HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Mark Hatfield

Interview conducted May 20, 2003

by

Roy A. Payne, M. D.

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Date: May 20, 2003

[Begin Track One.]

[high pitched noise]

HATFIELD: –between science and religion.

PAYNE: Oh, God.

HATFIELD: Did you see that?

PAYNE: Yes. [laughs]

HATFIELD: They give it front page. I mean, how many of them were there?

?: Okay. You fellows ready?

PAYNE: Whenever you are.

?: This is an interview with Senator Mark Hatfield by Roy Payne on the twentieth of May, 2003.

PAYNE: Well, Senator, how did you get started into the healthcare area? What was your initial exposure to the–

HATFIELD: I suppose when it really hit me between the eyes was when I was looking to be part of the United States Navy after Pearl Harbor. And I was in a line taking a physical in Portland. And here were all these football players and muscle men. I was sort of the Fleischmann Yeast before ad. I was a skinflint. I was a guy that didn't want to be seen in a pair of shorts on the beach. And as I say, these guys, real muscle bound, would walk through that line. And this one would flunk, this one would flunk. And then I came along, expecting to flunk. And the guy said, "Well, we'll just have to put a little meat on your bones." He said, "You pass."

And I thought, gee whiz, after all, I realize that then following that up with the number of people who were rejected in the draft, even, as well as Officers' Candidate School, it hit me between the eyes that health really was a factor that we took for granted or knew very little about. This was before the surgeon general's report, where smoking was the in thing for my generation.

And then I was in the navy, and went into China and other places in the Far East. And I found the poverty of the people, and the emaciation of the children, particularly, emaciated status of those children.

So all of those things were sort of my awakening that health was more than just a matter of being able to get into Officer Candidates' School. And it really affected far more people than we'd realized: the poor, the underserved in our own country.

PAYNE: Now after you got into the political field, into the legislature, where did you start getting involved there? Was it the dental school issue then?

HATFIELD: The dental school was the very first, because it was not in the top level of the consolidated programs for building and higher education that had been developed by the chancellor's office. So a group of students were helping to lobby for a new building, as well as faculty. And I remember the most, perhaps the most fantastic piece of lobbying that I ever experienced were these dental students saying, "You know, the saliva injector is something we have to pump by our foot while the patient is having his dental work done. And then after a while, something happens, and it reverses itself."

Well, just the imagery of a saliva injector reversing itself from a common pot, so to speak, it won the day. And we put that dental school right at the top of the list.

The more studied kind of issue was the teaching hospital. But this time, I was in the state senate in 1955. And we had a bill to establish a teaching hospital at the Oregon Health Science University, then called the University of Oregon Medical School. And I thought, something like this is very simple. But on the other hand, it became a very politically charged issue. Those hospitals around in the city of Portland that had provided that service in the past were not supportive. Even the Oregon Medical Association officers called on said, "We think this could be the first step toward socialized medicine."

So consequently, it was a political hot potato. And my mentor on this was Dave Baird, the dean of the University of Oregon Medical School. And no better political mentor I ever had in my life. Here was a man who knew his data. He had all the cards in his hand. And he was very calm on all these tirades against him. And he'd sit there and after a while, for a little while, then he'd go outside, get a breath of fresh air and come back in and sit through all the rest of it. But he would tell me, "Here's the answer to this. Here's the solution to this." And he had it down so well done, and he'd brief me so well. And as I was carrying the bill on the floor, we won it. But it was Dave Baird, really, manipulating my voice and my mouth with his wonderful briefing.

PAYNE: You talked about this major committee for medicine and science development in the state of Oregon. I believe the acronym was SANTE. Is that correct?

HATFIELD: Yes. We had been in a very heavy recession in the '57 and '58 election taking place in '58. So it gave me time to think of what can we do to get a more stable economy. We had three major factors: the agriculture, the tourism and the timber. They were all very seasonal in character. And so, again, having grown up in education, I always thought to myself there must be some kind of data, some kind of analysis that would help us.

And I talked to a couple of people, particularly Howard Vollum, who at that time was our premier high tech operator. He and his partner, Mr. Murdock, had founded the oscilloscope instrument and Tektronix is the company. He said, "Yes," he said, "You know what we ought to do is to get a group of scientists together and make an analysis. What could we do in translating science and support of institutions of science in developing jobs and diversifying our economy?"

So with his counsel, again, I always have been fortunate to have good mentors on major issues, we got Richard Sullivan, who was president of Reed College, a scientist himself. We had Howard Vollum, we had Sam Dyak, who was also a scientist and a doctor. We had a good cross section of the science community and the leadership. And we had Doug Strain, who is the only survivor of that committee that I had set up. And it was called the Committee on Science, Engineering, and New Technology. CSENT was the acronym. They put together their heads, and came up with the proposition that what we ought to do is to fill a vacuum in Portland and the metropolitan area. We did not have a critical mass of science or any postdoctoral work in education. We didn't even have a graduate program at Portland State University at this particular time. It was strictly undergraduate.

