HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Dorin Daniels

Interview conducted September 14, 2010

by

Jim Kronenberg

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[Begin Track One.]

KRONENBERG: This is tape one of an interview with Dorin S. Daniels, MD. It took place on September 14, 2010, at Dr. Daniels' home outside of Ontario, Oregon. This interview is a part of the History of Medicine Project of the Oregon Medical Education Foundation. The interviewer is Jim Kronenberg. Dr. Daniels, I'd like to kind of turn this over to you for a little while. And just tell us in your own words about when you were born, where you were born, your childhood, and things that you recall about that.

DANIELS: Okay. (laughs) That's sort of a big, open-ended thing, isn't it. I was born in Madison, Wisconsin, in 1927. September 23rd. So I'm just around the corner from 83 now. I was born into an academic family. My dad was a professor of chemistry at the University of Wisconsin. And he became very well known internationally as a physical chemist.

Of course, I think we all think that what we're brought up with is normal. But as I got older and realized the fabulous origins I had, I realized it wasn't really a normal childhood. Both my parents were good, solid, Christian background. They didn't smoke, they didn't drink. And everything was oriented towards learning. It was just a different, different atmosphere than a lot of people have. I was really very fortunate, but didn't know it at the time. Such things as, my dad was so busy, he was a workaholic. And he would put tremendous hours in. Total dedication to his job. But extreme, extremely high moral standards. He did many, many, many projects from which patents were derived. But he never took a nickel of royalty money if it was done on the time that he considered work time at the university.

And one of my nephews did some research one time and figured that the patents that he generated put over, I think it was two billion dollars into the university. And we never saw any of that at home. (laughs) It was always very frugal.

This was Depression times. His salary, I think, was, for the day, you know, we were comfortable. It was about a five thousand dollar a year salary. And that doesn't sound like much nowadays, but it was an adequate living. I had one brother and two sisters. I was the youngest of the group. And I was sort of the black sheep. My brother and two sisters were just academic wizards. And I just sort of was a little on the lazy side. So I wasn't straight A, and they were. And being the tail end of the bunch, why all the teachers that had had us all were sort of worried about me. I managed to get along, you know, I wasn't the poor student in the bunch, but I wasn't the straight A.

Anyhow, through the Depression, one of the things we did is, being a professor, my dad had summers off, except when he taught summer school. And he had terrible hay

fever. And in those days, the only medication they had was oh, I'm blocking on the name, but there wasn't much good for hay fever in those days. So in Northern Wisconsin in the Door County Peninsula, if you look a the map of Wisconsin, it's sort of like a hand. This would be the thumb sticking up into Lake Michigan. This is Green Bay over here. And that was sort of an air conditioned spot. So a lot of people with hay fever went up there for the summers and camped. And we did that for a few years, and then we found some property.

It was great. We got some property, and the four kids and my mother and dad built a cabin. And it wasn't like it would be now, with all the hoops you have to jump through to build anything nowadays. We just sort of eyeballed it. And stretched out some string. And my mother drew some plans, and we got some logs, some cedar logs, that some other locals found a swamp that had some cedar logs. And they cut them down and delivered them for an incredibly small price. And my kids, we got a little help for a few days to get things started, but the rest of it, we did mostly on our own. And of course I was just a little kid then. But I helped strip the logs and notch them. And, you know, it was great. So we spent a lot of our summers up there. Because Dad really was so miserable down in Madison, where there was lots of allergens in the air.

Well, then the war came. I was still not the straight A student that I was expected to be. Oh, I'd forget to turn in term papers and a few things like that, that kept me out of the straight A class. But as the war really got going, and other members of the class were going off to war, a lot of them weren't graduating, they were just going right in the service.

So I sort of readjusted my thinking on life, and decided I better buckle down a little bit. So I accelerated my high school. Graduated in three years with one summer school.

Then my dad, who was a professor at the University of Wisconsin, was asked to run the metallurgical laboratory at the University of Chicago, which is the atom bomb project, the Manhattan Project. And he was the director of it. They had already done the, they'd already reached the critical mass type stuff and they already knew where the things would go. But when he came into it, they were well into the process of heading for the atomic bomb. So he was rubbing shoulders with, and first name with all those A bomb people.

And he, of course, moved to Chicago when I was finishing up school. I went to one summer school at Wisconsin and at the university level, and I sort of got burned out, and I was getting close to where I was old enough to go in the service. So I moved to Chicago with my mom and dad. And one thing I hadn't really taken in high school was typing. So I went to a business school and just took some typing. Everybody advised me, and it was very good advice, that you needed to learn to type. So I did that.

And then as soon as I was old enough, I went in the navy. I took a test for what was really radar engineer. But they called it radio technician, because radar was still

secret at that time, supposedly. (laughs) of course, other countries had it, but we didn't know that. Anyhow, I went in the navy in 1945, January. And was in school at Great Lakes in this radio technician school, which was really electronic engineering. And math was not my forte. And this was all math. So the navy and I both decided that that was not where I belonged.

I'd passed this highfaluting test, and they'd put me in as a seaman first class. So I had a jump on ranking. But anyhow, both the navy and I decided that the hospital corps was where I should be. So they put me on a troop train.

And those were interesting days. They'd resurrected the old boxcars and the old passenger cars that had been in retirement. Everything was brought out during the war. So we'd be on a troop train and it would take three or four days. Because high priority trains would take priority, and we'd be on the sidelines. And we'd get sandwiches from the USO and so forth. Those were interesting days.

I went to San Diego for my hospital corpse training. We'd already had V-E Day. That happened while I was at Great Lakes. And so the war was winding down in Europe, but still very hot in the Eastern, in the Japanese Theater. So while I was in San Diego, in training, the A-bomb ended the war.

Interesting sideline, my dad was one of the few, of course, that knew what was happening. And he was the contact person when the news broke that the atomic bombs had gone off. So when he was interviewed for the paper, as soon as it was open to say anything, he was their contact person. And he made a comment when he was asked, "What do you think the implications of this is?" It was just brand new stuff.

And he said, "Well, I'm pretty sure we've saved our sons, but I'm not so sure about our grandsons." Rather prophetic, because he and a lot of the other scientists realized that we really had a Pandora's box. They were really worried that if we didn't catch up socially with our technology, then we were just going to blow the world up.

Anyhow, I was at San Diego on V-J Day. That's victory in Japan day. And that town went berserk. San Diego was a big military town. And big navy base. And there were all sorts of air force and army nearby. And everybody was so pent up with all this wartime emotion that when the war was over, they just exploded. So I was able to get an evening leave, and went downtown. It was just something you can hardly describe. There were just hordes of people in the streets. And the military guys would be walking down in groups. And there'd be a pretty girl, and she'd disappear into the group here and come out over here rather disheveled but happy. Lipstick smeared everywhere, and so forth. And there were some mischievous things, like a few of the patrol cars were tipped over. And some, they had trouble keeping the trolleys going, because every now and then some serviceman would pull the thing off the wires. (laughs) But no really serious damage. Just incredible amount of release of tension.

Then I went to Newport, Rhode Island, worked in the hospital there. The war was now over. But of course, in the hospital corps, you were still seeing the effects for a long time. So here I was, a pharmacist mate third class, actually I became pharmacist mate third class very soon after, as soon as I was eligible. I didn't even know the test was coming up, but somebody says, "Hey, have you looked at the bulletin board?" By this time, I was knight and master of arms at the whole damn hospital. I mean, that's a big naval hospital. And they had this little 17 year old, 18 year old kid, knight master of arms. That's way too much responsibility for somebody with my background. But apparently I did okay.

Anyhow, I saw this notice that there was going to be a test for pharmacist third class. And I said, "Am I eligible?"

And they said, "Well, yeah." And of course I hadn't studied. But night duty, I didn't have much time for sleep. I studied a few days, and took the test, and got bumped up, about as young as you can ever be. Of course, I was in a reserve type unit. So I didn't have to stay in very long. I went in in January of '45 and came out in July of '46.

And then I went to Oberlin College in Ohio, which is a nice liberal arts school. Extremely high standards. And very, very high quality school. I realized that I was up against people that were a lot smarter than I was. (laughs) And so I almost didn't make it. I spent too much time. There was one other fellow and myself who were photographers for the school paper. And that took a lot of time. We were in the darkroom, very poor ventilation, lots of chemical smells. And we'd be working there till twelve or one in the morning in order to meet the deadlines. And I should have been studying more.

Anyhow, I struggled. And the big problem on staying there was that there was such an influx of post-war vets that they were just overwhelmed. When I went there, I lived in the gymnasium. They just had cots and cots and cots. And it was not as fancy as the barracks we were in in the military. And I'd already decided from childhood on that I wanted to be a doctor. But I was beginning to realize that I wasn't academically up there to where I had a good chance. Because at the end of the war, all these people that had had serious problems dealing with military hardships and really rough situations, they had decided what they wanted to do with life, and they were darn serious about it. And they all came back at the same time. So colleges all over the country were just overwhelmed. And I couldn't get this small school, I just couldn't get the classes without going five or six years, just the way the scheduling was. So even though I was beginning to feel my chances of medical school were not great, I still pursued the pre-med program.

And I transferred back to Wisconsin, because that way I could get my scheduled courses through in a reasonable period of time. And I got back there and of course they were overwhelmed, too. But it was big enough that you could work around the course scheduling.

So I graduated, not at the top of my class, in zoology, with a zoology major, bachelor's. And about the time I was finishing up and feeling pretty gloomy about my

chances of getting into medical school, I heard about a job at Oak Ridge, Tennessee. And I fit the requirements that they had. They were looking for, they didn't say when—(coughs) Excuse me.

SIMEK: Let's take a sip of water.

DANIELS: Okay. When I interviewed for the job at Oak Ridge, they didn't tell me what it was for. They just wanted a technician who did cytogenetic research. And I had a zoology degree and met the requirements that they were looking for. So I took that job. My dad sort of was aware of it, and sort of steered me towards it.

Anyhow, when I got interviewed, they accepted me, but I had to go through the FBI clearances and so forth. And they were really, really detailed in their investigation. You worked for the atomic energy people, and it was top secret stuff. So it took three or four months for that to go. And then I went to Oak Ridge. And then I found out why they hired me. They needed a male technician to go to Enewetak for some of the bomb tests.

And the project I was on was sort of interesting. Because what we were doing was studying the radiation effect on chromosomes. [glitch] stuff on radiation genetics. And we worked with a little plant called tradescantia. It has wonderful chromosomes, big chromosomes that you can stain and see the breakages. And they have some definite patterns on cross linking. So you have certain types of breakages in the chromosomes. And our job was to compare the radiation dosage to the biologic effect. And we could do that in laboratory conditions. And then, once we could make graphs of those dosage versus effect, then we had a handle on going the other direction. Because we were testing on specific types of radiation, gammas and betas and alphas and neutrons. And we could do it all in a controlled manner. But you go to an atom bomb test, and it's mixed bag. You don't know what percentage of what, and so forth. So our purpose of our project was to, after the bomb test, compare the biologic effect against the physical dosimeters, the film badges and so forth, to see if there was a good correlation. Because atomic bomb radiation is a mixed bag. You just don't, you can't say it's X number of neutrons and X numbers of alphas and so forth. So it's a mixed bag.

Actually, it turned out pretty well. There was a pretty good correlation. So the film badges and the other, the testing devices, were reasonably accurate as far as the biologic effect. On that test, there were other, lots of other biologic programs. They had pigs, because their skin is very similar to humans. And they had thermal studies. They'd put pigs in the lead shields. But they'd expose certain amount to, of their skin, to the radiation that the bomb blasts, would have a controlled skin burn study. They had purebred dogs, and did LD50 studies, to see what dosage of radiation blasts in distances from time, from Ground Zero and so forth. So what dosage it takes to kill 50 percent of the dogs and so forth.

