HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Thomas L. Miller

Interview conducted August 22, 2006

by

Paul Frisch

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[Begin Track One.]

FRISCH: This interview with Dr. Thomas L. Miller took place on Tuesday afternoon, August 22, 2006, at the Oregon Medical Association in Portland. This interview was made possible by a grant from the Oregon Medical Association Department of Loss Prevention Education. Paul Frisch, loss prevention coordinator, is the interviewer.

Dr. Miller, please give us a rundown of your early life, including your parents' origins, your family, early schooling, and interests.

MILLER: That's a large order. I was born in Nez Perce, Idaho. December 13, 1931. I attended public school in Nez Perce through the eighth grade. Then I transferred to Gonzaga High School in Spokane, Washington, and spent three years there. Graduated in 1949. Attended Gonzaga University subsequent to that for three years. Entered Creighton University School of Medicine in Omaha, Nebraska. Graduated from there in May of 1956.

FRISCH: How did you get out here?

MILLER: Well, I intended to come to Oregon. I only applied for one internship, and I fortunately got matched. I'd heard about the Providence program, so that's where I wanted to intern. And actually I had a sister who worked for a physician in McMinnville for several years. And thought if all else failed, maybe I could hook up there, go into practice. But I didn't.

FRISCH: It says here that you met Dolly in Nez Perce as a child. Did you marry a child bride? Is that what happened?

MILLER: No, she wasn't a child bride. She wasn't twenty-one when I married her, but she was quite mature. I first dated her when she was in grade school. I was in high school. I was the older guy from out of town. [laughter]

FRISCH: And you married her when?

MILLER: August 13, 1955. Between my junior and senior year in medical school.

FRISCH: And together you raised a family of how many kids? Where are they and what do they do?

MILLER: I have six sons and two daughters. The eldest is not working. He lives on his investments. The second is a, just entering a new career as a teacher. He's in Moses Lake, Washington. My third son is an insurance broker here in Portland. My fourth son is

retired from Precision Castparts as an engineer, structural engineer. My fifth son is the only Ph.D. in my family. He's in Canada and works for a company called I-Stat, which is a wholly owned subsidiary of Abbot Labs. And they make handheld devices that do bedside patient testing. Blood gases, electrolytes, enzymes, cardiac enzymes, trichonin, so forth. He invents the (?). My sixth son, he's my youngest child, he will turn twenty-eight in December, he was working in a sign shop now, but he plans to go to medical, go to law school, probably this fall.

FRISCH: That was the little baby I knew when I first came to the OMA.

MILLER: Christopher.

FRISCH: Christopher. Yeah. Was there any reason that you didn't add another for a full-fledged sports team? Or was that not your intention?

MILLER: We actually had our sixth child before our sixth anniversary. And there were no twins. We did it the hard way.

FRISCH: You made some choices about who you practiced with when you came to Oregon. Could you tell us a little bit about (Hardaman and Gamby?).

MILLER: Well, they were established in a family practice in Northeast Portland. And had recently lost a third member, so I filled that spot. And it looked like a good opportunity.

FRISCH: Can you kind of list out for me some of the material differences between practice in 1958 in Portland, Oregon, and practice in 2006 in Portland, Oregon? Things that really stick out in your mind.

MILLER: Well, I think the biggest change is the collegiality of the medical profession itself. In the old days, there wasn't the competition. There was enough to go around for everyone. There wasn't the primary care medical specialty competition that there is now. There wasn't a whole lot of insurance available, so most people were paying their own fees. I think patients have become slightly more difficult, the better educated they have become. Sometimes you have to sell like crazy to get people to follow the medical regime that you'd like to lay out for them. They have their own ideas. They've studied the Internet, pulled up all the available television commercials for medications.

FRISCH: I don't suppose you had drugs to control the effects of diabetes or high blood pressure, some of those things in '58.

MILLER: No.

FRISCH: What was that like, then, dealing with chronic illnesses? What did you have to use?

MILLER: The selections for medications and management were a lot less than they are today. That's very true. But we had drugs. It wasn't quite the Middle Ages. [laughs]

FRISCH: Yeah. If you had a patient who had a heart attack, how long did they spend in the hospital?

MILLER: Six weeks.

FRISCH: In the hospital.

MILLER: Mm hmm.

FRISCH: What did they do?

MILLER: Some of them died. [laughs] We kept everybody in the hospital a lot longer in those days. Certainly surgical patients stayed a lot longer. Obstetric patients stayed a lot longer. Three, four days in the hospital.

FRISCH: You developed pretty close relationships with your patients. Would you say that was more typical of physicians in your generation than in latter generations? Or–

MILLER: I think probably that's true.

FRISCH: Did you, is that what you liked about practice?

MILLER: Yeah. Yeah. I always enjoyed new patients better than old patients. New challenges.

