HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

with

W. Richey Miller

Interview conducted May 20, 2003

by

Hugh Johnston

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Interviewee: William Richey Miller
Interviewer: Hugh Johnston
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[Begin Track One.]

This is an interview on the 20th of May with Richey Miller of Eugene. As conducted by Hugh Johnston, of Eugene.

JOHNSTON: Okay, well Richey, why don't we start with, you tell me about your growing up in Oklahoma and how you got interested in medicine back then.

MILLER: Well, my interest in medicine came from a student at the University of Oklahoma who rented a room in our home during the Depression. He was a son of a doctor and got his interests from his family, I guess. But he was about the only university student I saw over those years who was really interested in what he was studying. And he liked to verbalize this with me. I'd go up to his room and he would tell me all about zoology or whatever he was studying, getting ready for a test or something. And so I was stimulated by him to the idea of being a doctor, because it seemed so interesting to him. And I found it interesting, too. So I decided to be a premed student.

JOHNSTON: And you were how old when this, what was his name again? What was the name of the doctor?

MILLER: It was Frank Joyce, who became a neurologist in Denver, I think.

JOHNSTON: And you were–

MILLER: I was in early high school.

JOHNSTON: Okay and so that's, and then you went to what medical schools?

MILLER: University of Oklahoma.

JOHNSTON: Okay. Tell me about, a little bit about the training that was going on at that time as a medical student.

MILLER: Well, the best training they had was in the clinical years, the last two years of medical school, which was done largely by volunteer doctors who were practicing medicine in Oklahoma City. They made rounds with medical students at the hospital, and lectured to us about what they observed or whatever they wanted to talk about that day. And I felt that was really a good education, because it was coming from very intelligent, good doctors who were active in the practice of medicine every day.

JOHNSTON: And these, the hospitals they were in, was it a medical school hospital? Or was it a county hospital, or what?

MILLER: It was a university hospital in connection with the medical school.

JOHNSTON: Okay.

MILLER: It was a charity hospital.

JOHNSTON: So they had a separate ward based on color at that time?

MILLER: Yes. That's right.

JOHNSTON: Can you tell me something about how that related to things at the time?

MILLER: Well, everything seemed to go along all right, until somebody in the state legislature complained that student nurses, these young girls, he said, were working in the colored wards at the hospitals.

JOHNSTON: White girls.

MILLER: They were all white girls. All of them. And they were taking care of these patients on the colored ward. And even to the extent they were carrying bedpans, sometimes, for them. And that was absolutely intolerable. So the legislature decided to call the dean of the medical school out to testify about this. And he went prepared, though. He took a poll of all the student nurses, secret poll, and he went with this poll to a formal session of the Oklahoma state legislature. And they asked him about this practice of the nurses carrying bedpans and all sorts of things like that, doing for these colored patients. And he said, "Yes, that's quite true."

And he was asked, "Well, what do you think about this going on?"

"Well," he said, "I think it's more important to know what the student nurses think about it, not what I think about it. So I asked them. I took this secret poll and only asked them one question: Which place do you prefer to work in the hospital, on the white ward or on the colored ward?"

And the poll came back, I think it was something, there were only one or two students who said they preferred the white ward. Everybody else preferred the colored ward. And that kind of ended the legislative session. They thanked him very much for his coming out. And that was the end of that.

The reason I think the student nurses preferred that was just because they found the, overall, the colored patients were nicer and more appreciative, and people just enjoyed taking care of them.

I saw that in the homes where we went to deliver babies. A junior medical student and a senior medical student would go out in a pair to the home to deliver babies. And it was, I observed, and almost all the medical students agreed with me, all of whom were white, that we preferred to go to the colored homes rather than the white homes. And the reason, again, was, as I saw it, it was a more pleasant experience. The homes were

cleaner and the people were nicer, and they appreciated very much what we were doing. It was just a more pleasant experience.

I had an interesting experience with that once when we had, we were tending a black girl who was an unmarried teenager and was at home with her parents. And she had a long labor, and after we had been there with her about twelve or eighteen hours, I guess, and it was the middle of the night, we determined that she had an undilated cervix and was going to need some surgery to deliver that baby. So in that case, we were supposed to call the resident of the hospital, and they would send an ambulance out, and we would send the patient into the hospital.

So I told the father, who was a very large, strong man that I needed to use his telephone because we were going to have to take his daughter into the hospital. He said, "Well, I don't have a telephone, but I'll take you to where one is." And we went out of the house on a black night, no streetlights in that area or anything, and walked several blocks. I was sure glad I was accompanied by this big, strong black man.

And we came to a place that looked like it was an old, abandoned service station that was, that had been converted to some other kind of store or something. He walked up and knocked on the door, and a little squeaky voice inside said, "We're all closed up in here. Go on away." And he knocked again and said, "We're all closed up in here. Go away! Go on away!"

He got swelled up and looked down at me like, watch this. And he hammered again on the door, and he says, "This is Big Joe out here. I'm going to ask you a question." He said, "I've got a white doctor with me. And he's going to use your telephone. What I want to ask you is, you going to open that door or am I going to knock it down?" [laughter]

With that, the door opened up and little man inside was bowing and scraping, "Good evening, doctor, good evening, doctor, there's a telephone right over there. Anything else I can do for you?"

So that's what my experience is like with the race problem.

JOHNSTON: Tell me more about your training. You went on to Oklahoma medical school, and then to a residency there. Is that correct?

MILLER: Yes, I graduated at the University of Oklahoma medical school in 1942. And of course the war had started in 1941. And I had a commission in the medical corps of the army to be activated when I completed a year of internship. So then went to Good Samaritan Hospital in Portland and interned there for a year and met the girl I married. And then went into the army, and was in the army in various ways for three years. And then went back to the University of Oklahoma and had two years of my residency there. And then I wanted to return to Oregon, as my wife did. So I wrote to some of the doctors I had known during my internship at Good Sam, and asked them if they could help me get my third year of residency at University of Oregon. Well they wrote back and explained that they had the same problem as Oklahoma. They were taking only people who had had military experience for their residency programs. So I couldn't do that.

JOHNSTON: You'd had military experience, though.

MILLER: Yeah. I'd been, yes, but all of the residents at Oklahoma were people that had military experience. And the same is true for Oregon. But at Oklahoma they were all University of Oklahoma graduates, and at Oregon, all Oregon graduates.

JOHNSTON: I see. You didn't qualify there.