And one of the biggest problems (laughs) was not the secrecy of the atomic bomb, so much, but they were trying to keep the Hearst newspapers from finding out that we

were using purebred dogs. (laughs) Because they, the publicity would not have been very pleasant. And, of course, there were many other biologic studies.

Well I was there for three bomb tests. And we had our plants out in the little greenhouse, just outside the door of our lab. And we'd gone over early and nurtured these plants so that they were healthy and pretty well standardized. And it turns out that that little greenhouse, which was probably only about eight by ten feet, showed up on the overall plans when they were planning for this operation. And they said, "Oh, let's call it Operation Greenhouse." So our little project was the basis for the name of Operation Greenhouse.

Anyhow, when the bombs went off, I was high enough up as a scientist that I was one of the group that was issued extremely dark glasses. You know, welder type glasses, only maybe a little darker. And when those, when we tested those out, middle of the day, you'd look right straight at the sun, you could just barely see the outline of the sun. That's pretty dark.

And the bombs were set off at daybreak, so we had all day to get out and get our material and come back. And we'd put our material out the day before. And the service people and so forth, and those that weren't reasonably high up in the project, had to look the other way. They hunkered down, and couldn't look towards the bomb blasts. But we had these dark glasses. And I'll tell you, it's pretty impressive. This was before the H bomb. This was atomic only. And probably a little stronger than the Hiroshima/Nagasaki bombs. But at the time the bomb blast went off, it was extremely bright, even with these glasses. Far brighter than your normal daylight without the glasses. That's bright. And it just kept building and building and building and building. And you begin to think, God, I wonder if the people that predicted that this would set a chain reaction in the atmosphere and the whole world would go, you began to wonder, did they have something?

Anyhow, it stopped. It gradually petered out. And over several minutes, seemed like a long time. But I don't know how long it was. Maybe five, ten minutes, it started to fade out. And then when it got to where you could just barely see through these glasses, you'd take the glasses off. And again, it's still brighter than daylight. It's pretty impressive. And I'm sure the modern bombs would be worse than that. But it was pretty impressive.

Anyhow, as soon as the bombs went off, we'd jump in the landing craft and go the fourteen miles or whatever to the blast site and pick up our biologic materials. And come on back, and then start analyzing it. Another break. (coughs) How we doing?

?: Great. Perfect.

DANIELS: Okay. Well we did that for three tests, and gathered lots of material to study there while we had time, and to analyze further when we got back to Oak Ridge. So I was over there for almost three months, I think. One little side thing. On my little greenhouse, my job was to keep the plants going so that they'd be healthy and pretty

standardized from test to test. One day they had let me look at an overall project plan. And it was top secret stuff about the whole operation. And I had never been exposed to that, never been allowed to see it before. But they said, "You can read this. We've got to have it back. Don't take it out of the lab," and so forth.

So here I was poring through this fascinating stuff, and I hear this small aircraft. It just didn't sound right at all. And I knew that they had little spotter type planes that brought mail and dropped it in the baseball field on our little island of Jap Town. Jap Town was one of the few, actually, one of the only island on the atoll of Enewetak that hadn't been flattened in the war. And the bigger island of Enewetak Island is where the base of everything was except the biologic unit. So we had a jungle with shade and coconut trees. It was sort of a recreation area after the war for people getting R&R and then going back.

Anyhow, there was a baseball field, and this spotter plane had come over and dropped the mail in the baseball field. And they did that every day. So I wasn't surprised to hear the airplane. But it didn't sound right. It just sounded awful. [makes growling sound] And then, clunk, clunk, clunk. And I realized something's really not right. So I finally came out of this book that I was reading, that had my full attention. I went out the door to the greenhouse. And just as I got out the door, this little plane went right through my greenhouse. Oh! If I had been where I should have been, watering the plants, I would have been the target. He went right through the greenhouse. And what had happened, with the trees, he'd dropped too low and lost his prevailing wind. And so his air speed went down and he stalled out and tried to power out and hit the palm trees. [makes roaring noise] Finally came, he glanced off, glanced off our roof and went right through the greenhouse. So that was a close call.

One of the, years later, my boss, Dr. Alan Conger, a great geneticist, he was a great guy. When he died, somebody wrote his obituary. And I happened to see that obituary. And it said, "Dr. Conger was really very lucky, because in Enewetak, when he was there for genetic experiments at the A-bomb tests, a plane crashed through his greenhouse and killed his assistant." (laughs) I was the assistant. And fortunately, that obituary was not correct.

The pilot died, and that was interesting from the medical perspective. I had not been to medical school yet. I was just out of college. But a lot of the people on the project were ex-military physicians. And one of the high-ranking officers, one of the medical officers, was walking down the road and saw this plane coming at him. And he jumped right out of his shoes and got out of the way. But when he came back and tried to help the pilot, he immediately said to the rest of us, "This guy's dead." I mean, he was alive, but he said, "He's going to die." He says, statistically, he'd had so much experience with aircraft injuries, that he had enough broken bones, enough combination of things, he says, "He's just not going to make it."

They flew him out to Hawaii, and he did die in two or three days. But this physician was just beside himself. He said, "Damn it, we've been telling them for years

how to prevent this accident." Because the seat of that spotter plane was just bolted to the floor. It didn't have other support. And he says, "As physicians, we've told them for years, as medical officers, we've told them for years that they've got to improve that bracketing system. Because the seat goes forward, and head injuries, the whole bit." He was just furious. And he had reason to be. And I remembered that years later, when I was involved with some crash investigations.

Anyhow, the director of the overall operation, biomedical operation, was Dr. George Leroy. He was one of the first American physicians into Hiroshima and Nagasaki. As soon as we occupied Bingo, they sent this medical team in to see what they could learn. And he was in that first team. And he had been currently at Heinz VA Hospital outside of Chicago. And he was coordinating this with all the other laboratories around the country in the biomedical program. He was the overall director. Great guy. And I got to know him pretty well. And you know, I may have been an underling, but on a small island, when you're living there for several months, you get to know everybody pretty well. And you weren't treated like a peon. You were just part of the group. And so knowing him made a big difference later in my life.

Anyway, I went back to the bomb tests, went back to Oak Ridge to finish up our analysis of all the material. And it took quite a few months. In the meantime, with only a bachelor's degree, I knew that I wasn't going anywhere in research with just a bachelor's degree. So I had to make some decisions. Do I go on, get a PhD or at least a masters in one of the biologic sciences and keep on doing what I'm doing? Or do I try to go on into medical school, which his something I really wanted to do all my life.

So as I was winding down on that research project, I was making applications to medical schools and just sort of hoping maybe there'd be a chance. But at that time, medical schools could throw out everybody but straight A and then start sorting. And I didn't think I had a ghost of a chance.

So I was still struggling with what I was going to do, and making applications to medical schools. And Dr. Leroy came into my office. He was making his rounds to finish up all the loose ends on the project, and get a final report out and stuff. So he came in and visited with me. And he propped his feet up on my desk, and he says, "Well, Dorin," he says, "what are your plans?"

And I said, "Well, George. I don't think I'm going to be able to get anywhere without an advanced degree in the research line." And I said, "I've always wanted to go to medical school, but I just don't think I can make it."

He said, "What do you mean you can't?"

I said, "I don't think I can get in. I'm not a straight A student."

He said, "Well, grades aren't everything."

I said, “Well, yeah, they are, when you’re talking to the dean of admission.”

He says, “Well, have you applied to anyplace?”

And I said, “Yeah.”

And he asked me where I’d applied to, three or four schools. And he says, “Have you applied at the University of Chicago?”

And I said, “No. Their standards are so high, I don't think I’d have a chance.”

And he says, “Well,” he says, “you’re dad worked there at the university in their met lab, and so they know your family. And they know you’ve done research, and they’re pretty high on research there.” He says, “You apply.”

I said, “George, I don't think there’s a chance.”

He says, “Yeah, you apply.” He says, “I’ll be glad to write you a letter of recommendation.” He says, “It won’t mean anything, but go ahead and try.”

I said, “Okay.”

And as he’s walking out the door, he turned around and says, “Oh, by the way, I’m leaving Heinz VA. I’m going to be assistant dean at the University of Chicago Medical School.” (laughs) He said his recommendation wouldn’t mean anything. Well, I think it probably did.

So I made my application and took my interviews. And the recommendation went downhill to the new dean of admissions. (laughs) Anyhow, sometimes it’s who you know. But his letter was, I’m paraphrasing it, I don’t remember the details. But his letter of recommendation started out something like this, “I lived on a desert island with this man for about three months. I think I can attest to his qualifications.” (laughs) Oh, man.

Anyhow, while I was at Oak Ridge, I met this young lady who was in research. She was doing bacteriology research, and was actually dissecting bacteria and getting the nuclei out with rather fine techniques. And her name was Catherine Myer. So it was a rather wild romance, and we got married. So that was, starting a family. And we had a first son before we left Oak Ridge.

And then we went to Chicago. Started medical school there. It was a struggle. I was not the brightest student. But they sort of liked my background. And the fact that I had research and experience. And came from an academic family. I mean, you know, I wasn’t a poor student. I was just a poor student by my family’s standards. Anyhow, it was a struggle. And medical school was a real drag, you know. In those days, you’d go to school all day and then you’d have to do lab work and stuff at night. It was a real, real grind. And I wasn’t, some of the basic sciences, I always had trouble with math. So it was

a squeaker that I got through. But everybody that went to medical school had that same struggle.

Well, Dr. Leroy came back into my life again. He was assistant dean, and he had appointed himself as my advisor. And he had to get tough with me a few times. And tell me, "You've got to buckle down again." And so forth.

But at Chicago, the senior year, we had medical clinics, surgical clinics, an elective and an off quarter. So we were just coming up, I happened to draw the medical and surgical as the first and second quarter. And I had an elective set up as a research project in the mouse lab. But I had actually had an interesting project going with oxygen toxicity studies on lung tumors. And that would have started right after the Christmas holidays, because I had the elective and off quarter I was going to do the research through the six months. And not, probably early December, in '56, no, it would have been '55, George Leroy called me into his office. And I thought oh, no, what's coming now? I was on shaky grounds.

He says, "Well, Dorin, how would you like to go to Alaska?"

And I said, "What? I've always wanted to go to Alaska, but I don't have any money. I mean, gee whiz."

He said, "Well, if we paid your way, would you be interested?"

What?! (laughs) I said, "What are you talking about?"

So he said, "Well, we've got a program for one student, one senior student, who has an elective and an off in sequence, so we've got a six-month stint, to go to Alaska, work in a TB hospital, under the direction of a thoracic surgeon. And we've got it set up so that one student can go every six months. And he says, "It's sort of interesting." He said, "I think you'll enjoy it."

I said, "Well, it sounds great! It sounds better than working in the mouse lab." So I went home, and I said, "I've got to check with my wife." By this time, we had two kids.

So I went home for lunch and I said, "Honey, how would you like to go to Alaska?"

She laughed at this. "Are you out of your mind? What are you talking about?"

"Well, I've got this chance to go to Alaska."

She said, "What in the world are you talking about?" So I explained what I'd been told. And she said, "Well, that sounds very interesting."

So we started making plans. Here we were going to stay for six months doing research, and had to pack up and leave in two weeks.

The hospital in Alaska was at Seward. It was an old World War Two barracks hospital. Built on the government model, which would have been the same for Georgia. No insulation. But it was the old World War Two barracks hospital. It was thrown up to protect the port of Seward.