So consequently, with that kind of blueprint, I asked the legislature for a million, six hundred thousand dollars to launch a graduate center for research of science and engineering. They wouldn't go for that. So then I asked them for six hundred thousand, and they wouldn't go for that.

So Dick Sullivan went out and asked the University of Portland, he asked Linfield, he asked Pacific, he asked Willamette. He asked, there were six private schools, Reed College, in this area. He asked them each for a thousand dollars. And they came up with a thousand dollars each. And with six thousand dollars, we went to the business community and said, "Will you make this a reality? We got the property donated, we've got the money." And we launched the Oregon Graduate Institute, which is now forty years ago.

PAYNE: Fantastic.

HATFIELD: Now that was the beginning of the kind of higher education and laboratory research that was sort of the crux of our expectation of diversifying the economy. But in the meantime, we brought one of the nine centers of primate research that the health education and welfare department that the federal government was establishing across the country, using primarily Rhesus monkeys in their research.

I happen to know Arthur Fleming, who had been President Eisenhower's officer, and secretary of HEW. Called him up and said, "I see by the *New York Times* that you are establishing nine of these centers. Do you have a Northwest location?"

He said, "No."

I said, "How about Portland?"

He says, "Great. Great idea."

So we have that out here in the Beaverton area. Now our idea was to see the OHSU to expand in its research as a medical education service and research institution. And at the same time, to then blend with it, and merge with it, the resources of the primate center. And then the OGI, and that has now occurred, as you know, over this period of time when we did have the merger with the primate center. And we have now had the merger with the OGI.

So that was the building of our critical mass of science and research in the Portland/Multnomah County area. We also began to look at Portland State University beyond just an undergraduate program. And we were able to organize the support of the legislature to establish a graduate center of social welfare and social study. So that became their first in that.

Interestingly, we begin to, I had read an article one time in *Saturday Review* that education is indivisible. We have artificial divisions by our governing agencies or the support agencies. But really, education is indivisible. So that made me start thinking about what do we do with our high school graduates who aren't bound for college? All of our high school programs were geared for high school prep. But a lot of those students couldn't afford to go to college, or didn't have an interest in going to college, or had other interests.

So this created the idea that we needed to look at post secondary education beyond just college work. And about that time, I had to appoint a new superintendent of public instruction, because of the death of Rex Putnam. And so I selected the principal of Benson Tech High School in Portland. And he was geared to then draft up the community college program for Oregon, so that we would have two-year terminal programs, and two-year transfer programs. And build that community college for opportunities for a lot of young people in geographic areas, in poverty, or less resource available.

And that began to feed in, then, to our four-year degree granting institutions. Because those two years, they could be mechanical, technical, at that. Or paraprofessional, paramedical, paralegal, paradental, all of these things that really become the indivisible feed of our massive center for medical and other research.

PAYNE: How about the medical school itself now? This has undergone great changes. I wonder what you have worked with as far as influence and some of the funding and programs that you've been involved with, and how much they wound up with.

HATFIELD: Well, it was interesting how these events and circumstances that you don't plan for begin to affect and impact upon your strategies to respond. First of all,

we knew that the veterans' center on the hill, one of the old veterans' hospitals, was in need of great restoration, more than just remodeling. It was at a time when it had to be replaced. It was old, one of the oldest. It was totally inadequate. I remember as a young man, going up and visiting my father who was a veteran of World War I. He had some medical problems and he went to the hospital. And I couldn't believe the condition of that hospital. You had linoleum on the floor of an old hospital. Well, linoleum isn't even a word in my children's lexicon. You weren't able to keep it clean. You have to have grown up with that to know you grew up with it. So it was covered with linoleum and other things like that, showing its age.

So then the question came, do we replace these hospitals? There was now a Reagan administration coming aboard. Now the Reagan administration says, we should mainstream veterans' benefits. We should not rebuild hospitals. We should phase out of the veterans' hospitals. We should certify the veteran to get to a hospital of his choosing. And that way, we wouldn't have the government running a hospital.

Well, that argument continued into his election period. And then right after his election, it was proven that the American Legion, the Veterans of Foreign War, and the other veterans' organizations were too much to overcome. They were not going to stand by idly and let the federal government get out of the veterans' hospital entirely.

So they finally came to the conclusion that they would only rebuild two hospitals.

[End Track One. Begin Track Two.]

HATFIELD: –out of the whole number of veterans' hospitals across the country. And they came to select, I think, Baltimore and Portland. And the Portland selection was political enough for that. That was the fact we were selected. So consequently, the question then rose, do we build it up on the hill, replace it on the hill, or do we go over here on the east side as part of the urban renewal program, and put it near the hospital over there. And that was argued back and forth.

