Hundreds of physicians in private practice in St. Louis make up the clinical teaching faculty of the Washington University School of Medicine. Their role as unpaid teachers of medical students and of interns and residents in training at the Medical Center contributes vitally to the prominence of Washington University as a major center for life science teaching and research. Outside of the medical center, they lead busy other lives caring for patients in their offices. Some 75 percent of the persons cared for in the medical center's hospitals are patients of the clinical faculty.

**George Sato: Clinical Teacher**

By Dorothea Wolfram

Dr. George Sato is a St. Louis pediatrician. If one were to define a doctor's doctor, surely the definition would fit him, for he cares for or has cared for the children of a large percentage of the physicians in this vast city. In 1955, after graduating from Washington University School of Medicine and completing specialty training, he joined the office of Dr. Park White, one of the city's busiest and best-loved physicians. As Dr. White moved out of the practice, Dr. Sato took over a greater and greater part of the patient load and added patients of his own. Today, his practice covers several thousand families.

Dr. George Sato is also an unpaid teacher at Washington University School of Medicine, one of hundreds of private practitioners who make up the School's clinical teaching faculty. From this segment of the faculty, the third- and fourth-year medical students learn important things about how to care for patients, how to use the tools of their trade, and how to apply the foundation of medical knowledge built during the first two years in classroom and laboratory. Among this segment of the faculty, the interns and residents in specialty training find their teachers and models for careers as practicing physicians. With this segment of the faculty come about 75 percent of the patients treated at the medical center.

The division of the medical school faculty into full-time teaching and research professors and part-time clinical professors is not unique to Washington University, yet in medical schools across the country, this dichotomy is the exception rather than the rule. The full-time salaried model was developed at Johns Hopkins University School of Medicine in the 1900's and in the past quarter-century has been adopted, with variations, by a number of major hospital/research centers. It is not the model of state medical centers or of most independent universities. These generally adhere to some kind of "practice plan" in which faculty members receive a basic salary to teach and do research. In addition, they generate patients and income for themselves and their school through a part-time private practice.

Dr. Samuel Guze, vice chancellor for medical affairs, says that no one who understands the historical development of the Washington University Medical Center could fail to understand that the contribution of the part-time faculty is indispensable. "I am quite sure that today we could not be a national research center without their input. They free the full-time faculty from the burdens of practice, so that its time can be devoted to research.

"The full-time/part-time model has many pitfalls," he adds. "There is always tension between the staffs because their goals and perspectives are different, but it is a healthy tension. It keeps us aware that both viewpoints are vital for us. There are other tensions I would like to eliminate, however. These occur, I think, to the degree that professional life-styles overlap. If the interests of the full-time faculty member and the part-time faculty member are in doing the same thing, there is bound to be conflict. If, for instance, they are competing for patients, the full-time faculty member may envy the fuller practice and the better income of his clinical counterpart.

"In areas where we don't have this competition—in internal medicine, in psychiatry, in neurology, in obstetrics and gynecology, in pediatrics—I think the plan works smoothly. There is absolutely no question for me that even when the system doesn't work smoothly, it is worth working at, because everyone benefits from the diversity."

The role of the part-time faculty member differs greatly from department to department," says Dr. Philip Dodge, head of the Edward Mallinckrodt Department of Pediatrics and medical director of St. Louis Children's Hospital. "In pediatrics our roles are so complementary, we would have to work hard to generate significant discomfort. Our clinical faculty carries the load of caring for children with minor illnesses, preventive medicine, child development and helping parents to cope. Our full-time people are subspecialists who serve the part-time staff as consultants in many areas, including neurology, metabolism, nephrology, oncology, and cardiology. Everyone in the department works out his or her best world. George Sato represents one of the best in the world of the private pediatrician. He is
a physician who can see 100 or more patients a day and rarely, if ever, miss anything."