MILLER: Yeah. So Blair Holcomb, one of the doctors I had written to, wrote back to me and said, "Well, we could, I could take you on to work in my office here for a year, because it's going to be a year before I have an endocrinologist join me. And you might speak to your chief of medicine there at Oklahoma and see if you could get credit for this for your third year." Sounded like that would be a good third year and all, and a way to get back to Oregon.

So I checked with chief of medicine. He investigated Dr. Holcomb and learned of his great reputation in the Northwest, and somewhat in the nation. And he said, "Sure. We could certify that for you."

So I wrote back to Dr. Holcomb, told him yes, I could get certified that. And I'd like to come out and spend that year with him. He wrote back and said fine, report here June first, and I can pay you five thousand dollars for the year. That was the first time money had been mentioned. I wasn't expecting any money for it. I went, wow! I've got it made! [laughs] Five thousand dollars in addition to ninety dollars a month from the GI Bill until I completed my residency. And that's the way I came back to Oregon. Good old Blair Holcomb was my meal ticket.

JOHNSTON: I want to back up a moment. In World War Two, you said you did various things. What were you involved in in World War Two? What did they have you doing?

MILLER: Well, to begin with, I was the only medical officer I ever heard of that didn't go through Carlisle Barracks. Carlisle Barracks was where you had training for several weeks of how to be a medical officer in the army. Why they didn't send me there, I don't know. But I reported to Fort Sam Houston and worked on the medical wards in the hospital there. Brook General Hospital. Then after being moved to Washington to go to the School of Tropical Medicine, then down to Panama to the School of Malariology, then back to duty in the States.

Then I got a call to report to a certain address in Washington, DC. It didn't say what this was for. It was just addressed to Lieutenant Miller, and you report there on a certain day. I showed that to the regular army officers around Fort Sam. They didn't know anything about it. So I went back and looked up this address and knocked at the door an identified myself and found out that I was reporting to the Office of Strategic Services, which was the cloak and dagger unit of World War Two.

And after getting interviewed by the head of the office there, then I was introduced to some people, some army sergeants, they were all master sergeants, were going to go on a mission to the China/Burma/India theater and conduct a guerilla warfare. They would function as officers for this guerilla warfare operation.

And in the training cycle for this, I fell off a suspended girder going over an obstacle course and fell on my face and broke my neck. And that was the luckiest break I ever had. Because I had a severe fracture of the atlas, you know, the first vertebra under

the skull. And when that occurs, almost invariably the odontoid process that sticks up through the atlas to stabilize it breaks off. I also had some fractures lower down in the spine, cervical spine, in the bodies of the vertebrae. And miraculously the odontoid process didn't break off, and the broken atlas didn't move any. And I had no paralysis. Almost invariably when that happens, the odontoid breaks and the person is quadriplegic. But I had no paralysis whatever. I made an un(?) recovery and went back to duty at the station hospital.

But the unit I was training with to go to the China/Burma/India theater were, well, they never reported back. So that was a lucky break.

JOHNSTON: So they all disappeared in the jungle.

MILLER: Apparently. Yeah. They did.

JOHNSTON: So while you were there at Walter Reed, was it?

MILLER: Yes. Walter Reed.

JOHNSTON: You got to go see Roosevelt inaugurated. Tell me about that.

MILLER: I did. That was most interesting. He was being inaugurated for his fourth term. I guess his last term. See before that, I might tell you a story. I saw him at the beginning and end. I saw him campaigning for office the first time, when he was elected in 1932. I went with my class in school to the Oklahoma State Fair in September. And at that day, Roosevelt was appearing on the campaign trail. He was speaking in a large field with bleachers around. And he showed up in a big limousine and was helped out of the car, had braces on his legs. But he was able to walk a little bit at that time. He was dressed in a white Panama hat and white suit, white shoes. He was a study in white. And everybody kind of held their breath as he was assisted up several steps to get to the platform. And he finally got up on the platform and then alone with these two crutches to help him, he struggled slowly across the platform to the podium, and got a hold of the podium and stood there. The crowd was deathly silent all this time, watching every move he made. Then he took off his white hat and gestured to the crowd with a big smile, and pandemonium broke loose! The cheering didn't stop for several minutes. People threw their hats in the air and everything. Now that's real charisma. He hadn't said a word, just doffed his hat.

So anyway, at his inauguration in this, for his fourth term, I was a patient in the hospital with my broken neck at Walter Reed. And they were taking some of the patients that wanted to go to attend the inauguration. And I wanted to go. And I was a weird sight in a cast from the top of my head down to the waist. And so they, I guess naturally selected me because I was such a sight. And I got to go to the inauguration, and was seated with the United States Senate, just below the portico of the White House. And we weren't more than maybe something like fifty, sixty yards from the portico. And–

JOHNSTON: Feet or yards? Was that feet or yards, I'm sorry.

MILLER: Maybe fifty yards.

JOHNSTON: Okay.

MILLER: So he was wheeled out in his wheelchair, and he had an attendant on one side, and on the other side was his son James Roosevelt, who was an officer in the army. And they pushed the wheelchair up behind the podium, and then the attendant and James Roosevelt literally lifted him up and placed him behind the podium. He grasped the podium with both hands and didn't say anything. And then in just a moment, he just went blank. Just looked like he was dead. And he slowly leaned over and James Roosevelt just happened to see him out of the corner of his eye and turned and grabbed him and pushed him back up behind the podium, held onto him and got around in front of him and talked to him, I guess, for a short time. And then the president grabbed the podium again, and James Roosevelt stepped aside, and then he began his speech, which was very short.

It was obvious to me that he had what we call now a TIA, a tran (?) attack. He'd had some interruption in the flow of blood to his brain. And it was obvious to the entire United States Senate and anybody who was looking that something had happened to him, or he was unconscious briefly.

So that was most interesting, and I was interested to see what the press would report this, how they would report it. And I carefully examined the newspaper thoroughly for the next several days and listened to all the news radio broadcasts, and no mention was ever made of that. In those days, you couldn't say anything about the president's health.

JOHNSTON: So you came to Oregon to practice, and after being with Bill Holcomb–

MILLER: With Blair Holcomb.

JOHNSTON: Blair, yeah, Blair Holcomb. There's the other Bill Holcomb. You went down to Eugene.

MILLER: Yes.

JOHNSTON: Did you go in with a group? Or what did you do?

MILLER: No, I went into private practice by myself. I knew one family in Eugene who was from Norman, Oklahoma. Otherwise, I didn't know anybody. And I just opened my office, a very, very small office and set up practice. And had no patients to begin with. But about the second or third day I was there, I had announced my presence to the doctors' exchange. And at that time, the doctors' exchange was eager to find people who would make house calls, emergency calls. So I said I was that doctor.