And finally it prevailed that we should remain on the hill because we could interrelate the hospital there with the university hospital. The teaching faculty would have teaching status at the veterans' hospital. And we could bring the patients together, and so forth. And it was finally then decided politically that it was going to be on the hill.

Well, we built this magnificent hospital on the hill. A hundred and seventy-five million dollars in that replacement. And then we began to realize again the inefficiency of having to jitney our patients around that arroyo up there to get from the veterans' hospital over to the medical school, or from the medical school over to the veterans' hospital.

So then the idea came up for a bridge that would link the two institutions. And that bridge was one of the most controversial things that I ever had to work with. I had a man from Massachusetts on the House side that just was opposed to any veterans'

expansions of any kind. I got it passed in the Senate; he'd kill it in the conference committee. Or he would go, say, "We have to have a study." We had one study. We had two studies. We had three studies. He was never satisfied.

And finally I was able to persuade a couple of other people there to vote with us, and we overcame him. Six million dollars for that bridge, you see. Six million dollars. But look at how high it is. It's air conditioned, because we're transferring patients. It has to be wide enough to push those jitneys, to push the patients. We found that we could repay in eleven years what we were paying for a jitney service by having that six million dollar bridge. So it soon, now, will have paid for itself, in another couple of years.

So that's how we began to build that kind of a interrelationship. Because in my view, there will be a time when the veterans' number reduce to such a degree, and pray that there will not be wars to make more veterans, that the mainstreaming of veterans' services will probably take place. But those institution like this one will be even merged closer between them and the university hospital.

The next step was to find research. Leonard Laster was my mentor on this. He was the president up there. And Leonard Laster had a vision in which he said, "You know, we could become a major research hospital. And that enhances the teaching part, and the education of doctors. It provides more resources that can come by competitive grants to those scientists who are in the field of research. And it can be hope for many people who now have little hopes because of diseases that have not yet been addressed." We have maybe three to five thousand orphan diseases that don't even have a registry or a research project. So we had lots of reasons to start for that.

But interestingly, the first twenty-five million dollars that we got in an amendment to the appropriations, the faculty communicated that we don't need research. What we need are faculty salaries competitive. We need to increase faculty salaries. So don't send the money for research; send the money for faculty salaries.

Well, I wasn't going to get into that battle. That was (?) last year's battle. I said, "You've got to cover your front. I'll get the money, but you've got to make it welcome."

And so that's where we began, then, the commitment which led first to the Howard Vollum Research Institute. And by the way, Howard Vollum then endowed that, dollar for dollar, twenty-five million dollars of tax money, matched by twenty-five million dollars from private money.

And it's been that kind of pattern that's expanded not only the university's capability into research, but has stimulated a lot more gifts to maintain that commitment to research and to see these projects move along, like Dr. Drucker's project, which now has defined and produced the medical support for a type of leukemia. And all over the world, that was front page news in Rome and Paris and London when Dr. Drucker of Oregon Health Sciences University made that breakthrough in leukemia.

And we have other programs that are at a level where we can hope and expect a breakthrough. So that's how we got started on the research. I think we probably have three hundred and, I don't know, a hundred and seventy-five, we probably have close to six or seven hundred million dollars of federal money that has been invested in there, which is the biggest multiplier of any economic action the federal government can take is a medical, is a health dollar. That makes jobs. This is the biggest payroll in Portland. It's the seventh greatest business in the whole state of Oregon.

So consequently, it's an economic engine, as well as an institution of hope, and dreaming of better life and a better control of disease that people suffer. I think it's one of our greatest assets in this state.

PAYNE: That sounds wonderful. Some of your experiences have not been so successful in their outcome. I understand when President Clinton was in office, there was a health plan that was a problem, one way or another.

HATFIELD: I just want to preface a response to that question. Because I have to say that President Clinton came at a time when there had been building up a support for reducing the funding for the NIH National Institute of Health. That had become increasingly a focus of, boy, here's some money we can transfer over here for something better, and so forth. Everything was being looked at in a little bit less generous way. A lot of budgets, most of the budgets at that time that President Clinton was in office.

So he set up his annual budget – this was '95 – in which he suggested a 5 percent, across the board cut in the NIH budget. The House, controlled by the Republicans, suggested a 10 percent reduction in the, President Clinton, let me back up. President Clinton was going to have this 5 percent reduction over a period of time. The House wanted a 10 percent reduction over a period of time. The Senate decided they wanted a 10 percent reduction now. Everybody was outdoing the other. It was a contest on how much you could cut, between the president, between the House, and between the Senate.

