HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Ted Merrill

Interview conducted June 12, 2006

by

Matt Simek

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[Begin Track One.]

SIMEK: This interview with Dr. Ted Merrill of John Day, Oregon, was recorded on June 12, 2006 in the historic cellar of the Geiser Grand Hotel in Baker City, Oregon. This interview is made possible by a grant from the Oregon Medical Education Foundation. Matt Simek is the interviewer.

This has been a long awaited and very welcome opportunity to talk to you and hear some of the stories of your early days. Not only as a practitioner of medicine, but in some of your other ventures as well. And as we do with most of these, we usually start off with a summary review of your early days. Where you were born, when you were born, your early schooling and so forth. So I'll just turn it over to you and you can give us an overview of that part of your life.

MERRILL: Well, where I was born is rather irrelevant. My dad was going to school, summer school there, a semester there, to Columbia University of Missouri in Columbia, Missouri. And I was born in Columbia, Missouri. Moved away when I was three months old, and I've never been back.

So I grew up in the small town of Fairfield, Idaho, population around 350. And I lived there from the time I was in the sixth grade till after I finished high school.

Probably the reasons that I decided to go into medicine, or that medicine called me, were several. My dad was a schoolteacher, and he taught various subjects, including physics, chemistry and math. And he always enjoyed telling Bill and me, my brother, about how the world works. About molecules and atoms and the movement of heat through substances and so on. Always made the way the world works so interesting and exciting.

Then, somewhere along there, I received a little microscope for a birthday present. And that just opened a whole new world. I got to dipping stuff out of the pond, the little slough down at the end of our block and putting it under the microscope and seeing ooh and ah stuff under there. Little things moving around that would have gone totally unnoticed without the microscope.

And then the other big thing was that the local doctor, Dr. W.B. Parkinson, was our family doctor. And he was desperate for somebody to talk to about medicine. The nearest doctor, nearest other doctor, was 40 miles away on gravel tortuous roads. And he was really isolated there. So when he found out that I would enjoy listening to him, he took me under his wing and would describe various cases to him and invite me over to his house to read medical journals because, he said, "Well, my eyes are getting weak, so

you read this to me." And then he'd explain to me what it was talking about. And he let me come over and watch attempted tonsillectomy on a wheat rancher one time. And he got a dog from the dog catcher and we took it up in the attic of the high school and I anesthetized the dog under his direction with ether while he showed me an operation of resecting a bowel. So that combination of things set the hook.

And by the time I was ready to start to college, there was no question whatever that I was going to register as a premed student. And it all went from there.

I'm going to stop you right there. I'm hearing a vacuum.

SIMEK: Am I in your way of your shot?

You are not.

MERRILL: You want to just do that over again about W.B. Parkinson?

No, I don't think so.

SIMEK: No. But I do want to explore a little bit more. And so, once again, it was a town of 350 people. One doctor. And he did have other people down the road, but he didn't call them on the phone?

MERRILL: Well, he didn't get help from anybody down the road.

SIMEK: Did he get along with the other people, or was he—

MERRILL: With the other doctors?

SIMEK: Yeah.

MERRILL: Oh, yeah. I don't think there was any problem with that. But the next town down the road was maybe, I don't have much of an idea, maybe 4,000 or so with one doctor there. And then the next town, another 15 miles, 20 miles, was the hospital. So everybody was working pretty much independently. I mean, he went to do surgery in his office, some things in the home.

SIMEK: Now tell me about the rancher that you saw an attempt at a tonsillectomy.

MERRILL: Dr. Parkinson asked me one time, "Would you like to see a tonsillectomy? See some tonsils taken out?"

"Oh, yeah!"

Okay, so the appointed morning I went over there. And the nurse, the nurse actually was justice of the peace and worked over in the courthouse. But she was a nurse, and for medical needs she could be called over to his office. So she came over to give the anesthesia. And the anesthesia available at that time was open drop ether. You put a gauze, a metal mask with a gauze covering over it. Take a can of ether, put a safety pin through this soft metal top. Then you could drip drops onto the mask.

And the patient goes through a series of stages. First kind of goes partly unconscious and gets agitated and restless and struggles. Then if you can go beyond that and get them to breathe in enough of the ether fast enough to go beyond that, then he'll begin to settle down and eventually smooth sleep with pretty good muscle relaxation.

And with kids, it's pretty easy to do that, because they breathe in faster and you get past the agitation stage more quickly. With an adult, it doesn't always work out well. And this guy, it didn't work out well.

SIMEK: What happened?

MERRILL: Well, he just started kind of gasping and making these weird breathing sounds. And he started to turn blue. And you know, I had never seen this before, but it obviously was not right and was scary. And the doctor finally said, "This isn't working out. We better stop." And the nurse agreed.

So I can go through more or less the detail, I put it in a book, if you want.

SIMEK: Yeah, but what happened to him?

MERRILL: Well, he said, "We better stop."

So she took off the ether and he didn't, he didn't have oxygen facilities like we have now. So she took off the ether mask and the guy gradually settled down and he started breathing normally again and he started to wake up. And a few minutes he said, "What happened?"

The doctor said, "Well, you weren't getting enough air. And it doesn't always work out well with the grownups, so we had to quit. Maybe we'll try again later."

And the guy just stood there, he sat up on the edge of the table, and he stepped down on the floor and just stood there and staring around, didn't say anything. Looked at me, looked at the doctor. Looked at his wrists where the leather straps had kind of chafed him. Just walked out the door. Got in his car and bazoom, down the road.

SIMEK: So now back to the doctor in your hometown, Dr. Parkinson, taking an interest in you, was that unusual? Or did he mentor a lot of people?

MERRILL: No, I was the only one in the town, so far as I know, that he ever talked to like that. And I'm not quite sure how that came about. But he had two daughters, one of whom was in my class at school. And the other one was a couple of years older. And they weren't interested in medicine at all. So I think one time when he came to our house for something, I asked questions or stood around watching or interested in looking in his bag or something, you know. So he started to talk to me a little bit.

So then we'd meet on the street, we'd greet each other and stop, and I'd hope to hear something more from him. Then he started telling me about some interesting case, you know, didn't mention any names.

We met in the grocery store one time and he said, "I had a patient once who had diabetes. And it causes acid in the blood and she was in a bad way. And I boiled up some baking soda and shot it in her vein and she got better." Well, great, you know, I don't know anything about diabetes or acid in the blood or what to expect from that, but it sounded, sounded like it must have been a great thing to do. And there were little things like this.

Probably the best was when he invited me to his office and gave me the *Journal of the American Medical* Association and he'd pick out an article and say, "Here, read this to me." And sometimes he'd let me take the magazine home for a few days. Then he'd explain to me what the article was saying when I came to big words and strange meanings.

SIMEK: So at this point you were already, had the idea that you wanted to be a doctor.

MERRILL: Yes. I mean, this kind of, just pick up contacts every few weeks or something. Went on for, I guess, four or five years.

SIMEK: Now what was, he came to your house to show you how to resect a bowel.

MERRILL: He came to my house to see Bill, I think, because Bill was sick with the flu or something. And he and I had been talking some before that. And he had told me, he was explaining to me on the street one time about when you are repairing an intestine that's been cut in two, or have to take out a piece of intestine, to sew the ends together, you have to turn the edges in. So the outer surfaces meet. Otherwise, it won't heal. You can't sew it with the inner surfaces together, it won't heal up. It will leak and be fatal.

So then this time he came to the house, he said, "Esther, I'd like you to sew me up a gut. A cloth tube about the size of a broomstick, so I can show the boy how to connect the ends of an intestine."

So the next day, she had this gut sewed up, and I ran over to his house with it. He showed me how you put the stitches, you know. In here, in and out there, and then take the curved needle and pull it through, and then take a bite over here, in and out and over, in and out and over. And the minute he had this sewed together, so it was like a cloth donut, you know, with the raw edges turned inside. That's the way you do it.

SIMEK: Now he showed you on this? Or you did it?

MERRILL: I don't remember. He showed me how to start. I think I may have done some of the stitches.

And then when we did the dog, that was the main operation he did, was to cut out a piece of intestine and do the anastomosis.

SIMEK: And you were the anesthesiologist for that.

MERRILL: Yeah.

SIMEK: And how old were you?

MERRILL: At that time, I was a senior in high school.

SIMEK: Now that was not an open and above board situation, was it?

MERRILL: No. I was surprised. But he said he wanted to keep this secret. Because it was a dog that was picked up by the dog catcher. Because he had suggested this months before. So I was just waiting for him to find a dog. I thought maybe he'd forgotten the whole thing.

So then he called the house one day and talked to me. He said he had a dog but he had to pick it up that day and do the job the next morning, because he couldn't keep it around his house. So luckily the next day was Saturday, so we could do it. And he had asked my dad if we could do it in the high school. The high school had sort of an attic. And I made that into an operating room with a couple of chairs and some crates with a board laid on it for a table and stuff. And we climbed this sort of ladder, dragged the dog up the ladder into the attic and did the job.

SIMEK: And that was a secret.

MERRILL: Yeah. Yeah. He didn't want anybody to know about that because people might talk about cutting up a live animal. And some people were against the dog catcher doing that sort of thing anyway. This dog was destined to be shot, so we had a chance to do this, be the proxy executioners.

SIMEK: So then you graduated from high school. And then what?

MERRILL: Then I went to the University of Idaho premed school. See, that summer I got a job working up on a, building the biggest wooden grain elevator in the world. And walking around on top of the walls carrying two by sixes to the carpenters, 60 feet up in the air. Then I went off to university.

We didn't have any money. Dad's salary was $1950 a year for being principal of the high school and teaching four different courses, I think. And luckily at that time the tuition at the University of Idaho was free for Idaho residents. And we had a family friend who was on the faculty there, an English teacher. And he invited me to live with him and his family. You have board and room in exchange for babysitting and dishwashing and lawn mowing and odd jobs. So that didn't cost me anything. So I was able to do the whole thing. My dad sent me an allowance of ten dollars a month. So I did that for two years.

And then, during that first year, the Pearl Harbor bombing occurred. So in a few months, the navy had a reserve program set up, a special program to provide them with what they expected to need in the way of doctor, dentists, engineers and airmen. So the navy V12 program came along. And I signed up for that and just kept on going to school and was inactive reserve for a while. That went on the rest of that school year.

But then finally we were ordered to so-called active duty, which meant going to the University of Idaho southern branch in Pocatello, which had been taken over by the navy for this purpose.