And I got an emergency call at night to see a woman who was sick at home. And I went out to see her and diagnosed chicken pox, which was a rare condition in a fifty-three year old lady, which she was. But it did look like chicken pox, so I prescribed something to ease her discomfort, and went on my way. And I went out to see her the next day and didn't charge anything for the second call. I just wanted to satisfy myself that that really

was the right diagnosis. And I examined her again in daylight, and yeah, she did have chicken pox. So that was the beginning of my practice.

And then I made my presence known to the hospital. The hospital was often looking for a doctor who would see a patient in the emergency room, which wasn't very much of an emergency room then. So I let them know that I was available. And I got a lot of calls to the ER, oftentimes at night. And my practice developed from there. One patient refers another, and so on.

JOHNSTON: You made house calls then.

MILLER: Yes.

JOHNSTON: That was sort of a thing to do.

MILLER: Yeah. That was, most doctors were making house calls then. Although they, a few years later they began to drop off. There were more and more doctors who didn't want to make house calls. They'd rather the patient go to the emergency room. And during those years, I was seeing a patient on a Sunday morning at home. And after I was finished with my work, the patient, who was the wife, thanked me very much for coming to see her. And her husband said, "Oh, yes, Doctor, we really appreciate your coming out here to the home on Sunday morning. And we won't tell anybody, either." [laughter] They didn't want too many people getting onto me for house calls.

JOHNSTON: So you came to Eugene in about 1949 or something like that.

MILLER: Yeah, 1949.

JOHNSTON: And back then, or what would you say in the next ten or fifteen years were the innovations in medicine that helped you or hindered you or whatever ways, what do you think was outstanding back then?

MILLER: Well I think it was all related to the technology of medicine. At that time, the only antibiotic we had was penicillin. And there were very few drugs to treat any heart disease. There was no effective medicine for high blood pressure. There were just very, very few medications that really had an effect on the body chemistry. And the, I guess the first great innovation in technology, perhaps, was the intensive care unit at the hospital, which Dr. Wes Jacobs developed in Eugene.

And that stimulated the interest of the cardiac surgeon who was then just finishing his training at University of Oregon. And so Bob (Hodum?) came to Eugene to establish his cardiac practice. And for the first time, we were really able to do something about treating directly the problem of heart attacks, and treating valve lesions in the heart, doing open heart surgery.

And that transformed a lot of lives when cardiac surgery became available in Eugene. It was being done for a few years before that, but the patient would have to go to Portland or a farther away place for cardiac surgery. Of course, a lot of those surgeries

needed to be done soon when the patient (?) such as coronary artery obstruction, most common form of heart attack.

JOHNSTON: You mentioned one time there's a man who's now ninety years old that had his coronary bypass back then?

MILLER: Oh, yeah. He had his first heart attack at age fifty-two, while he was jogging. Then he had, he recovered very well from that. I trained him to do advanced walking so that he would, he'd walk until he had chest pain, and then he would stop and rest. He was so careful about this, to follow my directions, that in the wintertime, when it was raining, he measured a track around the pool table in the basement of his home. And he'd walk around that pool table and know exactly how far he was walking, and know whether he was increasing his walking or not. Anyway, he recovered very well from that by being able to walk farther and farther until he could walk the golf course and not have any pain.

And then he had another heart attack, and made a quick recovery from that. I think it was his third heart attack, which was about a year after Bob (Hodum?) came to Eugene, and Bob (Hodum?) operated on him, and he made a good recovery from the surgery and didn't have cardiac symptoms after that. He's had a lot of other things happen to him, but he's now, this year, will be ninety years old, starting with his first heart attack at age fifty-two. So you might say that our cardiac surgeon got a good result there.

JOHNSTON: The practice of surgeries back in the early '50s, you said one time, sort of set Sacred Heart Hospital up. Is that correct? Am I correct?

MILLER: Well, I told the sisters at Sacred Heart that, how they got going on their reputation of becoming a top notch medical center in the southern half of the state, which I'm sure they are today. And the way that occurred was one of my early years in Eugene, I was asked to see a patient in consultation by a surgeon. And I determined that the patient very likely had a leaking abdominal aneurism. Aortic aneurism. And I reported to the surgeon immediately that I thought this patient had a leaking aneurism and needed immediate surgery. He said, "Well, if that's the diagnosis, then," he said, "there's no hope for him here in Eugene. Because there's no way he can have that surgery done in Eugene. And I guess we don't have time to run him up to Portland."

I was shocked by that, and hardly knew what to do. It so happened as I walked down the hall in the hospital, I encountered Dr. Leonard Jacobson, who had come to Eugene just the year before I did. And I told him about this case, and how he couldn't be operated here. And Jake says, "Oh, no, that's not true." He said, "We can handle that." He said, "In fact, I just saw Jule (Hessle?) downstairs. And he's had some training in vascular surgery." He had just come to Eugene that year. And he said, "I'll get Jule, and the two of us, we can do that."

I said, "Well, good. Come down and see the patient and see what you think."

So we went down to examine the patient again, and Dr. Jacobson says, "Yeah, I think you're right. He very likely has a (dissecting?) aneurism, or a leaking aneurism."

JOHNSTON: This was without any special x-rays and stuff like this.

MILLER: No, we didn't have any kind of diagnostic tests that we could prove that. But those were the days when you operated on a surgical abdomen, so called, if you thought the lesion very likely was something that should be treated surgically, then you'd open the abdomen and confirm the diagnosis or not confirm it.

So he was taken down to surgery immediately, and they operated and did find a leaking aneurism, and corrected it. And the patient made an uneventful recovery. And then liked to stand around on the street corners telling people about it. He was an insurance adjustor who kind of roamed around downtown, liked to meet people on the street and talk to them about all sorts of things. And he liked nothing better than encountering somebody he could tell about his hospital experience. And he wanted to tell them what a wonderful medical center this was. What wonderful doctors and a hospital we had here, it was really great. So I told the sisters, that's how their reputation started.

JOHNSTON: So there were other, you mentioned penicillin. You told me one time that you should even go out and get penicillin shots on house calls. You'd be sent out to do a house call.

MILLER: Oh, yeah. One of my, the first year, probably, I was in Eugene. One of the doctors I met at the hospital said, "You like to make house calls?"

And I said, "Oh, sure, yeah."

He said, "Well, how would you like to go out and see a lady for me?" And he gave me her name and address.

I said, "Sure, I'll do that. What kind of case is it?"

Oh, he thought for a minute. He said, "Oh, I think it's a shot of penicillin." [laughter] That was what we had to treat almost any infectious disease. And whether the doctor wanted to give a shot of penicillin or not, the patient would like to have it.

