throat, and

I wonder if you'd be willing to talk about it a little bit: "If there is no pain behavior, there is no pain problem." Do you really believe that? Is there a limited sense in which that's true, or do you think that's always true?

FORDYCE: Okay, I think I can do justice to that. First of all, I'm looking at it from the point of view of a clinician who is presented, confronted with a person who says "I have a problem." I am not functioning in a lab, for example, when I'm exploring neurophysiological events and so forth. Now, in that context, if a person says, "Well, I have pain, but it doesn't influence anything I want to do," then I would say from a clinical point of view, and assuming that the "I have pain" is not something that is readily fixable, then from a clinical point of view he doesn't have a problem. Is that responsive? Does that catch much in your throat?

LIEBESKIND: It still does.

FORDYCE: Okay.

LIEBESKIND: Here's someone then who's saying, "I'm functioning, I'm going to work, I'm getting sleep and it's not affecting my sex life and so forth and so on, but I do hurt a lot." Isn't that still a problem that we would want to try and do something about? I mean, I see the opposite.

FORDYCE: Okay, I understand. Now presumably some interesting percentage -- what I've come to of late is a focus on back pain, that's the easy example. It's not limited to that, but that's the easiest example. If one looks at the people who come to the health care system and the problem is identified as a back pain problem, usually it's the person who says, "I have a back pain problem," but sometimes it's his family or his doc or a compensation agency or something. The problem is defined as a back pain problem -- I think that those probably tend to fall into three broad groupings. One group is people who have been what I come to call wounded. They have had something happen to their bodies that has produced some defect.

LIEBESKIND: The car fell on them.

FORDYCE: Yeah. And in the base rate among chronic pain clinics, the base rate values are something less than two percent -- a very small group. Very small. If you are running a causalgia clinic or something like that, then you get a different base rate. A second group are those who, they have a backache, but so does everybody have a backache, and for a variety of possible reasons that backache has come to be identified as a problem, for which the health care system is pertinent. And I don't know whether the health care system is pertinent because the backache is a little more intense, or, there are a lot of possible reasons.

As I'm sure you know, something on the order of eighty-five percent of the people who say, "I have a backache" will go on to say, "But it's not a problem." It's a small number who say, "I have a problem" and an even smaller number, though probably not much smaller, who say, "Since I have the problem, the health care system is pertinent." But that's the second group. And those people mostly, and I would imagine something upwards of 90% of them, will get better no matter what you do, what the health care system does. And they're the ones that give

the pain clinics a free ride and they get all kinds of credit and so on and so on. Another characteristic they have is that they have something to go back to. They have a job, a credible family, something better to do than be sick.

Then there's the third group, that I would choose now to call chronic sufferers. They have backache just like everybody else does, and their backache may be more or less intense, but because they are suffering for a variety of reasons, there is some kind of -- I'll go to the word compounding effect -- I don't mean that in a very narrow, let's say mechanistic sense, but in some interactive effect of suffering, being unhappy, things like that, and having a backache, or maybe they don't even have a backache. I'm sure there's some of both, or they have a backache, but it's such low-level music or noise that nobody can hear it. They come to the health care system, and those people who probably make up something in the neighborhood of twenty percent overall of the ones who walk through the front door of the pain clinic, probably no more than that -- will tend not very often to get better. The sophisticated, effective pain programs will peel off of that twenty percent -- we'll now call that a hundred percent of the chronic sufferers -- they'll peel off up to fifteen, twenty percent of those and really make some major impact. The balance, they won't really have much impact on. So is that responsive?

LIEBESKIND: Yeah. It looks as though it's partly context-dependent. You might use that expression less if you were dealing with postoperative pain, let's say.

FORDYCE: Oh yes. Oh absolutely.

LIEBESKIND: You're talking here about the domain of chronic pain and disability and this whole issue.

FORDYCE: Absolutely. Now I guess I want to say -- I'll go back to the study we published back in the middle '80's, when we were comparing traditional and behavioral programs and then the Volvo study, and there have been two or three others since then, that essentially replicated -- which suggest, and I think the findings are now beginning to accumulate to make it more and more solid -- it would suggest that if the health care system would simply let them alone, if we could keep the health care system out of it altogether, everybody would be better off.

LIEBESKIND: We'd be ahead of the game.

FORDYCE: Instead the health care system collectively tends to do things which increase the probabilities of the person to be worse -- it's not necessarily iatrogenic in the sense of cutting the wrong tissues or something of that sort, but just conveying that you are sick, you poor fellow, and so forth.

LIEBESKIND: Conveying the wrong message, if not doing the actual wrong thing.

FORDYCE: And that's with acute -- I'm not talking about chronic now.

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TAPE TWO, SIDE ONE

FORDYCE: I'm saying that illness is a complex phenomenon and when the health care system brings to bear its armamentarium on disease, then they influence the extent to which the person defines his illness as being a real problem.

LIEBESKIND: Which even in the case of acute pain can serve to turn it into chronic pain.

FORDYCE: Maybe you know about this. I learned this a few years ago and tried to set up two or three different places of study to test it out and have never been able to get it going -- and that is with knee replacements. I am told that if the person with a total knee replacement on coming out of the anesthetic -- if the limb has been put into a ranging device that is passively but mechanically moving it -- so that on awakening and opening his eyes, he sees the knee moving -- subsequently the amount of medication, analgesics, and the amount of time it takes to get walking to freeway speed are significantly diminished. Just by, "Hey, it works."

LIEBESKIND: This is just your hunch, or you have actually observed this?

FORDYCE: No, Chuck Strother, my thesis sponsor, had a knee replacement, and we talked about it, and the pain.

LIEBESKIND: This is recently?

FORDYCE: No, this has been five or six years ago, seven years ago, something like that. And he commented that he had a lot of trouble -- they didn't do that to him -- and he said it took a long time to get function and to get the pain bill down and so on. But he said to me, "But I talked with somebody else who said, what's the problem? And so we sorted out what the differences were;" and that was the difference that they could identify.

LIEBESKIND: He woke up and the device was on.

FORDYCE: And the thing was moving. So Vic Frankel, who was by then at the Hospital for Bone and Joint Diseases in Manhattan, they have a big flow of orthopedic surgery. So Vic and I and Margarita Nordin [current Director of the Occupational and Industrial Diseases Center at NYU] and some other people, we tried to set all this up. We were going to set up a big study, but it required that two or three of the surgeons in the place agree to certain things, and they wouldn't do it, and then there was a turnover of personnel, so we dropped it. I tried it here too, but there was not enough volume.

LIEBESKIND: And part of your idea here is that the physical movement may be important, that may be good, but it's more the issue that the patient on awakening sees that things are functioning.

FORDYCE: Their anticipation.

LIEBESKIND: Their anticipation and whether they label that they have a nonfunctioning knee now or, hey, I've got a functioning knee.

FORDYCE: Well, I remind you, you've heard me use these anecdotes in a lecture -- we had this fellow as a medical student who was a running back in the NFL, Dan Doornick -- he's an internist now over in Yakima. I brought him in and then John joined me, John Loeser, to lecture to the first-year medical students about pain. To get Dan -- the combination, he is a very insightful fellow, but also with a different kind of a background, the football, but medical school, and he taught us a lot. He said that, you ask him how long does it hurt, and he said, "All the way back to the huddle." Fifteen seconds. That's impressive -- what does that mean?

LIEBESKIND: That's incredible.

FORDYCE: Don't tell me that nociception stops in fifteen seconds. There are lots of examples like that.

LIEBESKIND: All right. Would you focus on any controversies in the field of pain? Are there any that you perceive that you've brushed up against or that you think are particularly poignant?

FORDYCE: Well, one that I've been sort of involved with in the last couple of years is with Russ Portenoy [now Chair of Pain Medicine and Palliative Care at Beth Israel Medical Center in New York] and others having to do with the use of opioids with chronic pain.