And it had been taken over by the Methodist women. They had gotten it from the military and made a TB hospital out of it. And Alaska TB situation was really pretty bad. Every year the public health people would go farther and farther into the interior and find more and more advanced cases, and they'd bring them into the hospital. Mostly under the auspices of the Alaska Native Service. Because it wasn't a state yet. And so this was in '56. And we landed there, well, we drove from Chicago to Portland. As soon as I was through with classes, we loaded up. We had a VW bus at the time, two kids and a parakeet. In the middle of winter. So the plan was to go to Portland. My brother was at the medical school at the time. He'd had his internal medicine and was taking dermatology at the University or Oregon. So he was at Portland. And we were going to stay there for Christmas. And then go to Seattle and fly up, and send our car on a barge.

So here we are, traveling across country in the middle of winter, VW bus, 236 or 38 horsepower. You know, you could get up to 60 downhill with a tailwind. (laughs) It was slow. And all our belongings had either been shipped to Portland, hoping that we could get an internship there. And that was a big gamble, because we wouldn't know until after we had been in Alaska.

One of our stops along the way, we pulled into the, they didn't have the freeway. So it was the old highway. Two-lane road across a narrow bridge, come across from Idaho into this little town of Ontario. And that was just one night away from getting to Portland. So it was eight, ten hours to get from here to Portland in those days, because the roads were narrow and windy, with no freeway. But we pulled into a motel in the town of Ontario. We were tired and bedraggled. The kids were hungry and fussy. And the parakeet we couldn't leave in the car, so we had to check in somewhere. Went into the hotel, motel, and unpacked for the night.

We said, "We're hungry. Can you recommend a good place to eat?" So they sent us down the street to a restaurant. We came out of the restaurant. The kids were settling down a little bit. They'd gotten some food. They were getting less cranky.

My wife turned to me. She says, "You know, we left on short notice, and we're going to Canada, to Alaska, and I don't have a winter jacket." And that does present a problem. She said, "There's a men's store open across the street." It was dark, you know, it was close to the shortest day of the year. Men's store called (Tyrie Bills?).

So I said, "Yeah, let's go across." She didn't care if it was a men's jacket or a women's jacket. She was looking for jackets, and the kids were running around the store,

and I was trying to keep herd on them. and just had casually mentioned to the clerk in the store, I said, "You know anyplace that might need a doctor in a few years?"

And he says, "Well, what do you mean?"

I said, "Well, I'm finishing up medical school. And after I take a little more training, I think I want to go to a small town." And it was just like [makes noise] (laughs)

Turns out that he wasn't just a clerk. He owned that store. He owned another store in Ontario. He owned a store in John Day. He owned a store in Pendleton and Caldwell. And his avocation was trying to attract doctors to the area. (laughs) Serendipity again.

So he started to sell me on coming to Vale, right then. And gave me quite a sales pitch. Telling me that yeah, I would be very welcome. So filed that in the old mental filing cabinet.

Went down to Portland. Had Christmas with my family. Then we flew to Alaska. The planes in those days were not jets. They were prop jobs. You reach a point that you can't turn back. And there were lots of flights going back and forth from Seattle to Anchorage. But our plane got to the point it couldn't turn back. The planes that were half an hour behind us were turned back, because Anchorage was having its worst snowstorm in many, many, many years. and it was, everything was closed. All the airports were closed except Elmendorf. This was Cold War days. And the air force kept Elmendorf open. I mean, they just, plows were going constantly. And we landed at Elmendorf, right behind a snow plow. And taxied up to where they were letting us off. And the drifts were huge. And the military guys kept shoveling the walk so that you know, you would go through a tunnel, basically. The drifts were six, eight feet high. And it was just an incredible snowstorm.

Some of the servicemen helped carry the kids off the plane. And we got in there and actually got a taxi. There wasn't hardly anything moving. And we got to a hotel. Because Dr. Philips, who was going to meet us and take us right down to Seward, we knew he couldn't get through. All the announcements on the radio were, "Road to Seward closed. Road to this closed. Stay off the roads." So we knew we couldn't get through, so we figured we'd just go to a hotel until we heard from him and the roads cleared a little bit.

So we checked into a hotel. And were coming out of our room to go get some food, and Dr. Philips showed up. Francis Philips, he was the only thoracic surgeon in Alaska at the time, and Alaska's big. He says, "Well, you ready?"

And we said, "What? The road's closed."

And he says, "Yeah, it's closed." But he had a four-wheel Jeep, four-wheel drive Jeep, one of the old box station wagons, one of the first ones. I'm a little fuzzy on whether we actually left at that point or whether we stayed till the next morning. But the

roads were officially closed. And they should have been. They were just awful. And he said, "Well, I've got to get back. I'm the only doc there at the hospital." So we piled into his vehicle. And of course with the roads closed, if you go off, nobody knows you're there. We could have been found in the spring. (laughs) But he said, "Well, I know the road pretty well. I drive it a lot." What is it, 120 miles or something from Anchorage to Seward. I can't remember exactly how far, but it's something like that. And we were going through along these windy, narrow roads with no markers, no nothing. And drop off over here, you know, if you'd slid off, you would have gone 500 feet. All they'd know about you was that you didn't show up. It was sort of a scary trip. And on the way down, of course, my wife was a little like this.

Dr. Philips was cluing me in a little bit on what my duties would be. And one of the things that he told me, just matter of factly, was, he says, "Oh, by the way, you're going to do all the deliveries."

I said, "What?!" (laughs) I'm just out of, in my last year of medical school, and the OB training was basically observation from about five posts back. Because they had the chief resident and the resident on the case, and the intern, and the nurse midwife in training, and then the medical student. So you'd sort of look around, and can't see much. I think I've mentioned elsewhere that I would have done better with a periscope. I didn't consider that adequate training to be turned loose as being the obstetrician for a hospital. But anyhow, he told me a few other things that had me wondering if I was going to be in the right place.

And we get to, we get down there, they had a nice little house for us. It's just a little crackerbox, but there's a little room that we can put a double-decker bed in for the two kids. And a small bedroom and a kitchen. And they had it nicely laid out. And the hospital had supplied enough food for a day or two, until we could get settled. And they showed us where the linens were and so forth, and the bathroom.

And we looked, and they had a big bag of salt by the bathtub. And we said, "What's that for?"

He said, "Oh, forgot to tell you. Whenever you use the bathtub, make sure just as the last of the water's going down you pour it full of salt. Otherwise it freezes up and we have a hell of a time getting it thawed. So every time you use the bathtub, you've got to pour salt in. Otherwise, you're in trouble."

SIMEK: Let's pause here and change tapes.

KRONENBERG: Yep. End of tape one.

[End Track One. Begin Track Two.]

DANIELS: We were unpacking in this little house of ours, and it was near the hospital. They had an intercom hooked up so that they could call me from the hospital or

from Dr. Philips' home. But we were just starting to get settled, and I get this call. Dr. Philip says, "Can you come up to the hospital?"

I said, "Well, yeah, I guess so."

And I walked up and he had a little office where he did some private medicine. He was the director of the hospital, TB hospital. I think it was about 90 beds. It was about a third Eskimo and about a third Native Indian, and about a third Aleut. Basically white origin, some of the old Russian blood in it and so forth, but these were mostly Alaskan native people.

But he had this little private office, and this was the old military barracks. And this was New Year's Day, or the day after, I can't remember, but it was a holiday. And he says, "I want you to get introduced to Alaska medicine."

And I said, "Okay."

A woman had walked in from the city, from the town. Had a terrible toothache. And she couldn't find a dentist. It was a holiday. So I think she was expecting to just get a pain pill or something to tide her over till she could see a dentist. But Dr. Philips looked in her mouth. Then he called me. He says, "I want you to get used to Alaska medicine. We don't do things quite like we do in the States. You've got to do what you've got to do." (laughs) So he says, "Look at this mouth." It was awful. Just a few snags left and they were all, it was awful. And obviously terrible hygiene. And this lady had, I don't know how she could eat. She just had a few snags at different places. And she was pointing to this one tooth. And she had been terribly frightened of dentists. She just refused to see dentists. She was just scared to death. But she was hurting bad enough she was willing to let something, anything happen, to get some relief.

So he walked her into the old dental lab, which was still equipped from World War Two. Just rows and rows of different shaped pliers and so forth. And found some Novocain and deadened it out a little bit. And found some pliers that fit that tooth and jerked it out.

And she said, "That wasn't bad! This one's been bothering me." So does the same thing. She says, "Yeah, that wasn't too bad, either. Can you work on this one?" So wound up with a full mouth extraction. This is a thoracic surgeon and a medical student using World War Two equipment, which was still there in the drawers, untouched. So that was my introduction to Alaska medicine.

Then I found out the next day when I got a more formal introduction to the hospital and we made rounds, he introduced me to personnel in the lab, and the X-Ray, and we made rounds and met the patients. I realized then why he had told me some of the things that my responsibilities would be. He was so crippled up with arthritis, it was extremely painful for him to make rounds. He could barely move. And that's one reason he—I was the first in line for any problem. And then he'd help me on anything I needed

help with. But he didn't want to do deliveries. That was my job. And I felt totally inadequate.

But I learned then, as time went on, that the old-time nurses were just great resources. They'd seen it all, they'd done it all. You put some of those old-time nurses up against any of the modern PAs. They were just great people.

You know, the first time I had a delivery, I was shaking in my boots. But these calm old nurses just talked me right on through. Without them, I would have been really lost.

And the deliveries, some people came in pregnant. When they found them, they had TB, they were pregnant, you couldn't do anything about that. And these native people were extremely stoic. You knew they were pregnant. You did prenatal exams on them. You measured the uterus. And usually language barriers. You didn't know exactly when their last period was, or they didn't remember, or what have you. You know, I was measuring the uterus and getting a pretty good idea of when they were due. These gals would not say peep one. They just wouldn't say anything until, well into labor, they'd call a nurse over and said, "Baby come now." You better start moving. Because when they said, "Baby come," they were ready. And you had to hustle like hell to get them down to the delivery room. And most of them went easy. I had a few where I struggled a little bit. But fortunately they were easy, and the nurses were very, very helpful.

It was a little sad because these mommies could look at their baby, but they couldn't hold them. They couldn't take care of them. Because they were contagious. They wore masks all the time. Of course, we wore masks. So when the baby would come, I'd hold it up and Mommy could see her baby, but couldn't touch it. And then the babies were taken immediately down to the City Hospital, which was a small hospital. And they were kept in the nursery there until a public health nurse could make arrangements to get this baby back to the village that the mother came from. And that was just the way of life. You'd get the baby back, somebody would take care of it. That was their culture. But very, very stoic people.

And the non-pregnant ones, it was a real learning experience for me on the culture. We had language barriers. They all spoke different dialects. You could get people in that came from 100 miles apart that couldn't talk to each other. You had the Indians, one culture very different from the Eskimo culture. And at first you say, "Well, how do you tell them apart?" But you learn pretty soon the difference in their appearance and their behavior. But it was very difficult to talk to them, because there was no common language. All the patients learned a little bit of English and that was, of course, the common language when you could use it. But all new patients coming in were just totally at a loss.

I remember one girl who was a patient had advanced TB, was just an absolutely gorgeous Eskimo lady. She was eighteen, nineteen. Just a beautiful girl, and extremely bright. Everybody in the hospital, all the staff, all the patients, just loved this lady.

Extremely bright. And she could visit with a newcomer to the hospital, no matter what their dialect, no matter where they were from, and within an hour or two, she could make some meaningful communication. She was just absolutely outstanding as an interpreter starting from scratch. And this gal was so, so remarkable that everybody in the hospital was saying, as soon as she's well enough, we want to all get together and send her to college. She is just absolutely, needs to have every advantage to get to college. She is so bright.