FRISCH: Well, how would you go about working up a new patient that sort of fit into your style of doing things?

MILLER: Well, the history is extremely important. What the patient's complaints are. How they express themselves. Physical exam, lab X-rays, other modalities. To investigate their problems and make up a differential diagnosis and pace through it.

FRISCH: I know you've always talked about how much you did enjoy talking to your patients. You had a whole range of folks from out in Northeast; it would be now sort of inner Northeast. It was probably outer Northeast back then.

MILLER: It was.

FRISCH: What sorts of people did you get in your practice?

MILLER: Oh, working people, mostly. A few professionals. But mostly working people with families.

FRISCH: Sick or well or both?

MILLER: Both. Both.

FRISCH: Old and young?

MILLER: Yeah. Yeah. Excuse me. Oh, God, my back is killing me.

FRISCH: Is it that–

?: Stop the tape. Rolling again.

MILLER: –gin and some aspirin.

FRISCH: How would you, how would you describe the sort of scope of your practice? What did you cover? How did you do it?

MILLER: Well, to begin with, we did everything. Anybody that would lie down. We did our own OB and a lot of our own surgeries. After about twelve years, we abandoned obstetrics, for several reasons. One of which, Providence, my major hospital, did not have an OB section. That meant you made rounds at two hospitals every day instead of one. And that just added an hour to your day.

FRISCH: Where was the other?

MILLER: It varied. It started at Portland Adventist, and then moved to Holladay Park.

FRISCH: What was a typical day like for you?

MILLER: Well, if I had surgery, I was at Providence by seven, seven-thirty to scrub, make rounds, go to the office, break for lunch. Get out at 5:30, six in the evening.

FRISCH: Were you on call?

MILLER: Oh, yeah. When there were three of us, I was on call every, well, two of us were usually on call. One would be off. So you'd take your own calls and half of the partner who was off for the night. Alternate weekends the same way.

FRISCH: Did you get to see any of your kids' baseball games?

MILLER: Not very often.

FRISCH: That's kind of the typical now, is people sort of have, the life sort of is the predominant thing, and medicine works its way around. How would you characterize when you were practicing?

MILLER: Medicine was the handmaiden. The family was in there. They were important. But probably your practice was your big devotion. That's changed now. And I think, for several reasons. Half of the entering students in the medical schools now are female. Females are smarter than males in some respects. Organizing their lives. And they won't allow medicine to be the outstanding item in their lives. And the male students are learning from them. So I think the level of dedication of individual physicians has changed.

FRISCH: In the community at that time, people that you had interactions with, who were some of the people that sort of stood out in your mind as exceptional physicians that you either referred patients to or practiced alongside with?

MILLER: Oh, general surgery, Rich (Warrington?). Alvin (Uly?).

FRISCH: Tell me a little bit about each of them.

MILLER: Oh, they were outstanding human beings. Rich (Warrington?) was probably the best anatomist I've ever met. He started out his postgraduate training in pathology, and switched to general surgery. And every time you scrubbed with him, it was an anatomy lesson. He was a constant teacher. Also flew his own airplane.

Alvin (Uly?) was a different sort of guy. He was rather (Prussian?), abrupt. But an excellent surgeon.

Ivan Langley, an OB/Gyn, Ed Davis, neurosurgery. There were a number of outstanding physicians. (Em Hardwick?), colo-rectal surgeon.

FRISCH: You would scrub with a lot of these folks?

MILLER: Oh, yes.

FRISCH: The year's 1958. Where's polio in all this?

MILLER: Where's what?

FRISCH: Polio.

MILLER: Pretty much historic. I never had a polio patient. I had post-polio.

FRISCH: Did anything mark those early years in terms of challenges in medicine for you?

MILLER: Not that I can recall. Nothing specific.

FRISCH: Anything come in later that was a unique and difficult part of your practice?

MILLER: Managed care.

FRISCH: [laughs] Oh. Somewhat like a disease, huh?

MILLER: Yes. For my practice, it was.

FRISCH: Did it have an impact?

MILLER: Oh, yeah. I didn't join the Providence plan, so I was kind of the fifth wheel. I didn't agree with it, and spoke against it. And refused to join it.

FRISCH: We'll probably catch up to that in a minute when you talk about the things that you did in your practice, you also participated in hospital activities, which I assume were either morning, lunch or evening activities. Would you talk about what was kind of normal for a physician during that time?

MILLER: Well, it would depend on what committees you were on, or if you were an elected officer of the medical staff. Being president of the medical staff, you sacrificed all of your time off. Your day off was spent at the hospital. Most mornings and evenings were meetings. I made it a rule when I was chief of staff that meetings were at six o'clock. If it was important enough to have a meeting with me, it was at six o'clock. Not ten o'clock. That's when I work. And if it wasn't important enough, no meeting.