My good friend was the chairman of the budget committee, Pete Domenici from New Mexico. And the Republicans controlled the Senate at this time. So he had built up a very strong role there as chairman of the appropriations committee. I mean, excuse me, I was chairman of the appropriations committee. It was a butting head, head butting contest, between Pete Domenici of finance and myself as appropriations.

Now when Bob Packwood of Oregon was chairman of the finance committee, we just had a hand and glove operation. He would raise the taxes, and I would spend them. But consequently, this was not going to be a battle of Oregon senators. This was now New Mexico and Pete.

So they had organized to reject all amendments, all amendments to the budget committee. And they had been knocking them off, one by one. Two and three a day, there was the end of that amendment. So when I realized the impact on this 10 percent reduction, I had a lot of good support from NIH and other places to say, "This is what the

impact would be on cancer research. This is what the impact would be on juvenile diabetes research."

So I made a speech on a Thursday, and I voted against televising the Senate. Now I'm so glad that they beat me on that vote, because we had that television going out over CNN. And Bill Dement from Stanford saw it. He was the man who set up the sleep center at Stanford. So he was very moved by the fact that I was saying, "This is a disaster for the NIH, because this is what it's going to do." He got copies of that and sent to about eleven hundred centers of research all across this country.

Because I had said, "I'm going to introduce an amendment to not cut the 10 percent, but to increase the budget by 15 percent." And of course I was going by faith a lot on that ability to do that. And Pete Domenici just sort of smirked a little bit. He's very sympathetic to medical research, and he's a very dear friend. But he knew we had the votes to kill every amendment.

But, in the meantime, Bill Dement's letter had triggered action of pouring and flooding the Senate with letters and telegrams, I guess they don't get telegrams anymore. Emails, and all the other things. The next Wednesday, or that weekend, we had a convention of the advocate group for MS and other neurological disorders. They, then, took the word up. I had the privilege of addressing that convention. I said, "I don't care what else you do here. Stop what you're doing and contact the home folk. And get these letters in here. Get this pressure on the Senate, because it's do or die at this time."

Fortunately we had, there's a television program about Washington politics. The *McLoughlin Gang.* He was there. So he made that his first question on that Saturday night that he was broadcasting. We had a *Time* magazine editor who was there. And we had another editor who has a wife who had MS. So consequently, those things just all began to multiply.

We had a debate. It was a tough debate. But you know what? We beat them. And we increased the budget 15 percent at that particular time, and held it in the committee with the House. And that was our sort of natives' uprising against the king and his henchmen. [laughs]

PAYNE: Now not all of your efforts were successful. The National Health Plan–

HATFIELD: No. The Clinton plan for, universal health plan, it was probably the most distinguished blue ribbon committee during my thirty years of the Senate. It was tremendous stature of that members individually and collectively. They came up with a comprehensive health plan. In spite of the fact that it was so well appointed, and such outstanding individuals. Do you know, they forgot, and the didn't include, when they developed and provided us with a copy of their product, they'd forgotten all about rural health as distinct and different from all other health. So with even that kind of talent, you could see that the background, they were urban people, and agriculture and the rural areas

didn't have that much focus in their daily work. So it was left out. Unintentionally, but it was still left out.

I came to the conclusion that when the House and the Senate debated, and it was obviously going to go down, they didn't have the votes to pass it. That it wasn't a question that we didn't need it. It was a question of the diversity of this country. A group of Republicans and Democrats alike, Diane Feinstein of California and John Chafee of Rhode Island, Republican, Democrat. A number of us together, about twelve of us, got together and we though, well, we're more the center of the Republican Party and the Democratic Party. Maybe we can come up with some basic consensus. And we worked and we worked and we worked. And we failed. The whole thing failed.

But I also came to the conclusion that to develop one system that's going to be uniform across this country is never going to happen. I mean, just as we had moved in, being one of the leaders, Oregon, under Senator Kitzhaber, who later became our governor, and his idea of a health plan was different than Washington state. Was different than Hawaii. That we should probably stimulate those states that had not yet taken action to develop a health plan of their own. We should subsidize even some of the poorest states to go ahead and do that. And then let's say put it into effect, whether we have a single payer plan, or not have a single payer plan, and so forth and so on. And in five years, let's gather all of that experience into one place–

[End Track Two. Begin Track Three.]

HATFIELD: – and see what the federal role should be. Rather than saying, this is the federal role, and here's the plan, and it's going to fit everyone alike. It's not going to happen that way, I'm convinced. We should start the other way around, and get every area of the country starting and trying and testing, finding out what the health plan is worth, and which one is effective and what part of one. And then find if the federal government can find a role in bringing together a health plan.

PAYNE: And over your fifty years of involvement, you've watched Oregon and its programs develop. What do you feel has been successful in Oregon, and what has not? Where has Oregon been able to work with the health care, and where have we made little or no progress?