So the USS Gravely floated proudly in the hot desert of Southern Idaho at Pocatello. They christened one of the dormitories as the USS Gravely. And that's where I spent the next year, college year.

Then I finished there. And meanwhile had applied and been admitted to medical school at Columbia University. So I waited, I had five months to wait from February, when I finished that year at Pocatello, until my medical school class opened in September. So the navy had to figure out what to do with us. We were a weird, unspecified group of sailors, apprentice seamen. But the navy had taken over the Sun Valley Lodge as its convalescent hospital. So that's where I was assigned, along with four other guys in my category.

So the first day of active duty in the real native outside of school, I soaked in the heated pool of Sun Valley in a snowstorm and had a grand time there. By then, my dad had quit teaching school and had a little photo shop in Ketchum, just two miles from Sun Valley. So in the afternoons I could finish my daily sailor duty, climb out the back window with my fishing rod, fish down trail creek to Ketchum, have dinner with Dad and hike back up to the hospital in the dark. So that went on for several months.

Then I got on the last outpost of the Union Pacific Railroad in Shoshone in an old-fashioned car with a pot-bellied stove in the middle for heat, and headed off for New York City.

SIMEK: And the New York City trip was for—

MERRILL: That was to go to medical school. So three days later, two train changes later, I got off in Penn Station in New York City.

SIMEK: And that was what year?

MERRILL: That was in 1944.

SIMEK: So now the war was raging, but you had a deferment because you were in medical school.

MERRILL: Right. Yeah. My brother was in the navy by then. He was off being a real sailor in a destroyer up in the Bering Sea someplace. And I was cutting cadavers and looking through microscopes in New York City. Getting apprentice seaman pay and 50 bucks a month and all my expenses paid, tuition and all.

SIMEK: How did you take to medical school?

MERRILL: How did I take to it? I'd been waiting for that for so long and looking forward to it, and holding my breath about what it would be like to get in. And it was just a dream come true. It was grand. I don't remember what we did the first, the morning the first day. Just registering and paperwork and stuff. But that first afternoon, we went in the anatomy lab and just entered a whole new phase of existence, you know.

SIMEK: It's something you never yielded on, never gave up on. What do I mean to say? Your enthusiasm for it never faded.

MERRILL: No, my enthusiasm never faded. There were times, you know, it was, it was a struggle. And my first impression after the first few weeks was how much we were expected to learn in how short a time. But then it became clear that that was easily achievable if you just concentrate all your effort and your attention on that, and don't get distracted with other stuff, you know, like driving your mind like a spike into the massive material to be learned. It was great.

SIMEK: What were some of the challenges that you had there, if you had any? Or was it smooth sailing?

MERRILL: Well, it was total dedication to the job at hand. There were free times, you know, obviously. I'd go downtown with some of my friends. We'd take the subway down to Times Square and go to the music, New York City, Radio City Music Hall, watch the Rockettes. Then we'd walk back from 42nd Street up to 168th Street at one o'clock in the morning. Never a fear. New York City just felt like a perfectly safe, comfortable, amazingly varied environment. Not like now, I guess it's considered hazardous to walk out on the streets any time of day, some places. But New York was a

great place then. I would not want to live there. But four years of living there and being in school was just fine.

SIMEK: Now at some point there, you start looking at different ways to, I don't mean to say narrow your practice, but to specialize.

MERRILL: Yeah. Late in the second year we had what was combined oral examination in a subject of our choice, and a career conference with a faculty member. And I was assigned to the professor of bacteriology. Because we had been studying bacteriology during that semester.

So I went into his office and he said, "Well, what topic have you chosen for your quiz?"

"Well, Rocky Mountain Spotted Fever." Because my Sunday school teacher had died of that when I was twelve.

So he said, "What's the causative organism?"

"Well, Rickettsia rickettsii."

And we went on, you know, a few simple questions, and I knew the answers.

"What was the treatment?"

"Well, there is no specific treatment. You just have to give supportive treatment and maintain hydration."

Dr. Parkinson had been noted as especially skilled in treating spotted fever. But I'd never discussed Rocky Mountain Spotted Fever with him, so I don't know exactly what his methods were, but there was no specific treatment.

So then the professor seemed to be satisfied with my answers. So he leaned back and relaxed, and so did I. And he said, "So what are your plans for the future?"

I said, "Well, I'm going to go back out west and go into general practice."

And boy, he leaned forward and said, "Oh, no! You don't want to do general practice," he said. "A Columbia man is too good for general practice! You ought to go into a specialty or research or maybe teaching."

And I had never realized that there was that kind of feeling about general practice. It had never come up before in the school there. And all the doctors that I had ever known had been general practitioners. Dr. Davis in Twin Falls that delivered my brother, and Dr. Cromwell in Gooding that had lanced a boil on the back of my neck, and Dr. Kerns, who just the summer before this had taken, when I was home on vacation had driven me from

Fairfield down to Winslow and taken out my appendix. You know, they were all just whole, regular, normal doctors, not confining themselves to some specialty. So I was surprised to hear that reaction.

So it ended up there were only two out of my class of 110 that went into general practice. There were 18 women in the class to start with. Ended up with eight. Several of them dropped out. Two of them dropped out in the first three days. They obviously had better things in life to do than lean over a stinking cadaver every afternoon for a year. But there were, I guess, eight in the class that graduated. I think it was eight women.

SIMEK: Out of how many?

MERRILL: Out of 18 that started.

SIMEK: Oh. I mean, eight—

MERRILL: Eighteen.

SIMEK: Eight women graduated out of the total class size of—

MERRILL: A hundred and ten. [glitch]

SIMEK: Ten percent.

MERRILL: Yeah. It was a little bit of an anomaly for a woman to be in medical school at that time.

SIMEK: Your internship now was—

MERRILL: Well, I had to figure out where to find an internship. And I knew nothing about this. I had no advisors there that knew anything about Idaho. And there were no formal internships in Idaho at that time.

And my stepbrother had gone to medical school and had had an internship at Santa Clara County Hospital in San Jose. And I talked to him and talked to the school, or talked to the hospital there. And they had a rotating internship, which was the right preparation for a general practice. So that's where I went had a year of internship.

And then, you needed, to be a general practitioner, you needed to have a fair command of surgery. So I stayed there for another year of residency in combined surgery and anesthesia. That hospital turned out to be the perfect place because it was a county hospital where there was not much competition for, among the staff, for work and experience. Teachers came out from San Jose out there to Santa Clara to the hospital every now and then to do some teaching. But mostly it was the residents that was teaching the interns, and a lot of hands-on experience. So I got to do more surgery in that first year than most surgical residents do probably until their second or third year. You

know, I got to do, the resident, the chief surgery resident there had already, was in his, I think his fourth year. So he didn't mind letting us do the appendectomies and hernias and hemorrhoids and tonsillectomies. And we assisted with a lot of things. So by the time I left there, I could do a gallbladder, a thyroid, even – I didn't do many thyroidectomies – and some orthopedics.

And so at the end of the internship, plus residency, I went into general practice.

SIMEK: There was something that rang a bell for me about being in a, was it like a county hospital? So that you would see a wide variety of things coming through, say, through the emergency department or—

MERRILL: Yes. Yes.

SIMEK: And you'd see things that—

MERRILL: Yes. Most of the patients that came to that hospital were self-referred. Some were referred by family doctors in town. But a lot of them just came into the emergency room or the outpatient clinic. And the hospital had three outbuildings, separate buildings outside. One was for geriatrics, kind of like a nursing home. One was, or two, I guess, were like a nursing home. And one was the TB ward.

And I saw a lot of cases of TB there. Much more than I ever have seen since then. And they had some what now seem like strange treatment methods. There was no drugs to treat TB. And TB most frequently starts in the upper part of the lung. And the theory was that putting that part of the lung to rest would allow your body to heal the infection. And it seemed to work. But the way that you put that part of the lung to rest is sort of tricky. And one way to do it is to inject air into the chest between the chest wall and the lung. Partly collapse the lung. You know, a partly collapsed lung now you treat like a medical emergency and put in a test tube to get the air out. But we would go to the TB ward there and they had an outpatient clinic. People with TB that were still living at home would come in twice a week and get a doctor-induced pneumothorax. We'd put a needled in there. Put it under the fluoroscope. See how much the lung was collapsed. You'd run in air from the tank until the lung was halfway collapsed and take the needle out. Come back on Thursday.

Then they tried it for a while to do a pneumoperitoneum instead. We'd put the needle in the abdomen, and inflate the abdomen with air so that it would push the diaphragm up. That never seemed to make very great physiologic sense and didn't seem to work much. But the pneumothorax was quite common for a while. But it would last only a few days. And hard to control.

So soon they developed an idea of a thoracoplasty, meaning they would surgically remove, say, the top three ribs, so that that whole upper part of the lung would be compressed down. And that seemed to speed up healing, or improve your chance of

survival. But I don't know, I've never really seen any good statistics on how good that was or when and why it was stopped.

SIMEK: When do the drugs come about?

MERRILL: I can't remember for sure when the drugs for TB came about. That was a whole other interesting historical progression of the advent of antibiotics. I can't remember just when the drug treatments began. There were some drug treatments that came along not long after I was an intern there. But I don't remember. I'm blanking out on the name of the first drug that was used for that. That tends to happen when you arrange to be born a long time ago.

But the main management of TB then was prevention. And there were X-ray trailers that went from community to community, inviting people, urging people to come in and get an X-ray to identify unsuspected cases of TB so that they could be isolated, treated, managed, instructed how to keep from passing it around to the family and friends.

SIMEK: Was that effective?

MERRILL: Yes. It was. It was also suspect in amount of radiation that was delivered to a large population, a large part of the population, because at that time the cancer-producing effects of radiation weren't fully recognized or understood or calibrated. And there was quite a lot of X-ray energy delivered per customer in those trailers. Especially because they had to reduce the size for convenience of storage and processing and so on, they reduced the size of the pictures down from the 14 by 17 inch films that are used now down to postcard-sized. So it took more X-ray, more radiation to produce one of those than a full-sized film.

So eventually, that was one of the reasons that those trailers were discontinued, I think. Plus the fact that they did, in some areas, at least, appear to reduce the incidence and spread of TB.

SIMEK: Do you think the radiation diagnosis might have been part of treatment?

MERRILL: No. No. No. Any effects of the radiation, aside from the diagnosis, was probably a hazardous side effect.

SIMEK: So the treatment prior to the drugs was primarily isolation. Well, you said prevention. But if you didn't prevent it, then it was isolation in a sanitarium.