Well, her TB advanced and advanced, and nothing we did could stop it. So we had to do a major pneumonectomy on her. And post-op, the parameters we could measure didn't look like we were in trouble. But she didn't look good. And very serene, very accepting. Three days after surgery, she just smiled and says, "I die now." And she died. And everybody was just devastated. I mean, there wasn't a dry eye for days in that hospital. You know, every now and then you meet somebody who's just so outstanding that it really makes an impression. And she did. It was a terrible loss.

Other older people, I remember one old gentleman who had advanced tuberculosis, started developing some chest pain. And we had an old EKG machine, the old galvanic light beam type that was left over from earlier days. And you had to get this strip of photographic paper and get that beam adjusted. So I was fiddling with that, and I finally got it working. It took me maybe 20, 30 minutes to get the machine working right. I was doing all this fussing around. And I take the paper into the dark room and develop it in the X-ray developer, come out, and I was trying to analyze this. I didn't consider myself an electrocardiographer at all, but I knew some of the basic patterns. And I was looking at that, and the guy looked up at me. "Oh, thank you. Thank you." All this fussing around that I had been doing, he thought was good treatment. (laughs) But these old folks, you'd' think they were stable. Their lab work hadn't changed. And one day they'd just very matter of factly said, "I die now." An hour or two later, they were gone. Interesting, interesting culture. Very accepting. Death was not only accepted, in some cases it was looked forward to. They just accepted things. A lot of my patients since then have not been quite that serene. (laughs)

I learned some interesting techniques while I was there. Every couple of weeks we'd take a different segment of the hospital population and do bronchoscopies. Well, this was way before the days of the flexible fiber-optic scope. So it was a rigid scope. So you had to learn the technique of a sword swallower. You had to adjust things just right so you'd get a straight shot. And it was, we would usually do this in a darkened room. Had the lighted scope. And I watched a few and they said, "Go ahead and try it." And of course I tried it, and I manipulated the laryngoscope and thought I was in the, going down the trachea. And the nurses in the room started giggling.

I said, "What's the matter?" I could see the light going right down through here. I was in the esophagus. And they said, "Everybody does that. Ha, ha, ha." (laughs)

So they had a production line. There were about five stations. They'd squirt cocaine into their throats to anesthetize them. And then get another shot and another shot.

And about the fourth station we do this, and then the fifth station, we put a tube down through the bronchoscope and inject some dye and take them into the X-ray and get beautiful bronchograms. I've got some pictures of some of those, better than, better visualization of the abnormal branchae than you see now with the modern technologies. It was great. So here I probably did several hundred bronchoscopies as a medical student, with a rigid scope. Scary.

Well one day, Dr. Philips was gone. And I got a knock on the door. And I went to the door, and a fellow who worked at the hospital, I don't remember what his capacity was. He says, "Doc, you've got to help me."

I said, "Well, I'll be glad to try. What's the matter?"

He says, "Well, it's my dog."

I said, "What's the matter?"

He says, "Well, my dog got into a porcupine." He said, "I've been trying for hours to get those quills out. And the dog's just had it. It's so painful. It's just awful." He says this is his friend, his hunting buddy, it was everything to him.

So I looked at the dog, and it was just plastered, I mean, quills everywhere. Just right at the eyeball and up the snout, and mouth was just full of them. It was awful.

And I said, "You know, I'm not licensed to do anything. I'm not a veterinarian, or I'm not officially a doctor. I'm still a medical student."

He said, "I don't care. You're the only one around." He says, "I'll trust you. Do whatever you can."

And I said, "Well, I did anesthetize some dogs in the dog lab, the physiology lab, I guess I can try." I said, "I can't guarantee anything. We may lose the dog."

But he says, "Yeah, but the dog's going to die. He can't eat and he's miserable."

So I said, "Okay." So I went to the hospital. The head nurse is gone. The operating orderly is gone. Dr. Philips is gone. So I get somebody with a key and we get some nembutal, one of the sleep-inducing agents. And I try to figure out how much to give, because of course that's a human dose on the literature. I finally say, well, this is probably about as good as I'm going to do. And I gave it intraperitoneally and the dog finally went to sleep. And I wasn't sure it was going to wake up. But it went to sleep. And the owner of the dog and I just went to work like crazy. And these quills were right next to the eyeball, and it was awful. Anyway, we got the quills out. Just about the time we were done, the dog started waking up. And boy, did I feel great that I hadn't lost the patient.

So the owner was just extremely grateful. And he tried to pay me. I said, "I'm not licensed. I can't take anything. I'm glad I could help." He just kept insisting. I said, "I can't do it."

He stuffed a bill, I think it was a five dollar bill or something in my pocket. And he says, "Don't you look at that until I'm gone." So that was my first fee for service. (laughs) And the patient lived, and everybody was happy.

Well, the next day, when Dr. Philips and the head nurse and the operating room nurse were back in town, they called me in to Dr. Philips' office. And with very stern, you know, they were just really chewing me out. They said, "Do you realize you have no authorization to take anything out of the narcotics cabinet? You're not licensed to." You know, they were just trying to be so severe. And I could see the twinkle in their eye. I mean, their body language was, "Yes!" (laughs) But they were having to tell me that I wasn't authorized, and I was going to have to pay for the medicines, and blah, blah, blah, blah, blah. But you could tell that they were saying, he's arrived, he's an Alaskan, we do what we have to do. (laughs) And for days, every time I'd see somebody in the hospital, they'd sort of give me a wink. It was sort of neat.

Got away a little bit. Every once in a while, Dr. Philips would say, "You've got to take a day off and go see the countryside." So we'd get in our VW bus. One time we went over by Kenai and Homer, Alaska. And the road had just been opened up a very few years before that. Before, to get over to that side of the Cook Inlet, you had to go by boat or airplane. So they, we had some nice trips and some nice photography, and watched some people catch some fish. It was salmon season one time and I saw people catch fish were so big they had to put them over their shoulder and the tail was dragging on the ground. I mean, just incredible size fish.

I couldn't fish for salmon, because I couldn't afford a license. I was out of state. Well, actually, it was a territory still. But Dolly Varden were considered trash fish, because they ate the salmon eggs. So we could fish for Dolly Varden. And people would come from all over the world to fish Dolly Varden in Alaska. But we could do it because they were considered trash fish.

And every now and then I'd come home and somebody had been fishing for salmon, and they'd stick a stiff, frozen salmon in the snow bank outside our back door and give us something to eat. It was a great experience.

One time when I was, we didn't have an anesthetist at the hospital. And Dr. Philips was a thoracic surgeon. Now those who are familiar with medical techniques, one of the operations we did, sort of as a stopgap, was collapse therapy. We'd collapse the lung and collapse the cavity of the tuberculis legion. And that's supposed to allow them to heal better on some of these that are refractory. Well, there's several techniques for thoracoplasty type stuff. And some of them, you cut the ribs and just totally collapse the ribcage. And then they'll never expand. Other ones can be sort of reversed. Well they, there was a new technique, which I don't think stayed around very long. But you'd open

the chest up and put in paraffin to collapse the lung. And it was paraffin that melted to a little above body temperature. So it was just firm enough to keep the lung collapsed.

Because we didn't have an anesthesiologist of an anesthetist, we did thoracoplasties under a local. Now that's an awful lot of anesthesia, local anesthesia, and a brutal procedure. Then whenever we could get somebody lined up from the Elmendorf Air Force Base, we'd get an anesthesiologist for a weekend bootlegging out of when they had some time off. And we'd arrange this weeks ahead. And we'd get patients lined up that we (know?) immediate surgery, they'd been sort of on hold. And we'd do ten, fifteen major chest surgeries in a weekend. What an experience! I was number two at the table. As a medical student. I got some surgical experience that surgical residents don't get for years. And I helped Dr. Philips with some of his private patients. We did appendectomies and gall bladders and things like that. But it was a fabulous experience.

As I was getting near the end of my six months in Alaska, I was in the operating room one day and the nurse asked me to turn around. And I turned around and she pinned a little surgical gauze thing on my cap. What's going on?

She said, "Okay."

I turned around and we kept on operating. A few minutes later, Dr. Philips looked up at the clock and he says, "Well, it's about time. Welcome, Doctor. You just graduated at Chicago." (laughs) So they had a little piece of cake between surgeries, and that was my graduation ceremony. So that was sort of neat.

Anyhow, we left. By this time we learned that I did get an internship at Portland, at the old St. Vincent's Hospital. So we were supposed to start that in July first, I think. And so we got in our VW bus and started down the Alcan Highway about two weeks before I was due in Portland. And we'd converted the bus so that the two kids could sleep in the back. And we had the seats arranged so that we could make a bed for the two of us. So we could sleep all right. It took some rearranging every time we stopped to camp, but we camped on the Alaska Highway coming down. Beautiful scenery. Washboard road, long, long drive. We didn't stay at many formal campgrounds, because they were usually around water. And where there was water, there were mosquitoes that were just incredible. So we usually camped in the old gravel pits from when they built the highway, because there was usually less mosquitoes.

My wife was pregnant at that time with twins. And we were coming down the highway. Long, long, long, long ways between hospitals. And we knew we had an abnormal pregnancy. Not only twins, but because we had the, the growth in the uterus was far excessive and abnormal, we had taken an X-ray. We didn't have ultrasound in those days. And the X-ray showed two babies. But only one head could be found. Well, we didn't know if that meant motion in the head, or if there was really something wrong. But we knew we didn't have a normal pregnancy. And we were bouncing down that washboard road for an awful long ways.

But we made it to Portland. And went to St. Vincent's Hospital. And said boy here we've got to find a place to live. And of course up until about the time I was finishing medical school, there were almost no married physicians, married medical students. It was just taboo. You didn't have time to be married, and that was the argument. But when I came out, a lot of people had been in the service. They had their families going. And the medical schools and the hospitals had to adapt to married interns and residents.

Well, if you're familiar with the old St. Vincent area on Westover, there's some big houses there. You go around and up the hill behind the old St. Vincent's there's just some huge, elegant old houses. The hospital had picked up one of those because they at that time thought they might be expanding in that area. So here they had this big old house. And they said, "Well, you know, we've got a house. You've got two kids and your wife's pregnant and going to deliver soon. So you're going to need more than just a little tiny apartment." So they gave us this huge house on Westover. And they only charged us—I mean, they knew what they were paying me. I think I was, I'm not sure, I think it was $200 a month was what we were paid. And one of the reasons I picked St. Vincent's was that they paid something. In those days, the so-called prize internships and residencies didn't pay. They gave you board and room and some uniforms. So they gave us this big house for $70 a month or whatever. It was ridiculous. Because even in those days, the rent would have been ten times, whatever. So we had this big house. And it was walking distance from the back of the hospital. So that was great.

One of the things I had learned by that time was that I really enjoyed obstetrics. So I took every bit of extra time I could in obstetrics. And because we had an abnormal pregnancy, we looked around for one of the top notch obstetricians for abnormal pregnancies and were given good advice. And Dr. Opie McCall was an excellent obstetrician. He was very active in the society, too. Nice guy. And he would give us as interns and residents a type of training that was just almost beyond comprehension. He would spend hours with sort of the mannequin and the pelvic model and forceps, and showing just a tremendous force of training, which nowadays the residents don't get. If anything's wrong, they'll go to the knife. They do all the C-sections for stuff that we were taught how to handle with surgery. So I felt that my training was pretty good, and I took extra training in my residency so that I was, I was way ahead of the game as far as general practitioners being, doing obstetrics.

Towards the end of my, well, in doing internship I realized that being a small town physician, which is where I wanted to go, an internship wasn't quite enough. I'm not the bold type who jumps in. The old adage of see one, do one and teach one on a surgical procedure just wasn't enough. I felt I needed more training. There were several of the good old family doctors that, some of them were just excellent. I'm trying to think of some of their names that were at St. Vincent's. They encouraged me to apply for a Meade Johnson Scholarship Award in general practice. And in those days, most people who went into general practice just took an internship and went out. Often they'd affiliate themselves with some older doctor that was wanting to retire, and they could take over the practice. But sometimes they'd go out on their own without really much supervision.