That final remark reflects two aspects of pediatrics with which Dr. Sato has made his own peace but which distress him as a pediatric practitioner. He wonders, often aloud, if his specialty is not a disappearing one. The responsibilities of the pediatrician have eroded as pediatric subspecialists have appeared, so that much of the challenge of the job appears to have been siphoned off.

"Given this fact, pediatrics seems to appeal little to the medical students of today," Dr. Sato said. "They ask me, 'Would you go into it again, if the decision were yours to make today?' I can't answer that satisfactorily for them. Pediatrics is all volume. It is the lowest paying of today's specialties. You keep fees low because you want parents to bring in well babies regularly. The students also say, 'But all a pediatrician ever really takes care of is runny noses.' I can't answer that satisfactorily either, except to say, 'Thank heaven.' Perhaps 85 percent of pediatrics is seeing healthy children, but it is the 15 percent that counts. If you had more than 15 sick kids to see a day, you couldn't deal with it. You'd get behind, be rushed, start making mistakes. You have to know. You can't treat the wrong kidney disease.

"I've been through the other. Gosh, we used to dread seeing the first case of an infectious disease, because we knew what was to come, how severe it would be, and how many we wouldn't be able to pull through. The joy of pediatrics is now. It's watching children grow and develop over the years, it's seeing the wonderful recuperative resources of children, once you get them over the hump.

"And it's being able to turn your patient over to a specialist who knows more about handling a diabetic child than you do. I can't feel jealous of the inroads specialization has made. That's what I want to see, people who can care for my patients better than I can. But it is happening and I don't wonder that these young people are skeptical."

WHAT THE YOUNG doctors and medical students who question Dr. Sato fail to see as heroic is the essence of the heroic role of a pediatrician like Dr. Sato, said a colleague. "As Phil Dodge said, 'He doesn't miss a thing.' His clinical judgment is so sharp, his good sense so intact, he has seen so many children for so long and he knows the whole family history (and maybe even the extended family history), that he is a very special kind of specialist—the diagnostician. What could be more exciting? And with whom, if not children?"

Most importantly it is clinical judgment that Associate Professor (Clinical) Sato brings to the teaching of medicine at Washington University. The demand which the School makes upon his time in exchange for permission to bring his patients to the medical center varies. It may be as much as one afternoon a week for four six-week periods during the school year. Ironically, of course, it is likely that the better the clinician is as a clinician and a teacher, the more likely he or she is to be asked to teach. Clinicians complain about the injustice of granting hospital privileges to physicians who are members of the clinical faculty in name only. Dr. Guze says, "Some members of our full-time faculty don't teach (though no more than 10 percent) mainly because they are good as researchers but not as teachers. The same is true of clinical people. We simply find some are not good teachers and we don't use them."

In addition to teaching, Dr. Sato has served for many years as a member of the Children's Hospital committee which selects its interns. He took a leave of absence from that decision-making body last year, since one of the candidates for internship was his son Richard. Richard, however, was selected without benefit of his father's vote and Dr. George Sato is now back on the committee. He has also served as president of the hospital's medical staff society.

Dr. Sato spends his teaching time in the clinics or emergency room of St. Louis Children's Hospital with junior and senior medical students. They are in pediatrics on their rotations through the medical center's clinical services—medicine, surgery, ob/gyn, psychiatry, pediatrics, etc. Students examine patients, taking family histories and notes on specific complaints. These are then reviewed with the clinician, who helps refine the students technique of examination and information-gathering process and monitors his or her clinical judgments.

A YOUNG WOMAN sat on the couch across from Dr. Sato. She had systematically run down her notepad of patient responses. She ended with an evaluation of her dialogue with a girl referred by a welfare agency because it was believed the child might have a physical disorder affecting her thought patterns. "Remember," he said, "you never know what the mind is doing in a nine-year-old. Find out from the mother how she is doing in school. If there seem to be problems there, you probably want to recommend psychometric testing. But if she's not having school problems, it's probably not necessary. Then just note that you found no physical cause, so that the record has that when you are no longer around."
Dr. Sato generally starts his day in the nursery of St. Louis Maternity Hospital. In pediatrics today, patients are frequently followed through age twenty-one.