MERRILL: Isolation, yes. Rest. Sanitarium. Supposedly moving to a warmer, drier climate was useful. A lot of people moved down to Arizona or someplace, or southern California from the northern climates. And it was trying to just wait for your body to heal it up. Which of course is the way you heal up everything. But there was very little that could be done that really, really contributed to the healing process at that time.

SIMEK: So I'm not sure I really understand what tuberculosis is, except it's tubercles in the lungs.

MERRILL: Yeah. It's a bacteria. And it's what's called an acid-fast bacteria, which is just a laboratory term. It's your class of bacteria of which that's one. Leprosy is another. They stain differently under the microscope with laboratory stains so you can distinguish one from another. And they're a very slow-growing bacteria. They grow and act more like a fungus than a bacteria. So it takes a long time for symptoms to show up.

In recent years, I saw a fellow from Samoa who came in with a cough and flu symptoms. And the cough didn't go away after three weeks or so. So he took an X-ray. And there was just this faint suggestion of a little shadow up in the top of his left lung. And the, in fact the radiologist read it as negative. It probably wasn't significant.

But because he was from Samoa, and because I remembered these cases from way back when TB was a big deal, I got a sputum culture. And it takes three weeks or so for a sputum culture to be ready to read on TB. But he has a positive test. So that was the very beginning of TB.

And the treatment now, of course, is a combination of drugs. I'm sure he was, should be cured of that. And his family members had negative skin tests.

But TB, outside of recent immigrants, is really much more rare in this country than it was then. The incidence is increasing now because of immigration from places where it's endemic.

SIMEK: Now on the, I'm thinking of the X-ray vans that used to go around, and it just reminded me again. Did I remember reading something in your book about Dr. Parkinson had been using X-rays and he had some results from using X-rays in overdose? Or was that another doctor's book I was reading?

MERRILL: No, I'm not aware of that.

SIMEK: Okay. All right.

MERRILL: He wasn't, at that time, X-rays were not used for treatment of anything, so far as I know.

SIMEK: Okay. Let's go back for a little bit. I know we've been sort of following your life chronologically. But I want to hit a little bit more on this pharmacology since we were talking about it more on the break. I remember in some of the interviews that we've done, doctors were talking about carrying a little bag, which was pretty easy in those days, because there were only three or four drugs or whatever that they would have to carry with them. But pharmacology today is a vastly different matter.

MERRILL: Yes.

SIMEK: And so the evolution of pharmacology, you had some strong opinions about that. About where it's come from and where it's going and why it happens.

MERRILL: Yeah. I inherited Dr. Parkinson's little black bag that he carried everywhere. And in it were some little tiny glass vials. Smaller in diameter than a ballpoint pen, than a small ballpoint pen, with little tablets in them. And that was the main pharmaceutical armamentarium of a doctor then. Codeine, morphine, calamol, which as far as I know now is totally useless. Phenobarbital. Strychnine. And digitalis. Strychnine was used as a stimulant. In larger doses it was used to poison dogs and coyotes.

And those, the only drugs that were of any use were palliation, you know. Sedative and pain relievers. At the time that I came on the medical scene, sulfa had just been, had come into use. Propacil, I think was the first, you could say the first chemotherapy. It was not an antibiotic, in a sense. It was made in a chemical lab. But it was the first of the sulfa drugs, of which there were several that followed that. And that had been in use for a while. And sulfanilamide was available when I first was aware.

But if you talk to really old doctors now, like me, they always have to compare their first awarenesses of penicillin. When I was still in college, I had read about penicillin, the new discovery of penicillin as a treatment for infections. And I read about a little girl in Salt Lake City who had been sick with pneumonia. And they made a special, flew a special allotment of penicillin from back east somewhere to Salt Lake to treat this little girl. And she recovered from the pneumonia. And this was big medical news.

So not too much later, when I was assigned to the naval hospital up at Sun Valley, we had, the patients there were sailors and Marines that had returned from the fighting in the Pacific. And some were psychiatric patients and some were chronic illnesses and some were physical rehab patients. But there were also some gonorrhea cases. And sulfanilamide, or maybe they had started using sulfadiazine, I'm not sure. But the sulfa drugs cured most cases of gonorrhea, but a few cases didn't respond to that.

So they were going to try penicillin on these sulfa-resistant cases of gonorrhea. And I sort of, remembering this little girl in Salt Lake City, I was sort of uneasy about using such a precious resource for such a—shall we say a mundane purpose, if other people were desperately in need of it elsewhere. But anyway, it wasn't my call. And I was glad to help in the trial. So I participated in giving an injection of 10,000 units of penicillin every four hours for two days to these guys. And it worked beautifully. Ten thousand units is a miniscule dose now, you know. The doses now are in millions of units. But it worked.

And when I was in medical school, then, penicillin was just starting to be used. And it wasn't known how, what all it would work for. But it seemed to work for

practically everything. It worked beautifully for strep infections and for staphylococcus infections. And now it still works just as well as before for streptococcal infections, and almost, hardly works at all on staph infections, because the staph has been able to mutate to more and more penicillin-resistant strains of it.

SIMEK: So that was today what might be Cipro, or—

MERRILL: Right. A whole series of antibiotics. The next one that I remember was Tetracycline. And various brands and slight variations of that for marketing purposes. Terramycin. And then after that came chloramphenicol, which would work nicely on the staph infections that penicillin wouldn't touch. Except that chloramphenicol after a while was learned to be causing a fatal side effect of aplastic anemia. See it poisoned the bone marrow so you quit making red blood cells. So chloramphenicol fell into disrepute for most purposes.

And there's been a whole sequence of antibiotics come on the market, some targeted specifically for certain kinds of infections. I mean, would work well on certain kinds of infections but not others. And Cipro, Ciprofloxacin is one of the more recent, it's, there are others more recent than that now, but that's one of the good, so-called all purpose antibiotics that when used for all purpose will hasten the development of resistant strains to Cipro. So the beat goes on.

SIMEK: Yeah. When you think about it, it's just been 60 plus years since penicillin. And that was the first real miracle drug, so to speak. But in that 60 years, the pharmaceutical industry has changed in an enormous way. And we were talking about inventing diseases to make drugs for. And the advertising of drugs to the general public. What are your views on that?

MERRILL: Well, those diseases we were talking about, I'd prefer to call them conditions, mostly are not infections. They're not traumatic. Most of those diseases that, or those conditions that drugs are eagerly used for, a lot are behavioral problems. And it's really hard to separate things out.

One of the kinds of behavioral problems that drugs have been used for is schizophrenia. And the discovery of Thorazine, and then a series of other similar anti-psychotic drugs, so-called, just transformed the whole world of mental health, of psychiatry, enormously. It emptied out the mental hospitals, to a great extent. Because a person who is agitated, violent, depressed, all sorts of, the various symptoms of schizophrenia, would often be made much better by Thorazine. As long as he continued taking it. It's not a cure. So the mental hospitals were able to discharge patients with a prescription for Thorazine refills. So many refills. You come back and see your doctor in a month and get some more. And that worked wonderfully if the patient would take the medicine. But then the problem is that the patient gets feeling better and decides he doesn't need the medicine so he quits taking it. So he becomes violent and agitated and confused and disrupted again.

So you know, we could extrapolate that a long way into the cities full of homeless people on the streets now who are mentally ill and either have never been diagnosed or treated or been on any medication, or who had medication and don't take it or forget to take it or can't afford to take it or don't have the insight to understand that they need to take it.

SIMEK: For a lot of, especially seniors today, I see seniors who are taking so many medications that they have to list them, that they can't even keep track of their own medications. Are we overmedicating?

MERRILL: Well, it's very easy to overmedicate. And it's not easy to define what overmedicating means. But the technology of diagnosis, of understand physiology, of being able to manipulate physiology and things like blood pressure, diabetes, kidney disorders, various kinds of blood aberrations, variations or abnormalities in the electrolytes, sodium potassium levels caused by some other drug that you have to take to keep your heart working right, all of these things now you have to play the physiological system like a piano. And one drug to counteract the effects of the other drug. And it's really hard to sort that out sometimes.

I would tell my patients that are on multiple medicines, every time you come in here, bring all of your medicines in a paper bag. All the leftover, expired bottles. Everything you have, put it in a bag and bring it in so we can look it over and see if there are duplicates, which sometimes there would be. If there are conflicting medicines. The patients either misunderstood or deliberately taking the wrong dose of the medicine. All sorts of complexities come up in the pharmaceutical musical chairs stuff.

And I would say first of all that we're tending to overmedicate because the areas where so much medication is used now is treating just behavioral patterns that have been given names, like attention deficit syndrome or attention hyperactive, attention deficit hyperactive disorder. Depression.

Depression is such a good example. There's nobody who isn't depressed once in a while, to some degree. And to define, to decide what's the degree at which you should be considering it a medical problem, that is a really fuzzy line. And then once you decide that it's a medical problem, what to do about it is not obvious, either. It used to be that depression was considered, if it was to the degree that it was clearly troublesome, it was considered a problem for a psychiatrist or a psychotherapist or a clinical psychologist. It was a behavioral matter and that you could do things, change your life dynamics in some way to make it better. Or at least figure out why you're depressed and then would give you something more to deal with. But now it's so easy to just write a prescription, here's an antidepressant, come back in a month when you run out of the pills.

And that sometimes works well. But often it doesn't work well at all. And the side effects and the failures and the problems of evaluating whether it's working or not is tricky, you know.

And of the placebo effect, the placebo effect is something that is always there, and is always used as a comparison for evaluating new medicines. But once you've made that comparison, if you find a new medicine that works 7 percent better than the placebo on depression or some other problem, then that medicine is accepted. And why the placebo worked is ignored.

I would say that a trusting and respected relationship between a competent, well-intentioned doctor and a needy patient is the greatest placebo of all, you know.

SIMEK: Am I mistaken, or do I remember hearing something about a doctor or, maybe not just one, that it's not uncommon for doctors to prescribe placebos so that their patients think they're actually getting something, and the patients get better, just taking the placebos that are given a fancy name and come in a pretty bottle. And they go home and they take them and they get better.

MERRILL: That happens. That certainly happens. And different figures you look at, that happens maybe somewhere between 10 and 20 percent of the time. And a lot of so-called disorders. The problem with that is, nowadays I think, and I believe this is right, that deceiving a patient is not an appropriate way to go. That it's very seldom appropriate to lie to the patient or deceive the patient about what you're doing, why you're doing it, what it is you're giving them. so if you tell somebody, "This medicine is for depression. Take it and see if you get better," you know, maybe you're technically not lying if the pill is just a starch pill or a capsule with flour in it.