JOHNSTON: Is this the doctor that did abortions? There was a doctor–

MILLER: Yes.

JOHNSTON: Tell me about it.

MILLER: That was our famous Dr. Gentle. He did abortions in Eugene, the only doctor who did. And he did them very well. And almost never got into trouble. If there was any difficulty at all, he could immediately send the patient into the hospital, and there would be a skilled surgeon immediately available who could take care of whatever the problem was. And the entire community, the medical community and people generally, were very happy with this arrangement. Because if Dr. Gentle wasn't there doing abortions, then it would be somebody else, not a doctor, who didn't know anything about it, who was just sticking a probe into the uterus, and hoping that aborted the person, and hoping they didn't perforate the uterus or something. Many people died from those abortions that were called back alley abortions. So everybody was very happy with Dr. Gentle, who they knew could be trusted and everything would be all right.

And then, one of the doctors for some reason, decided that he didn't like that and he was going to turn Dr. Gentle in, which he did. And they set up a deal for the cops to walk into his treatment room in his office just as he was starting an abortion. So he was convicted and sent to prison. And it happened to be my job to do a physical examination on him before he went to prison. That was a requirement at that time, anyway. So we talked about his career during that examination. And I asked him if he was disappointed or wished he had never done this, and what did he think about it now.

"Oh," he said, "I just have one regret." And he said, "That's because of the people I took care of." He said, "I've worked for doctors and lawyers and businessmen and college professors, and judges." He said, "Yes, even judges, I've worked for. And still, that system is sending me to prison." He really didn't like that. And this was a fellow who was well respected in the community. He had a home in a nice neighborhood with nice neighbors.

One of his neighbors was my patient, and she told me what transpired. She went to see him in prison, she and her husband. And she told me about his homecoming. He was in prison about four years, I think. And when he was released, the neighborhood had a big party, welcome home party, with flowers and balloons and cards and everything. Decorated outside his home. And he got a most cordial welcome home and sympathy and appreciation from all of these neighbors. So that's the way abortions were then.

JOHNSTON: There were some global changes occurring, not global, in the state. Polio, when you were going into practice, was very prominently having epidemics all the time.

MILLER: Oh, yeah. Polio was, in my mind, the most tragic part of practicing medicine then. Because during an epidemic, we'll get a lot of patients in the hospital. Sacred Heart, I think, was kind of the polio center for southern half of the state. I guess because they had several iron lungs, a big canister that you could put the whole body in with just the head sticking out. And alternating pressure in this big canister to provide breathing for the patient. Compress their chest and exhale, and so on. So the tragic part about that was that we admitted lots of patients with, in the early stages of polio. And we'd see the paralysis progress from day to day, and we couldn't do anything about it. There wasn't any treatment. I think it was Sister Kenny who devised hot pack treatment. And I think the main thing that did was give a lot of tension to the patient. People were working with the patient every day. But it really didn't produce any curative results.

So immediately with the coming of polio vaccine, we got the whole community vaccinated with vaccination clinics that were set up by the Lane County Medical Society. This is all a voluntary thing. I don't think anybody paid for the vaccines. Maybe there was some voluntary payment to support the thing. At any rate, everybody got vaccinated, and polio disappeared. Never saw it again.

JOHNSTON: There are some other changes that have occurred in medicine, such as all the imaging studies and things like that. That's come up during your time. What do you think about all that?

MILLER: Well, I think all that has been a marvelous development of the technology of medicine, and there are lots of good things about that. I've personally experienced some

of that increased technology to my benefit. But there's a bad side to that, too. To begin with, I think that's what's responsible for the high cost of medicine. It was getting so high that nobody could afford it. Almost nobody. And the reason for that is that formerly, let's say when I first started practice in Eugene, in '49, we didn't have any of this technology. There was very little money that could be spent caring for a person. Hospital rates were low. I think hospitals were about fifteen dollars a day then.

So since then, we developed this increasing technology, all of which adds to the examination and diagnosis and treatment you can give to patients. But every improvement, every new development, is more expensive than what preceded that. So that the practice of medicine has become so expensive, we can't afford it. We literally can't afford to keep giving people all this increased technology because nobody can pay for it. Our insurance plans are breaking down now.

And the worst part of it, by far, in my mind, is that the working poor, so many of the working poor, do not have access to any medical care. You know, meager medical care, or long waits in line, or anything, would be a whole lot better than no medical care. And there are, as you know, millions of people who are working to eke out a living, but they don't have enough left over to afford any insurance plan, which they don't have access to, and can't afford the medical care.

One of the worst aspects of that is if a person is on welfare, that person has access to good medical care. But if the person gets a job and gets off medical care, they don't have access to medical care any longer, unless their employment provides it, or unless they have enough money to buy insurance. And almost none of them do, because insurance is so expensive, bought on an individual basis.

JOHNSTON: But when you first started practice, there wasn't insurance, there wasn't Medicare, and there was only a modicum of Medicaid or welfare.

MILLER: Yeah.

JOHNSTON: What would you do with the patients that came in and basically couldn't pay?

MILLER: Well, we had two groups of patients like that. Some people who couldn't pay, and acknowledged it, "I can't pay your bill now, but I'll pay you when I can." And another group were the people that just ignored the bill. And if you'd write them letters and ask them why they hadn't paid the bill, they wouldn't respond. That group of people we'd turn over to the collection agency, and they would collect the bill if they could.

We did that because we didn't know if these people had the ability to pay or not. They never said they didn't have the ability; they just ignored us. However, in the group who said "I can't pay you now, but I'll pay you when I can," every one of those people paid. I can't remember a single person who said that who didn't pay their bill. I well remember one woman who paid hers three years later. [laughs] She remembered, even though I'd forgotten it.

JOHNSTON: So insurance started in, too, the concept of that.

MILLER: Yeah. Yeah.

JOHNSTON: That was the early time.

MILLER: Yeah.

JOHNSTON: With all these insurance and technology and stuff, how did the doctor/patient relationship change in medicine, do you think?

MILLER: Well, I think it's changed so that the doctor/patient relationship is kind of growing apart. The one thing I learned about that from spending a year with Dr. Blair Holcomb, who was a diabetes specialist, wasn't so much how to take care of a patient with diabetes, but how to listen to a patient and relate to the patient. That's what he was a master at. He wasn't just a doctor for diabetes, although he conducted a school on diabetes. But following him around in the rounds of the hospital, I got the distinct impression that he seemed to be genuinely interested in every word the patient was saying. And if a patient mentioned something about his home or his job or something, he'd immediately want to know more about it. So he gave all these patients that idea that he was really concerned with them, and really interested in them as a person who they were.