LIEBESKIND: What's your take on that?

FORDYCE: Well, both Russ and I are blessed with confidence that we're absolutely right. And one of us is more right than the other, but we haven't conceded, each to the other. I think that the issue there is a combination of two things: One is that the clinical exposure, the kinds of people who present to Russ's group are very different from the kinds of people who present to our group. And I'm sure he's giving valid and careful expression of the experience and observations he's made. And I think people who live in Manhattan are different from people who live in western Washington culturally. I'll digress in a little while and comment on that. So I think that's part of it.

I think another part of it is some real differences about the meaning of pain, that I think Russ, more than I think he appreciates -- he'd argue with me -- I think more than I think he appreciates, is imbued with a disease model perspective, and I'm not, I'm in a different place -- so he's speaking French and I'm speaking Italian and we share a few words now and then, but there's a lot of divergence. I think also that there are differences in terms of how does one judge whether an intervention works or not? What are the outcome measures? We go different ways to some extent about that. So I think that's one kind of a controversy.

I think that there are sociological or institutional controversies. The field of anesthesiology has strived mightily to sort of take over -- I don't know if that's a fair word -- but ascend a lot in the

pecking order of the medical world as it relates to pain. I think that, obviously from a sociological perspective, there are always competing fields. But in addition to that, I think that the relevance or pertinence of anesthesiology as it relates to pain, insofar as it has that, has got to be to a disease model-imbedded pain program, postop, things like that. Indeed, the very nature of the traditional training for anesthesiology probably, in my opinion, tends to work adversely to ease a functioning in chronic pain domains. But many anesthesiologists, from my point of view, have risen above this, as it were -- Steve Butler being a classic example [longtime member of the Anesthesiology Department at the University of Washington, Butler is now practicing in Uppsala, Sweden]. He's marvelous in chronic pain. But Steve got there not because of, but sort of in spite of -- and there are any number of exceptions to this.

LIEBESKIND: That's the classic anesthesiology training.

FORDYCE: So I think the controversy of not only medical vs. nonmedical, but within medical, this specialty vs. that specialty, those are controversies. I think that another kind of a controversy which will become more visible in the coming years is with what's the nature of society's obligation to people who suffer. That gets us into disability management and so forth.

LIEBESKIND: That's a very Hillary-relevant question, isn't it?

FORDYCE: Very Hillary-relevant. As you know, in Southern California, to name one area, stress and so forth and repetitive strain -- these things are getting increasing ascendance. I go back to Paul Harvey [radio broadcaster, b. 1918] -- I don't think he originated it, but he said it: "If everybody's going to ride in the wagon, who's going to pull it?" And a lot of people, for good or bad reasons, are trying to crawl into the wagon. I think that's going to be a problem. I think that, pretentiously, that the PIW report, the *Pain in the Workplace* - IASP report -- [*Back Pain in the Workplace: Management of Disability in Nonspecific Conditions*, ed. by Fordyce, IASP Press, 1995; now out of print] it may well wind up on a shelf and gather dust, but insofar as it has some impact, I think it will move in the direction of diminishing society's readiness to see the health care system as a solution to pain problems, and I think it's going to go beyond that. So I think that's coming down the road, and we, and now I'm talking about not just our society, but worldwide, are really going to have to come to grips with that a lot more than we have.

LIEBESKIND: Which really gets into my next question. It's one that was not on my general list, but one that I wanted to ask you about particularly, which is, what's happening with the whole multidisciplinary approach? Is it financially viable? It sounds like there are an awful lot of these multidisciplinary clinics going down the tubes, and maybe that's not going to survive. I mean, here was this supposedly great idea and it took hold in the '70s and there was this great dissemination of this idea. It looks like it's going the other direction.

FORDYCE: It's a little bit peripheral, but I've been arguing for years that I wouldn't want to buy stock in a pain clinic. But the reason I've been saying that is because I think that, if the health care system does what it ought to have been doing all along, the need for things like a pain clinic would drop down to 20%, something like that, of what it is now. I think that the phenomena that you have described of clinics folding and so forth -- there are a lot of reasons for that. One of course is that some of them don't know what they're doing. It's a complex process.

One has to learn how to do it and it's not just learn the rules, read a book -- it's easy enough to describe -- but let it be viable, and this is where John Loeser, I might say, has made such an important contribution. John has been unusually gifted in getting diverse people to work together. Sometimes he has to swing a mallet to get it, and he can swing a mallet too, but it's not just that. So I think that's part of it, that the process -- clinics vary in the effectiveness with which they perform.

I think another part of the process is, and I think this is particularly true in Southern California -- the payment system is changing. And you have this unholy alliance of attorneys and physicians and insurance companies in varying combinations that are, by their actions, trying to maintain a status quo that is too expensive. And so again maybe Hillary [Clinton] can come to the rescue, but we're just going to have to see. I don't have a question in my mind that appropriately selected patients going through an appropriately designed program can be led to a very different place from where they were when they came in. I've just, we've seen too many cases -- and if anyone wants to dispute that, they haven't had a chance to observe enough what's going on. Joan Romano [Department of Psychiatry, University of Washington] was telling me the other day -- I was asking her as she was just coming off the inpatient cycle in the treatment program. I said, "How'd it go?" and she said, "Well, I just discharged two miracles," and she was beaming from ear to ear. And it happened.

LIEBESKIND: Well, kind of an allied question would be your own approach, you know -- is that moving forward? Is it gaining strength? Are people accepting it more and more or is resistance increasing? What do you see as the future? What's going to be ten years from now, twenty years from now, with this approach?

FORDYCE: Where the society in which it's imbedded is reasonably open, and by that I mean not only the health care practitioners but also the third-party payers -- it's expanding. Sweden is a classic example of this. They now have a nucleus of these programs around the country and they are just cost-effective in every sense of the word. In the UK it's expanding very rapidly and apparently -- we have a young psychologist visiting us from the UK now, Nick Ambler [now at the Frenchay Healthcare Trust in Bristol] -- and he said it's just really taking off.

LIEBESKIND: Isn't that kind of a bottom line, that if you can show the cost-effectiveness of a program at this time when not only Hillary and the United States, but every other country is faced with these rising costs and problems with disability and so forth. That would be a very deciding factor politically, if you could show that.

FORDYCE: It would be an influential factor. I don't know if I would say deciding factor, because I don't think these decisions are made particularly on how well it works. That's necessary but it's not sufficient.

LIEBESKIND: There are other interests at stake, and so forth.

FORDYCE: I know of a program in the Netherlands that is very well-done. I know the people involved and it's really very well-done. But the medical community says "No," they want to

maintain the status quo and they use all kinds of elaborate rationalizations, but people are really struggling to survive just because of that.

LIEBESKIND: One of the so many wonderful quotes that you have made that I have borrowed and used so much, crediting you when I think of it, is that information is a low-grade way to change behavior. I've become so impressed with -- in the days when we were trying to get this International Pain Foundation off the ground -- with, we stand for education about pain, but mere information transmission is not what that educational issue is all about. The issue is attitude change, prejudice, I mean, you talk about these doctors in Holland, the Netherlands, who won't have anything, they won't let their eyes convince them of what's going on. What's the solution to that -- I mean, this is more your brand of psychology than mine, although not your brand either, from social psychology -- what do we know about how to change attitudes -- is it an intractable problem?

FORDYCE: Let me go to this pain in the workplace -- PIW [Pain in the Workplace study] thing that I've been working on for about four-plus years now. It's sort of all consuming -- it's a tiger by the tail who's going to swallow me up and so forth, although I hope to finish in a few weeks. But one of the things that we've found out of this -- and it's management of disability, in terms of what should be changed -- and I guess two things that I would say. The rest of the group hasn't signed off on everything I've said yet, so don't hold them responsible for where I am about this yet. They'll have a crack at it.