But in the long run, that's going to come back to bite you. And the patient will learn that you can't be trusted. And it messes up the doctor/patient relationship, I think. So I have almost never given placebos under another name. Although I have often given some medicine and happily accepted the fact that it helped in ways that I hadn't expected or that the patient hadn't expected or that the patient felt better from taking it and made their own conclusions. But there's a fine line there that's sort of an ethical problem in the use of placebos.

SIMEK: We were talking about drugs and the amount of, or whether, the question of whether we're overmedicating. And the number of drugs that some people take has come up a number of times. When you increase the number of drugs, of course, you're increasing the possibility of counter-indications and interactions that have negative effects. And I'm wondering, I see, sometimes I see drugs like surgery, that you have life-saving surgery, you have elective surgery. And you can have life-saving drugs like diabetes drugs and high blood pressure drugs. And then you can have optional elective kinds of drugs. And those seem to be the ones that get advertised these days. How much of this is driven by the needs of the patient, and how much of this is driven by the needs of the drug companies?

MERRILL: One has to tread a little lightly in answering that question because well-intentioned people on both sides of that question are doing what they believe is right. But certainly in some cases an individual patient is taking more medications than

are needed. And sometimes in fact the patient unknowingly is taking duplicate medicines prescribed by two different doctors, maybe under different names. A brand name and a generic and not realize they're taking a double dose of an anti-inflammatory medicine or something like that, which increases the hazard of side effects.

But the point you were making, I think, is important, that some drugs are clearly needed because of acute or specific physiologic problems. Like asthma. The spasm of the bronchial tubes brought on in an asthma attack by allergies or whatever it is, sometimes the drug can be life-saving there to dilate the bronchial tubes and let the air move in. Sometimes, you know, insulin is often a life-saving drugs. If someone has gone deep into the complications of diabetes, high blood sugar and acidosis. Not only insulin, but other things to re-regulate the blood components and the body's function are necessary to save life, perhaps.

Other medicines are much less critical. Like one you see advertised now on the television for dry eye syndrome. "You may have dry eye syndrome and not even know it, so ask your doctor if this is right for you." Now I'm not saying that Restasis is not a useful medicine. But to put it out in a, or let me say, drugs are presented in such a tempting and persuasive way by advertising that there's a, it's impossible for a patient always to know whether they really should take that medicine, whether they should run to the doctor and ask for it or whether it's a trivial thing that they don't need to worry about. And so the degree of urgency and necessity of the medicine is part of the answer to the question.

Like surgery. Surgical procedures, or most surgical procedures, are clearly, easily justified by some abnormality, a trauma injury or tumor or something that can be corrected by a surgical procedure and then let the body recover and go on from there. And that part's pretty easy to diagnose, justify and carry out. But a lot of the use of drugs is not. And I would say especially the so-called psychopharmacy, the treatment of behavioral changes, behavioral quirks, even. Behavior that is uncomfortable for society sometimes can get named as a disorder and drugs developed and used to treat it. Though it's controversial, you know, I would say that attention deficit disorder is in that category. And a lot of cases of depression, anxiety.

There have been a whole series of fashionable conditions. I won't call them diseases, but conditions that have been identified, named and treated. When I was first in the medical arena, neurasthenia was a fairly common term. Usually it meant a nervous person, an anxious, whiny, somewhat impaired person, usually a female, who just couldn't quite cope with things. Now that would be called generalized anxiety disorder, perhaps, or some variant on that.

Then there was a period when hypoglycemia was touted as a widespread problem. And with some scientific basis for it in some cases, at least. But it was greatly over-advertised. There were books in the lay press about it. There were support groups developed for people with hypoglycemia.

Then came hypothyroidism. Then came, well, chronic fatigue syndrome, Epstein-Barr Virus. Fibromyalgia. All these are so difficult to diagnose. The criteria for saying "this is a disorder" are so nebulous, and there's so much overlap between those individuals and people who consider themselves normal that it's hard to sort all that out.

SIMEK: When you were in medical school, did you contract, if you'll pardon the expression, medical student syndrome?

MERRILL: (laughs) I would say in the second year of medical school. The first year of medical school we spent learning the normal. What's normal. I mean, how a normal body functions. Then we got into pathology. And Boyd's pathology book was the thing I spent a lot of time in. And we had learned physical diagnosis. You know, how to listen to the heart and lungs and how to feel for enlarged liver and so on. Now we read about pathology. And reading about liver disorders, cirrhosis of the liver, hepatitis, tumors, so on. And put your hand here under your right ribs. Take a deep breath just to see if you can feel the edge of your liver. And how far down is that supposed to come now? Does that liver come down a little farther than it should? And do I have the beginning of some kind of disorder here? And should I go get a blood test or what?

And then the same thing with lymph glands, you know, Hodgkin's Disease and lymphoma and metastatic cancer. Feel the lymph glands under your arm or in your neck or in the groins. Oh, I can feel lymph glands there. Is that one a little bit too big? That one's bigger than any I've felt before.

And so, yes. I would say a lot of people in our class went through the whole gamut of diseases during the third year, and survived them all. All except one student who developed tuberculosis and died before graduation day.

SIMEK: The reason I bring this up is because I'm really struck by the similarity between medical student syndrome and almost an induced medical student syndrome that seems to be on television these days. Either through entertainment programming or through advertising, so many hundreds of new conditions and diseases and minuscule circumstances seem to be presented to the viewer that the viewer suddenly becomes convinced that he or she has at least a dozen of these things and wants to run off for a cure, not even knowing whether they actually have something serious or not. And even if they do have dry eye syndrome or whatever it may be, that they insist on having a cure. Because now they suddenly have a fear that they have something terrible.

MERRILL: And it's difficult to trust anyone that says, "No, you don't have the disease. This is normal. Don't worry about it." Some people find it hard to accept reassurance, while others find it hard to accept warnings and disastrous news.

I think, yeah, there's such a dramatization of health problems now. Maybe that's one of the big changes in the so-called healthcare system is that so much of it is on public television and hyped for advertising reasons. And really makes it hard for the ordinary

person to understand where they, what they should do about this. It's hard enough for the doctor to figure that out, you know

To carry on with the medical student syndrome, in my first months or years in practice, one of the problems was to become familiar with what's the range of normal? When you see somebody who looks different or is different size or some organ is different or function is different or blood tests are different, then how do you decide whether this is within the so-called normal range or something to be concerned about and dealt with?

SIMEK: That brought up something else I was going to ask you about, about liver function tests. But we might be getting a little bit too technical for what this is about. So as you were going through medical school then, what were the most intriguing parts to you about that whole process of learning to be a doctor?

MERRILL: The part I enjoyed most was anatomy. I was fascinated by anatomy. And I kind of developed my theory of learning in the anatomy lab. We had our first whole year, every afternoon in the anatomy lab. We had one cadaver that we worked on for three months. And then we got a new cadaver and spent the next six months on that. Or five months. And went into much more detail.

But we were dissecting, for instance, dissecting the arm. Take the skin off the arm. Take off the fat. Try to not damage the things underneath, the muscles and blood vessels and nerves. And identify all the things there. So here's the biceps. And I see that on the cadaver and I can feel it on myself.

So one day I move over to the next table and look at what they're doing. "What's that?"

"Well, that's the biceps."

"But it looks so different from the biceps on our cadaver." It's a little bit thinner. It doesn't have the shreds of fat that have been inadvertently left hanging on our biceps. And its color is a little different. You know, I have to reorganize my concept of the biceps. This is where it is, and it's the one that goes from there to there.

And one day the professor comes in with a cadaver from which all the arm muscles have been removed, and just little half-inch stubs of tendon. Each muscle remains only as a tendon attachment. And all of these tendons have little tiny tags of paper with numbers on them. And we're to go around and identify all of these little tendon stubs. So you have to suddenly refocus on what the biceps is. Down here it attaches to the radius, the little tubercle on the radius. And up here it attaches two different places, that's why it's called the biceps, two heads. So now you have to identify it not only by how it looks, but the attachments. Because that's the crucial part. Then you see what it does. Then you can feel it on yourself and feel how it changes as you do this

and how it changes as you do that. And what other muscles work with it and what work against it. So the whole concept of the biceps gradually develops bit by bit.

And the more different aspects of it you can see, the more you understand the biceps. Like you now looking under the microscope see the structure of the cells, skeletal muscle cells. Now you can picture the biceps, what's inside it and how it does what it does. And then later you see a fracture of the radius there and how the elasticity of the biceps pulls that little piece up out of the way so you have to do certain specific things to put it into alignment again to put the cast on. And how it is if the nerve that goes to it has been injured so the muscle is paralyzed.

So you build an understanding of the structure and the function of the body. Just piece by piece by piece, seeing it in as many different contexts as possible. So different in the operating room from what it does in the dissecting lab. The color.

SIMEK: So anatomy was your favorite.

MERRILL: That was your favorite subject.

SIMEK: And yet you didn't choose pathology as a specialty.

MERRILL: No. I chose general practice, which involves surgery. Involves anatomy in action. How you diagnose where the fracture is. I always enjoyed when I saw somebody who I thought had a fracture, I'd enjoy sketching out the bones, where I think the fracture is, while the patient's in X-ray. And then come back and I could show this to the patient, "Well, I think it's probably right there, but let's look at the film now and see." And you know, if the film looks quite a bit like the sketch, then you've really made some brownie points. And if it doesn't, well, okay, I was wrong on this one. It's farther up or farther down or oh, there's no fracture at all. But it was always fun to try to visualize the anatomy and connect it with the symptoms. And that's what leads you to what you do next.

SIMEK: This is a little bit off the track for the moment, but we'll draw it back in. there's been a great deal of emphasis, especially in the past two or three decades, on advancing technology. Like there's a magic machine Dr. Spock that you can just put a person in and it will tell you everything that's wrong with the person and what to do about it. And it seems that a lot of newer doctors rely a great deal more on technology than what could be called the old-fashioned diagnostic methods of working with the patient and palpating or manipulating or in some way just figuring out for yourself what's wrong with the patient without relying on technology. Which way do you swing on that?

MERRILL: Well, many years ago I was greatly amused by an advertisement by a chiropractor in a newspaper that said, "Full length X-rays. Complete diagnosis. No questions asked." And that, to me, was the ultimate of what you're referring to. Years ago. By a chiropractor. Just from X-rays. But yes, I have seen that tendency. And there's the upside and the downside of that, you know. It's a wonderful thing when you need a

CT scan, for instance, or an MRI, to tell you details of what's going on in the brain. Or in the abdomen.