And the (Harpels?) and oh, I'm blocking on their names. But there was a whole bunch of really good family doctors at St. Vincent. And they encouraged me to apply for this scholarship. Well I think there was only five or six in the country, and I got one. And that gave me another hundred dollars a month or something for residency training. The baby that we had, Cathy, that you fellows have met, was one of the twins. The other twin, as indicated by the X-ray, was acephalic. It had no normal skull. It was just brain stem.

So I was a little nervous when I started at a Catholic hospital. I hadn't really been, I'd heard some stories at a Catholic hospital, what you could and couldn't do. It was sort of interesting, because here we had this baby that obviously wasn't going to live, and it died within a few hours. And our choice was to send it to the medical school as a pathology specimen. And one of the sisters in the delivery room, "Ohhh!" They were just so upset because the baby wasn't going to get a formal burial. Underground. She wanted that baby underground. And it was pretty hard to convince her that it would serve a purpose as a specimen for study. And we finally convinced her that sometime, eventually, it will be underground. I mean, maybe centuries, or maybe a few years, but eventually it will be underground. "Oh, okay."

But I felt much more comfortable, at some of our mgs, and this is something I think our modern generation doesn't really have a handle on as well as the old ones did. Being a Catholic hospital, there were some ethical standards that were spoken and unspoken. And at one of the breakfast meeting type things for the house staff, one of the older gentlemen who was about to retire, so that would have put him 60, 70 years old in 1950, so he'd been around for a while, gave us some very solid advice on medical ethics. And we were in a transition state historically. We were now getting post-World War Two technology. Ventilators, medications that were totally new and gave people incredible power to keep people alive. And we got a generation of intensivist type people who felt that nobody should die on their watch, and they would do anything to keep a body alive when that body had nothing going for them, and no future whatsoever. But the doctors would assume that they had to keep that patient alive at all costs.

Well some of the old docs gave it sort of straight to us. They said, "You are obligated to offer sustenance. If they cannot or will not partake thereof, it's not your fault." And some of the modern docs can't accept that. But I think it's a very good philosophy.

And we've all had patients who absolutely refused to eat. And the lawyers get involved. And the families get in squabbles. And some say, "Let them go," and some say, "Keep them going." And the old-timers had a pretty good handle on it. Sometimes it's worth listening to the old-timers.

Well and I went into the general practice residency for the second year after internship, and got a lot of extra OB training. And good medicine, good surgical training. I knew I would not be doing a lot of surgery. But I got a lot of exposure, so I knew what it was, and could do things if I had to.

About this time we were looking around for a place to live, a place to practice. By this time, I was getting an occasional weekend off. You know, an internship, you very seldom get off at all. And we went out to some towns around. And my oldest son was having a lot of trouble with asthma. It turned out later it was probably because I was smoking at the time. But we thought maybe we needed a drier climate. And we remembered our stop in Ontario on the way to Alaska.

So I called this Mr. Quisenberry that owned the stores that we bought the jacket from. I called him up one day and I said, "This is Dorin Daniels. Do you remember me?"

And he said, "Hell, yes. When are you coming?" (laughs) That was it.

So we went out for a weekend and he showed us around the town of Vale, and gave us a real sales pitch. Got me in touch with a real estate guy. We found an office, which is upstairs over one of the automotive garages. And got to be pretty much a story that if you could make it up to Doc Daniels' office, you probably didn't need to see him. (laughs) Because it was such steep, narrow stairs. But we got lined up. Real estate guy introduced me to the banker. Of course we didn't have anything. No money. Plenty of debt. The real estate guy loaned me the down payment so the bank would loan me the money. You sort of feel at that point that well, maybe you are wanted. Small town. You wouldn't get that treatment in a lot of places.

So we decided to go there. And I started getting some supplies lined up for the office in Portland. Mainly it was Shaw Surgical, because they had a branch office in Boise. And they said, "We can get this stuff all for you here, but you can get service and supplies out of Boise when you get over there."

So here I was committed to office equipment. Also went and look at X-rays. Because I figured in a small town practice, you're going to need an X-ray machine. Well, I went to several of them, and I learned a little bit about business that I hadn't known before. Medical students aren't taught any business. At least, they weren't then. Didn't know up from down, as far as how to run an office financially. Anyhow, I looked at several X-ray machines. If you had done atomic research at Oak Ridge, you know, we had all sorts of fancy gadgets. So I knew a little bit about radiation, and a little bit about X-ray machines and so forth, because we used them all the time for our experiments. And GE had one that they thought I had to have. And then some other company, I had to have this one or I had to have that one.

And one of the big companies was telling me about this wonderful machine that it does all the figuring for you. Now this is before calculators and computers. They were trying to tell me, you just dialed the name of the extremity and the thickness of it or something. You put in a couple of numbers, and that's supposed to give you the right thing.

I said, "What if I use a film of a different speed?"

He says, “Oh, well we’ll come up from Portland to Vale and recalibrate your machine?”

I said, “Well, what if I want to use different speed films alternating?”

He said, “Well, we can still come out.” But you know, they charge for travel time, and 300 miles.

I said, “Let me see in the machine.”

So he took the panel off. It was crummy! It was just wired like rinky dink. And their calibration system was just a clip, a wire clip that went on another wire so it changed the resistance a little bit. And there was just a wheatstone bridge. I said, “No.”

I found another machine from an off-brand company that when you look inside was beautifully built. Heavy wires. Well dressed, everything organized. Obviously a quality machine. Totally unknown brand. But that’s what I bought.

So when I went, when I finished residency, I had some supplies coming, and an X-ray coming. Over my head, no finances. Been loaned, given money by the real estate guy so I can get a loan to buy a house from him. And get to Vale. The house isn’t available for another couple of weeks. So we stay in a motel. Interesting enough, it was the Bates Motel (laughs) on the edge of town. Hot summer. First of July. Rodeo time. And so we didn’t have any money to fix the office up by hiring people. So we went in and painted and stuff. I had a bag with a few instruments. You know, an otoscope and a stethoscope and a shot of morphine for heart attacks. I mean, basic stuff. And we’d be up there painting the office and no sign anywhere, nothing.

And somebody would come strolling up the stairs. “You the new doc?”

“Well, yeah.”

“Well, I got this problem.” (laughs) Here I was with no office, no office material, no paperwork, no ledgers, no nothing, just working out of a black bag. And steam kept increasing. People heard that I was in town, and come up the stairs.

Then we finally got to our house, and that was rodeo time. So we were moving into the house. No, I don't know how they knew it, but I’d be working in the yard trying to straighten something up or doing something in the house. And somebody would show up and dump out an injured rodeo guy. Broken arm or something. And he’d say, “Take care of this guy.” And I didn’t have an office set up. Didn’t have my X-ray in.

So I’d put him in the car and bring him over to Ontario, 18 miles. We didn’t have much of an emergency room at that time. Just a little one-room closet, basically. X-ray was run pretty much by one of the Catholic nuns, who was an X-ray technician. Obviously trained in the Dark Ages. Really quite an experience, because these nuns ran

every department in the hospital. There was a nun at each station. They ran the business office, and Sister Superior was the administrator. And they were good, dedicated people. But they really had not been business trained. And they were losing, they hadn't kept up medically. And here's this sister. I can't remember her name. She was a, sort of a gruff old lady. And she was on call 24/7. And somebody would come in in the middle of the night with a broken arm. She'd be called and she'd come out. You just cringe when you think—I saw her with a kid with a broken arm. No splint. She just flops it on the table. And then she flops it over. The kid's screaming. We've come a long way on that aspect of medicine. At least people splint things. Pretty crude.

Anyhow, I'd bring a rodeo injury to the hospital. Get X-rays. Put a cast on. Take him back. Dump him at the rodeo grounds. I don't think I ever got paid for them, because I didn't have any paperwork that I could—(laughs) And I'll tell you, rodeo people are a different breed. The next day, they were so determined to get back in and ride that damn bull that they'd take the cast off again. You can't win. And talk about macho. These guys are nuts. But anyhow, that's part of the culture in this part of the country.

Finally got my office. Got the X-ray machine installed. Hired a gal right out of high school. Mr. Quisenberry had gotten me to come to Vale, recommended her as a very reliable, hardworking gal, and she was. So I had one girl and myself. And neither one of us knew diddly squat about running a business.

At that time, office calls were three dollars. I think my deliveries, obstetrical care and delivery and postpartum check-up was 35 dollars. After the end of the first year, I had to do a little reassessing, because I wasn't taking anything home. So we increased our fees a little bit. But we did a lot of service for three dollars, I'll tell you. (laughs)

When I got the X-ray machine in, I got a little lesson in business. The GE representative out of Boise came to my office. Told me in no uncertain terms that I had to buy all my supplies from him. He had the whole Boise valley, and he had pretty much the whole market.

I said, "Well, I don't have to buy everything from you."

He said, "Yes you do, or I'll run you out of business. You're not using our machines, and if you don't buy your supplies from us, I'll run you out of business."

And what ticked me off, I never did buy anything from him. I got stuff sent out of Portland rather than deal with him. That was a little bit of an awakening for me that not everybody was quite as nice in business as I thought they were.

I started having a lot of obstetrical patients even coming from Ontario to Vale because Dr. Belknap, who was the old obstetrician, he delivered thousands and thousands of babies during the war. And he delivered just about everybody in the county for a long time. But he was getting sick. He had prostate cancer. And that was getting to him. And he had a lot of arthritis. And he was phasing it down. And Dr. Burdick, who'd been in

general practice, was picking up a lot of that slack. And I was getting busier. And Dr. Burdick was real busy with obstetrics. And then he went off to become a psychiatrist.

Joe was a great guy, just a wonderful person. He came back from his psychiatry residency and went back to the Ontario Clinic as a psychiatrist. But for his own sanity, he kept doing general practice. He felt he was more in touch with reality working with those people. So he was about half time psychiatry. Wonderful person, wonderful sense of humor. And he just died recently. I don't know if you knew that.

But when he left for psychiatry, and Dr. Belknap was phasing down to just a few a month, my obstetrical practice exploded. And it got to where I was, well, I think I was, during my busy years, there was 175 a year or so. And it was getting very difficult for me to stay in Vale and work both Nyssa and Ontario. Nyssa had a hospital at that time.

And patients were pretty divided. Some of them wanted to go to the Catholic hospital. Some didn't want to go to the Catholic hospital. There were a lot of Mormons in the area, and a lot of them wanted to go to Nyssa. So it began to look like it made sense to move closer to the hospital. So after about five years in Vale, maybe a little less than five years, we moved to Ontario, so I'd be closer to the hospital.

Then I learned quite a bit about patient dynamics and funny attitudes. When I moved to Ontario and joined Dr. Tanaka in the Tanaka Clinic, we had a nice arrangement. We were all independent. We shared some facilities, we shared some personnel. But we weren't tied to each other. We didn't get into that clinic mentality where wives start fighting because they think my husband's been working harder than your husband, and he's getting as much as mine. Those squabbles can get pretty nasty. But we were all independent. Great arrangement. But I was closer to the hospital.

Patients from Vale, a very high percentage of them, came to me in Ontario. Instead of me traveling many times a day back and forth, they'd come to see me the once that they need to be. But also some other interesting things. Patient dynamics. Patients who had been to me in Vale but never bothered to pay a bill, came to see me in Ontario and started paying their bills. They figured I was a big town doctor now, and obviously a better doctor because I was in a bigger town. And they started paying me. Well, that was sort of strange.