But two things that I believe are the most important here about chronic low back pain, is, number one, to keep the health care system out of it as much as possible, and there are some fascinating data from Michigan that just came out in May, where industries, if they do some things in the plant -- I don't mean ergonomics, not that -- in fact, their data suggest that ergonomics, if you get very sophisticated about that, tends to make the problem a little worse. And what that addresses is not that ergonomics is wrong, but that the problem isn't pain. So they're hitting one target when the other one is the one that counts. So keeping the health care system out, doing some things in the plant and places like that, before the person ever gets in the front door of the health care system -- that's probably the most powerful cost-effective thing.

Then, of those who do go to the door, and some should come to the door, of those who do go to the door, set the rules, and I emphasize that word rules, set the rules up that the health care system has a time-limited period in which to do its thing. If it hasn't accomplished it by then, then the person, you've had your shot at it, now let's go at it a different way. So you change the rules. And so one of the things that will, I think and hope, come out of PIW is a set of policy changes. We've already got those fairly well articulated. But in support of that -- I had to lecture on this several times in the last few months, so I came up with a set of changed rules. I'm not sure how well I can do this on memory now, but one of them is that information is a low-power way of changing behavior, so if you're going to change things, don't rely just on information.

The second thing is that when you are analyzing that which needs changing, you have to use -- and now I go to a cliché I got from a former colleague -- the natural ecology of winners and losers. That, in any situation, some people are getting payoffs for this and some aren't. And you

have to find out what that is, who that is, and so forth, and address those issues. A third thing is that power corrupts, and of course absolute power corrupts absolutely, so if you are going to change by changing the rules --

LIEBESKIND: Who is going to be affected?

FORDYCE: Well, not only who is going to be affected, but you have to build in a sunset clause capability so that when you change the rules, you've got to follow along and say, okay, was this the right way to go, and is it being corrupted and what kinds of course corrections need to be made. And a fourth thing -- I got this from Jack Lean, who was our dean for continuing medical education years ago in another context, he has this slide in Latin -- Alf Nachemson and I were trading slides -- that's what we were talking about over dinner in Dana Point the other day -- and the slide reads in English, "When you have them by the balls, their hearts and minds will follow." And my point about that is that the way you make not just a physician, but the health care system, to shut down its persisting and repetitive interventions that no longer work is to change the rules. You don't educate them, you don't give them information -- I mean that's nice, and you want to do that, and its great stuff, but don't rely on it -- but you have to change the rules. But you have to be very careful if you change the rules. Power corrupts, and if somebody is going to set the rules, that somebody is not going to be pure forever, even if he's wise. He or she.

LIEBESKIND: Those are great, those are very, very good. All right, let me see where we are in my list of ideas here, my list of questions. I don't know if you want to tackle this one, this one could take us for a few hours: From your point of view, what do you consider to be the most important or influential ideas in the field of pain -- those ideas that have most changed how we think about pain or how we deal with it clinically? Now here I'm asking you to go beyond your own ideas, but to look at other people's ideas and see what's moved the field, what are the really important ones?

FORDYCE: That's a tough and very complex question. I could nibble at the edges of it, but I don't feel like what I have to say by any means works the problem as well as it ought to be worked. Forgive me for being sort of trite about this, but I think that the ideas behind the gate control theory and the part of that that I want to seize upon particularly is the idea that the organism has a capability for influencing what happens in the presence of an adversity stimulant.

LIEBESKIND: Modulations.

FORDYCE: That's right. I think that is tremendously important, and I would say almost apologetically that when we started on the behavioral stuff, yes, I had read about the gate-control theory, but I couldn't bridge that over to what we were doing. That came a few years down the road. "Oh yes, by the way!"

LIEBESKIND: Now that I think about it --

FORDYCE: But anyway, I think that has been terribly important. I think the appreciation which has gradually evolved -- I think we contributed to it and others have contributed to it -- on the

distinction between acute and chronic pain. I think there are at least two ways that that is important -- one of course is that once it becomes chronic, the effects from the environment become ever more important. But I think also the plasticity of the nervous system, what's the influence on the wiring.

LIEBESKIND: Which we are seeing a lot of work being done on now.

FORDYCE: That's right. And I think that's only really, as you would know better than I would, it's only really begun. And I might add on that, that it seems to me one of the critical things is, okay, if repetitive nociceptive stimuli produce these kinds of changes in the transmission system both ways, then what are the circumstances under which that can in effect be unchanged? As far as I know, relatively little has been done on that in a way that applies clinically. I don't know what else to say about that.

LIEBESKIND: Well, that's fine. What are the traits in a scientist or a clinician that you personally most esteem, as you look around at others in the field?

FORDYCE: Run that by again, I'm not sure.

LIEBESKIND: What are the traits in a clinician or in a scientist that you most esteem as you look at your colleagues -- what are the ones you esteem the most, what is it about them that earns your greatest respect?

FORDYCE: Well, I'll tell you what I like to characterize as my value system. I'm not sure that my behavior meets that value system very well, but I first heard it from Don Baer [Donald M. Baer (1931-2002), Roberts Distinguished Professor of Human Development and Family Life at the University of Kansas] -- I'm sure it wasn't original with him -- what's the definition of a scientist? A connoisseur of proof. I think that one of the most highly valued things in our world is that some people can learn to sort out what's the truth. Truth is not the right word, of course, but I think I'm communicating all right. I think that the ability to change directions is extremely important.

I think quickly of Alf Nachemson; when I first knew Alf, the world of back pain was a function of the biomechanical pressure on the spine. And indeed I want to tell you a story about this -- forgive me if I've told you before -- Stan Bigos told me that he was sitting in the audience when he first heard this and Alf was lecturing -- Alf said -- and when Alf lectures he is very assertive - - and he said something like this: "For twenty years I have been going around the world insisting that if you wanted to understand back pain, you had to understand BIOMECHANICS" - - long pause -- "I was wrong." [They laugh] "If you want to understand back pain, you must understand PSYCHOLOGY." And he can make that change.

LIEBESKIND: Where did he get that? Did he read it from your work?

FORDYCE: Yeah, here. And he's gone a hundred and eighty degrees -- not many people can do that. That's a very difficult thing to do, to let go. One of my analyst's clichés is, one of life's

most difficult tasks is to learn that what you know to be true is not. That's really tough. And that's what we're talking about here.

LIEBESKIND: That's great. That's very poignant, and you can see where that's been an important signpost for you -- you say, well, this is your value system and you're not so sure how much it characterizes your behavior, but actually it does characterize your behavior very nicely, because you yourself have been through this.

FORDYCE: Well, it took a few years, but I try to do that as best one can. But the number of times you get caught up in trying to hold onto something you know damn well isn't right!

LIEBESKIND: Well just a moment ago, when you were talking about changing the rules and built into that, that power corrupts and you have to have change, future change built in.

FORDYCE: That's right.

LIEBESKIND: Well, the next question may be silly in view of the preceding, but what are the faults, flaws or weaknesses in scientists or clinicians that concern you the most, that disturb you the most? Maybe it's just the absence of what you said, but are there other issues too that when you look around at colleagues in the field that sometimes concern you? You're a very positive sort of fellow, maybe you don't want to emphasize the negative, but can you make any comment on that?

[BREAK]

FORDYCE: You know, John, I went through analysis many years ago and so I had a lot of practice on free association. I'm sort of free-associating now. I don't have a clear set of answers. I have one thought that entered my mind, and that is I think all of us, and certainly professionals and clinicians, tend to engage in a kind of masturbation. I'm not talking about self-stimulation sexually, but self-stimulation in other ways. I do it all the time with my computer. I play with the computer for the sake of using the computer, as much as for doing that which I'm trying to accomplish with it. I think any number of us professionally will do that and I see this in myself and I see it in others. I guess it's not so much that I feel badly about it, but I'm impressed with how much time and energy --

LIEBESKIND: It's called play behavior.