But I was accustomed to diagnosing appendicitis by carefully questioning the patient about the symptoms. When it came on, where it hurt, were they nauseated, diarrhea, whatever. And then feeling the abdomen and see if there's muscle spasm and where the tenderness is. And if you press on the opposite side and suddenly let go, does it hurt over there on the right?

And when I was working in a little clinic in Clackamas toward the end of my career, I had a patient that I thought had appendicitis and called the surgeon over at the Willamette Falls Hospital. And told him what I had, what the patient's problem was. I thought he had appendicitis. And he said, "All right. Send him over to the hospital. Order a CT scan and I'll see him after that's done. They'll call me when that's done."

And to me, that was doing things backwards. Now I think that probably has become the predominant approach now to appendicitis. But I think a lot can be missed that way, too. You have to see the good and the bad of the technology, use it appropriately. And I always felt that specialists were an adjunct to my practice, just like an X-ray or a blood test was. Get a consultation with a specialist, you know. Depend heavily on them for some things, less heavily for other things. And sometimes for, just for reassurance for me and the patient. But yes, the reliance on the technology now sometimes crowds out the other parts of it.

But the other part is, there's so much more to learn now, so much more to know. General practice is not possible anymore in the old sense. There's so much is possible now. And sometimes I miss the old days when we didn't have even heart monitors and CPR and defibrillators, because it's so easy to get relying on that and miss some other things.

Anatomy was my favorite course in medical school. Probably my least favorite was biochemistry, because while anatomy was so visible and tangible and structural and clear, biochemistry was nebulous. You could not see the molecules or the atoms that we were presuming were there. And it never seemed as logical as chemistry, inorganic chemistry had in college. So I never felt, probably, as comfortable and confident in pharmacology and problems of physiology as I did with surgical problems later in my practice.

SIMEK: And that informed the way you developed your practice, preferring to go into surgery rather than just internal medicine. Is that—

MERRILL: Well, general practice involved all of that. You know, I guess all of that, to a limited degree, including the surgery. But that was the part that I enjoyed the most and tended to lean toward.

SIMEK: As an aside, is the term that was generally used years ago of physician and surgeon, is that pretty much gone, except for people who specifically go into long-term surgical training, as well as long-term internal medicine?

MERRILL: Well, Columbia University College of Physicians and Surgeons still has the same name that it had when it was founded a couple of centuries ago. But yes, where that, where that divide became most apparent was in the whole thing about general practice versus everybody else. And if you want to go into that, we could do that now.

SIMEK: Yeah. It seemed to me that when I was growing up as a kid, we had Dr. [Kleinwater?], physician and surgeon. And he would do the tonsillectomies and the routine surgery.

MERRILL: Mm hmm. Yeah. Well I think that term is still used quite a bit. But one of the things that I hadn't realized when I was first starting out, except with my career interview with Dr. Microbe, was the way that general practitioners were viewed by specialists, by medical schools, and often by patients. And by hospital staffs, which were dominated by specialists in the cities.

And during my first year in general practice, which was 1950, one of the other staff members in our staff at Wheeler Hospital in Gilroy, California, came up to me in the parking lot and said, "Ted, I think you should join AAGP."

"Well, what's AAGP?"

He said, "It's a new medical organization. A new kind of medical organization." He said, "I'll send you some information about it."

And I didn't do anything about it then. Then I went in the army for a couple of years. And when I came back, Al [Kerry?] had tragically been killed in a plane wreck. But I had gotten the information and I joined the AAGP, which was the American Academy of General Practice.

And much later I learned sort of the history of that. That there were some general practitioners in Oakland, California, who had gotten really disgruntled with being shut out of the operating room and the delivery department in the hospital because they were GPs instead of specialists. And so now I'm blanking on the name of the guy, and I'd like to look it up and put it in there. Stan Truman. Dr. Stanley Truman in Oakland, California, got together with a bunch of his colleagues in the general practice section of the annual meeting of the American Medical Association in Chicago that year. I think in 1946. And they got together and decided they needed to do something to improve the situation. Because general practitioners were looked down upon so by their specialist colleagues, by medical schools, and even by patients, in many cases.

So they got together and eventually during the next year or so, a lot of negotiations across the country, they formed the American Academy of General Practice.

And one of the key features was that in order to remain a member of the academy, you had to have 150 hours of continuing medical education. Lectures, workshops, courses of some sort, every three years in order to maintain your membership. And that's the first thing that that kind of continuing education requirement had ever been put in a, on a medical organization.

SIMEK: Of any kind.

MERRILL: Of any kind. Yes. That's where the concept, so far as I know, that's where the whole concept of CME began. Continuing medical education.

And indeed, over the next several years, the status of GPs in the public eye and in the hospitals was improved quite a lot by that. Because it was a proof that they were dedicated to and consistently carrying out attempts to maintain up-to-date information and skills and knowledge. Whereas the American College of Surgeons, I believe, you could join. And then you could still remain a member, even though you didn't go to the courses and lectures and so on. So that helped some.

And that academy was started just about the time that I graduated from medical school. So it was several years later before I really found out about it and became a member. And belonged to it from there on.

SIMEK: At one point, Columbia's view of general practitioners was, and I forget how you put it—

MERRILL: Well they said, "A Columbia man is too good for general practice."

Yeah, if I could have, talking to Dr. Microbe again 20 years later, I would have said, "Oh, no, you've got it all backwards. Only a Columbia man is good enough for general practice."

SIMEK: (laughs) So you chose general practice. And you joined the academy. And you even rose through the ranks of the academy, as I recall. How did you go about choosing John Day, Oregon?

MERRILL: Well I first started practice in Gilroy, California. That was only 30 miles from where I had my internship and residency. And one of the GPs there invited me to share his office. He had extra space. And he was a wonderful doctor, Dr. Oscar Carlson. And he was a mentor to me in my first years there. And I practiced in Gilroy for eight years. and Gilroy at that time was a town of 6500 people. Agricultural community. Surrounded by tomato and strawberry fields and prune orchards. It was the garlic capital of the world.

But over the next few years, the people got restless and they decided they needed to get more people, more industry to come into the town, to help share the tax burden. So they agitated and they recruited, and they got more people and more industry. So they

had to build a new school and new sewage treatment plant and more streets. And the tax burden doubled. And it was just getting crazy. And between Gilroy and San Jose, there were new subdivisions growing up all the time. So we could see that we had to get out of there. There was just no vision of the future you could hang on the walls of your mind that was comfortable. So we decided to move.

And we had been on a camping trip up to Oregon a couple of times, actually. And had been through John Day. We decided that we liked the feel of Oregon and the people, and there was space up there. And so I flew up to Portland and took the Oregon Medical Board examinations so I could get a license. And I asked if they knew of any place where, any small towns that was looking for a doctor.

So one of the medical board members said, "Well, there's a doctor, Howard Newton is just finishing his residency down at Physicians and Surgeons Hospital, and he's thinking about John Day. So maybe you should talk to him."

So I called him up and made an appointment for lunch. And by the time lunch was over, Howard Newton and I were partners headed for John Day.

And so we moved there the same week, in 1958. The last week of June in 1958. Because it looked like here, the population was 1,625 in the town. And in the county, about 7,000. Between six and seven thousand. And it looked like a place where the growth would be limited by how fast the trees could grow and how fast the grass could grow, because it was timber and cattle country. So that's where I went.

SIMEK: And what was the medical condition in that town at that time?

MERRILL: Well, there were two doctors there. There was Doctors Martha and Jerry Vanderflute, a husband and wife pair that had been there for, I think, 20 or years or so. And they had a little private hospital in John Day that they had remodeled out of an old residence added on to, an old two-story residence. And the county hospital that had been in use for quite a long time before, was in Prairie City, 13 miles from John Day. And when I came on the scene, that hospital was closed, because there had been no doctors to use it for a year and a half. It had been locked up.

And I didn't realize at the time, but I fairly rapidly learned that both the medical politics and the non-medical politics in that area were so thick you could cut it with a knife.

SIMEK: Is that why there were no doctors practicing then?

MERRILL: Well, the story that we got was that there had been about a half a dozen doctors in the previous ten years had come there to use that hospital. And the Vanderflutes had driven them away.

Well, I didn't know quite how the Vanderflutes would drive them away. But we talked to the hospital board, Howard Newton and I, and they agreed to reopen the hospital for our use.

When I first got to John Day, looking over the place, I went and visited with the Vanderflutes. And they were very friendly and invited us to come and work with them. But it seemed like what they meant was to work *for* them, in their hospital. And it just didn't feel like a comfortable sort of arrangement. So we thanked them but we said we would arrange to use the hospital in Prairie City, the county hospital.

Besides that, the hospital in Prairie City had been built by the city many years ago, 1940. It had been used for quite a while but then it had been closed. But while it was being used, the city found it was too much of a financial burden and they deeded the hospital to the county, to Grant County, with the provision that it would always be used as a hospital.

So when I got there, they had a lawsuit in progress, or pending, to regain possession of the hospital from the county. The city was suing the county for possession of the hospital because of breach of contract. Because it wasn't being used as a hospital or anything else.

So when I went to look at the hospital, I had to go and get the clerk of the county hospital board, Barbara Reynolds, and get the pharmacist, Harvey [Willheight?], who was mayor of Prairie City, each to come with the separate key to unlock the two locks on the front door of the hospital so I could go in and look around. And they stood outside kind of glaring at each other in the meantime.

Well, so that's the way we started. It was going to be open for us to use. But when Newton and I arrived there, went up to see how the hospital was, it was all polished up and staffed and ready to go, it was still locked, cold and dark as before. And the hospital board member said, "Well, we kind of decided that we'd wait and see if it looked like you and Newton were going to stay around before we opened the hospital."

Well, that's sort of a catch-22, you know. Are we going to stay around without a hospital?

So within a week, we had gotten courtesy privileges to use the hospital in Burns, 70 miles south. And four months, I guess, from first of July until October, somewhere like that, we used that hospital. And there are some both tactical and ethical problems involved, you know, in having your hospital 70 miles away when there's a hospital in town.

So we would ask the patient, or we would first ask ourselves, this patient needs to be in a hospital. Is he or she safely transportable to Burns? If yes, then we would say to the patient, "You have this choice. We don't have a hospital to work in here. So you can either go with us to Burns to be treated down there, or you can go over and see Dr. Jerry

and Martha and be treated by them in their hospital." And the patient could have the choice.