Now, it seems like there isn't enough time for that sort of thing under the HMOs and managed care plan. The doctors seem to be on a set schedule, and they're concerned with keeping up to the schedule. They've just got a lot of paperwork to manage in addition. There's a lot of demands on their time outside of when they're in the room with the patient. And so the doctors feel increasingly rushed. And they've got all these technology to keep up with. And the patient has tests done, and they have to find out about that, and maybe talk to some other doctor about it, and so on. So it all boils down to the doctor seems to, or feels, anyway, that he has less and less time to just work on this individual as a person. And I think maybe that shows through that, it's not intentional on the part of the doctor. It just happens with the system the way it works. And the doctor's dissatisfied with that. The patient is dissatisfied, too. So nobody seems to be happy with the system. And in the meantime, it gets more an more expensive. Too expensive.

JOHNSTON: You must have made mistakes during your career. When you made a mistake, what did you do?

MILLER: Oh, just told the patient what happened. If the patient didn't already know. [laughs] Maybe they did. But that worked out all right. I think everybody understands that everybody makes mistakes. I don't think there's ever been a doctor that didn't make a mistake. I heard about, read about, one of the famous mistakes William Osler made, and he's supposed to be the greatest.

Anyway, I learned about how to handle mistakes early on, when I was an intern. I was assisting a doctor late at night on a twelve year old boy. And after he opened the abdomen, we located the appendix right away. And the appendix looked perfectly normal. So he went ahead and removed the appendix anyway, and looked around for any other disease in the abdomen. He couldn't find anything at all.

So he closed up. And when we walked away from the operating room, he said, "Well, I have to go down and talk to the parents and the family about this. They're waiting downstairs. You want to go along?"

Sure, I wanted to go along. I was wondering what he was going to tell the family. Just had this useless operation, because the diagnosis was wrong. That's not the only time that's ever happened. Diagnosis of appendicitis isn't one hundred percent accurate today.

And so we went down and found the mother and the father and a couple of the older kids waiting there. And the doctor who had done the operation said, "Well, we didn't find a doggone thing in there. Nothing wrong at all." He said, "His appendix was perfectly normal, so we took it out, anyway. So he's not going to have that problem again." He said, "I don't know what caused his bellyache, but I'm sure that he's going to be all right, he'll recover from this. I don't think he'll have any more trouble."

And the parents were both most appreciative. They said, "Oh, thank you very much, Doctor. We're so happy everything was all right. And we're so grateful for you to come out late at night and take care of our boy. We really appreciate it." [laughs]

So I decided, hey, that's the way to go. Tell it like it is. I think that's pretty much true in life everywhere. When you goof up and you try to concoct some excuse to make it look good, it's a lot better to just tell a person, "Hey, I goofed up, and this is the crazy thing I did." [laughter]

JOHNSTON: What did you enjoy most about medicine?

MILLER: Oh, I enjoyed the people most. I got acquainted with such a variety of people. I can't imagine what other endeavor I could do to get to know people, such a variety of people.

JOHNSTON: You're talking about patients.

MILLER: Yeah, about the patients. And my, and they weren't all alike by any means. My patients ranged from saints to criminals. But whether one would call them a good person or not a good person, they were all interesting. There's something interesting about–

[End Track One. Begin Track Two.]

MILLER: –everybody. And everybody's different. With no two exactly alike.

JOHNSTON: What did you learn from them? What do you think you learned through the years? You said you enjoyed them.

MILLER: Oh, I think what I learned from them mainly is to enjoy the day. Live for the moment.

JOHNSTON: How did your family react to having a doctor in the house? Running out, making house calls on Sunday morning, at night, all that sort of thing? How did your family do with that?

MILLER: Well, they did very well, my son now tells me. [laughs] My wife was a great homemaker. And she was always there when the boys came home after school. And she did all the things that parents need to do to keep them on the right track, and going good. I always got home much later in the day. Too late, a lot of times. But they seemed to survive it all right, and it worked fine.

JOHNSTON: Have you got any other questions?

Simek?: I have a few.

?: –for the tape change?

JOHNSTON: I'm sorry–

MILLER: We all done?

JOHNSTON: I think they want to–

[End Track Two. Begin Track Three.]

Simek?: Rolling

JOHNSTON: So, do you think the practice of medicine in Eugene was different from what it was in Portland? Sort of rural medicine versus–

MILLER: No, I don't think Eugene was ever like rural medicine. The, some of the technology developed in Portland ahead of Eugene. For example, they had radiation therapy for cancer in Portland a little before we did in Eugene. And they had cardiac surgery in Portland before Eugene had. But I never thought of Eugene as being much rural medicine.

JOHNSTON: Did Eugene ever innovate anything that Portland took up later? Can you think of anything?

MILLER: Well, Eugene, Bob (Hodum?) in Eugene, the cardiac surgeon, had an innovation in one thing in that he used less blood in his heart surgeries than anybody else was using. When he came to Eugene, the common practice in heart surgery was to use a lot of blood, transfusion blood, I mean. Put a lot of blood through the patient, try to keep their circulation full. And Bob (Hodum?) decided that not near that blood was used. And he used something like a quarter or a third, I don't know, amount of that blood. And his patients got along very well with that.

In fact, his first series of patients after he had been in Eugene a few years were published in some medical journal, I forget which. And his results from cardiac surgery were as good as anybody in the country could quote. He really was a top notch surgeon. And the idea of using less blood kind of spread to other places. I think Dr. (Hodum?) in Eugene may have been the first person who figured that out.

JOHNSTON: At times since you were sort of the dean of internal medicine in Eugene, there must have been times in which you were uncertain of a diagnosis, or things were not clear, and nobody else in town seemed to know what it was, either. Where would you send those patients? What would you do with that patient?

MILLER: I sent several patients to see Dr. Howard Lewis in Portland, because he was the professor of medicine. So he was kind of the top of the pile, you know. You couldn't do much better than that. And that was very satisfying to patients, because they realized they were seeing the great man, you know. So that worked out very well. Oftentimes, when I was seeing a diagnostic problem, we didn't have the sub specialists then. And I would just have another internist examine the patient, and see if we concurred on the diagnosis, or if the other internist had any different course of action. In other words, that was getting a second opinion that you hear a lot about today. I don't know why some doctors, I'm told, have been reluctant to get second opinions, or sometimes kind of hesitate, or don't seem to like it very well. Today if a person requested a second opinion, I think I would eagerly endorse it. You can't do much better than sharing with some other doctor and get some agreement.