FORDYCE: Yeah, right. Except we're charging people for it and allegedly, not always, we're trying to solve problems.

LIEBESKIND: Well, probably. Maybe you're speaking of self-delusion, because presumably these people who do this for a living and who charge people for it think they're doing something at some level that's beneficial.

FORDYCE: That's one aspect of that that indeed happens.

LIEBESKIND: All right. Do you have any particular favorite examples of blind alleys in the field of pain that we've gone down? You know, one of the things that's impressed me is the faddishness of science, and for a period of time, this is the hottest topic and everyone's doing it, and then it's not as if the problem gets all solved and, well, we finished that and can put an X through it, let's move on to the next one. I don't know, sometimes I think at the end of having worked on something like that for five or ten years, the field kind of leaves it but not necessarily better off than the way it found it. Are there things like that that you would point to?

FORDYCE: Speaking personally/professionally, I think the closest thing to a blind alley, that I poured the most effort, into has to do with what they now call cognitive remediation. That has always been an interest of mine and antedated my involvement with pain. I had two or three papers on that and so on and so forth. I spent quite a bit of time thinking about it and reading about it and trying some things out clinically and so forth. My older son, who's a psychologist --

LIEBESKIND: Oh really?

FORDYCE: A neuropsychologist.

LIEBESKIND: Is that right?

FORDYCE: He headed up the cognitive remediation program at one of the major private hospitals here in the city; and about a year or two years ago he said, "This is not getting anywhere." So he was able to bring about a shift in assignments to get away from it.

LIEBESKIND: He has a gene from his dad that permits him to make a paradigmatic shift in his thinking.

FORDYCE: So I certainly think of that. I'm sure there were lots of other things, but that's what comes to mind.

LIEBESKIND: Now I want to get back to where we started, before we even turned on the machine, which was the question we were addressing in the car coming over, of who else I should interview. It was in that context that you've mentioned this fellow Rick Deyo [Professor of Medicine and Health Services Research at the University of Washington].

FORDYCE: Yes. I think that the BOAT -- Back Outcome Assessment Team is what the program is called, which Rick heads -- and John [Loeser] says that he has had more fun with the research and relationship with BOAT than anything he's ever done.

LIEBESKIND: Give me the acronym again.

FORDYCE: Back Outcome Assessment Team -- BOAT -- which is one of the seven POATs -- Program Outcomes Assessment Team [BOAT was actually the Back Pain Patient Outcomes Assessment Team, one of several multidisciplinary PORTs -- Patient Outcomes Research Teams -- funded by the U. S. Agency for Healthcare Policy and Research (now the Agency for Healthcare Research and Quality) in the 1990s] -- I have known what the other six were, but I

don't remember them all. I would certainly think that the BOAT group -- and Rick more than anyone else clearly deserves the major share of the credit, the big share of the credit -- it has been one of the most productive, wise, helpful, contributory things that I know about in this domain that we're talking about. So I would certainly encourage you to --

LIEBESKIND: So you focused in the car on this fellow himself on his own -- he's bright and productive. But what's the idea behind it, that you see as key here? That it is focused on the topic of outcome?

FORDYCE: He is applying to a number of strategies of the health care system which are conventional wisdom, and in effect asking, is it really so? That's what they're doing.

LIEBESKIND: Assessing treatment approaches and asking, did they really work.

FORDYCE: Judy [Turner], as I'm sure you know -- she's been very active in this -- Judy is particularly good at detailed macroanalyses. It would drive me bonkers to go through the things that she can take and dissect, but she does it. She has the persistence of Job, and so forth, so that her work with Rick, and with others also, is representative. They have challenged from a scientific methodology connoisseur of truth perspective, what really works and what doesn't. I was mentioning the fusion business [The BOAT research showed that spinal fusion was not more efficacious for back pain than other less expensive and less risky surgical procedures]. He presented that -- this is all hearsay --he presented that at an orthopedists' meeting in Texas. There is a group of orthopedists in Texas, Dallas and San Antonio, who are very active and involved in putting on continuing education things about this. So they had Rick down for one of their things and he presented on the fusion bit. Of course this was greeted with less than enthusiasm. This one fellow, whom I shall not name, apparently got to his feet and was just incensed, vituperative -- if you don't like the message, shoot the messenger sort of thing. And when he finished, I'm also told, that Rick got up and very calmly, very quietly --

LIEBESKIND: Took him apart.

FORDYCE: Yeah. And that was the fellow who Alf was telling us at Dana Point -- that they had a meeting there and he got up and he was describing Rick Deyo as the "devil Satan" or whatever it is -- what the Ayatollah used to say -- I never remember the phrasing of it. So when Alf told me this -- he had just flown in from there, that's why he was so hung over with jet lag -- and when he told me this, I said, "I'll tell Rick when I get back." He said, "Don't you dare. I'm going to tell him." So Rick is a luminary, I think, and a very competent one. I think another person, of the young psychologists I know in the world, would be Mark Jensen [Professor of Rehabilitation Medicine at the University of Washington].

LIEBESKIND: Yes, if I'm not mistaken, the APS is recognizing Mark, this year.

FORDYCE: That's right, he's the Young Investigator award this year.

LIEBESKIND: I think John Reeves is head of that committee. That's great.

FORDYCE: I don't know if you want to go into that, but I'll be very surprised five years hence if Mark's name isn't up on the marquee somewhere. He's very able and very productive. Incredible things.

LIEBESKIND: Well it looks like I'm going to have to make another trip or two back to Seattle. I wanted to go all around the world, I don't want to just do this up here.

FORDYCE: Well, this is the world, John. I don't know why you'd want to go anywhere else, except for Lower Slaughter [town in England with a country house hotel where Liebeskind and Fordyce had stayed for a meeting]. This Mark Jensen, he got this bright idea and when I heard about it, I thought, "Why didn't I think of this?" He collected from this TV program, "America's Funniest Videos" -- he pulled together some vignettes that apparently are super-hilarious, and then he has been showing this to groups of chronic suffering back pain patients. I don't know what all he's doing about that; but two of the things he is doing are -- one, he gets a before and after, how much are you hurting, how's your pain, and how much are you suffering. It shows no difference in the pain, but a very marked difference in the suffering.

LIEBESKIND: That's wonderful.

FORDYCE: Yeah. And those data are just coming off the line.

LIEBESKIND: Norman Cousins [Cousins (1912-90), was a well-known American writer, editor, and promoter of holistic healing and the power of laughter] must be turning over in his grave. He would love this.

FORDYCE: That's right. And Mark will tell you that's where he got his idea. I don't know.

LIEBESKIND: Worldwide --

FORDYCE: Oh, Gordon Waddell.

LIEBESKIND: Tell me about him now.

FORDYCE: Gordon Waddell is a young orthopedist -- he must be in his middle to late forties now -- he recently, just early this spring, got his doctorate in science from Glasgow, so he has both his various degrees in orthopedics and he has a doctor of science. And he and his colleagues have been prodigiously productive -- I've got, on this PIW [Pain in the Workplace study], he worked with me on that, I've got some papers that haven't been published yet that are just marvelous work. So I would think of the people outside the country, Alf and Gordon, of the two that I know.

LIEBESKIND: I think Waddell spoke at a recent APS meeting, wasn't he?

FORDYCE: He spoke in San Diego. He talked about the history of back pain.

LIEBESKIND: At Burroughs-Wellcome [a pharmaceutical company, now Glaxo-Wellcome, that sponsors medical education events], or one of those things, whatever it is.