If the question to transportable, safe transportability was no, then we would just have to say, "You need to be in a hospital now. We don't have one, so you have to go and let Dr. Jerry and Martha take care of you."

SIMEK: So you were barred from privileges in their hospital.

MERRILL: We weren't barred from it, no. They would have invited us to come do that on their terms. And it was clear that we had to keep that separation clear and sharp, or else there would be all kinds of problems down the line. We'd become subject to their whims, their terms, or whatever thing we did.

One of the ways that they had driven doctors away from Prairie City Hospital was preempting the schedule for the operating room so much that the other doctors couldn't count on ever using it, and bumping them off the surgery schedule so it was just too uncomfortable.

So finally the hospital board-- well then, there was one of the attorneys in town put on a welcoming party for doctors Merrill and Newton, a little cocktail party in his backyard. And a lot of the businesspeople in town came around. Newton didn't come because he had to be taking care of a patient down at the office, but I came to the party. And Dr. Jerry was there. And Dr. Martha was on duty back at her hospital.

And Jerry and I were visiting and sipping a martini or something. And he said, "You know, I think it just wouldn't be in the interest of the community to reopen that hospital. And I think I have enough clout to keep it from reopening."

Okay. So that was where the situation became clear, you know. So that's when we started, by then we were already signed up in Burns. But in October then, the hospital board somehow changed their mind. We didn't request it, never talked to them about it. But they let us know that the hospital in Prairie City was reopening and we could use it. So we used it for two years.

When we first arrived there, the other political aspect of the whole tense scene was that a bond issue had been passed, a county bond issue to build a new hospital in John Day. So we used the one in Prairie City for two years while the new on in John Day was being built. And the people in Prairie City, of course, resented that part, too. And some of that tension still remains, almost 50 years later.

SIMEK: So what happened to Jerry and Martha when this hospital was being built?

MERRILL: While the hospital was being built, they just kept using their hospital. And meanwhile, they hired a surgeon to work with them. A British fellow, Brian King,

who was a general surgeon. British citizen. Who was, because of his citizenship, he was susceptible to military service. And so he got an exemption from that on the basis of serving in a community that was in need of a surgeon. And they had provisions for doctors to go to underserved areas and be exempted from medical service for a period of time. So he was there, and he still used Jerry and Martha's hospital till the new one was built. And then he and Martha both started seeing some patients there and some in their hospital. And it kind of gradually shifted over.

Meanwhile, Jerry got sick and died. And eventually, Martha kept on, Martha and Brian King kept on for several years.

SIMEK: With their hospital? Or was it closed by then?

MERRILL: No. They kept their hospital open for quite a long time. And used both of them. and Howard and I used the new county hospital in John Day, after it was built.

Then we recruited another partner, Craig Bennett, who came to join Merrill and Newton. And then eventually both he and then later I kind of separated off. And Newton and I separated our complete partnership but still were on good terms and exchanged calls but had separate offices. Because we worked differently and there was confusion with the money and the charges and the payments and all that. So it worked out better separately.

SIMEK: And that went for—

MERRILL: Well, I was there eleven years. And in the tenth year, I began to think, because that was almost 20 years of medical practice for me by then. Eighteen years.

SIMEK: Since 69?

MERRILL: That was in, yeah, '68 I started thinking about this. That's twenty years after I graduated medical school. So I started thinking is there anything left of me besides this MD stereotype? Could I do other things? Or what kind of a break could I take that would be useful and serve as self evaluation.

So I started looking into teaching possibilities. And University of, well, down at the medical school, they might be able to use an assistant in the anatomy lab, maybe two years from now. And up at University of Washington, they could give me a part time job in teaching nutrition. And neither of those was going to work out.

So meanwhile, one of our sons was going to a little college back in Vermont that we had learned about through a Quaker friend who had a friend who had gone there. So I contacted Goddard College, flew down to San Francisco to meet the president when he

was out there on a speaking engagement, and talked to him about joining the faculty there. So we spent a long, long evening discussing this.

And after he got back to Vermont and I got back to John Day, he wrote me a letter and said, "What four courses could you propose to teach that could justify my hiring you? Two courses each semester."

So I divided all my main interests into four pieces like a pie and sent off a proposal. And I went back for an interview. And that's where I went.

SIMEK: And that was wood carving and astronomy and—

MERRILL: (laughs) Anatomy and physiology.

SIMEK: One course or two?

MERRILL: That was one course. This was not a medical preparation course. This is a little experimental non-structured abnormal kind of college. Fashioned out of an old farmstead there.

SIMEK: How many students?

MERRILL: I think there were 200, between two and three hundred the first year, when I first went there, yeah. So, and the other subjects were ecology and zoology and some aspects of death and dying, which I'd gotten interested in.

So I got hired. And I taught there for two-and-a-half years. but the main course I taught as it settled out, each semester I taught this anatomy and physiology course. But I had to rename it. Because this was the hippie capital of New England, the drug center of the New England states. And everybody was kind of anti-authority, anti-science, anti-education. So instead of anatomy and physiology, I called the course "human form and function as a basis for identity." And it worked out beautifully. I had a good time. The students had a good time. So it was a good move.

But then I began to see after two-and-a-half years, I would either have to get back into medicine or forget the whole thing. So another doctor came bumbling along looking for a place to fit in. So he and I persuaded the staff of Central Vermont Hospital to set up an emergency department staffing system so the local docs wouldn't have to be interrupted in the middle of a busy afternoon to leave their office full of patients and come over to stitch up a cut in the ER. So I did the ER there for three years then.

SIMEK: And no longer at the school?

MERRILL: I quit at the school. Yeah. For half a year I was divided back and forth. Then increased the time at the emergency room. And I quit the teaching.

SIMEK: So three years at the hospital and then?

MERRILL: The winters were kind of hard and heavy and long for my wife, Betsy. And besides, there was no lava rock and sagebrush in Vermont, and that just goes against nature. So we moved back to Oregon. And I took the first emergency room job I could find in Oregon, which was at Good Samaritan Hospital in Corvallis. They had just built a new hospital. So I think I worked my first four shifts in the old hospital, and then in the new hospital.

SIMEK: Year was?

MERRILL: 1975. So I worked there, did that for three years. And during I guess early 1976, we bought a piece of property over, close to John Day. And eventually, in '78, we moved back over there and I went back into general practice in John Day.

SIMEK: What were the conditions there then? How had you noticed that it had changed since you'd been away?

MERRILL: Some of the changes were similar to what I had seen in Vermont. I would say one of the biggest changes in the whole healthcare system was taking place while I was in the ER in Vermont. There and when I was in John Day previously, the ambulance service was provided by mortuaries. They brought their mortuary vehicle out, not call it a hearse, but they had another vehicle that was similar. And they had the gurneys. They were the ones that had the vehicle and the equipment to transport human bodies horizontally. And so they did all the ambulance work.

And the vision is still vivid in my mind of being in the emergency room in Central Vermont Hospital and hear the door open and footsteps coming down the hall and the guy is kind of humming a tune. He works for the local funeral home. And he's pulling the gurney down here and says, "Where do you want him?" And we had gotten a phone call that there was a motor vehicle accident and we'd be getting a patient from that

So he pulled the patient into the emergency room. The patient was lying there on his back, his airway almost blocked. Snoring, blood in his mouth. Head rolling back and forth as he turned the corners. He was transporting the patient exactly as he would a corpse. Because that was his training. That's all he knew. And that was the way the ambulance service was operated then.

But just during that same year, there was movement afoot, both here and in Vermont, nationwide, I think, to set up the EMT service. The trained people to go out with an ambulance and help stabilize a patient. Stabilize the breathing. Check the blood pressure. Stabilize their heads if there was any possibility of head or neck injury. So that the, a good part of the hospital facilities were moved out into the field. A patient had a much better chance of surviving an auto accident or any other kind of a serious injury being transported and partially stabilized on their way in, and transported, prevented from further injuries taking place during transport. And at that time they weren't given IVs.

They just could stabilize the fractures. Before very long, they were given IV fluids. And they had two-way radios to communicate with the hospital. So that whole system, I think lots of places in the nation in smaller areas were just, that system was just getting going then. And made a tremendous improvement in your chance of survival of some mishap out in the woods somewhere.

SIMEK: Did the one-hour rule still apply then? Or was that a later development?

MERRILL: That was a later development. I had never heard of the one-hour rule, or the golden hour, at that time. No. But of course, that one-hour rule was still operating even though nobody recognized it as such. Because the first hour after an injury is the time when treatment, stabilizing and action has the, will bring you the most potential benefit in survival.

SIMEK: Now the EMT development, was that something that people individually did? Or was that a program? Or how was that put together?

MERRILL: It was a program. And I don't know much about the details, the background of that. I knew how it was being done in our hospital. And it was done with some outside funding to buy an ambulance, for one thing. The training was mostly done locally. I helped with training the EMTs, the early stages, and there was then a prescribed course was developed, not by me, but somewhere else. I think partly at the University of Vermont Medical School was involved with that, and I think some federal involvement, too, but I don't know exactly how that came about.

But when I came back to John Day, it was already operating here.

SIMEK: How big was John Day at the time?

MERRILL: When I first moved here, it was 1625. And now it's 2000.

SIMEK: Not much.

MERRILL: It's almost exactly the same.

SIMEK: Do you include Canyon City with that? Or is that--

MERRILL: No. That's the population of John Day itself. If you add Canyon City in, Canyon City is about another 800, give or take 100. I'm not sure what the latest census was on that. So the two cities together, they're only 100 yards apart. And function in many ways as one city. And the total population then was under 3000.

SIMEK: And what year was this that you came back the second time?

MERRILL: When I came back the second time was 1978.

SIMEK: Was there an active PA program, an NP program, at the same time? Or were those developed subsequent to that?

MERRILL: Those were developed subsequently. I had heard of the PA program, that medics program in Washington. I think it started in ’75, about 1975. So there were some graduates were out and working by the time I came back to John Day. But they were in short supply. I think there were only 30 or something like that in their first graduating class. I’m not sure about that number.

SIMEK: What was the medics program? And how did they come about?

MERRILL: Well, Dutch Reinschmidt was, had a big hand in that. Because University of Washington was pretty new at that time. And he had been a general practitioner out there in Eastern Washington. And he suggested to them, to the University of Washington Medical School, that it would be helpful to figure out some way of providing what he was thinking of as physician extenders. And he was thinking of the medical corpsmen that were trained in the military. And how, how useful and essential their services were.