JOHNSTON: There were a lot of characters – doctors, patients – in Eugene at the time. Can you think of any of them that were sort of different kinds of people? [laughter]

MILLER: One of the greatest characters I remember was Dr. Lester Edbloom. And he was a good doctor, and quite a character. He was the only doctor who'd served in both World War One and World War Two. He was a soldier in World War One, I think, and a medical officer in World War Two. And he was kind of a crusty, rough and tumble guy who told it like it is his way, I guess.

There were several stories about him. One was the lady who was in his office with a monilial infection of the vagina. This causes a terrific itching. So Dr. Edbloom had put her up in the stirrups with the nurse, and the light shining in there, ready to do the examination. Right then he was on the telephone from the hospital. And the hospital said they needed him right away for an emergency. So he just put the phone down, and took off for the hospital. And the nurse was slow in coming back to the room. And the lady lay there in the stirrups for quite a while with the light shining on her. And the nurse finally came back in and turned the light off and explained that Dr. Edbloom had been called to the hospital and couldn't do any more today. And the woman apparently didn't understand this communication from the nurse. Anyway, she understood that she was finished for the day, so she departed.

And a week or two later, she came back to the office. And the nurse said, "What is it you're coming in about?"

"Oh," she said, "that itching is getting so bad again, and that light treatment helped before. I want to get another one." [laughs]

Another Dr. Edbloom that I liked was the house call he made at night to see a lady with abdominal pain. And the husband was there with her. And he made the diagnosis of appendicitis. He said, "We have to take your wife to the hospital to do an appendectomy."

And the husband said, “No, way. She ain’t going to no hospital. That’s that.”

Dr. Edbloom didn’t say anything, but he sat down and lit a cigarette. He was sitting there by her bed, smoking.

After a while the husband said, “Well, what are you doing here, Doc?”

He said, “Well, hell, I thought I ought to wait till she dies.”

So she then went to the hospital and had her appendectomy and lived happily ever after.

JOHNSTON: You mentioned earlier that Dr. Osler made a mistake. What was the mistake that Dr. Osler made? Do you know?

MILLER: Oh, yeah. My professor emeritus in school had been a student of Osler’s. And he told about the time that Dr. Osler was presenting a patient to his class of students. You know, Osler was a person who developed a style of hands on medicine. He taught medicine from the bedside. Before that, medical students read it in books and didn’t see patients until they graduated from medical school. So Osler was great at physical diagnosis and having the live patient there any time you talked about disease.

And one day he presented a case of pneumonia. And the students examined the patient and talked to the patient. And he lectured about pneumonia. That was that day.

Oh, sometime later, maybe two or three weeks later, maybe, he was lecturing on tuberculosis. And he brought the patient in. and one of the students said, “Well, Doctor, isn’t this the same patient that we saw who had pneumonia?”

And Osler said, “Well, yes, it is. But that doesn’t interfere with teaching any. We can still teach about tuberculosis now that this patient has.” [laughs] So I guess Osler made a mistake for about three weeks, anyway.

JOHNSTON: You’ve described that medicine has become somewhat impersonal with all the technology. You described the patients are not totally happy with the way things are, and the doctors are not happy with the way things are. Medicine is becoming too expensive. Where do you think medicine is going to go in the future? Where’s the answer? How do we get out of this?

MILLER: Well, I’ve thought a lot about that. my first thinking on that started about the time I retired in 1984, when managed care was just getting under way. I’d been thinking before that that medicine was getting too expensive, and people couldn’t afford it anymore. We were told that managed care would solve that problem. That would reduce the cost of medical care and everything would be fine. So I thought, well, that’s fine. So I’d like to see how this plays out. If managed care can solve that problem, that would be great.

Well, it seems that managed care has not solved that problem. We still have the problem of the working poor without access to medical care. And nobody has suggested anything else that could solve it, other than a national health plan, where everybody would have access to health care, and it of course would be paid for by taxation. People aren’t in a mind to be taxed for that, I think. But if somebody could suggest some other plan, I’d sure like to listen to it and see what could be done. But if nobody can come up with any other plan that will take care of those people, it seems like a national health plan

is inevitable. Particularly when you consider the rest of the Western world, the rest of the developed world is under such a health plan.

JOHNSTON: How's that going to come about? You just said the people don't want taxes. And the only answer is some sort of universal healthcare system nationally. How's that going to happen?

MILLER: I think the only way it can happen is through the pressure of voters. The big problem of the working poor is that they don't have any representation. They don't contribute any money to campaign funds, so they don't have any political clout. And politicians, I guess, can't afford to be concerned with a small segment of the population who don't contribute to campaign funds. A step might be campaign reform, to eliminate money controlling elections so much. And then, when enough other people get concerned, I mean, people who, the average middle class people and so on, they get so concerned about the state of medical care that they want to try a national health plan. I don't see how else it could come out in this republic that we live in other than pressure from the voters. I don't know.

JOHNSTON: Is that going to take care of the technology drive, which seems, you know, every year there's more and more technology, costs more and more. And at the same time, we talked about the impersonal care that people get. Wouldn't this drive more technology and more impersonal care?

MILLER: I don't think it would drive more technology, because as I see it, there would have to be some rationing. You know, the Oregon Health Plan has some rationed care. There's not much debate over the question of whether a taxation plan healthcare would provide cosmetic surgery for the breast, without cancer of the breast or anything, or most any other cosmetic surgery. Because that isn't necessary to a person's living. And, well, as you know, the national, the Oregon Health Plan made a long list of all sorts of procedures. And I mention cosmetic surgery because that was the bottom of the list of things that you will provide. And at the top of the list was either prenatal care or newborn infant care. They were both right at the top of the list, I think. So the Oregon Health Plan committee just decided how much to chop off at the bottom and say, "We won't provide this."

JOHNSTON: And you think that form of rationing is a good idea.

MILLER: I wouldn't describe it as a good idea. I'd just describe it as a necessary idea in order to provide healthcare for everyone.

JOHNSTON: Did we drive up anything more?

Simek?: Any more anecdotes?

Okay, we're rolling.

JOHNSTON: You mentioned your family earlier, and how your wife sort of managed things at home. But as you well know, as I well know, rather, she subsequently died of Hodgkin's Disease, or lymphoma, some sort. And then you've remarried. Is that correct?

MILLER: That's right.

JOHNSTON: Tell me more about that.