And other people who hadn't seen me in Vale, had taken their families to Boise, or Ontario or Nyssa or something, started coming to me in Ontario because they figured I was now a bigger town doctor, I must be okay. The patient dynamics are pretty hard to explain. It was an interesting, interesting analysis to see what was going on.

[End Track Two. Begin Track Three.]

KRONENBERG: Dorin, I'd like to go back to Vale. And I'm aware of at least two fascinating incidents that occurred to you. And the first had to do with at least based on my understanding, the development of an early version of EMT or first responder

services in this valley. And as it turns out, you had a lot to do with that. And you had a compelling event that sort of made you decide that something needed to be done. Can you tell us about that?

DANIELS: Yeah. I hadn't been in Vale very long. I can't remember exactly how long. But at that time, we had an ambulance service out of Ontario that was run by the undertaker. The hearse was the ambulance. The undertaker was the attendant. He was also the coroner, which was the, more of a political job than a trained job. And at that time, I didn't realize it when I came out of training, that the basic rules of the ballgame were that if there was a suspicious death, or an accidental death, nobody was to touch the body until the coroner got there. Well, Malheur County is awfully big, land-wise. I mean, we're bigger than many of the New England states, just as a county. The state police, their communications were by radio, but the coverage was very limited. If you go west of Vale, there's a hill at the end of the valley called Vines Hill that if they're on the Ontario side of that hill, they can communicate with the Ontario office. If they're beyond that hill, there's no communication. And many parts of the county, the state police had no communication until they got to a high point or some known area.

I was not really aware of the situation, but the coroner, the undertaker, was the ambulance. And my first real exposure to this situation was I got a call one evening from the dispatcher in Ontario, I was living in Vale, and they said, "We've got word that there's a bad accident out on Vines Hill. We've sent the ambulance, but you're closer. Would you go out to the scene of the accident?"

So I said, "Sure." So I grabbed my bag and drove out. The circumstances that I found really bothered me. And were pretty formative on what I did over the next several years. when I arrived on the accident scene, it was a wet night, one of our rare times when we had a rainstorm. And remember, this is in the late '50s. Muscle cars, lots of power, rigid frames, steering wheels which were solid and would, you know, it was just awful. People weren't wearing seatbelts.

Anyhow, there was a rollover accident. Two prominent Ontario business people were in the car. And when I arrived on the scene, there was a state patrolman standing by the accident scene, waiting for the ambulance, and waiting for me. There was one victim facedown in a mud puddle that was probably no more than an inch, maybe, of water. Motionless. Probably had been 20 minutes or so from the time they called before I was on the scene. And the policeman was there watching the scene, not touching anything. The other victim was moaning and groaning and obviously had injury type behavior. So one was alive and one was probably dead. But the state patrolman, following protocol, had not touched the body, because he had to wait for the coroner. That just infuriated me because to this day, I still don't know whether the guy was killed instantaneously or whether he was knocked out and drowned in the half inch or an inch of water. It really haunted me.

And I wasn't the only one in the state that was thinking things needed to change. There was a big motion underway to get rid of the coroner system. And I don't remember

the historical details of when it converted to a medical examiner's status, but it was in the process.

But then I found out, first of all, it just haunted me that he didn't turn the guy's face out of the water. If he had just been knocked out, he might have been totally survivable. But after 20 minutes of your nose in the water, there wasn't much hope of any revival. And he was dead when I got there. I mean, anything I could check, he was dead. So that bothered me.

When the ambulance arrived, he threw the dead one and the live one in the back. No attendant. He was just, meat wagon. Pile them in. Drop the live one off at the hospital, take the other one down to the mortuary. And I thought, something's got to change. This just isn't what I would consider adequate.

We also had fire departments around, in all the towns that did what we would now call first responder work. They were, had basic first aid training. Basically what you'd get is a Boy Scout. How to bandage things. And the old prone pressure, artificial respiration, which wasn't very effective. And we didn't have cardiac resuscitation, like came in shortly after.

Which reminds me, back in our training days, as an intern and resident, the talk around the intern quarters was not how to jump on and give cardiac massage, closed chest massage, it was still open. If somebody collapsed, the decision had to be made, who do we slash the chest open on and put your hand in the chest and massage the heart. That's pretty brutal. Because if it happens on the golf course or on the street or something, if you get a live patient out of it, you've got bleeding, you've got infection, you've got all sorts of problems. [unclear] thorax, so the new ways of taking care of people that have been so effective hadn't come in yet.

But I felt that the people who were volunteering to do, to help their fellow citizen, really needed to have better training. And they were so grateful when I offered to help train them, it became really quite an experience for everybody. I'd meet with them cold nights upstairs in the fire department. And everybody from all around who volunteered to help people on the volunteer ambulance services and so forth, started flocking in. And we didn't have a canned course. We didn't have an EMT program. We didn't have the protocols. So I just basically gave them an abbreviated medical school. What do you do in this sort of case? And splinting and airway, you know, the best I could for what they had. They were so appreciative, just hungry for that kind of knowledge, that the next thing I knew, it was expanding. They were getting a program going at the new college, Treasure Valley Community College. And they asked me to teach that. And then they brought people in from all the surrounding towns.

Then they would, they'd have to split shifts, because you couldn't take every responder and put them in a class. Somebody had to be ready, able to cover. So it wound up that I was giving two courses in parallel, maybe three or four hours, twice a week, in the evening. Sometimes I wouldn't even have time to eat before the meeting. And I was

totally exhausted. But it was so well received, and everybody was so appreciative, I kept going for a long time. Finally I just had it. I couldn't handle it physically. And I told them, "you're going to have to find somebody else. It's taking too much time away from my practice and I'm not getting any time with the family."

They said, "Well, you can't do that. You can't quit."

I said, "What?!" (laughs)

"You can't quit."

I said, "Well, I'm sorry. I have to. You've got to find somebody else to pick it up."

They grumbled and grumped. I found out later that it wasn't just that they couldn't find somebody else. They couldn't find somebody else to do it for free, and they were going to lose their matching funds from my in-kind service. So they were making money for other programs on my efforts. And I felt just a little bit used, I guess, is the word.

But about that time that they were starting to come through with the real EMT type training, and I felt that my students who, for years, including even just a few weeks ago, fellow in his nineties came up to me at a picnic. And came to thank me so much for the training I'd given him when he was a volunteer fireman back in the late '50s. Because when they started the EMT programs, everything was protocol-driven. My teaching philosophy was to give them as much education as they [unclear] , and then they'd common sense take over. With protocol, common sense isn't part of it. It's this step, this step, this step. If this goes this way, then you go that way. So I feel we lost something in the educational process. But the EMT program did do a lot to save lives.

And there are several instances I could talk about. But back to the Vale emergency situation. There's no question that these people who were eager to learn picked up very rapidly and it did improve their service to the community. And I feel good about that. There might be some other interesting—

KRONENBERG: Let me ask you about another one that I'm particularly fond of, that happened a little bit further out the highway to Burns. Can you tell us about that?

DANIELS: Yeah. I was still in Vale when that one happened. I got a call from one of my patients. If you're familiar with the geography there of between Harper and Juntura, there's a windy road through canyons along the Mount Hood River. And I got a call one morning from a patient of mine who lived in that general area. And he was the only place that had a phone for 40 miles or so. And he called me and he says, "There's been an accident."

Let me give you a little bit of the background. That was when they were redoing that highway, that highway from Vale to Burns is the only real road you can go on that route. And so they can't close it down, because there's no good detours. So in came this construction, it was in the big rock stage, I mean, the small boulders. And the road was really impassible. I mean, it was really rough.

But I get this call about daybreak. Patient saying, "There's been an accident. Would you please come up?"

I said, "Well, really, there's not much I can do on the scene. We need to get an ambulance and get them into the hospital."

And he says, "I promised them, Doc, you'll come." I mean, this guy didn't take no guff. He insisted I come. (laughs)

Well, I would have gotten there a little bit ahead of the ambulance. But I figured I was a fairly new pilot, had a Super Cub available, best plane in the world for getting off airport landings. And I had just enough experience that I thought well, I'll try it.

So I got in the Super Cub, flew up past Harper, followed the highway along till I saw the accident down there. It's in a canyon. Steep walls and stuff. But interspersed, if you've been on that highway, there's a few hay fields at the bends of the river where there's flat spots. So I flew around the scene and then headed to, looking for a place to land. I had never done an off-airport landing before. But I find this hayfield that's, I think big enough. And it's been recently cut, so I'm not in the high stuff. And it doesn't look like it's been recently irrigated, so I'm not going to flip over in a muddy field. And so I wind up on this hill and landed. And got out of the plane, picked up my bag, climbed up the bank to the highway.

And a car that was coming from the direction of the accident, I flagged them down. It was a minister and his family from Ohio, I think. I said, "I'm a doctor. Would you mind taking me back to that accident?"

And they said, "Oh, cool!" (laughs) They thought this was neat, doc dropping out of the sky. So, two or three miles away, I guess, and took me back to the accident.

Well, I've always looked young for my age. Most people don't believe I'm 82. Most people when I was 30 didn't believe I was over 20. So I looked like a green kid, had no business being a doctor. I mean, that's how I probably looked to these people.

Anyhow, at the accident scene, there's a Volkswagen gone into the ditch. Hit the embankment. The car was immobilized. The woman is frantic. She's just, the wife, and her husband is pretty much incoherent. He's just not making sense. Typical concussion type symptoms. But as I talk to the wife and find out, he's diabetic, he's on insulin, so now we've got a complication. This was before we had the finger stick blood sugar testing equipment. So you either had to go on urines, or you had to go to the hospital to

get a blood sugar, and that took maybe three-quarters of an hour to get your blood sugar back. Nowadays, it's just instantaneous.

So I was trying to sort this out from what I could see on blood pressure and pulse and behavior and so forth as to how much is concussion, how much is diabetic, is he high, is he low. Really groping in the dark. Well, it was sort of funny. This lady, little small talk, trying to get her calmed down. And saying, "The ambulance is on the way, and he seems to be holding." And I'd check him periodically. He wasn't deteriorating. That was about all I could say at the time was, "He's not getting worse, and so that's good." And then the small talk. I get the impression that she thinks I'm too young to be a doctor. She doesn't know me. Out in the middle of nowhere. And if you're from Chicago, between Juntura and Harper is nowhere. It's way beyond nowhere. (laughs)

So I find out she's from Chicago. I said, "Oh, that's interesting. That's where I went to medical school."

"Oh." She took a deep breath and said, maybe he knows something, you know. (laughs)

And so we keep chatting. And small talk goes on. I ask a little bit more about his diabetes and what his insulin requirements are and so forth. She said, "Oh, Doctor—" I'm trying to think of his name, I'm blocking on his name. But anyhow, "Dr. So and So is my doctor." Is his doctor, his diabetic doctor. And I ask a few more questions, and realize that he was the professor that taught me endocrinology.

So I tell her, "Oh, I know Dr. So and So. He's the one who taught me about diabetes."

[imitates woman sighing in relief] So I went from being a country jerk that she didn't trust to being awful close to being God. (laughs) My status was elevated beyond belief.

But anyhow, he was stabilizing. The ambulance came. I helped load him in the ambulance and had somebody take me back to the airplane. And flew back to Vale. The roads were so slow because of construction that I took a shower and then drove over to Ontario at the hospital, and was there when he got there. So that was one of my first flying house calls.

I made a few others. I landed at an airstrip that was so short I couldn't believe it. A rancher up at Harper had a real high fever and was real sick, and wanted me to make a house call. So I thought well, I'll just take the Super Cub. He's got an airstrip of his own, so I ought to be able to land there.

So I landed on this little tiny strip with white knuckles. Thinking wow, that was pretty tight. I walk over to his house across the road. He's real sick. And I think he had

probably Colorado tick fever. He had a biphasic fever and so forth. But I got to talking with him and I said, "Boy, that strip's pretty short."