SIMEK: Vietnam was just winding down at this point.

MERRILL: Yes. Yes.

SIMEK: I mean, our role in it.

MERRILL: Yeah.

SIMEK: We were just saying, before you left for Goddard College, what was the condition of medical staff in John Day at that time?

MERRILL: When I left for Goddard College, when I decided to leave for Goddard College, that was in December of ’68, I figured six months would be plenty of time to recruit another doctor to take my place. Soon after I made that decision, or announced that I was planning to leave the following July, Dr. Jerry had died by that time. Dr. Martha and Dr. King were still using their hospital. Dr. King had completed the period of time when he was trying to avoid military service. So he was free to leave. And he moved to a clinic back in Illinois, I think. Then Craig Bennett didn’t get along well with Howard Newton, and didn’t feel comfortable about being left alone with just the two of them in town, so he moved to Klamath Falls. Dr. Martha had been saying she was going to close down. She left and moved to Washington, DC to work for the Public Health Service. So when I left town, Howard Newton was the only one left.

So with so deep in a swamp of guilt, but having signed a contract, I left him hanging there, twisting in the wind. And he was there for quite a while. And then a Dr. Bothwell came, and then a Dr. Miller. And I don't know all the details after that. But for a while, it was really desperate there, and doctors from other parts of Eastern Oregon were

offering to come over for a weekend or give Howard a break. And things were really tight. And I don't know what all the hospital experienced from that. But it wasn't pretty.

SIMEK: Was the Vanderflutes' hospital torn down?

MERRILL: No.

SIMEK: It's still there?

MERRILL: No, it's still there. But it's now had some more additions and it's a nursing home now. And the county hospital's still, the John Day Hospital's still there.

Well I guess you would say their old hospital has become an assisted living place, not a full nursing home. The place in Prairie City, the former hospital, is now the Blue Mountain Nursing Home. Excellent nursing home. It just had its sixth consecutive year of inspection, state inspections, with no points taken off. Perfect score.

SIMEK: And the John Day Hospital?

MERRILL: It was remodeled extensively. Basically rebuilt. They built a hospital around the old one, and tore the old one out from inside. Just finished, year before last.

SIMEK: 2004.

MERRILL: 2004, I think, was the finish of it, yeah.

SIMEK: What role did Kam Wah Chung play. Of course that was from the 1800s, 1870s or perhaps before, and into the 1900s, how far?

MERRILL: When I came there in '58, the Kam Wah Chung building was not in use anymore, it was locked up. But the last doctor who had used it lived in a house across the street. The famous doctor that was there, Dr. Hay, had died. And Dr. Bob Wah had, I'm not sure about the overlap or the sequence there. But Dr. Bob Wah had been there for quite a few years when I came, and he was getting quite old. And his son was my dentist in John Day for several years. his son, Eddie Wah.

And Dr. Bob died, I think I saw him a couple of times as a patient in my office with heart trouble before he died. And knew his, I believe it was his second wife lived down there for a while. I was acquainted with her. And that building was locked up for quite a long time. And thanks to the dedication and vision of one of the citizens there, Gordon Glass, in John Day, it was converted into a museum and cared for, and now has been taken over by the National Park Service, being expanded, upgraded and really gone uptown now.

SIMEK: And the significance of that was that it was Chinese herbalism.

MERRILL: Yes, it was Chinese herbalism, and it was a Chinese store. Grocery, pharmacy, liquor, gambling place, opium. You know, the full gamut of Chinese commercialism, so far as I understand it. And for a long time was one of the main medical providers.

And when I was there, there was just Doc Hay, who had cut down on his practice, but still he was seeing quite a few patients. Usually patients who had been seen by me or some other Caucasian. And they had gotten disgruntled because they weren't cured, and went to see Dr. Bob. He was a revered and well-respected citizen during that time, up to when I got there and a little beyond.

SIMEK: Okay, when you returned, where did you plan to go from there? When you returned in '78?

MERRILL: Yeah. The situation was somewhat different then. The main difference being that there was a general surgeon on the hospital staff, Clare Spalding. He had been there for several years when I got there. The doctors there then were Dr. Bill [Staw?] and Bruce Carlson, who had been there, I think, more or less the same period of time. I think they came early '70s. '72 or somewhere around there. Lee Harris came a little bit later. And then Clare Spalding was the surgeon.

And when I came back, basically, I took Bruce Carlson's place in the office and he moved to working in the emergency room in the Dalles.

So I started back in general practice, obstetrics, the whole thing, except that the surgery that I did was quite a bit less, because there was a general surgeon there. And so I didn't do hysterectomies and gall bladders and any abdominal stuff except appendectomies and hernias. And I did somewhat less orthopedics than before.

SIMEK: Now the people of John Day are sort of a rugged bunch, aren't they?

MERRILL: Yes they are.

SIMEK: What were they like as patients?

MERRILL: The ran the gamut. There were a lot of rugged guys there. And Howard Newton and I, because of our personal styles, I guess, kind of tended to attract different styles of patients. Most of the, or there was a lot of overlap. But if you break out the statistics of it, more of the loggers and cowboys and ranchers went to Howard, and more of the old ladies and women with little kids came to me. Though I think Howard and I did more or less the same number of deliveries.

But when I came back, of course, Howard had moved away. He stayed in John Day about a year after I left the first time. Then he moved to McMinnville and stayed there till his death two years ago.

But when I came back there, yeah, the situation was different, mainly in that there was a general surgeon there. The ambulance system had been further improved. There were good, well-trained EMTs on the ambulance. The hospital was operated on in pretty much the same way as it had been before. The nurse anesthetist was the same one that had been there when I met the first time and is still there. Yep. Bonnie Hilleyard.

SIMEK: So you saw quite a bit of improvement, then, in the time, from your first exposure to John Day—

MERRILL: Yes.

SIMEK: --through your second coming, as it were.

MERRILL: Yes. Yes. A lot.

SIMEK: Give us an idea of what maybe a typical [glitch] kind of patient might be. What are some interesting patient stories?

MERRILL: Well, one of the unfortunate events was a guy, well, this is back in my first incarnation in John Day, when the ambulance service was conducted by the mortuary. And I would get a call from Carl Driscoll, who owned the mortuary. If he thought it was, an accident call was serious, he would call me and see if I would want to go out with him. So I did quite a few times.

Went out once to see a guy who had fallen down a mine shaft. About a 40-foot hole in the ground. He was halfway down replacing some old rotted timbers and one of them gave way and he fell to the bottom. So I went out there with the ambulance to take care of the situation.

There was one guy with him there, and that guy had raced to the nearest farmhouse, which is three miles or so. Phoned for help and ran back again. So my job was to go down and take care of him and get him out of the mine.

So he had a, I could pretty well tell he had a compression fracture of a vertebra, one of his lower vertebrae. And he had a badly broken. Both bones of one leg. So I put a, well, first I climbed down. The ladder's nailed to these old rotten timbers that he was working on. (laughs) And he and his helper, his helper went down with me. This guy named John. We were down there and Bandy said, "Man, I'm glad to see you, Doc." He told me where it was hurting and I felt around to see what the problem was.

So his helper was, had lowered my medical bag down on a rope. And by that time, there were two other men up above, besides the mortuary fellow. And so I had an air splint with me. I'd usually grab some supplies and bring them with me when I run them down to the mortuary to go out. So I had an air splint to put on his leg. And the Driscoll vehicle had in it an extra stretcher, that was one of those folding ones. If you turn it right side up and unfold it in the middle, it would be a solid stretcher. You could pick

somebody up on it. Metal frame and canvas across it. But it was too long. You couldn't pull it up through that hole without hanging up on the timbers even diagonally.

So, but by turning it upside down and letting it fall, strapping it securely to it, it fixed it sort of like a chair, you know, and stabilized his back on one side and his leg on the other side. And John and I hung for a minute on the rope to test and see if it was strong enough for the two of us.

So then I cut a piece off of that and tied it like a bale diagonally across the stretcher so that you could pick up the center of the rope and lift the ends of the stretcher and tie that to the end of, what was left of the rope.

And I asked the two guys above if they thought they could lift him up. Yeah, they could. So they started pulling him slowly up the, I'm down there and it's starting to get a little shadowy down there, but starting to move up.

When we first got down there, a few pebbles had dropped down from the edge of the hole, so John had taken off his hard hat and put it on my head. And I thanked him and went on.

So when we're partway up, some more pebbles started coming down, or just about to start up. Some more little bigger rocks came down. So he reached over and took the hard hat off and put it back on his own head. (laughs)

So then I didn't say anything about that. Then we went on up inch by inch, you know. And I'm climbing up the ladders and then shift over to the ladder nailed to the adjacent set of timbers, and then back this way. And I'm guiding the stretcher so that it doesn't hang up on things. And the two guys above are lifting it up.

And we finally got up there, and some pushing and pulling and we got him landed no the ground. And I turned around to thank these two guys for lifting him, and I was really scared then because they both just looked like they were about dead. I mean, sweating, their hands raw and bleeding. One was retching and coughing and could hardly move. They had put the last ounce of strength they had into lifting this 170-pound guy 40 feet up. But he made it okay. Got all right. Hauled him into the hospital. And he got well.

I don't think he ever went down that same hole again, but he did go back to some prospecting.

SIMEK: What a story. At some point we need to get into the changes in the sociology, economics and politics.

MERRILL: Okay. Then there's another one or two stories we could throw in if you wanted.

SIMEK: And the sociology has a lot to do, I think, with the doctor/patient relationships, the economics of insurance and Medicare and all of those, and the politics, the Oregon Plan and all that. Why don't I just toss it to you and say go with it, because you've thought about this a lot.

MERRILL: Okay. When I first started in practice, the economics of medicine was confusing to me. Still is. But it was all a one-to-one thing. A doctor could set whatever fees he wanted, charge the patient whatever he wanted. The patient could pay or not pay, or pay whatever he could. And the negotiation about that was always either implicitly or explicitly between the doctor and the patient. And medical insurance was almost nonexistent.

It was somewhere around the time that I started in practice, I think, that the first medical insurance policies came into being. A Blue Cross and Blue Shield program, I think, started with a few doctors in Ohio who were concerned about patients that weren't able to pay their bills, and had no money but needed care. So they set up an insurance program. And that went on for a while and it expanded some. And I think maybe there had been some other trials with that here and there that I wasn't really involved in. But the insurance was not a big part of our payment system at that time.