FORDYCE: A couple of years ago -- he's on the advisory board for the BOAT, Rick Deyo's thing, and I was taking Alf and Gordon out to the airport after meetings. Gordon was saying, "I don't think I should stay where I am academically, I mean, orthopedics. I don't do surgery and I don't think it ought to be used very often, and I feel like I'm now a foreigner or a traitor to my own group, and I'm considering moving over to rehab medicine." I thought it, but Alf said it before I did: "Don't do it." He said, "If you stay there, then you have a chance to have impact. But once you move over, you lose much of that."

LIEBESKIND: You'll just be cut off.

FORDYCE: Yeah. And that's what he's chosen to do.

LIEBESKIND: Reflecting on all the things we've said, it sounds like that's really one of the great areas of need that we have here in 1993, is to try and have an impact on these orthopedists. I mean, there are a lot of them, they've got the wrong idea, they are interested in pain and they're going about it the wrong way, and we have not had much of a dent there. Obviously anesthesiology has been greatly influenced by the revolution in pain, but orthopedics has not.

FORDYCE: I don't perceive it that way. Why do you say that, that the anesthesiologists have been influenced that much?

LIEBESKIND: Well, there are so many of them who are trained in, have some training in pain. They're the largest group in any of these pain organizations, IASP or APS -- maybe your view would be that that represents only a very small fraction of the total, is that what you're saying?

FORDYCE: No, the point I'm making is, okay, they have this training and this certification, but what is it they do?

LIEBESKIND: I see.

FORDYCE: And I would suggest to you that in clinical practice -- John Loeser and I and John Bonica were with Jack [John S.] McDonald [now chairman of the department of anesthesiology at Harbor-UCLA Medical Center in Torrance, California] on Maui [Hawaii] on the first of April, and it was an impressive thing to me to hear those lectures that they gave.

LIEBESKIND: The anesthesiologists?

FORDYCE: Yes. And they're not where John and I are. They hear us and they are very friendly to us and they invite us to their meetings and all that sort of stuff, but --

LIEBESKIND: They're not listening.

FORDYCE: They're not listening.

LIEBESKIND: Yeah, you know, I was at UC Davis not too long ago to give a talk in anesthesiology and a young fellow met me at the airport and brought me in and so forth -- Brian Tsang -- had been at UCLA and had had a class with me, and then gone on to medical school and anesthesiology and so forth. I was very happy that he credited me with personally getting him interested in the field of pain. He confided in me that he was very disturbed at what was going on in his own department, in his own institution, because he felt that he understood that you needed to take time and apply the interdisciplinary approach and bring in psychologists and so forth to the management of pain; but that the economics of the situation wouldn't permit that, and he was faced with having to do procedures, nerve blocks, in circumstances that he didn't really think they were warranted, where he felt they wouldn't do any good. He recognized that, but he felt that his hands were tied -- he was a young man, he's an assistant professor, you know, he has to make a certain amount of money, bring in money to the department. And he didn't know what to do. And I didn't know what to tell him. [Brian K. Tsang is now in the Department of Anesthesiology at the University of Mississippi.]

FORDYCE: That's the same position Gordon Waddell was in. His department expects him to generate revenue and the way you generate revenue -- John Loeser is in the same situation. And so you make the money by doing surgery, but that doesn't necessarily reflect -- and let me say, in defense of John, the surgery he does is not pain surgery, but in Gordon's case it was much more conflicting, because most of that was [for] back pain.

LIEBESKIND: Well, I think it's bad enough when you're at the stage of someone like John Loeser who is, after all, a very senior guy and so forth, but when you are a beginning faculty member, he must be under a lot of pressure. You can see where that's a major problem. What are we going to do about that? How are we going to change all that? You know, it's going back to the same issue again.

FORDYCE: Well, and forgive me for being stuck on this, but I say again, information is a low-power way of changing behavior. We're not going to change it by educating --

LIEBESKIND: Giving lectures in Maui.

FORDYCE: Yeah, lectures in Maui or lectures at the University of Washington or UCLA. That's helpful and it sort of maybe legitimates some ideas, so that then as things go on, people are more likely to buy into them, but it won't change their behavior. Are you familiar with this study that was done on the NIH consensus conferences?

LIEBESKIND: No.

FORDYCE: They had one a few years ago on cesarean section. And the conclusion was that cesarean section is highly overused and not very often indicated -- that's a rough statement of it. So this very smart fellow, a year or so after the session, decided he'd try to see what effect it had. So he went to, I believe it was Chicago -- I've not read this, it's all hearsay -- and as I understand it, what he did was he got a pool of OB/GYN people and the questions were something like this: "Do you do cesarean sections?" "Yes." "Are you aware of this NIH conference?" "Yes." "Are

you aware of the conclusions?" "Yes." "Do you agree with the conclusions?" "Yes." "What changes have there been in your practice?" "None." I'm exaggerating.

LIEBESKIND: Sure, sure, I understand, exactly.

WILBERT E. FORDYCE INTERVIEW

TAPE TWO, SIDE TWO

FORDYCE: These orthopedists had me and Alf and who knows all, to lecture to them, but it didn't change what they did.

LIEBESKIND: Let me put it in practical terms. We're talking here theoretically and there will be a wonderful book someday somebody will write about the history of ideas and so forth and so on. Great. Right now there's a foundation that's gotten started called the Mayday Fund. I don't know if you've heard about them. It's very recent, within the last couple of years -- it's a private foundation, they're fully endowed and they're not going out looking for money, they've got all the money they're going to get from some woman who died and gave them money, and her children have set up this fund. Very wisely they have decided to focus on, to use their phrase, filling the gap between current knowledge and current practice in the area of pain.

FORDYCE: Is that right?

LIEBESKIND: That is exactly right.

FORDYCE: For heaven's sake.

LIEBESKIND: In fact, if you're interested, I think I have a brochure of theirs that I was going to give to Louisa, but I've got another one. I'll leave it with you.

FORDYCE: I'd like to see it.

LIEBESKIND: All right. They're starting to really look into this. When I read this, I got shivers -- because this is what we wanted to do with the IPF and now, I don't know if you've heard -- there's some talk we're going to start something like this for the American Pain Society, and of course we're going about it the other way, we're starting something, we don't have any money, how can we get the money? This whole issue of, there's a problem out there -- a few people know what to do about it, most people don't, how are we going to -- and they ask questions like, what are the factors that are limiting our ability to fill this gap? And you, more than anyone I know, can identify what these factors are. You know, we've been talking about it. Now they've got some money and they want to spend some money on figuring out how to overcome those factors. So if there are attitudes that need changing, they want to know how are we going to go about doing that?

FORDYCE: This veers a little bit from the track, but I want to say it, if nothing else to hear myself say it to embed it in my memory a little better. It seems to me that if ever there was a marriage to be made in heaven, it would be with the mission of which the PIW IASP task force has been working on, but which will end with this report and what they want to do. The last chapter of our report, or the next to the last, not the last, will be on specific proposals for change. I was telling you about the laws of change -- that's part of that.

LIEBESKIND: I'm very eager to read that and see exactly what you're talking about there.

FORDYCE: Well, hopefully -- I don't think it's going to be *finished* finished by [the 7th World Congress on Pain in 1993 in] Paris, but the substance of it -- and Gordon Waddell and Joel Seres [professor of neurosurgery at the Oregon Health Sciences Center] and I will be making a presentation in Paris about that. But I think that I now believe it to be the case that, insofar as change will occur, it will occur because the rules have changed, and not because of persuasion or information.

LIEBESKIND: All right, well then -- how do you change the rules?

FORDYCE: I assume you are asking me not about what rules to change, but the process of changing them.

LIEBESKIND: Yeah, I mean once you've identified what the rules are and what they need to be changed to, how do you do that?