FRISCH: We didn't have healthcare systems like we do now.

MILLER: No.

FRISCH: What was life like at a hospital like Providence? Was it small town? Did it feel like a big town? What was it all about?

MILLER: Oh, I think Providence has gone through a real metamorphosis in the years that I've been associated with it. It was the friendliest hospital in town when I joined it in 1956 as an intern. It was extremely comfortable place to be. At one time I was interviewed by Jeff Goldsmith about the future of Providence. He asked me who I thought was the biggest challenge, the biggest worry for a private practitioner such as myself and I said the hospital. He said, "That's interesting, because they view you as the big potential problem."

FRISCH: But that wasn't the way it was back then.

MILLER: Well, it was becoming that way. As the hospital grew and the medical staff grew, it used to be, in 1958, all physicians, all specialties, all had coffee mid-rounds in the surgery scrub room waiting area. That's where all the BS took place, and lots of (group side?) consults, and lots of referrals, all kinds of things.

As the staff grew, we didn't even go in the same doors anymore. The psychiatrists went in the back way. Primary care people came in the front door. I don't know where the surgeons got in. [laughter] Maybe they didn't go home.

FRISCH: So it stopped being that collegial–

MILLER: Oh, yeah. In 1958, you walk down the hall; you wouldn't see a physician that you didn't know. Now you don't know a lot of them.

FRISCH: Well, that was probably true even twenty years after that, wasn't it?

MILLER: Yeah, I think. Yeah.

FRISCH: What about the religious mission of the hospital? How did that play out in all this?

MILLER: Well, it dimmed over the years as the MBAs gained control and the sisters stayed up in Canada, or up in Seattle. Their influence was much, much less.

FRISCH: For the better or for the worse?

MILLER: In some ways, mixed. Mixed, probably. It's been my observation that MBAs have a very short focus. Long-range planning for them is this quarter. Because they don't know if they're going to be associated with the same institution the next quarter. They're a nomadic group, and wherever the opportunity juts its head, that's where they go.

FRISCH: If you think of the medicine that you describe as being a relatively well-oiled, smooth running machine, what was the sand that got into the mechanism? What were some of the elements of friction that began to change the way medicine was practiced?

MILLER: Well, I think the health insurance industry changed a lot of things. They covered certain things. They didn't cover certain things. In 1958, '59 and '60, we were charging four and five dollars for office visits, and fifteen or twenty for an EKG, and it should have been opposite that, probably. But insurance companies would pay for the EKG or the chest X-ray, but they wouldn't pay for the office visit. So as physicians we tried to make it easy on the patients. Kept the office visits low, and charged for the ancillary things.

FRISCH: What happened next?

MILLER: Managed care. Anytime you have a system that is negotiated between two people, one as a benefits manager for a large employer, the other is an MBA representative of a health plan, when they get together without patients or doctors in the room, nobody's going to like what comes out of that decision making process. And we didn't like it, patients didn't like it. Patients tended to blame us. We blamed everybody else.

FRISCH: Was it something about your personality or your philosophy, or maybe all of the above and other things that kept you from joining up in all this, and becoming part of the managed care revolution?

MILLER: Oh, I was just probably too independent. I didn't appreciate calling someone on the phone, the person on the other end had a high school diploma, and I had to convince this person that my patient should get a test or go to the hospital, or whatever. And he or she is referring to a book, catalog. And if my patient doesn't fit, they don't get to go. I don't think decisions in medicine should be made on that basis.

FRISCH: Did you ever see any value to the managed care revolution?

MILLER: It made a lot of money for Kaiser.

FRISCH: [laughs] Any advantage for the patients?

MILLER: I don't think managed care has ever proven that it saves money. The model was Kaiser, of course. But Kaiser, the only way you could enroll in Kaiser, was to be employed. So they didn't have the Oregon Health Plan, welfare. They didn't have Medicaid, either, in the early days. So it was a poor model to pick for managing.

FRISCH: The big secret is, they don't have it now, either. [laughs]

MILLER: True.

FRISCH: Tom, what did you see your–

[End Track One. Begin Track Two.]

FRISCH: –role as a physician was in the lives of your patients?

MILLER: Healer. And a confessor. I think in primary care you have to be somewhat of a chameleon. And you treat different folks different ways. I think the era of political correctness has damaged some of the interpersonal relationship that I used to have with patients. I got away with murder. [laughs]

FRISCH: Talk to me about it.

MILLER: Well, nowadays you have to be so careful. Because almost anything can be found offensive. I had a lady one time who, I was obviously behind and rushed. As I was leaving, she was starting to re-don her clothing. She said, "Wait a minute, wait a minute. What about intercourse?"

I said, "I'd love to, but I don't have time." And I went out the door.