HATFIELD: Well, that's a tough question, because I think that we had, I had an understanding that Senator Kitzhaber was not presenting a plan that was end all, and be all inclusive, and be everything to everybody. He was starting an idea. He was giving a concept. He was putting together the rudiments of what he thought would be a workable plan at that time. And the others who agreed with him and passed it in the Oregon legislature.

I think that, in the meantime, there have been a lot of changes occur, both here in Oregon and elsewhere. Our culture has changed. Our laws have changed. We now have assisted suicide, for instance, as one example. We're always one of the highest abortion

sates in the country. Those things constantly change. We also have the highest hunger today. We have the highest unemployment. We have one of the highest child abuses. And we have these contradictions to what have been the progressive, forward looking plans that we have done and legislation that we have experimented with and proven successful in so many other areas. It's a contradiction. It's a schizophrenic kind of culture we're looking at in comparison.

And I don't think that therefore we have accomplished the undergirding of financial stability, the tax system. We haven't kept a pace with all of the demands for expanded healthcare and universal healthcare that I think was probably in the minds of most people. We'll start out with this, see how it works, and then build on it to a broader base of support to the underserved and the minorities.

And none of that continued in momentum. It all got sort of diverted to some other issue or some other problem. And in the meantime, the expense factor has been challenged by the lack of revenues and having a bad, bad economy. Now the whole nation is suffering from an economic back slump. But I think we have had a greater impact of our economy, perhaps, than others.

So these things are very complex. They cannot function on a single track. You've got to have a convergence of many forces where you're doing a major social reform.

PAYNE: You've dealt with the doctors over the years. And some of the problems, I'm sure, have been expressed about dealing with these changes and the record keeping that's been involved with keeping up with these changes. The government regulations requiring this and that. Do you see this as an increasing burden for the physicians in Oregon? Or is there going to be some way of getting relief? What do you see about this?

HATFIELD: Well, it's really a national concern, and a national problem as well as an Oregon program or problem. In my view, we have been, I suppose, slow in some ways of beginning to look at medicine not as an individual doctor and an individual patient, but as a team of health people. A team that work together as a team, rather than one on one. We're not going to ever get the one on one ratio, in my view, with the kind of complexities, the mix of kind of insurances and the coverage. The mandated programs that the federal government's put on, local governments that do not really carry within the funding system.

So that I think that we're going to have to see, really almost a new approach. In that team's going to have to be a record person that's going to be fulfilling the obligations under law in regulating certain kinds of coverage, or regulating certain medications and so forth. That has to be considered pretty much a team person all to himself or herself.

I think the doctors are reluctant to lose that one on one patient. And the patients themselves, I want to know who my doctor is. I want to know who my lawyer is. I want to know who my banker is. These are the cultures that I grew up in.

But I still think that you can get the team approach within the medical community without destroying the personalism. I don't think people want to become a number that's put into a machine and an answer comes out like a gumball machine. I don't think people want that kind of medicine. And I don't think we should try to make that kind of medicine.

But it's a fine line between the personalism and the team effort. I find that I'm really engaged in that now. I'll give you my medical history. I have a problem with indigestion, all right? I have my gastroenterologist up on the hill who gives me my tests, testing of the intestines from top to bottom. And he gives me my Prilosec prescription and that takes care of me. My general doctor is a man who I've known for many, many years, and a very fine internist. And I've had even a heart person test me to make sure that everything's going well, and it is. So I've had other specialties. In other words, that's kind of a team in itself in the making. But I think it has to be more structured oftentimes, and I think it has to be more consciously drawing on these expertise from different centers. And the individual, then, is not dashing from one office to another to try to get at a point to know about someone over there. He already has a contact. It's on this team.

Now it sounds very simple when you talk about it. It has to have a lot of study. It has to have a lot of testing. And again, I think one of the great things of this country was the opportunity in a federal system to test things at the state level. Or to test things at the county level. Let's send out a number of tests on these things. How do we better make more efficient the medical resource we have. How do we spread it over a bigger base. And I think the doctors themselves have to be an integral part of making those decisions.

PAYNE: How about the doctors? Over the years, you've met a lot of them. Are there any other unusual individuals you've met along the line over the years?

HATFIELD: Yes. I was a Caesarian by birth. And I was in Dallas, Oregon, the mill town. But there was a doctor, L.A. (Bowlman?), who was the one who presided, and a Dr. (Statz?), who was his assistant, or colleague. And as far as I was concerned, those people really walked on water. It was a small town. We had a telephone system, but you'd lift up the receiver, and Mrs. Hull, we knew who it was, would say, "This is Central."

And we'd say, "Mrs. Hull, where's Dr. (Bowlman?)?"

"Oh, he's over visiting with Mrs. Rice at the moment." Because Dr. (Bowlman?) had a(?)

"Well, tell him to call us as soon as he gets through with Mrs. Rice." And that was sort of our medical access. We had wonderful access.