He said, "You landed on the strip?"

I said, "Yeah."

He says, "I always use the road." (both laugh) Oh, man.

KRONENBERG: Speaking of landing strips, you have a wonderful story about the experience that turned a very, very isolated airstrip into the equivalent of O'Hare at that time.

DANIELS: Yeah. This was after I moved to Ontario. I was in a group of people that owned a bigger plane. I couldn't afford a big plane. But three or four of us were in a group and shared it. So the plane I had at that time was a Cessna 206. It would hold six people. We may be getting a little ahead of ourselves on the students, medical students. But I was in the early preceptor program at the medical school, before it became formalized as part of the curriculum. And when Laurel Case started as the family practice department, he very early on set up a preceptor program. It was totally volunteer. And they had to work their schedules around their required courses. But if they had some off time, they'd come and live with a doctor in the hinterland. Sometimes two weeks, sometimes even longer. But they'd come live with us.

Anyhow, that sets the stage for this episode. Because I always liked, when I knew a student was coming, to do something a little unusual so that they could get an idea, had some advantages. And you could do some things in small towns that you couldn't do in the big cities. So I'd take them skiing or hiking in the mountains or something. Always wanted to give them a little bit of something other than medicine.

Well anyhow, there was an insurance salesman in town that had been bugging me for months, wanting me to fly down and give an insurance physical to a rancher down near Jordan Valley. Well I always kept saying, you know, "I can't afford to take an afternoon out of the office. Take hours away from my practice. I can't afford to do that for the 35 bucks you're going to pay me to do the insurance visit."

He said, "Well, I'll pay the gas."

I said, "Still doesn't make it."

Well, one time a new medical student was coming, I thought this might be interesting. So I call the insurance guy and I said, "Leland, you've been wanting me to go down and do the insurance physical for quite a while." I said, "I've got a student coming. Maybe we can make a trip out of it that would be sort of fun."

He said, “Great.” He was a pilot also, and he flew down and landed at this rancher’s airstrip which was within a mile or two of where I was going to give the physical. It’s outside of Jordan Valley several miles. So he made the arrangements so we could borrow a car and get me to the insurance physical and take my medical student on a little tour of the area while I was doing the physical. That was great. He just thought that was wonderful. So he says he’ll pay the gas, and then my 35 dollars or something for the afternoon.

So I told the student that either his wife or his significant other, I don’t remember, but the couple. I said, “I’m not going to force you to go flying. But I thought you might enjoy this. I’m going to do an insurance physical down near Jordan Valley, and we’ll be flying down. Would you mind joining us?”

“Oh, yeah. Great.”

Well, this is, my son was in commercial pilot training. He had his private license and was working for his commercial license. So I figured I’d take him along as copilot. So here’s my son and myself up in the front. The medical student and his wife in the second seat. And Leland, the insurance agent, in the back. So there’s five in this plane. It’s a pretty heavy plane. He’s a pretty big guy. We’re pretty well loaded. Big tanks on the thing. So we’re fairly heavy.

I take him up the Awahi River and over the reservoir and pop over the hill. There’s some volcanic craters and lava flows. I mean, it’s a nice sightseeing trip. And then pop down on this rancher’s airstrip. And he had it all scoped out.

So we find the airstrip and fly around it and make sure it looks like it’s nothing on the strip, and it looks long enough. So my son and I said, “Yeah, we can make it.” So we landed. It was a little shorter than we wanted, but we were fine.

As we taxied back from the end of the runway, the rancher comes out in his car to meet us. And I stop the plane. He was expecting us. Was going to chauffeur us around a little bit. I said, “Where should I leave the plane?” There wasn’t a good pull-off or anything. It was just the strip.

He said, “Oh, my plane’s off getting its annual. And nobody ever uses the strip. Just leave it there.”

I said, “Oh. Okay.”

And about this time, we hear this noise up in the air. It’s just an awful sounding engine. Those of you who’ve had any farming experience might know what I mean when I say it sounds like a Johnny popper. Some of those old tractors were sort of one-cylinder type sounds. And they [imitates sound] Anyhow, we realized there was an airplane. And we realized it was an airplane without a normal running engine. And we finally spotted the thing pretty high up. And we’re looking at it. And the noise is getting worse. It’s

blown a cylinder. And all of a sudden we see him turn. He's spotted us. Knows it's an airstrip. And he's got to land, because his engine's going out. So here we are in the middle of the runway. So all of us pushed the airplane as far away from the runway as we could. Not good spot, just push it out in the sagebrush. But at least we got it off the strip.

This plane comes around, slips and slides, and makes a horrible bounce. I mean, he bounced 30 feet in the air. I thought he was going to [unclear] everybody. But he finally gets it down to stay on the ground. And gets to the end of the strip, and gets out, and he's sweating, and saying, "Boy, was I glad to see your airplane. I wouldn't have known that was a place to land."

So here's two planes on the strip that nobody ever uses. And we talked to him. And in spite of his almost crash landing, he seems okay. He's excited, but it looks like he's okay. so we start making arrangements for me to go do the insurance physical. [makes landing plane sound] Another plane comes in. two planes were going from Boise to Reno together, they were friends. So the second one has to drop in and see what's going on with the first one. So now there's three planes on the strip.

So I go do my flight physical, my insurance physical. And the student and his wife get taken on a little tour, including the Charbonneau grave, which is an interesting historical thing. Jean Baptiste Charbonneau was Sacagawea's son that was on the Lewis & Clark trip. And his story was pretty fantastic. He was a baby on the trip. And Clark took him in and educated him. He wound up in European royalty courts. Learned multiple languages. But really didn't like that kind of life, and came back and became an outdoorsman, a guide and a miner and all sorts of outdoor things. But he was on his way from California to either Idaho or Montana to work in the gold fields. He swam, got wet in the Malheur River and got pneumonia and died. And this would have been in the 1860s or something. So he died and was buried. There's a little kiosk type monument there. It's only just a few miles from where we landed. So that's what the medical student and his wife were doing.

Well, I get through with the physical, come back and now there's four planes on the runway. They've flown in a mechanic. (laughs) So if I'd left the plane on the runway, we either would have had a collision on the runway, or he wouldn't have made it, he wouldn't have made it down, at least on that airstrip.

Interesting thing, the Skinners who owned that ranch have just written a book. It's an interesting book about the family history. Including in the airstrip. Well, they were signing a book. I had a book signing at one of the local stores, and the same people had me doing a book signing for my book. So here we were talking and two of the members of the family were ranchers that were there that day that I landed. So we had quite a session of reminiscing. Because the one on the strip witnessed it. But also his brother was a couple of fields over and watched the whole thing. So it was sort of an interesting—

KRONENBERG: In the course of our discussion, you've mentioned a number of people, including your father, the assistant dean of the medical school that you went to

who had a great deal to do with the fact that you went there. And some other people. Can you talk a little bit about other people who have been notably, who have notably influenced you and been an important part of your life as a physician?

DANIELS: Sure. A little bit of history of the area. When I started in, I started in Vale and then moved to Ontario, but used the same hospitals. And when I came, the Ontario Clinic was the dominant medical group here. And Dr. Palmer was a surgeon who'd been here for a long time. He was also a radiologist and did a lot of his own X-ray stuff. And years later, his hands were awful. Skin was in terrible shape because he did a lot of fluoroscopy without lead gloves. But he was Mister Surgery.

Dr. (Wiest?) was with the clinic, and he was one of the formative physicians. And he was the first internist in the area. He'd had a little extra training. The specialists in those days were not anywhere near as completely trained as they are now. They'd take an extra six months on this or something, and they were specialists.

Dr. Emmett was an eye, ear, nose and throat before they split into eye for one, and ENT for the other group. So the specialty at that time, was EENT, not ENT. And he was very busy.

These were the old-timers that were quite influential on the group. Younger people coming in about the time or just before I did, I had mentioned Dr. Burdick who was just an absolutely solid citizen. He went into family practice and then psychiatry. He came back and practiced both.

But Lester Scott was another young surgeon who had come just a few years before I did. And he joined the Ontario Clinic. But the old Dr. Palmer still kept most of the patients to himself, and Lester was sort of a flunky for quite a while. He was a very good surgeon.

But the most influential one, as far as I was concerned, was Dr. Tanaka. Augustus, known as Gus. Absolutely incredible guy. I think you've got his story recorded. And you could go on for hours about him. But he was superbly trained. Was trained by, his mentor was one who said, "First you're a physician. Secondly you're a surgeon." And Gus kept that attitude. So many times you see the surgeons become technicians, and they really don't do as much pre-operatively and post-operatively in the care of the patient. Gus was always on top of it. If there was any problem, he was at the hospital all night. Patient came first. There's no question about that. And his own convenience was never part of the decision making. He and I hit it off quite well. And we thought pretty much along the same lines. And we had some really, really interesting, tough cases.

I don't know how much you want on individual cases that are interesting, but one I'll tell you briefly about was a patient of mine from Vale while I was, I had already moved to Ontario. But a patient came in and asked for me at the emergency room. And what had happened, he had one of these little gasoline trencher things that you dig a

narrow, deep trench to put pipes in. Somehow or other he'd tripped, and that thing had ripped his ear and scalp off. And he was just a horrible, bloody mess, just bleeding like crazy. And one of the trim young nurses, in those days they wore these starched dresses with the caps, she jumped right in bed with the guy to put compresses on his head to keep him from bleeding to death. And we got transfusions. And Gus and I went in and undid his scalping. Those are pretty dramatic things.

But another one that was pretty memorable, a lady bus driver who was a real go-getter, working all sorts of jobs, just trying to improve her status, she was driving a bus for one of the schools at a sports event or something. Thought she had a flat driver, got out of the car, out of the bus to look at the tire, and somebody hit her with a car. And she came in deeply comatose. And at that time, our neurosurgical coverage was one neurosurgeon in Boise. And that's 60 miles away. This fellow was overworked and had not the wisest sort of stress relief, because he was usually at the Elks Club. And when you'd get a hold of him, he wasn't much help. Well, he wasn't even available. And we finally, well, I got Gus immediately, because Gus had been through all sorts of special training in his surgical training. And he'd been on neurosurgical wards. And he absolutely, he was just absolutely wonderful at neurologic diagnosis. I mean, he had this pegged as to where the patient was bleeding. And she was going from bad to worse, rapidly. And Gus said "We've got to put [unclear] and we can't find a neurosurgeon." But he wanted some backing. He finally got a hold of a neurologist. And Gus described the neurologic findings to a T.

And the neurologist said, yeah, they've got to put burr holes and he told him just right exactly where to go from Gus' description.

And we went up to the operating room. Of course, we didn't need anesthesia, because the patient was deeply comatose. We didn't have any neurosurgical equipment, so we got the maintenance people in the hospital to bring us up some drill bits and something we could sterilize. And Gus and I put in holes. When we got through the bony table, blood shot up to the ceiling and the patient started waking up. Pretty dramatic. Patient had problems, but she lived. I felt pretty cocky about that. But here Gus and I had done a neurosurgical procedure and the patient lived. Then I was reading a book about Alvord Ranch, I don't know if you've read that one, *In the Shadow of the Steens.* They've got some, from the early days of the Alvord Ranch. And they describe in some of the letters about a cowboy down there near the Alvord either being kicked by a horse or bucked off or something. He had a head injury. He was comatose. And the story of them putting him in a farm wagon and taking him to Burns, two-day trip by horse drawn vehicle. And the little side comment on that letter was, "It was a good thing he was unconscious, because it wouldn't have been a fun trip." (laughs) Get him up to Burns. Some doctor up there puts in burr holes. The guy comes back to work. So we weren't the pioneers that that guy was. (laughs) My guess was that he was a Civil War surgeon. He had trephine and just did the burr holes with better equipment than we did. Anyhow, that's history.