She was dressed in a minute and was out and called me a really filthy name. And said, "Do you know what I meant?
"

And I said, "I know exactly what you meant, and its okay." [laughter] She was a long time patient. Nowadays, whew, you'd be on the yard arm.

FRISCH: You know, there are a couple of things you've told in various tapes and things, but I think they're kind of important to explore in the background. One of them was you talked about coming in to be with a patient, sitting down, and going, "Whew! Now I can finally relax." Tell us about that. Why it really is a part of who you are and what you did, and why it was such an effective way of communicating with patients.

MILLER: Well, it gave them a certain amount of confidence.

FRISCH: Would you describe what you did?

MILLER: Well, when I entered an exam room, if a patient was sitting, I would sit. And greet them and sit. Try to maintain eye level, on the same plane. And it's always nice to remember something about them, maybe a little jot that you put on the outside, maybe the jacket of their chart. And people appreciate that, that you really know them, care about them, remember things about them. Sometimes you can screw it up. [laughs]

FRISCH: For example?

MILLER: Well, Brian (Vo?) tells the best story. This doctor said, "Oh, how was the fishing trip you were going to take?"

And he said, "I don't fish." He said, "You write little memory things on your charts, don't you?"

He said, "Yeah."

"You must have the wrong jacket." [laughter]

FRISCH: You used to do that, though.

MILLER: Yeah. Yeah. And when I did OB, I would always tell patients whether I thought they were going to have a boy or a girl. And if I said, "You're going to have a boy," I'd write "girl," "female," on the chart.

So if they said, "No, you told me–"

I'd go, "No. Right here. I wrote it."

FRISCH: You actually speak in terms of sadness for having lost the ability to come in and really be on the same level as the patient, or perhaps even being a little lower, your

approach. Obviously as a healer, you saw this dialog as being important. What was it about that ability to communicate in that way with patients that you thought was so important?

MILLER: Well, they believed you. They were assured that you were doing things in their best interest.

FRISCH: So when you joked with them–

MILLER: You didn't have to sell yourself each and every time you interacted with them.

FRISCH: So you'd have fun with them.

MILLER: Sure. Sure.

FRISCH: Would you consider that part of providing healing care?

MILLER: It was for me.

FRISCH: In contrast, what about when you broke bad news?

MILLER: Well, same way. Honesty is always the best policy. You break it was softy as you can, but you can't unring a bell. And one moment, the patient or whomever you're communicating with doesn't have a clue what's happened. And suddenly it dawns on them what has happened. And I think it's important to spend some time with them.

FRISCH: You recall Dan O'Connell speaks about the "find it and fix it" model of medicine.

MILLER: Right.

FRISCH: This sort of comes after 1958, comes in with maybe around managed care, maybe a little bit earlier.

MILLER: A little earlier.

FRISCH: Can you talk a little bit about how, contrast how you approach things with that kind of model, and what you saw the advantages and disadvantages of your approach were?

MILLER: Well, Dan, of course, refers to the find it and fix it method as you don't ever have to talk to the patient. You just have a test or an X-ray or an imaging device of some kind that is so potent and pervasive that it gives you the diagnosis. You don't have to talk to the patient. In some ways, that's very efficient. But it kind of takes the fun out of it for the physician, I think.

FRISCH: And what does it take out of it for the patient?

MILLER: Well, it's impersonal. Trust of the physician. You don't know.

FRISCH: So a family physician, from your perspective, maybe they weren't finding and fixing things as much as they were what? How would you complete that sentence?

MILLER: Well, they were investigating and trying to learn about their patients.

FRISCH: You saw patients throughout their lives. I mean, from the time they were relatively young to the time they passed away. I assume there was something sustaining about that for you, to be able to share in someone's passages through different parts of life.

MILLER: Well, it's kind of nice to know their grandfather before he passed. And their grandmother, and their aunts and uncles. With the onset of healthcare insurance, all of that became a little difficult. Because each time an employer changed their health plan, they had a different panel of physicians. So it was very difficult for a family to carry on with the same physician year after year after year.

FRISCH: When did this whole transformation that you refer to, move from the late '50s to when all this starts becoming a factor?

MILLER: I'm not sure I can pin a date on it.

FRISCH: Did it feel like you'd been in practice a while?

MILLER: Oh, yeah.

FRISCH: So you had a fair amount of time with this other deal.

MILLER: With the good old days. Right.

FRISCH: Where were the drug detail people on all this?

MILLER: Oh, they were a source of great entertainment for us.

FRISCH: Tell me about it.

MILLER: Oh, we used to do all kinds of weird things. Putting competitors' samples in their sample case. [laughter] They'd go to the next office, and oh my God. Pull out a Lily product, and they're with Upjohn.