FORDYCE: In this state, you know this pain cocktail business has been going on now for 25 years or 20 years, and for easily the first half of that and more, it was almost impossible to see any discernible effect on how analgesics were handled out in the community with chronic pain. A little bit. Then, I don't even know who it was, somebody in the State Medical Licensing Board or more than one person, became persuaded that there was just no justification for prescribing big-league analgesics to chronic back pain after six months, unless one could document or somehow certify the need for it. So they brought into being a medical licensing board -- changed the rules. And they said that if -- now the computer capability makes it possible to do this, they keep records now of prescribing practices -- and if your prescribing practices indicate the use of analgesics with chronic low back pain after six months, you're going to lose your license.

LIEBESKIND: That'll change.

FORDYCE: And two things happened that I know about. One is that we and other pain clinics, but we certainly, received a flood of referrals, a big upsurge. And what these were -- they'd come couched in various phraseology, but basically what they were, was a physician was saying, "I'm going to get racked if I keep on doing this. If you give me your Good Housekeeping stamp of approval or tell me what to do instead of that, I'd be happy to listen." And so that's what we were really doing.

LIEBESKIND: Are they sending you their patients because they can't prescribe anymore?

FORDYCE: They're sending me their patients, that's right. "I have this fellow and he's still suffering, so tell me what to do. And meanwhile take me off the hook with the licensing board." So that was one thing that happened. The other was apparently, and I don't know the hard numbers on it -- John probably does -- apparently the use of long-term narcotics for chronic pain has plummeted in this state.

LIEBESKIND: This is the state of Washington.

FORDYCE: State of Washington -- state licensing board. And they changed the rules.

LIEBESKIND: Now I guess the answer here is you don't know how that exactly happened.

FORDYCE: Not exactly. John may be able to tell you more about that than I can.

LIEBESKIND: Was there any pressure from anyone that you know? Did you or John Loeser -- I mean, do you even know who the person was?

FORDYCE: I don't know who the person was.

LIEBESKIND: But apparently there was one person who did this?

FORDYCE: I can't tell you that. I understand the question, but I don't really have enough information. I can say that I was in a position for several years to have the ear of the Workman's Comp program and the director of it, Joe Deare, who's now dead, but he was really a great guy and a very sharp -- he's a former organized labor lobbyist attorney, a neat guy. When Joe was in charge -- you know, we've got to change this -- and so then radical changes were undertaken. He was listening, not only to me, but he was certainly listening to me too. You get somebody in a pivotal position, then that can do it. But it's like, you already know a committee's not going to do anything, you know that -- somebody does something and then the committee comes along or they don't, as the case may be. So I think those are the kinds of things that have to happen.

LIEBESKIND: So there's not a good systematic way to insure that these changes are going to occur, but you have to try and take advantage of opportunities, when you do know people who are in a position to make those changes, of influencing them.

FORDYCE: I would say, if this Foundation, if I were ever interested in getting a grant and starting a program to do something, what I would do would be to try to generate consumer demand for the change. And right now the injured worker is getting screwed by the way it works, and the employer is getting screwed, but they don't know what to do about it.

LIEBESKIND: Do they even know they're getting screwed?

FORDYCE: Well I don't think the worker does. The employer does, but they're not quite sure what's the alternative, and so forth, so I would start trying to generate consumer demand, particularly with organized labor, try to get them to realize, as they have done somewhat in Sweden, get them to realize that, if you don't change what you're doing, you're going to screw yourself.

LIEBESKIND: You know, it sounds so logical and it seems so obvious -- here's this whole insurance industry out there. I mean, I don't understand enough of the economics, but there's an awful lot of money being spent by insurance companies to reimburse, you know, and so forth.

So if there were treatment approaches which would get these guys off their books -- why wouldn't they be begging for that?

FORDYCE: But who is it who benefits? If it becomes much more effective, the bureaucrats who are the operators of all of this, they don't benefit. It's the person who pays the premiums who benefits.

LIEBESKIND: I see. So the insurance company doesn't benefit. They just raise the premium -- the higher their costs, the higher their --

FORDYCE: They are a cost-plus utility. And if they lay out more in benefits during a given year than they take in in premiums, they don't go broke, they raise the premium. And they continue to take off their administrative skim, ten percent or whatever it is, and ten percent of twenty million is more than ten percent of eighteen million. And so I was impressed -- years ago I had this naive notion, boy, you know, well, now we've got a way to change the world, let's change it! And so I tried to call meetings and get together with insurance companies -- they'd never show up. They'd say, "Oh, yes, that's a marvelous idea." I'd say, "Okay, let's get together for lunch Wednesday." "Let's see, I can't do it that day..." -- and that sort of thing would happen.

LIEBESKIND: So it's people, it's not the industry, it's private people.

FORDYCE: Remember I had mentioned earlier the natural ecology of winners and losers, and that's what you want to find out. Who's losing by the status quo. If you can generate consumer demand, as I'm calling it, from the losers, then you have a much greater chance of changing things.

LIEBESKIND: Well that's the toughest nut of all to crack. There are so many of them and there are so many of us people and it's a hard message to get across.

FORDYCE: Well, John, there's a case in point about that. We used to, and I've been involved in this myself, used to try to get an insurance company or an organization of insurance companies to listen to this. So you write them letters and you call them and so forth. And apparently what happens is that the senior vice president or whatever it is of the insurance company says, "Here's this guy, this psychologist from Seattle, who thinks he's discovered the wheel or something, and he wants to get together with us -- is it worth my while to talk to him?" So they ask the company doc -- "What's this?" "It's a lot of baloney, this is that muddle-headed psychology stuff, he's just blowing smoke."

LIEBESKIND: So the company doc can really screw this up.

FORDYCE: Oh yeah -- they've got the fox guarding the hen coop. And sometimes that's with malicious intent; usually it's not. It's just that they've got a set of convictions about, this is the way the world looks and if somebody says it's different from that, they don't --

LIEBESKIND: So again it has to do with rules changes and maybe with all this new health cost containment programs and so forth, maybe it'll come out of that. I mean, now you're talking about the federal government and state governments and so forth, having to reduce these costs, maybe that will focus attention. Do you feel some optimism in the current climate that this may happen?

FORDYCE: Well, it's going to be a matter of timing. I think it's going to be extremely difficult to get Congress to change -- they've got so many vested interests in the status quo, so many of them have, but I think early in the Clinton administration, when there's sort of a state of flux in our society about things, it might be a good opportunity, but by the time the ossification begins to set in two or three years down the road, it's going to be much tougher. John, the HMO concept -- you're familiar with that -- HMO was put together by this Paul Elwood I mentioned earlier, and some of his colleagues. They went to the White House when [President Richard] Nixon was in the White House, and they needed to get him to sign off on something or other -- I don't know the details of the paperwork, but Elwood told me this. And they got there and they had an appointment with Nixon -- you know, four o'clock on a Friday afternoon or whatever it was -- and they got there for the appointment and Nixon had been called away. But John Ehrlichman [Ehrlichman (1925-99) was Nixon's top domestic affairs advisor], and you'll recognize that name, was tending the store. And in addition to a lot of other things, Ehrlichman is a very bright guy. And so Paul said they laid this number onto Ehrlichman -- Nixon was gone -- and Ehrlichman said, "I think this is a good idea," and he signed Nixon's name to it. And so HMO got this quantum leap of support on the basis of Nixon having been called out of the office.

LIEBESKIND: Nixon's signature that he didn't provide. That's incredible.

FORDYCE: And I think things like that --

LIEBESKIND: Well, at some point, I'd really like you to be in touch with this Mayday Fund. I'm going to mention -- I'm going to be in touch with the executive director soon. We're having a meeting in Los Angeles, actually, at the end of this month, that Hugh Rosomoff [surgeon and rehabilitation specialist, Director of the Rosomoff Comprehensive Pain Center in Miami, Florida, APS President 1992-93], as APS President, has commissioned, that we should start thinking about whether we really want to produce an American Pain Foundation, and I invited her to that meeting and she's coming. This woman, I'm sorry, is the executive director of the Mayday Fund. Her name is Fenella Rouse -- she's English, and she's an attorney and she has a prior background in not-for-profit work, and she is running the Mayday fund. She's going to come out and talk to us about whether we should or should not have an American Pain Foundation [the American Pain Foundation was eventually established in 1997].