So, back to the emergency services. As the EMT program got going, I helped in some of the training on that, and some of the supervision of the instructors. But as I mentioned earlier, I didn't feel quite as comfortable with this totally protocol-driven system. It was probably the best system for people with no medical background. I mean, bang, bang, bang, bang, bang, if this happened, you do this. If this happens, you do that. That's probably in the long run the way you have to do it, but it bothered me a little bit.

And years later, it came home to me. And you may even know some of the names of the people involved that I've forgotten. But I was on the Oregon Health Council. I was chairman for a couple of sessions. And we were holding a meeting, the certificate of needs programs there. This was a, that was while I was public health. Anyhow, I'm getting my things mixed up. I was on Public Health Advisory Board, and I was chairman of the Oregon Health Council. So there was a meeting in Portland, and it was on the certificate of needs program. And there was a very nice attorney. You know, there are some nice attorneys. One in particular that I can't say was nice, the only one that ever sued me.

Anyhow, we were at the table at lunch, and the attorney for the state, for this committee, got sick. He got pale and he slumped. And I was across the table and I saw him going down. And I maybe went over and stretched him out on the floor. And he started to come around. And left him there for a little bit. He said he wanted to get up, he was doing okay. I got him up about this far and he blanched out again and faded out of the picture. I said, "Call 911."

Well, they were there, first responders were there very quickly. And they took his blood pressure and his pulse and respiration, and then sat him up. He immediately crashed again. And I said, no more sitting up. Then the ambulance arrived. And first responders were firemen or something. And the ambulance arrived and of course they took over. And by this time, I didn't want to do anything except get him to the hospital. He needed to be checked out.

So the ambulance group comes in and gets a little huffy and do their routine and start to sit him up and I say, "No! (laughs) We've seen him crash three times. Actually, at least twice. Don't sit him up. Transport him."

And they got real huff, and they said, "We're in charge."

I said, "Don't sit him up."

And they said, "Well, I don't care if you're a doctor or not, but if you're going to tell us what to do, you have to come with us in the ambulance."

I said, "Okay. just don't sit him up."

They were a little huffy about it. I left my meal. And that's not always wise when you're diabetic. I went to the ambulance with them. His wife was a nurse at St. Vincent,

so we went to St. Vincent. And partway along in the ambulance, his vital signs went all to hell again.

And they looked up at me a little bit and I said, "You got any atropine?"

"Yeah."

"So let's give him some atropine."

Okay, well that stabilized him until we got into the hospital. But I was a little ticked because they had to follow protocol. They couldn't use common sense. You know, I'd seen it three times. I knew that he needed to be where he could be evaluated. Putting him through the sit up test again was not in his best interest, but that's the protocol they had to follow. So I'm not totally protocol-driven in my mind.

KRONENBERG: Can you kind of finish this story and tell us why it was in his particular case that when he was sat up he would go bad again?

DANIELS: Well, this was probably just a vagal reflex. But I couldn't tell whether he'd had a coronary or not. And I wasn't going to take any chances. If every time you sit him up, his blood pressure goes to zero, you better not sit him up. Because if he's got heart damage, it's going to get worse when you don't have any blood pressure. So that was my reasoning. And you know, you hear stories about people dying in a phone booth because they can't, when they pass out, they can't get flat. So they're upright and their blood pressure stays low, and they're gone. So that was the rationale. And he did okay.

KRONENBERG: He survived?

DANIELS: He survived. And he didn't have any major damage. And the ambulance crew were mellowed a little bit because they realized that maybe this guy was sick. But I've seen it in other situations where those that have been trained by protocol think they know it all, and nobody else is going to tell them. On the other side of that coin, though, a lot of physicians are not good with trauma. So, in many respects, the well-trained EMT is better to have on the scene than a doctor passing by. So you can see both sides of the story.

KRONENBERG: Being in the medical profession, throughout my affiliation with them, a certain amount of angst about what the doctor's responsibility is when he or she comes upon an automobile accident, as an example, or someone who's hit by a car, or a lineman who's electrocuted and falls off a pole. And could you kind of comment on, the reality is that you're held to the same standards of practice as any physician in the state. It doesn't matter what his specialty is, or where he is or what resources they have. And so, in a way, a physician in a small town with a small hospital and limited resources, is at a disadvantage. And that's always seemed to me that when it comes to the good Samaritan role that physicians have, and I think it's one that most physicians take very seriously,

and they think about sometime in their career very seriously, the truth is, based on your experience alone, but on other cases that I've seen, things really are different in small towns, particularly that are remote. And do you feel that you and your colleagues in a town like Ontario, for example, or Baker City, do you feel that it's fair to hold you to the same standard with respect to administration of emergency care as might apply in Portland?

DANIELS: Well, yeah, but the reality is that the differential is, a lot of it is facility and technology. I've always been under the impression that you do the best you can under the circumstances. You can't do any better. This may take me back a little bit to the concerns I had as a new intern at St. Vincent's Catholic hospital. And we'd heard horror stories about saving the mother or saving the baby. And in the Catholic hospital, we're sort of under the impression that you had to let the mother go and save the baby or something. A lot of misinformation. And the old-timers said, "Look. There's no one or the other. You just do the best you can with both. There's no conflict." And that's the way I've looked at medicine. Do the best you can with what you've got. And the small town docs sometimes have to perform way beyond their training. And some of them were damn good at it. Like Bob (Bollingen?)

KRONENBERG: Like Bob—

DANIELS: In Lakeview. He had extra training in surgery, and he's been put through the wringer on some awful tough cases. But the patient would have died. And there's no way he had the facility or the backup or multiple specialty help that he would have used if he had it.

?: I'm sorry, [unclear]

KRONENBERG: This is interesting, because it gets me kind of to my next question. Because it gets between theory and [unclear] planning and logistics and you know, what's the best thing to do. Clearly in communities that are remote, like those in Eastern Oregon, the advent of Life Flight helicopters has been very useful over the years. And it's utilized all the time. I know there's a reason there's a helicopter pad in virtually every hospital in the state, because sometimes that's the only route. But the fact remains that there's a community relatively speaking not far from here where evacuation either by land or by air is simply not an option for the major part of the year, and that's Burns. When the fog comes, why, it stays. And there are many, there are many who advocate what we really need is a better transportation system. Based on your substantial experience, and particularly seeing technology, both medical and in terms of transportation evolve over the years, do you have a feeling about just what kind of limitations there are in terms of transportation? I don't mean, you know, "Beam me up, Scotty," because I don't think that's going to happen anytime soon, although I think it's going to happen. At any rate, give me your experience. Can you talk a little bit about the role of emergency transportation? And also remote technology, which I know is commonly used here. Particularly, for example, with reading really tricky EKGs and other diagnostic tests.

DANIELS: Yeah. Of course, I've been out of the loop for a while. I closed the office in 1994.

KRONENBERG: You've been paying attention.

DANIELS: Well—(laughs) I've got a few thoughts on the air evacuation that may be pertinent. As I was telling you, the neurosurgical problems that we had back then, with one neurosurgeon for the whole valley, I was totally frustrated because I had come out of a training in Portland where at least there were more than one. When I came out of training, we didn't have CTs. We didn't have, we were just getting nuclear scanning. And so you'd, for a tumor, you'd see a little fuzzy ball of blurred dots, and you'd say, "Oh, that's a tumor." Now you see it by millimeters with MRIs and CAT scans, which we didn't have.

But I would get a bad head injury here in Ontario. Patient fairly stable, but very confused, and I didn't know whether we were going uphill or downhill. And I wanted a neurosurgeon. In those early days, I'd get a neurosurgeon on the phone. And I'd describe the findings and the history. And I was hoping to have him say, "Well, ship him over." But I'd get an answer like, "Well, sounds like you're doing all you can. If they're still alive in two or three days, send them over." Now that's not the kind of help I wanted.

I think it's gone too far the other way, that if there's a head injury that's relatively minor and could do fine with just a local MRI to make sure they're not bleeding and so forth, they can be observed for a few days, knowing that we've got good diagnostics. But no. almost every head injury, immediately shipped to Boise. Now I think that's probably overdoing it. I think that's maybe not cost effective. But and not bad medicine if you've got the diagnostic equipment here to say, nothing bad is happening. And if there's something mildly bad that you can watch for a day or two, that's a judgment call. So I think we've gone from almost no help to almost a turf battle. Every head injury has to be seen by a neurosurgeon is maybe going too far.

[End Track Two. Begin Track Three.]

KRONENBERG: Dr. Daniels, I want to ask you a question that I think you have a unique perspective to answer. You practiced here in Ontario for the better part of 50 years. You've seen a lot change in technology. We've talked about transportation, we've talked about increased availability of specialized services, and so on. Given the fact that Oregon's population continues to grow, but nevertheless, the growing is not happening here, for all intents and purposes. Can you spend a few minutes talking about your view of the future of medicine and healthcare in small towns like Ontario? Understanding that there are small towns in Idaho or Montana or Wyoming. What is the future of medicine?

DANIELS: It's a little bit uncertain. We've had so much change in the delivery of medicine because of the dictates of insurance companies, governmental agencies, standards by which you have to practice and protocols. We've lost a lot of personal

touch. And the personal touch and the primary interface now has dropped a notch to the nurse practitioner and the physician assistant.

One of my big frustrations when I was doing a lot of obstetrics, and was well trained, experienced, had good backup, Dr. (Sigritsen?) came to town, was an excellent resource. So whenever I had a problem, I had him to lean on. I was very nervous when he left town and had me covering his patients, because I had an emergency, I had to go to the general surgeons for C sections, and they had a good job.

But in all the garbage that comes out of Washington, there was a big push, I can't remember, it would have been probably in the mid '70s, I can't remember exactly when. But I was called to a meeting with the higher up officials talking about neonatal care. And they were trying to set up regional obstetrical centers. They had absolutely no concept of what we have in open spaces of distance between towns. They wanted, I may be a little fuzzy on detail, but all obstetrical patients from Boise to something like Juntura, maybe Burns, and up to Pendleton. No, I think Pendleton had their own. But 100 miles around Boise all had to go to Boise by their planning. Their plans were to have only obstetricians, only pediatricians, at the hospital. Family doctors were not to be involved, whatsoever. And they were talking about, "This is the wave of the future."

Well, people coming down 50 miles from out in the sticks don't always make it to Boise before they deliver. And somewhere along the line, a doctor's going to have to be there. So why not let that doctor have a little training? Here I'd delivered thousands, probably by that time, 1500, 2000 babies. I was fairly experienced. And they were saying, "You're a family doctor. You can't have anything to do with obstetrics." And at the same time, the pundits in Washington were making a big push for nurse midwives. So a nurse midwife with a short course could do deliveries. But a family practitioner, who had experience and training, couldn't. That's what you get when you get into people sitting at a desk in Washington, trying to tell you what to do. And I think that trend is still there. I'm not trying to belittle the nurse practitioners and the physician assistants. Some of them are just damn good. But they have a little tendency to be, as I say, protocol-driven. And don't have the depth of knowledge from which to apply common sense. And I think that's going to be a continuing problem.

KRONENBERG: One final question. Just for the record. How many babies did you deliver in your medical career?

DANIELS: Well, it's a little hard to say exactly because, at least around here, if somebody was gone, somebody else would deliver. And we didn't charge, we didn't keep a lot of records. But I stopped counting at about 3500.

KRONENBERG: Thank you. That is it.

SIMEK: Wow. Thirty-five hundred.

You need to read the end slate, please.

KRONENBERG: Sorry. This is the end of the interview with Dorin S. Daniels, MD. The interviewer is Jim Kronenberg, and this is the end of tape four.

[End Interview.]