One time I had been to an athletic event at the Coliseum. We'd stopped at The Pantry on Broadway for something to eat. And someone stole my raincoat. And when we, my keys were in the pocket. And when we went back after the event, my raincoat had

been returned, because something in, had my name in the pocket. And the next time we decided one of the, it happened to be a Jewish salesman for Wyeth that we loved to bug, and he came in and we said, "Let's be nice to him. Let's really fake him out." So we were just super nice, and agreeing with everything he said.

And he said, "Okay. Who told you?" He had taken my coat! [laughter] "Who told you?"

I said, "Told me what?"

"That I took your raincoat at The Pantry."

FRISCH: That's how you found out.

MILLER: That's the first I knew about it. [laughter] So he 'fessed up on his own. We used to raz the hell out of him.

FRISCH: They'd be in the office from when to when, usually?

MILLER: Well they were always, right after lunch.

FRISCH: And their goal?

MILLER: Get you to write prescriptions for their drugs.

FRISCH: This was a time when there were probably not as many drugs as there are now.

MILLER: True.

FRISCH: But still, this was the beginning of that whole process.

MILLER: It was before television advertising.

FRISCH: "Ask your doctor."

MILLER: I don't know why, but at one time we always called them the ethical drug manufacturers. How they ever got that name– [laughter]

FRISCH: What were some of the other kind of oddities about practice? So you had people who weren't doctors, running through your office trying to sell you stuff. What were some of the other things that marked practice back then that were unusual, we don't do now.

MILLER: Oh, I'm not sure. We were very fortunate in the early years. We had all RNs, our employees.

FRISCH: Were all licensed nurses?

MILLER: Yeah. And we had also a licensed X-ray and lab technologist. She was one and the same person. She was licensed in both areas. So we were very fortunate.

FRISCH: Did you have a lab inside your office?

MILLER: Oh, yeah.

FRISCH: Who were some of the memorable people that worked for you?

MILLER: Alice.

FRISCH: You always talk about Alice. What was the story about Alice?

MILLER: Alice retired when she was seventy-five. She was an army nurse in Pearl Harbor. Went through the bombing. She was a tough character. She was going on vacation one time. And I always had a bunch of charts and letters to dictate and piles of stuff on my desk. And the first day she was gone, there was a note on top of it and said, "If this pile is not completed and finished by the time I return, you will be discharged, and you will find it very difficult to find employment elsewhere. Love, A." She was funny.

FRISCH: Did patients like her?

MILLER: She was going to give a shot to an eight year-old kid, boy, eight or nine, one time. And he said, "That nurse isn't going to stick me with no needles."

And I said, "Be careful."

He said, "Why? She ain't going to do it."

I said, "She's going to do it. She's got a black belt in karate. She'd break you in pieces."

He just sat there with saucer eyes, and she jammed him in the butt. [laughter]

FRISCH: Was Alice typical of the kind of person that you were able to attract into the practice?

MILLER: [laughs] Alice wasn't typical of anything. She was one of a kind.

FRISCH: She was unique.

MILLER: One of our first workshops, we had an employee who obligated the physician because she practiced a little medicine on the side. What was her name?

FRISCH: Oh, in one of the videos?

MILLER: One of the vignettes. Early one.

FRISCH: Ivy.

MILLER: Ivy. I used to tell the crowd that Ivy, although this was shot in my office, Ivy is not my employee. My Ivy is named Alice.

?: Stopping tape. We are rolling.

FRISCH: Well, you heard it. Let's talk about it. Start wherever you want.

MILLER: It became apparent to us that we should develop a program to help physicians avoid malpractice claims and suits. And we researched everything that was available. St. Paul had a program, St. Paul Insurance. Veterans had a program. There were several others. The AMA had one. And we didn't like any of them. They didn't seem to carry a message, something to take home and use, something practical. So we set about getting our own. We got a committee together that was a search committee. And we got some audiovisual people. I can't even remember the guy's name. He died on us after a couple of years. [laughs] And we quit using him then.

?: Was that the psychiatrist in Lebanon?

MILLER: Yeah. I can't remember his name.

?: Dougherty?

MILLER: Yeah, that's close.

FRISCH: Oh, yeah! Yeah!

MILLER: He had some very strong ideas. I don't know if we ever would have been able to put them together into a usable program. But Dr. Dougherty was our A/V guru at that time. And we were fortunate enough to discover Matt Simek. And he hired writers, and we wrote vignettes. In those days we were frankly afraid of physicians. We were afraid to show them what things we were seeing in a malpractice review committee, because we didn't think they'd believe us. Things sometimes got so bad.

So we picked four very simple subjects to make vignettes about. And there was a practical message in each one. One was not to alter your records. Don't even alter records. Doctors should practice medicine, not penmanship. The casual practice, I can't even remember the four vignettes now. It's been too long ago. Oh, the office staff practicing, and creating a doctor/patient relationship by doing so.