FORDYCE: To that particular mission, of what are you going to change between what's known and what's done in health care delivery in this domain of pain, I would be enormously pessimistic that APS would -- because there are so many vested interests -- I'm sure there are more than a handful of people in APS who would be extraordinarily qualified and interested and so forth. But, boy, they'd sure be paddling upstream.

LIEBESKIND: Well, it's going to be very interesting to see what happens, with this Mayday Fund.

FORDYCE: It sure is. John [Loeser] has asked me -- in one of the reports, in my report about PIW to the Council -- I talked a little bit about where might IASP go after this, and I don't remember just what I said then, but certainly this conversation we're having now would help me to think through that there really ought to be some sort of an effort at -- I'll call it implementation, but it's not really lobbying a state legislature to change. That's okay, and that should be done. But sort out just what are the strategies of change.

LIEBESKIND: Well, obviously these are very thorny problems and you take anything where their attitudes are getting in the way -- what makes information such a low-grade means of changing behavior, it's preconception, preconceived attitudes, or people don't hear. The information strikes the tympanic membrane but it bounces off.

FORDYCE: I think that's true, John, and I also think that another thing that is worth mentioning is that, what we do is sensitive to the consequences, and never mind what we think about it, it's still sensitive to the consequences, and that has a piece of the action too.

LIEBESKIND: I'm not sure I understand that. Run that one again?

FORDYCE: Okay. Nerve blocks and anesthesiologists. You know, there's plenty of information to indicate that for chronic pain, nerve blocks are playing games. But that keeps going on with bright people, smart people who study and read the literature and so on; but when they get right in there in that foxhole and there's that needle and there's that body, why that's an operant, you know, and their strategies are influenced by that.

LIEBESKIND: Yeah, I was just going to say, the world of pain is not the only world that faces this problem.

FORDYCE: Absolutely.

LIEBESKIND: There are things like racial prejudice -- we have problems like that. It's very hard to disabuse people of their prejudices.

FORDYCE: Well, look what we're doing about smoking. We had all this information out there for all these years. But change the rules -- there are more and more nonsmoking areas enforced if you're a smoker.

LIEBESKIND: It will be the same presumably with handgun control.

FORDYCE: One hopes.

LIEBESKIND: Hopefully, we'll maybe have some places where it's not legal to bring a gun, and just spread these out, until it involves everything.

FORDYCE: That's right. We make this -- it seems incredible, but we make this assumption that if people just have the information, that dictates what they -- and it's just not true.

LIEBESKIND: Education, well, lecturing, is an operant also.

FORDYCE: Sure, but you take, how do people learn arithmetic and, of course, now you're talking about a novel response. You don't have to compete with alternatives, and so then the social consequences are of less importance and the information is more, but once you get beyond that, it's a very different thing.

LIEBESKIND: Bill, do other people's names come to mind, as we look around? You mentioned Gordon and Alf and some of the younger people here. How about anyone else that strikes you that should be interviewed?

FORDYCE: Perhaps Dennis Turk [then Professor of Psychiatry at the University of Pittsburgh, Dennis Turk was named to the Bonica Professorship of Anesthesiology and Pain Research at the University of Washington in 1996; he served as APS President 2004-05]. In very recent weeks, particularly in relationship with this PIW thing, I've run across some issues and ideas and concepts and I think Dennis and his group, Tom Rudy [Professor of Anesthesiology and Psychiatry at Pittsburgh], they're doing some very interesting work.

LIEBESKIND: He's been very prolific over the years.

FORDYCE: Oh my gosh, unbelievable. And that might be somebody.

LIEBESKIND: That would be a very good idea. I think John Reeves suggested him too.

FORDYCE: Yeah. I think Chuck Berde [Director of Pain Treatment Services at Boston Children's Hospital] has been doing some interesting work with kids -- I don't know how well you know Chuck -- he's a bright guy.

LIEBESKIND: I've just met him once or twice.

FORDYCE: He's a bright guy and very articulate. That might be of interest. I don't know that it gets into the world of pain, but it gets into the world of suffering, and that's Eric Cassell [Clinical Professor of Public Health at Weill Medical College, Cornell University] -- have you met him at all?

LIEBESKIND: I heard him speak -- I think it was he -- his name came up a lot -- at this cancer pain meeting that they held.

FORDYCE: Dick Chapman [then at the University of Washington, C. Richard Chapman is now Professor of Anesthesiology at the University of Utah] and Kathy [Kathleen Foley, Professor of Neurology at Memorial Sloan-Kettering Cancer Center in New York]?

LIEBESKIND: Yeah. No, it was at M.D. Anderson [University of Texas Cancer Center] in Houston and they had some philosophers and ethicists and so forth speaking about the use of drugs and so forth, and I think Cassell was not there, but I think his name just came up a lot. I've seen reference to his work -- I haven't really read it.

FORDYCE: He's very bright and very articulate -- he's one who is not bound, tied up, by his ideas. He can take in things and use them in very effective ways. Very impressive guy.

LIEBESKIND: Where is he? Back East somewhere?

FORDYCE: He is a public health type at Cornell. His wife is Pat Owens -- she was the honcho of the Social Security Commission on pain a number of years ago when she was a Fed. She now works for insurance companies -- benefit payers for disability programs. They live in Brooklyn. I don't know how much -- I'm not sure what he does, how he spends his time, but if I were going to pick a handful of the wise people I've run across in my life, he'd certainly be one of them. And his ideas about suffering are very good.

LIEBESKIND: How about Mark Sullivan?

FORDYCE: Mark is a very bright guy and he has an unusual background -- as you know, he has a doctorate in philosophy as well as psychiatry. I don't know Mark nearly as well as John does. Mark has been feeling his way into the pain stuff and two of the factors which I think have influenced that are, number one, as a young faculty person he has to find a way of generating income, not only fee for service, but grant writing and so forth, and so he has to pick a horse that's going to be a winner in terms of grant writing. But also it gets into the area of psychiatry vs. psychology. And we psychologists have had a lock on that for fifteen or twenty years. I want you to know that, twice early in the history of this, psychiatry decided they wanted to try it. So they admitted patients to their wards and did one, and they asked me to come up and I spent many hours working with them -- this is the way you do this, this is the way you do this, and it didn't take. Their nurses couldn't turn it off; they were going to have noncontingent reinforcement. Then, about two years later, they tried it again and the same thing happened.

So anyway, it's not just that -- Fordyce as an individual -- I have lots of scars and stripes on my arm from my wars with psychiatry. But it wasn't that they were turning them out. Carl Eisdorfer -- I don't know if you know Carl -- he was first a PhD psychologist and then became a psychiatrist, and came here as chair of psychiatry [Eisdorfer left Washington in 1981, is now Professor of Psychiatry at the University of Miami in Florida]. And he came down to see me about the time he started in, something like that, and he was just sort of trying to build bridges and networking and so forth and that was fine. But I can remember so clearly at the time he was saying, "Well, I might try this, I might try that." I said, "Well, that's fine, but if you go down the pain route and decided you're going to go into the middle of the pain issue -- I'm going to be sitting right in the middle of the road." I don't know if that scares you -- I didn't say that -- "But at least I want you to know that's where I am." And he said, "No, I'll stay out of that."