He'd come to the house. I don't think I went to the office more, once to have my tonsils out, and I think maybe one other time. If I ever got sick, Dr. (Bowlman?) would come to the house. So that was our ancient culture of medical service.

I think, and of course great respect. The doctor had higher than most of the preachers of the town. You usually think that maybe the ministers have the number one respect of the community, and then the doctors are second. Doctors were number one in our community. They made a difference, you see.

So they had this very godlike status as I grew up. And I knew I was never going to become a doctor. Because I knew in the fourth grade that I wanted to be a politician. And of course my parents were, I think they were a little disappointed. I think everybody wanted their son to become a doctor. I said "son" in those days, because there were no women doctors.

Oh, yes, there was one. Willamette University graduated in 1895 a woman by the name of Mary Bowerman, who was J. Bowerman's, who was the governor of our state, sister. And Bill Bowerman, at the University of Oregon's, aunt. She never had male anatomy at Willamette. Those nice Christian girls didn't know anything about that until they were married. So consequently, she was sent up to Condon, Oregon, to be with her brother, who was a district attorney, so somebody could look after her.

Now she became my mother's doctor, and my grandmother's doctor. She was Mary Purvine by that time. Her son was our family doctor in Salem, Ralph Purvine. So we had a lineage of doctors when I was growing up that way.

I have to say that one, I would be wrong to not mention him, was Joe Trainer. Joe Trainer was a student physician at OHSU. Joe Trainer, you could call him on the telephone and he could hear your description and listen to your voice and diagnose you. Now I learned later from my daughter, who happens to be a doctor, that she calls that yes, and then you say to that person who calls you, "Put the telephone receiver where it hurts most." And that may be able to examine you a little closer. [laughter]

But Joe Trainer had that instinct, he knew you as a person, as a patient. And he knew the interrelationships of these things that happened to you, because he knew the total individual. And that's why we named the medical student center for Joe Trainer's honor. He was our doctor right up through the time of his death.

But Dave Baird, I've already mentioned Dave Baird, he was something special.

PAYNE: Are there any other comments that you'd like to make regarding healthcare in Oregon during the twentieth century?

HATFIELD: Yes. I have a feeling that healthcare is too often discussed and debated in this period of time as something that has to have a magic pill. That it's up to the doctor, it's up to the public health officer, it's up to the university, it's up to

somebody else. And therefore, I do not have to assume a great deal of responsibility for my health. And what we know about obesity, what we know about diet, what we know about drugs, what we know about alcohol, all these other things, we have enough information to make everyone realize that they engage in certain practices, they're endangering their health. And they shouldn't be waiting around for a pill or some kind of a quick fix by the doctor or by the medical services.

I don't think we have conveyed or communicated strong enough in this life of ours the responsibility of the individual to be concerned about his or her health to stop certain practices or to start certain practices in their life that can be more enhancing than damaging. And that's the choice: enhance my life expectancy, or damage my life expectancy. I just don't think that's in our culture today. When you look at feature stories in national magazines and news media today about obesity amongst our teenagers, with all of the quick food and all of the other things that do nothing but just add flab.

And if you want to sit in an airport, as I have done too much in my life, waiting for a plane, just watch the people walking by. How many of them are *fat!* Just plain fat. And you know what? I want to button my coat when I talk this particular issue, because I'm not slim enough in my belly. But I'm talking about this obesity. That's life threatening.

[End Track Three. Begin Track Four]

HATFIELD: –life shortening. But people just feed their mouths, on and on. I smoked for ten years. Inhaled a pipe, cigarette, tobacco, cigars. This was all before the surgeon general's report. And I quit thousands of times. But one time, I quit for good. I figure that if I have the ability to quit, anybody can. And there's nothing more obnoxious than a reformed smoker, I know. Because we get very impatient with anybody else smoking.

And I think back to how it must have offended so many people that I was smoking tobacco, any kind of tobacco, particularly pipe tobacco, in their home. It was my right. Just sort of one of those things. I said, well, I can smoke if I want to.

I think that's really one of the things that concerns me the most today about public health.

PAYNE: (?)

SIMEK: That covers it for me. [laughs]

PAYNE: Senator, you gave us an hour. We appreciate it very much.

CUNNINGHAM: Watch your head. Hold on a second, Senator. I'll lift that up for you. [pause] Okay.

HATFIELD: I mentioned Mary Bowerman Purvine, the first female graduating from the Willamette University College of Medicine. Which was the first college of medicine west of the Mississippi River. And later, as you know, combined with the University of Oregon in 1914. In fact, President Franklin Roosevelt's personal physician, Ross T., Admiral Macintyre, was a graduate of Willamette University College of Medicine.

Anyway, the family, as I say, did not know what to do with her. And they thought well, they'll send her up to Condon, Oregon, where J. Bower, her brother, was the D.A. He'd graduated, also, from Willamette Law School.