Having checked Noah, firstborn of Dr. and Mrs. Robert Lander, Dr. Sato stops to brief Mrs. Lander, MA 73, on Noah's health and to discuss his care and feeding after leaving the hospital. Dr. Lander is a clinical faculty member in orthopedic surgery.

The young woman nodded and went back to her patient.

"At Children's, we use our clinical teachers primarily in the ambulatory setting. Rounds on the floors with the interns and residents are handled usually by our full-time people," Dr. Dodge explains. But there is also informal teaching which takes place—often by telephone—as interns and residents discuss the diagnosis and treatment of a patient with his or her private physician. This teaching also is likely to occur as Dr. Sato visits hospitalized patients and discusses their cases with members of the house staff.

On most days, Dr. Sato's first stop is the Medical Center, where he checks on his patients at Children's and St. Louis Maternity and touches base with new mothers regarding the infant's health and care. Before 8 a.m., he leaves the hospitals for his nearby office to begin a long day, a day in which he sees some 50 or 60 families (of one to four children each) for routine physical check-ups. Continuously during the day, he also sees sick children and takes emergency telephone calls. After office hours, he picks up other telephone calls, which can number as many as 100.

When the office door finally slams behind him, Dr. Sato's working day is not at an end. On his way home, he stops
Immediately after a baby's birth, the pediatrician designated by the parents is contacted. Dr. Sato checks a newborn who has come under his care. He frequently transfers a baby born with a major problem from an outlying hospital to the neonatal unit at the Medical Center.

George Sato was born in Carlsbad, California, and reared in South Pasadena. He was groomed by his family from childhood to enter medicine. "Every good Japanese mother in California wanted her son to enter medical school so he could be independent and always have work," he recalls. "I went to UCLA and I really had almost no chance of getting into medical school in California, but my college career was interrupted by the relocation of my family."

During World War II, the Satos were sent to Gila Bend, Arizona, to a relocation center for Japanese-Americans. From that center, George was selected to be dispatched to the safety of a Midwest college.

"For some reason, Washington University accepted many of the students from those camps, so there were about twenty Nisei students who came here and, of course, most of us were premed. When we arrived Dean Arno Haack took us over. He guided us through many things, such as the chopstick to fork routine. Now it also happened that Washington University School of Medicine had traditionally accepted one student of Oriental descent in its medical school class. That student usually came from Hawaii, but with the war, that access was closed. Carlyle Jacobson, who was then the assistant dean of the medical school and in charge of admissions, somehow persuaded the committee that rather than close that place down, it open another, in addition, since there were so many of us wanting to get in. And, miraculously, the committee did and I was one of those accepted. I've never known exactly why, because every one of us must have had 3.8 or higher grade-point average. All we did was study."

He graduated from medical school in 1947, took an internship in Detroit, and returned to St. Louis for residence, and practice, marrying Marjorie Soo Hoo, who is also a physician, in 1948. Dr. Marjorie Sato, however, elected not to practice full time until recently. Instead, she reared the Satos' four children, beginning to practice part time with the St. Louis County Health Department when her children were in school. Only Rick, who is now at Children's Hospital, is following in his parents' footsteps.

"There was no way we could both have practiced," Dr. Sato says, "When we were still making house calls and checking back into the hospital constantly to see that our patients were being treated, I'd regularly get home between 10 p.m. and midnight. Now the house staff is so good, I'm usually home by eight."

But if you call Dr. Sato's office on Sunday afternoon, he is often there, talking to those children with whom he needs to spend unhurried and unhurried time. "I have some children—frequently teenagers—with whom I need to talk. Their emotional needs are as real as physical symptoms and I really enjoy being able to find that time." Admittedly, he says, he could send them to a counselor, "And I do, sometimes, but often just a few hours with a child I know well is helpful. I feel I should be able to give that."