So Mark has been feeling his way in. He's functioning not as a psychiatrist, but as an attending physician. And he's doing a good job of that -- not only in the sense of being an effective

attending physician, but as keeping clear in his mind what hat he's wearing. And I believe it to be the case -- Judy and others could tell you better, and as you know, Judy's married to a psychiatrist, a delightful guy, Chris -- they could tell you better than I could how he relates at the clinical level. But there's no question of what he's an interesting guy with a lot of interesting ideas; and he is one of those people whom I think is very flexible in his perspective.

LIEBESKIND: I was going to say -- I think he's breaking apart the mold in trying to do that. I suspect he's been very influenced by you, whether personally or through your writings.

FORDYCE: Some. He's a nice guy.

LIEBESKIND: What about Dame Cicely Saunders [b. 1918, founder of St. Christopher's Hospice in London and of the modern hospice movement]? Do you think that will be an interesting interview for me? Do you know her? I've never met her.

FORDYCE: I have. I was on a panel with her in London.

LIEBESKIND: What's she like?

FORDYCE: She is -- I'll go to a stereotype -- she is a high-powered social worker. She is a bright, articulate, dominating -- she'll never flunk an assertion training course -- not in an abrasive sense, but she's forceful. And she's an icon; you know, she's been fighting this battle single-handedly for years of the hospice program and so forth. I got into a debate with her; they set up a panel, she and I, and there was somebody else on the panel in London. And by my language -- I'll go back to Paul Meehl.

Meehl used to construct a continuum, and he published this in *American Psychologist* once back in the '50's. At one end is simple-minded, at the other end is muddle-headed. Simple-minded is somebody, a psychologist, who says: come in, take five pounds of tests, and then I'll tell you what to do with yourself. The muddle-headed -- I had a better example that I use -- I can't remember what Meehl used -- and that is when asked, an analyst, once when asked, "How do you know when an interpretation is correct or not?" And his answer was "I know because I know I know." That's muddle-headed.

LIEBESKIND: Can't prove any of them.

FORDYCE: Well, she's over on the muddle-headed side. And so she has a lot of ideas about what makes a difference in the lives of the people she is working with and those ideas I want to paraphrase, unfairly, I suspect, as "give them enough love". And so she takes that kind of a position -- stereotyping, I am -- with great force.

LIEBESKIND: Is her training in social work?

FORDYCE: I think she's a nurse. It might be in social work. I've forgotten.

LIEBESKIND: She's not an M.D.? [Saunders is in fact a doctor of medicine; she qualified earlier as a social worker and then as a nurse.]

FORDYCE: I don't believe so. I've got, way back in my files upstairs from twelve or fourteen years ago, I've got a program that probably tells, but I'm not sure. I would think it would be -- I'm sure she'll be interesting. And I'll bet she has some --

LIEBESKIND: Well, she's got a sick husband that she's tending, I gather, so, when I said, "Try to leave several hours and maybe a little longer," and she said, "Two hours will have to be the maximum," so she's containing this.

FORDYCE: Well, she's no kid -- I don't know how old she is, but she well could be well into her seventies, I'm not sure. It was in '81 or '82 that I was on this program with her and she was not a young lady then.

LIEBESKIND: I had the impression that her husband is terminally ill, he may himself have cancer or whatever, I don't know.

FORDYCE: Could be. Pat Wall could probably tell you more about that.

LIEBESKIND: As you reflect back on this interview, were there some questions that you felt were particularly good or that brought you out and brought out your thoughts? Some that you thought were useless? What other suggestions do you have for me about the interview process or the nature of these questions?

FORDYCE: As I perceive what you're up to with all this, in all of these interviews and so forth -- It seems to me that the greyheads in all of this -- if we're going to make a useful contribution, it will be to help the younger people perceive that it isn't all logic and good ideas and hard data and so forth. There are a lot of factors, a lot of forces at play in shaping what happens, and it's important to be mindful of that. So I think that you asked some questions that bear on that, and I think that's very useful. John, I don't think, quickly -- you know, ten minutes after we part company I'll probably think of six, but I don't think quickly of other things that --

LIEBESKIND: Is there an answer that you're dying to give to a question that I didn't ask? Have I missed something essential, Fordycean, that seems relevant?

FORDYCE: If that were to happen, it would be some smart-ass question, smart-ass comment, I should say. I will say this -- you didn't ask me, but years ago, and I don't even know now how it arose, but I formulated what I've come to call Fordyce's Law, which says that people who have something better to do don't suffer as much. And I think when I formulated that, I sort of thought in a very superficial way, yeah, that's probably okay. But as the years have gone by, I think, yeah, that's it.

LIEBESKIND: It's become central.

FORDYCE: What happens to people who are suffering depends so much on what else they have to do. So I'm proud of that.

LIEBESKIND: This has been a very generous allocation of time you've given me.

FORDYCE: I'm retired, John.

LIEBESKIND: I have a question about that. How has it changed your life, now that you're retired? Do you not go into work when you used to go into work, or are you doing a lot of what you used to do? What's happened to Bill Fordyce?

FORDYCE: Come back in April and ask me that. Of course, I've been caught up -- since the first of '88, I've been on this [the PIW project] forty percent. In my particular case -- it doesn't always work this way, but in my particular case it has been marvelously that I could decide how to spend the forty percent. In my clinical activities and obligations with the pain service, it didn't work for me to carry inpatient loads, which are the heaviest. The screening, I could do that standing on my head. So I have been able to decide what to do and when to do it and where to do it almost unfettered.

I have acted out a little bit about that, but, being caught up in the PIW stuff, I've been working a lot more than forty percent for the last five and a half years. And I'm still -- that's peaking now, since we met last fall here, and since the first of October I've been working every day -- I mean every day, seven days a week. I went fishing yesterday, I didn't work then, but almost without exception -- and that won't be over until -- I can see that I know I have to do this and this and this and then we'll be there, but I haven't done them yet. Hopefully it will be pretty well done by Paris and if not, I made it clear to John that I have no intention of disappearing after that. So that'll be done. And then I'll be much more faced with just what it is I want to do to keep me stimulated. I'm not very worried about it.

LIEBESKIND: I shouldn't think it would be something that would worry you a lot. You seem like the kind of person who has no problem in amusing himself intellectually.

FORDYCE: That's right. And I feel very strongly that it's important to disengage. It's important not only to me, but it's important -- Judy and the others will tell you -- I haven't been casting long shadows -- I've been stepping back -- they need to have room, too. And I feel that it's a personal conviction of mine. So I've been looking around. Retirement is something that's a skill like anything else -- you have to learn how to do it.

LIEBESKIND: How old are you now?

FORDYCE: I was seventy in January. I'm halfway to seventy-one.

LIEBESKIND: You're obviously still a young man intellectually, and your spirit and so forth, so there's no reason why you can't go on doing all kinds of fun things.

FORDYCE: We have a condo on Kauai [Hawaii] that we spend a couple of months at each year and we may start going over there more frequently, and the golf, and I love to play with that computer. I was talking about masturbation, well, I tell you, it's just scandalous now --I play with that thing just for the sake of playing with it. I try to do it with things that I want to do too, and need doing, and you know, computers, there's no limit. And I've been fortunate enough to get some hardware that works pretty well, so I'm having fun with that. And this place is a jungle here -- this house sits on land that is very rich and fertile sand, so we could spend our time full-time gardening. We hire a lot of it done now and will probably continue to do that.

LIEBESKIND: It's a real showplace, the view alone. Bill, thank you very much. This has been wonderful. I think, unless you have more you want to add, I'll turn off the tape.

FORDYCE: I don't have anything I want to add. I hope that I haven't bored you too much with this. I just love to have somebody to listen to me.

LIEBESKIND: It's been fascinating. I just think that I made one of the great decisions of my life by deciding to do this interviewing because I'm really enjoying it.

FORDYCE: And that, like the computers -- you can go on with this just as long as you want to.

LIEBESKIND: OK, it's ten after two, and the interview is over.

END OF INTERVIEW