Well, she got there, and they all tittered and tattered around the community about a female doctor. It would be over their dead body that they would ever have a female doctor come to call on them.

Well, they only had one doctor in the whole county. And he was called to Portland, he was the county health officer, and he was called to Portland for a conference. And while he was gone, diphtheria broke out in Condon, Oregon. Well, Mary Purvine, or Mary Bowerman, as she was then, had a horse and buggy. She trotted out to every single farm house, as well as every house in that community, to test the kids and what she could do for medication.

Well, you can imagine. When that was all over with, the county health officer didn't have any patients. Because they all felt well, if she comes to see us when we're in danger, she has to be okay. But it was an interesting part of her story of her medicine.

She did move back to Salem then, and then married a man by the name of Mr. Purvine, who was not a doctor. But Ralph, her son, their son, graduated from Washington University in St. Louis in medicine. And was our family doctor, and took care of our kids.

So we had two generations. And my grandmother always went to see Dr. Purvine. She was the epitome. Wonderful, grandmotherly type of woman, non threatening. But so inspiring. She just personified everything about a doctor that you see in those wonderful cartoons.

SIMEK: Could I ask you one more question? In all of our interviews so far, no one has given the history of the medical schools and the medical training development from the early part of the century the way you just did. Could you expand a little bit on that? The great historian that you are. You know more about that than any other practitioners we've talked with so far. If you could trace for us just a little bit from the late 1800s up through the first half, that would be wonderful.

HATFIELD: Well the, as you have here in the Oregon Medical Association's office, you have, of course, Dr. McLoughlin, who was head of the Hudson Bay Fur Company–

CUNNINGHAM: I'm sorry. Could you do it to Roy? Okay, from the beginning.

HATFIELD: As you have here in the office, the picture of Dr. John McLoughlin, who was a medical doctor. He not only was the head of the Hudson Bay Fur Company, but he gave great encouragement to the early pioneers coming West. And especially to the great party led by Jason Lee Abernathy, who founded Willamette University. Gave them food, gave them stores to get over to the next season so they could grow their own crops down in the valley.

Dr. John McLoughlin was from Canada, and had been educated in French Canadian medical programs. I think it's also important to note that when the Lewis and Clark expedition came here in 1805 that Thomas Jefferson made sure that Meriwether Lewis go to Philadelphia and take what we would call a paramedic course by Dr. Benjamin Rush, who was a leading physician in the colony of Philadelphia, and also in the state of Pennsylvania.

He gave Meriwether Lewis an entire pharmacopeia to take with him, along with the training. And his instruction to Meriwether Lewis was to observe the Indians' practice of health and medicine, and to bring a sample pharmacopeia back to him, Dr. Rush, when they returned from their expedition.

And Dr. Chuinard of Oregon, a former president of the Oregon Medical Association, of course, had made a life study of the Lewis and Clark expedition, and wrote this marvelous book called *And Only One Man Died.* In which he accounts the appendicitis that took this fellow by the name of Floyd shortly after they left St. Louis. But all the other persons who made the trek and came back from the trek survived. Now they were (treated?) for all kinds of diseases, from venereal diseases to flu, what we'd call flu, and other such viruses. And that was all done under the instruction of Dr. Rush to Meriwether Lewis. Which is a very rich part of our history of medical practice here, even before territory. Before the statehood.

Willamette, having been the first institution that was founded, higher education, west of the Missouri River, with one exception west of the Mississippi River, founded a school of music, a school of liberal arts, a school of theology, a school of law, a school of medicine. They had a total university down there, operated on a very, very limited basis, of course, in any one of these areas. And like the University of Oregon, much of their faculty and their teaching was from practitioners there in the community. They weren't full time faculty. Of course, Oregon Health Science University was not a full time faculty until after World War Two, as you know.

We had other examples of medical and health practices. There was this colony in Aurora, Dr. Kiel, German immigrant, founded this in what you would call a commune style. But they were very strict in their practices, both in diet and in the known what you would call naturopathic, probably, approach to health and medicine. I think the fact that OHSU is, I believe, one of the only universities in the country that gives graduate degree

in Oriental medicine, and embraces the other various alternative systems of medical practice to give everybody a very broad base, and to see what value may be in one kind as against another kind. And my one daughter who had breast cancer and took the surgery and the radiation decided not to go for the chemotherapy. She made a very thorough investigation. Even for the type of radiation she took, she had to go to the University of Wisconsin where they had this program going. But she opted for an alternative form of attention for her cancer. So far, it's working very well. We're all getting used to herbal tea and getting used to vegetarianism and a few other things. But as long as it works, let's work it. [laughs]

I think Oregon has been very open for many, many, many reasons. But I think that old progressive spirit that hit us in direct legislation, recall, initiative for recall, and environmental legislation, all these things, I think we've seen a very strong influence of that in the medical practices as well in this state. We have a very distinguished West German school of chiropractory medicine out here in Portland. I can remember when I appointed the first physician of osteopathy medicine to the state health board. I got hail, Columbia from the medical profession. "What do you mean, appointing an osteopathic physician to the state board of health?"