MILLER: Well, when my wife died, I was very grateful to you and Winston Maxwell for keeping my practice and yours together until that ordeal was over. When I started practice again, I wasn't thinking about remarriage. But I was thinking about getting back to my medical practice and getting going with that, and keeping busy with that. And it just so happened that Jackie Pettit, a woman doctor, pathologist, had come to Eugene about four years before that. And at that time, she was one of two or three, I think only two doctors, two women doctors at the time she came, and later, a third one. So she was always having lunch with men doctors at the hospital. And I was having my lunch at the hospital, too. And it just so happened that I got better acquainted with Jackie there.

She was pretty popular with the doctors because when she came to Eugene from Southern California, she didn't know anything about sports, and had no interest in sports. But every day at the doctors' lunch table, she'd sit down there and hear all these doctors talking about the latest sports activity at the University of Oregon and so on, whatever was big that day. And she didn't have anything much to say. So she decided to correct that right away. She started reading the sports section in the newspaper every morning. And every day when she went to work, she knew as much as any of those men doctors about what was going on in sports. And she started, she's a pretty good talker– [laughs] So she started talking sports with them, and they thought she was a pretty cool gal, you know. Knew all about sports and everything. Interested in sports. So I sort of cottoned on to her thinking yeah, she is a pretty cool gal.

Then, not long after that, some of her friends were inviting us to parties. And they would invite Jackie and invite me. I'd go to the party and find out that Jackie's there, too. But we'd be the only two single people there. So it just so happened that we would be paired up having dinner, lunch, or what not. So we got better and better acquainted. And the more times we were together like that, the more I began to think about hey, she'd be pretty nice to live with the rest of my life, if I could talk her into that.

So I invited her out to dinner one night almost a year later and proposed marriage. And she was kind of reluctant about whether we ought to jump right into this or not. But I was sure that this was a thing we ought to do. And by the time dessert arrived, it was a done deal. [laughs] We did get married, and have lived happily ever after for thirty-three years now.

I often, when people question our profession, say, "You were a doctor?"

"Yeah," I say, "Jackie and I, we were both doctors. Well, she was a pathologist, but I was a real doctor."

JOHNSTON: How did that work out, coverage call and all that sort of thing, two doctors in the house? Who's around to make sure the groceries are ordered?

MILLER: Well, when we got married, Jackie was sure she could handle the whole thing. And I was sure I didn't want her to. We had a lady who was very good cleaning lady who came once a week. But I said we had to have, get somebody to do the cooking and day to day housekeeping. So we agreed to have a lady do this four days a week. Monday, Tuesday, Wednesday and Thursday. So Bertha (Nickelmo?), we called Bert, came to our home every day those four days and did a little light housekeeping and straightened the place up. And by the time we got home, she had a nice meal prepared for us. And that was a very happy arrangement. Bert continued working for us till we both retired. We retired together.

JOHNSTON: It's a story about Dr. Edbloom again, who treated somebody for a rash in the hallway of the hospital

MILLER: Oh, yeah. Dr. Edbloom was late getting out of his office one day, very late. And he met one of the cleaning ladies in the hallway. And she knew him. She says, "Dr. Edbloom, what would you do with this?" She pulled up her sleeve and had a little rash on her arm. She said, "It itches to beat the band."

He took one look at it and said, "I would just scratch hell out of it." [laughs] And walked on out.

JOHNSTON: You also had a patient named Ray who was a physics professor that knew something about cardiac monitors and all that.

MILLER: Oh, yeah. Ray (Alexson?). He was professor of physics. And one day, a very smart professor of physics by the way. Very smart. He had a heart attack one time, and as a complication of this, he developed a heart block, where his heart was beating very, very slowly, and it appeared he was in great danger of having his heart stop completely. So we used a cardiac stimulator, which is new at the hospital. We'd just gotten it not long before this. And this thing operated by just hooking the electrodes up to the chest, and somebody had to be there to turn the thing on if his heart stopped. And at that time, the University of Oregon was just developing their cardiac intensive care unit, where they could monitor heart conditions like this automatically.

So they, we decided we'd take Ray up to the hospital in Portland at the medical school. And I got in the ambulance with him with my hand on the switch, and the electrodes on his chest all ready to go. And that was the most pleasant ride I've ever had. Ray entertained me the whole way up there with stories and what not. We just had a real good time.

And I left him then in the cardiac unit. They hooked him up to this electrode system. It operated automatically. They had just before put this thing in, and they didn't know quite how to operate it yet. And Ray found out later, Ray spent the first two or three hours in there showing them how to get this thing working. But he got it in good working order, and he survived that heart attack, and came back to Eugene and lived several years after that. Quite a few years.

JOHNSTON: If somebody starting out in medicine, or even going to medical school and all, what advice would you have for them?

MILLER: I'd advise them to go for it! Being a doctor was the only ambition I ever had, the only thing I really wanted to do. And I don't think doctors are going to disappear. We're always going to have doctors. And they're needed. Right now, we need more primary care physicians in Eugene, I know. And if I wanted to be a doctor, I'd want to be a doctor, no matter what the system is, you've got to– and I'm sure the world's not going to come to an end. Besides, the doctors coming out today don't know anything different. And I think it will work out all right for them, some way. So I'd do it again.

JOHNSTON: What do you think makes a good doctor, like you've been?

MILLER: Oh, thank you. Well, I think it's primarily, well, it's two things. An interest in the continuing study of what you're dong, always wanting to know more and never thinking your education is finished. And then secondly, I think it's liking the people and enjoying getting to know people, and trying to help people. You get a tremendous lift out of that.

You know, after I retired from active practice with you, several patients told me how much they appreciated what I'd done for them. And recall some incident that I couldn't remember, and how grateful they were with how much I'd helped them. And I'd listen to that and I'd think, I can't remember anything very remarkable was wrong with this person. So I'd get their file and look it up, and I couldn't find anything in there except a series of very ordinary, simple illness that I didn't think I'd done much for that person. But this person had the idea I'd done a lot for them.

And I know that all doctors have many, many, many patients that feel the same about their doctor, but they don't say it to them. It's kind of like your favorite schoolteachers. You may have an excellent schoolteacher, or someone later on you realize was an excellent schoolteacher. And you never did tell that teacher how much you appreciated him. I know several like that, and I imagine you do, too.

One more? I missed out some.

JOHNSTON: You mention that there was Jackie and one other doctor was the only two women doctors in Eugene. Is that because Eugene just didn't want women doctors, or what?

MILLER: No, there just weren't many women doctors coming out of medical school. Jackie was one of two women in her class, and that was true of most medical schools. Admitted two or three women to every class. Tokens, I guess. But that was it.