FRISCH: Cursory practice.

MILLER: Cursory practice. The coumadin. The physician was so hurried that he didn't even take the guy's shirt off, and he had shoulder bursitis. He didn't see the sternal split scar. The guy was on coumadin, and he put him on butezolidin or (danderil?), and the guy bled out. So we thought there were four simple messages that were practical things that physicians could take home.

Over the years, we got a lot more aggressive, and started showing them things. At one point we made a good doc/bad doc tape. We wrote essentially one script and had two different vignettes. Different actors and different inflections, and so forth. But they were essentially the same script and the same thing happened. We would show the bad doc first, and people would be angry, just infuriated. "I'm not sitting through this," kind of crap.

So I finally learned how to present it. I'd stand up and say, "Is anybody offended by that?" And some people would hold up their hands. And I'd say, "Well, you all ought to be offended by that. Because we didn't invent that. We took it from actual case reviews. It's a compilation of a whole bunch of different things, but its actual Oregon experience."

Then we'd show the good doc, and say, "Is that doctor likely to get sued? Or claimed against?"

And one of the guys was writing out his evaluation sheet. "That's the way we do it down here at Medford."

And we said, "No, the docs made the same mistakes the first one did." He scratched it out, but we could still read it.

FRISCH: How did things get on the radar screen for inclusion into the work?

MILLER: Well, through the case reviews, we had our finger on the pulse of what was going on in Oregon. And originally, every three years we would recycle ourselves. We got CNA to give us a premium discount. Seven and a half percent for three years if you attended a workshop. That was before we were a purchasing group, so people could elect to come or not come. I often pointed out to neurosurgeons they were making more in the back of the room than I was presenting the workshop. [laughter]

Since then, it has evolved so it's kind of an ongoing changing thing. When we see new problems, or there are new solutions to old problems, we incorporate them in a new segment of our workshop. We do much less clinical vignettes now than we did in the past. They're more expensive to do. Take more actors. We do more interviews with topical people, people who have answers, experts. It's changed over the years. The whole malpractice scene for us has changed. CNA got away from doing practice review by committee, a mixture of committee, different kinds of physicians. Probably because it

was too expensive. Instead they use individual expert reviews. And I think they save money by doing it.

But originally, the committee reviews, a lot of defense theories were invented at the committee reviews. Often the defense attorney would walk out and say, "I'm looking at this case altogether differently after tonight." And a hundred million dollar claim in Eastern Oregon, the theory that made it go away, was invented at one of the committee reviews.

FRISCH: Well let's go back to kind of the naming principles, how it all started. Tell us how the Professional Assessment Committee came into being, and under what name and circumstances that led you to have to be essentially secret for a period of time.

MILLER: Well, when I joined the Professional Consultation Committee, that was the name of it, which doesn't mean anything. Professional Consultation Committee. The subsequent committee was the Malpractice Loss Prevention Education Committee. I used to tell people if you name your committee properly, you don't have to have a charter. It's all in the name.

Originally, the Malpractice Committee was called the Malpractice Committee. Even before Budget Bob Dernedde got involved with the OMA, the OMA operated very frugally. Cheap. [laughs] And they sent meeting notices on postcards to save money. And I think he was a general surgeon. Postman comes in, hands him his stack of letters, his mail, and says, "I'm sorry, Doc, you must have screwed up. You have to go back to the Malpractice Committee." So they changed the name.

In those days, we did not have ORS 41675, the peer review protection statute. And we were in constant fear that we would be discovered, be summoned, and have to report what went on at one of these practice reviews. And it could be, ooh, make a plaintiff attorney's job very, very simple. Because we wanted to see where the skeleton was, and wanted to know how all the bones fit together in a claim. And we often role played as vicious people. We took turns. And with that, when we were transitioning from a –

[End Track Two. Begin Track Three.]

MILLER: –Park Avenue building to this building, for some months we didn't have a kitchen. And we got in the habit of going to the Mallory Hotel. And I was deathly afraid that the plaintiffs (bar?) had put a wire in there. So we started moving it around. In the first early days, you couldn't even tell people that you were on the committee. You couldn't tell them when meetings were. We were highly secretive. Now, of course, it's wide open. With 41675, we have immunity.

FRISCH: You've talked about the early days of the committee. What's different about you is that you never had a claim against you. Is that right?

MILLER: I had two claims.

FRISCH: Two claims.

MILLER: Yeah.

FRISCH: And they were closed without payment.

MILLER: Oh, yeah. I had to submit– it was interesting. There were two claims, a husband and a wife, from the same attorney, on the same letter.

FRISCH: A twofer.