I said, "He's one member of the three-member board of the medical examiners of this state. If they're not adequate, then you should stop them at the examination period. Once you've certified them, as far as I'm concerned as the governor, if this man is qualified to be a medical doctor and passes the examination that the regular medical doctors, as well as the osteopathic pass, then he ought to be able to serve on the board of health."

Well, that didn't really satisfy as an answer. But I also know that when it came his turn around the rotation, they rotated over him as far as being chairman of the state board of health. So we've had interesting kind of things like that that have not been as progressive as they might have been at the time.

You want me to continue?

SIMEK: It was wonderful. You had already started with the evolution of Willamette into–

PAYNE: Oh. Yeah, I think that was pretty, Willamette in medicine preceded the University of Oregon in medicine. But again, I emphasize I didn't read the catalog of medical offerings, or what the courses were. I think it was more an apprenticeship type of things to most professions. They didn't have a full time law faculty. But the lawyers of Salem, like the doctors up here and the lawyers up here working part time, and even the Northwest College of Law, which was a proprietary law school.

So Willamette did start those, and then had good sense enough to know that it got beyond their capacity to do a quality job, so they were far better off to merge with the state institution at the University of Oregon. I mean, under the University of Oregon here

in Portland. Willamette also started a second college up here in Portland. And the main building that University of Portland is the old Willamette University building that was built up here. To have two universities under the same heading, well, that was ridiculous. They couldn't afford the one in Salem, you know, that all they needed. So then they sold that to the Catholic community up here.

So these things have been evolving. And I think more often than not, economics have probably stimulated a lot of changes that might have come earlier if they had been looking at it from the standpoint of pure quality.

But in those days, we have to understand, too, the knowledge that an average practitioner had, really, how to deliver a baby, how to pull tonsils, cut out adenoids. And how to deal with fever. And how to deal with sprains and breaks of limbs. It was a far simpler practice, but it satisfied the needs of the people at that particular time, as compared to today.

SIMEK: Last question. What pleases you the most about your contributions to the medical field in Oregon?

HATFIELD: What–

SIMEK: What pleases you the most about your contribution to the medical field in Oregon? I'm sorry, can I have you lean to the right, please? Roy, Roy? Could you lean to the right?

PAYNE: You bet.

HATFIELD: Well, when I look at, I have a bias, because as I say, my oldest daughter is a product of the opportunities of medical education here. So education, to me, is part of my own background, my own professional background. Not in medicine, but in political science. But I think when I–

[End Track Four. Begin Track Five.]

HATFIELD: –look at where we have moved in research, as to preservation and improvement of the quality of life, I think I would have to say research. When I was governor, we had a senator by the name of Richard Neuberger. He had been elected in 1954 as a Democrat. He had been a distinguished legislator before that time. And he was filing for reelection for his second term in 1960. And just before the filing deadline, he died of testicular cancer. And as you look at the cancer graph, you'll find the testicular cancer of that particular time was 95 percent lethal. Yet now, today, it's 95 percent curable. And you just see that flip flop in that one particular type of cancer. And where I had a very personal relationship to both the victim and to the political vacuum that he created. I would have to say, research.

When I think of what's happened at Doernbecher, with the children, particularly, and how it has elevated the curable rates in numbers of diseases, where they have been able to bring to full fruition their adulthood, because of medical research. Any direction that you look, it's the area, it's the focus of hope.

I have probably talked or been involved with at least twenty to thirty advocate groups. I remember one time where my assistant came in and said, "You've got to come see this young man who's in a wheelchair out here in your office with his parents. You have to see him."

I went out, and his name was Larson. A young man by the name of Larson. His mother and father were with him. He was in a wheelchair. He looked like he might have leprosy. He had this outbreak in his skin. His fingers had become almost gone in terms of withering away. He just had two little club hands here. He had E.B., Epidermis Bullosa, which is a pigmentation, lack of pigmentation in the skin. The skin cannot handle even artificial light, let alone sunlight. It breaks out. Their teeth fall out. They have scabs on their head, they have scabs on their face. Their appendages wither away, toes and fingers. They usually die by about fourteen or fifteen.

And this young man was sixteen. And he was just saying, "I've come here to lobby for some medical research." He said, "We don't know how many there are of us." He said, "There's no registry that's been formed."

And I said, "I'm going now, this is where I'm headed, is to chair my appropriations subcommittee on medical research. I want you to come talk to my committee. Talk to my colleagues."

[End Session.]