Regarding one woman doctor, I should mention Emily Fergus, who's recently deceased. Emily came to town as the first nephrologists [audio trouble]

Ready?

Rolling.

JOHNSTON: So tell me about Emily Fergus.

MILLER: Emily Fergus was the other woman doctor in Eugene when Jackie came here. And she was the first nephrologist in Eugene. Take care of kidney problems. And she was excellent at that. She was highly educated in her field, and was a top notch nephrologist. And not only was that part good, but also, she did an excellent thing when she found some of the best nephrologists in the country, I think, to join her as partners. And they formed a top notch nephrology group that I think is probably not bettered anywhere in the country. Really good.

JOHNSTON: You mentioned that nowadays the coordination of care of referrals and there's a lot of paperwork and all that sort of thing that goes on in medicine. Back in the '50s, how did you refer a patient?

MILLER: We just called the doctor on the phone, and (?) like, "Will you see this patient?" And the doctor would almost invariably see the patient that day.

JOHNSTON: The doctor would come to the phone, so you weren't put on hold.

MILLER: No. The doctors that didn't come to the phone weren't very popular. Almost invariably, the doctor would interrupt what was doing. This may have delayed that doctor working with this patient, but it speeded up the care of the doctor on the other end. You know, so it's a trade off.

JOHNSTON: And they would not say, would they say, "Well, I can fit them in two weeks from now," or something like that?

MILLER: No. No. They didn't do that.

JOHNSTON: Didn't do what again?

MILLER: Didn't say, "We'll fit them in two or three weeks from now." No. If they said something like that, you could call another doctor.

JOHNSTON: You, during the '50s I know in Eugene was a certain amount of turmoil. You mentioned the hospitals was getting better professional, doctors from World War Two were coming back. How did you discipline doctors back at that time? There wasn't a lot of governmental regu– I was in the Board of Medical Examiners. There wasn't any– what happened?

MILLER: In the early 1950s, most of the doctors coming to Eugene had had some military experience. This was a pretty confident, maybe almost cocky group of guys who felt that after World War Two, we won that, all right. And put that behind us. We could do anything. I guess we were thinking early on we were the greatest generation, or something like that. Anyway, there was a great camaraderie among the doctors then. And if somebody didn't fit in right, I mean, stepping over the rules or something, a committee of doctors would just meet and confront him with that.

I remember one doctor who came to Eugene in those days, two doctors came as partners in a sub specialty. And one of them was totally inept at taking care of patients. Amazingly, he could alienate a patient. Not just not please them, you know. So the other one was very good.

So we called the two of them in, there were three of us doctors from the hospital staff, and told them what was going on. How this fellow had been alienating patients. So something had to change. So they listened to all of this for quite a while. And very soon after that, the doctor that wasn't any good left town. That's kind of the way problems were dealt with.

JOHNSTON: You mentioned one time, for instance, a patient who had hyperthyroidism was operated on that didn't have hyperthyroidism?

MILLER: Oh, yeah. That doctor was kind of in the habit of diagnosing hyperthyroidism and telling the patient that they needed a thyroidectomy. So he would admit to the hospital and do a simple thyroidectomy, which I guess is not too difficult to do, if you don't mind how much of the thyroid you take out. Just take a little of it out. Maybe that's easy. Anyway, he was doing these operations repeatedly. And other doctors didn't think all these patients had hyperthyroidism.

So he had a patient admitted who was to have surgery the next morning. And I think it was the pathologist at the hospital, (?) who told me he wanted me to see this patient in consultation. And decide on the diagnosis.

So I saw the patient in consultation. And I didn't think there was a remote chance that that patient had hyperthyroidism, and I said so. And he didn't do the operation the next day. He discharged the patient. And his surgical privileges were removed. He didn't do anymore surgery at the hospital. I guess that's kind of taking care of your own.

JOHNSTON: So were there, you must have been around Oregon for all these years and such, you must have met some physicians who you felt were outstanding, either in Eugene or in the Northwest, because I know you're a member of the Northwest Pacific Society of General Medicine and all that. Who stands out in your mind?

MILLER: Well, of all the doctors I encountered in training, I think Howard Lewis stands out because I understood early on in my internship at Good Samaritan Hospital that Hod Lewis, as he was called, was the outstanding physician. So I arranged for the hospital switchboard and admitting desk to tell me every time Dr. Lewis was in the hospital. And whenever he was in the hospital, I would go find him and make rounds with him on his patients.

A lot of his visits came in the evening at the hospital. And after we'd made rounds and he'd told me a lot about each patient, we'd often go down to the cafeteria and have something to drink or eat. And he would just talk about diseases from the patients we had had. And I learned a lot from him. He was obviously just a born teacher. He seemed to love nothing better than teaching. If you can imagine working all day and coming late in the evening to see patients, and you're happy to sit down with an intern, and teach that intern. So I got a lot of that from Howard. Or Hod.

As far as Eugene is concerned, one of the outstanding doctors I remember was a Dr. (Fetterplace?) who was a general practitioner, called then. But he did a lot of surgery, which he had learned just by doing, I guess. He was excellent at the surgery. Other doctors, younger doctors who assisted him in surgery and observed in surgery testified to this. I remember one of the outstanding doctors in Eugene had him operate on his wife. So he really had great surgical ability. And he would respond any time of the day or night, and wanted to.

I remember one case, he was at his home up the river, several miles up the Mackenzie River. And a patient came into the hospital who had an acute abdomen problem. Appeared to have perforated the intestine, perhaps, and required surgery. And he was a friend of Dr. (Fetterplace's?). So I called, it was a bad stormy night. And his wife said Dr. (Fetterplace?) was a lousy driver. But I called him and told him about this patient. He said, "I'll be right down to take care of him."

I said, "Dr. (Fetterplace?), it's terrible outside tonight. It's really storming bad. I could call Jake," who was his partner, Leonard Jacobson. I said, "I could call Jake, and he could come over here and take care of this."

"No, no," he says, "I'll be right there."

So in very short order he called the hospital and operated this patient. And he did have a perforated intestine from a toothpick that he apparently swallowed. He was a great martini drinker. And also, he was in the wood products business. Ran a big lumber company.

So the next morning I was in to see him, not many hours after his surgery. He said, "What did they find?"

I said, "Well, you had a perforated intestine from a toothpick."

He said, "Was it wood or plastic?" [laughter] He was mainly interested in what kind of toothpick. Didn't want to have any plastic toothpicks in him.

Now that you're getting warned up, I hate like the dickens to stop. But it's after two, so we'll have to break now.

JOHNSTON: Okay.

[End Track Three. End Interview.]