MILLER: Right. He was trying to save money, too. He was frugal. His claim was that I had delayed diagnosing his carcinoma of the lung. In truth, I was the one who diagnosed his carcinoma of the lung when he came in with shoulder pain. And this is, I was so lucky. I got an X-ray of his shoulder. And in those days, we didn't have developing machines, at least we were too frugal to have one. And we had (wet reads?). And I thought I saw something in the apex of his lung, on the shoulder, PA. So I asked my X-ray technician to take just a single PA, chest film. And there was a lump. I subsequently dried the shoulder films and looked and I couldn't see a damn thing. Took them down to the radiologist and showed it to several of them. They couldn't see anything, either. I was looking at a water spot, apparently. So he was a very fortunate dude. I referred him to my usual chest cutters. And he called back. And he was a Mason, and he could get a discount at Good Samaritan. And at that time, one of the committee members was a chest cutter from Good Sam. So I referred him.

And the lady, his wife, that I had failed to diagnose her carcinoma of the breast. Alice, my nurse, distinctly recalled that she had gouged her to get an appointment. She hadn't been in my office for three years, and she insisted that she had. Alice looked at all the medical records, no office visits, even went to the financial record, the ledger, and no charges. So I wrote three different sets of summaries of my care. And copies of the X-rays, and sent them in to three different attorneys, and it finally went away.

FRISCH: A lot of people who have worked in this area, Tom, and you know this as well as I, got there for a period of time because of their experience getting sued, or in a claim. It raised their interest in it and it made them interested and committed. And then over time, like an angle worm, they sort of lost interest, lost their passion about it, and disappeared. We can talk about those people, but I want to talk about you. What kept you there so long in this? What was the reason you got started in the first place and stuck with it all these years?

MILLER: Well, I blame Tom Hahn. Tom was not a committee member. He was a fill-in for George Long. George Long, we all thought, was a dinosaur because he spent twenty-five years on the committee, and we had a big celebration when he retired. Gave him a

colored television set. Wow. (?) Taylor and Hayes paid for most of it, but all the committee contributed.

FRISCH: It was probably expensive.

MILLER: Oh, yeah. Oh, yeah. You bet. Anyhow, Tom Hahn recommended they wanted Opie McCall, the chairman, was looking for another primary care physician, family practice. Bob Tinker was a member. And I don't know if somebody retired or what. But anyhow, I remember getting a letter from Ernie Livingstone, who was president in '65 and '66 that I was invited to join the committee. And I just never quit. Never got around to it.

FRISCH: Well, what was your connection to it? What made it so interesting to you that you've done all these things, you've taught the programs for thirty years. You've never flagged in your interest at all. What holds you into this whole thing?

MILLER: Well, it was highly educational. Each of the case reviews, I learned something. Everything I know about necrotizing fasciitis I learned at a malpractice review. Bunches of things that I wouldn't have been exposed to otherwise. I think I grew with–

FRISCH: You think you became a better doctor?

MILLER: Oh, I think so. I think so. More well rounded.

FRISCH: So you got as much out of it as you gave, the way you look at it.

MILLER: Oh, hell yes. You bet.

FRISCH: What about teaching those workshops for thirty years?

MILLER: Well, I learned something every time. A new wrinkle, a new idea.

FRISCH: A new approach?

MILLER: Somebody last fall said, "Well, people who run out of their prescriptions, I've got a system for that." Apparently his pharmacist still uses cotton on the top of his prescriptions. And he has him pick the cotton out, dump all the pills out, take two weeks' worth and put in the bottom of it. Put the cotton back in, put the pills on top. When you have to pull the cotton out, it reminds you to get a refill. And we've all done that. "Oh my God, I'm out of medicine!" [laughs] We can't understand patients who do it. But when you do it yourself, you understand.

FRISCH: Let me give you some words and ask you to react to them along lines of–

MILLER: Is this a test?

FRISCH: Yes. What you've done. Legibility.

MILLER: [laughs] Guilty. Alice and I were the only ones who could read my writing. Historically, I had pretty decent handwriting when I got out of high school. And in college and medical school, where you take notes a lot faster and invent your own abbreviations and signals, other people can't read your writing. If the doctor can't read his own writing on the witness stand, he's in a little bit of trouble. On the other hand, dictated notes and the (T?) system bother me a little bit, in that I think sometimes more information gets on the record than was actually generated in the interface between the patient and the doctor. If patients go into their doctor and use a stopwatch and the doctor's with them three minutes and you get two and a half pages of single spaced, typewritten record, that's phony.

FRISCH: Haven't you seen some things in electronic records where it's supposed to be a man and it turns out the dictation comes out as a woman.

MILLER: Extremities normal, bilateral amputee. Each time my wife went to her cardiologist, each record showed blood pressure readings, different blood pressure readings, for the right and left arm. Each time her blood pressure was taken only once.

FRISCH: You were there.

MILLER: I was there. And I mean, it's phony information. Which vitiates the authenticity of the entire record, as far as I'm concerned.

FRISCH: Documentation. Malpractice lessons?

MILLER: [groans] More is better. In the courtroom, juries believe physicians when the record confirms what the physician is pleading to. In the absence of a record, the tendency is to believe the plaintiff. Because that's the only time Mrs. Jones ever had her gall bladder out, and she probably remembers specifics from the encounter.

On the other hand, Dr. Smith has done seventy-two gall bladders since then. How can he remember what was said, what was done, the order of things? And that's common sense. Juries believe doctors when they have records to back them up. They don't believe doctors if there aren't records. In the absence of records, it didn't happen.

FRISCH: Good record?

MILLER: Good medical record is a document that if the author falls off the face of the planet, another similarly trained physicians can pick it up, spend a few minutes with it, and be in stride in taking care of that patient. The thinking of where we're going to go next, where we've been, is pretty well apparent in the medical record.

FRISCH: Record alteration.

MILLER: Fatal. You just, it just can't be done. If there's a mistake made, the ideal way is to go to the chart where today an entry would be put, put today's date, "On review of the record for whatever reason, I discovered an error on June 13 last year." And make the correct entry, and initial it. You might want to put a star next to the thing that you've corrected, next to, outside and away from the body of the note to indicate where to look for this entry.

But there are so, it's a total science involved in identifying when pens, ball point pens were manufactured. Manufacturers put daters in their ink, in case somebody sends back a carload of pens and says, "Hey, these pens don't work." Well, that's because we manufactured them in 1979. They protect themselves that way. Analysts can look who know, handwriting experts, can test paper and find out how long ink has been on it. They can age that. There are so many tricks. You can't get any of these people on camera, because they're not going to share their tricks. That's how they make their living. We've tried.

FRISCH: In the area of delays in diagnosis, what's the significance to you of the unresolved diagnosis, or unresolved condition?

MILLER: Well, if you can't put a tag on it, you really haven't done your job, even if it's the wrong tag. I think physicians often make the wrong diagnosis for all good reasons, all the right reasons. And another physician can testify that, "I think this physician's thinking was proper." Shouldn't be expected to make a diagnosis of appendicitis with these presenting complaints and findings. But if you can't put a tag on it, you're at some risk. I think you have to be persistent enough to rule out really serious things, things of great consequence

FRISCH: Missed appointment or missed procedure.

MILLER: Well, if it's important enough, the physician probably has an obligation to pursue it. If it was a common cold and you wanted them back just for an office visit, another fee, and they don't come back, I don't think you have to follow up on that. But a missed surgeon that for a breast biopsy or suspicious lump, the patient doesn't show up, I think you have some obligation to pursue that. How much? Enough to make twelve people sitting behind an oak rail say, "That's enough for me."

FRISCH: Laparoscopic surgery.

MILLER: Well, it's kind of nice. It's quick. It's painless. I think, I think the problem has been one of personal pride of the surgeons. To them, it seems like a failure if they have to convert to an open procedure. It's a gotcha, they don't like to do that. And I think the real damages have been in those cases where it should have been converted to an open, and it wasn't. And it's a personal pride thing.

I had a general surgeon that I had only two gall bladders with him. And both of them, we opened. We converted both of them. And we got out and we're washing off our hands and taking off our gloves and stuff. And he said, "Well, I can see that this will be the last (lap coli?) I get from you. I had to convert them both."

And I said, "No, you're going to get them all. You've got 'nads enough to open them up." And I think that's the biggest problem I have with laproscopic procedures. Some of them need to be open.

FRISCH: Radiology reports.

MILLER: Well, it's not good when an abnormal finding appears in the report and it never gets in the hands of the ordering physician. And I think there's some obligation on both parts. I think if it's a serious enough finding, the radiologist has some obligation to make it apparent to the ordering physician by an email, voice mail, telephone call, would be the ideal. But radiologists tell me that they can't get a clinician on the phone, a primary care physician. The MBA who runs the place won't let them spend their time chatting with colleagues. They have to be turning the crank.

FRISCH: What do you recommend?

MILLER: Well, an email. A fax. Telephone call. Bump into them in the hall. Say, "Did you get that report?" Whatever. In an ideal world, it would be 1958 all over again. Déjà vu. You could pick up a phone and if a doctor was on the other end, you could get through. That just doesn't seem to, now you get into voice trees and God, you're there half an hour and you haven't got to talk to anybody yet.

?: Okay, I think we have a tape end here.

FRISCH: Good. Is this good?

?: Yeah. I think Tina's visit was energizing.

[End Track Three. Begin Track Four.]
[Tracks Four and Five are blank.]