Medicare came along in 1965, I believe. And it was a well-intentioned and laudable idea to help senior citizens who were retired, unable to work, had little money, needed healthcare. And this would help to do it. And it was intended to be a short of an insurance system, in that it would spread the risk and the cost of healthcare among the population.

The thing that, and to begin with, the payments were made to the patient. One of the things that concerned some of us was that the social security number was going to be used for the Medicare number, as the identifier for Medicare. And it seemed like this was distorting and perverting the purpose of a social security number. And the government bulletins assured us that it will never be used for anything except this medical purpose. Now if you want to go and buy a hot dog, you almost have to give your social security number. It's the universal identifier for everybody, for whatever purpose. But at that time, it was considered kind of sacrosanct and it gradually became something very different.

The other thing was that Medicare at first based its payments on what they called usual and customary charges. Fee schedule. Well I had a fee schedule in that I charged, see, in the beginning, five dollars for an office visit. I think $7.50 for a house call. And the entire charge for obstetrical care, from through the pregnancy, prenatal visits, the delivery and postpartum visit for the mother and baby at two week was all $125. And the hospital had a charge, too, which was, I think, more or less the same as that, or a little less.

And everybody in the town, I set my fees more or less according to everybody in the town of Gilroy. They all charged pretty much the same, and I kind of took the average.

If I felt like charging less to somebody, I knew somebody didn't have much money, instead of charging five dollars for an office visit, I could charge them two dollars and charge everybody else five dollars as before.

When Medicare started, they quickly developed a fee schedule profile for each doctor. This is what this doctor charges for an office visit. For a physical exam, for a tonsillectomy. And if somebody else is charging differently, they would pay that. But if I paid, if I charged somebody $7.50 for a house call, and I charged somebody else only four dollars, because they couldn't pay much, Medicare would find out about that somehow. They had ways of gradually developing the statistics. So they would lower my whole fee schedule profile because I was charging less to some patients. So one could hardly afford to fiddle with the fee schedule like that.

Then the next thing was that some private insurance companies appeared. And pretty soon the insurance payments, a claim would be put in by a patient to the insurance company and the payments from Medicare, particularly, would be paid directly to the doctor. Because that way it ensures that the doctor gets paid. Before that, the patient would take the payment from the insurance and spend it on a new dress or something. And not pay the doctor. So the insurance companies started paying the doctor.

So this had the unintended consequence of completely separating the financial intentions, expectations, responsibilities of both the doctor and patient. They're both dickering now with somebody else's money. So the patient is motivated to use the care freely. And in some cases maybe abuse it. And the doctor is motivated to set a fee schedule that he feels is comfortable for everybody, and is encouraged by the insurance companies to charge higher fees.

I was surprised when I was in Vermont and setting up this little emergency department coverage at Central Vermont Hospital with two other doctors, and we formed a little corporation. And started setting a fee schedule. And I talked to a Blue Cross fellow. And he said, "Oh, charge plenty!" He said, "Don't hesitate to charge enough. It's okay. It will be covered." Because the more we charged, the higher he could put the premiums, you know, justify raising premiums. So it was to the insurance company's advantage to pay the doctors more. And so that whole phenomenon gradually escalated.

And the day came when I suddenly woke up and saw how the terminology had changed. Insurance companies had proliferated. HMOs had come into being. Various experiments on how to do that. And all of a sudden I find that instead of just a doctor, a professional, taking care of my patients, I had become a provider of healthcare. Those people in the waiting room are consumers of healthcare. And they and I are parts of the healthcare industry. And that was a whole new paradigm. A whole new kind of relationship between me and them. And it affected not only our financial dealings

between us, but it affected patterns of practice. Like what can I, what things will the insurance company allow me to do for this patient. What do I have to do to justify ordering a white blood cell count, or an X-ray of the chest, or two days in the hospital. Or how can I justify putting the patient in the hospital the night before their gallbladder surgery and the hospital having to charge an extra night's service, instead of coming in at five o'clock the next morning.

So the whole pattern of relationships, the doctor/patient relationship from the pocket book to the prescription pad to the referrals was all different.

SIMEK: What happened to the healthcare dollar distribution in that time?

MERRILL: Well, at first, you know, I never, never have seen, let alone remember, any real analysis of that. But my own analysis is that the healthcare dollar, when I started, was divided between me, my office nurse, who was also receptionist and bookkeeper, the pharmacist across the street, and the people at the hospital. The receptionist, the shifts of nurses, the janitor, and that was about it.

And now, the healthcare dollar starts with the hospital administrative staff, the insurance clerks, computer, you know, data entry people who keep track of all of the charges and the insurance policies and who has what coverage. And the hospital administrator and, in fact, the hospital management corporation that kind of leads the hospital administrator through the swamp of regulations and so on. The insurance company, the legal system, which is always there hovering around, consulting and ready to answer people's questions and to point out opportunities. The healthcare dollar has just been fragmented so completely now. I can't say where all it goes on a quantitative basis at all. And it depends on--

SIMEK: So the insurance industry's sort of interjected itself in between the patient and the healthcare workers.

MERRILL: Right. Right. The insurance phenomenon, starting with Medicare but now most predominantly the private insurance companies, stands between the doctor and the patient. And the insurance companies are motivated to decrease, the principle of insurance is actuarial spreading of liability among a lot of people. Among all of the people that are involved. But the motivation of the insurance company, its legal obligation to its shareholders, is to minimize costs, which means minimizing paying of claims, which means restricting in any way they can the number and size of claims that they'll be liable for. And increasing the revenue, the profits of the insurance company as much as possible, which means raising premiums.

And then somewhere along the principle of expecting an employer to pay the private healthcare costs for an employee, and even his family, that got added into that. So that more and more of the healthcare liability is squeezed onto the patient and, in some cases, the employer. And the healthcare dollar goes farther and father up the ladder. So I

have to say that I've become cynical and depressed about that aspect of medicine, of healthcare.

SIMEK: What about other aspects of the doctor/patient relationship besides the economic ones?

MERRILL: Well partly connected and partly separate from the insurance thing is litigation. When I first started in practice in 1950, when I first applied for a license in California, the cost of medical malpractice insurance for one year was $125. Over the six years that I was, the eight years that I was there in California, it gradually went up to $375.

I moved to Oregon and the first year I was here, the malpractice insurance premium was $175 per year. And it gradually went up, in eleven years, into the $300 plus range, I don't remember exactly.

And then I moved to Vermont. And the first year in Vermont, the premium was $125. And it went up a little bit in my six years in Vermont.

When I came back to Oregon, to work in the emergency room in Corvallis, I don't remember exactly, but the premium was somewhere between one and two thousand dollars, I think about $1600. But the hospital paid the malpractice coverage for all the ER docs. So I was a private contractor to the hospital, not an employee, but a contractor to the hospital. So they paid for my private, my personal liability coverage.

SIMEK: When you retired, what was your premium?

MERRILL: Well, when I quit in Corvallis and went back into general practice in John Day, the premium was up to $3,000. And there was no way that I, I was trying to cut down the hours, cut out one day a week at the office. So I was trying to reduce my hours in the office, which meant reduce the number of patients. And following the prevailing fee schedule, that the other people were charging. There was no way I could pass on $3,000 charges to the patients to pay for my malpractice coverage and feel comfortable about it. So foolish as it may now seem, for eight years I practiced without any malpractice insurance. And it made me feel a little better about that that the surgeon there was doing the same.

So finally when I, in 1986, I'd been thinking about leaving and going into emergency medicine. And the hospital board was directed by their malpractice liability insurer that they had to require doctors all to carry their own individual malpractice coverage.

So the surgeon started carrying malpractice coverage. And I left and went to the emergency room in the Dalles, where they paid the malpractice coverage.

SIMEK: Did you ever have any claims?

MERRILL: No, I never did.

SIMEK: So you were lucky.

MERRILL: I never did. I read the figures that on the average, a doctor gets a suit against him every ten years. Or every tenth doctor gets a suit every year. But no, I never had a suit. And I have to attribute part of that to good luck and part of it to the fact that studies have been done on the reasons for lawsuits. And one of the biggest one is personality conflicts between the doctor and patient. That a patient that is critical of doctors goes to a new doctor and criticizes his last doctor in presenting himself to the new one, is more likely to sue whoever is there at the time. And a doctor who is critical of the work that the previous doctors have done on this patient, says, "Well, your last doctor screwed up, he didn't diagnose it right, he cut off the wrong part," or something, that doctor is the kind who is more likely to be sued. And if you get those two kinds of people together, the probability of a lawsuit is really high. There was a study in California that was done that brought that to my attention.

SIMEK: I hadn't heard that one.

MERRILL: Many years ago. So I think the main thing is to be open and honest with the patient and let them see that you're not trying to deceive them, that you're trying to help them and you're doing the best you can. And if there are things that you don't know, let them understand that. And look it up. Send them somewhere. So that they know that you're doing the best you can on their behalf. And I think that the motivation for suing a doctor that does that is low.

SIMEK: The expectations of patients have changed over the years, and that has a bearing on it.

MERRILL: Yeah, you hear, not just in medicine, you hear a lot of talk about the hazards of inflation, you know. But the inflation of expectations has been going on for a long time in medicine. And one of the things is that people have been taught to expect perfection. Not just perfection in performance by a doctor, but perfection in outcome.

I've even heard of doctors being sued because they delivered a baby and six years later, when the baby is in school, he turns out to be dyslexic or slow learner or has some kind of problems with learning. And the doctor is blamed for the fact that the baby's brain isn't right because maybe he didn't get enough oxygen during delivery.

So the expectations have been just stretched further and further. And I think that's one of the reasons, I mean, that has to be one of the reasons for the increased threat of lawsuits, and the increased malpractice premiums.

SIMEK: And the willingness of juries to award awards based on non-error.

MERRILL: Large awards. Yeah. Yeah. Yeah. It's reasonable to award somebody if fault is proven. It's reasonable to award a patient coverage for their expenses, their medical expenses, loss of income, whatever. But then to throw huge punitive awards of millions of dollars on top of that implies that the doctor did it on purpose, and therefore should be punished. And I think that's where a lot of the damage has been done.

SIMEK: Where do we go from here in terms of medical care? What do you think is coming? And what are some of the dangers?

MERRILL: That's a really complex problem. And you'd have to approach different parts of the possible futures. Different reasons for why things have gone as bad as they are now. Now this may sound heretical and it may sound foolish, but the technology, the wonderful technology that has developed since I started, I think has social costs that are not recognized. I've had two open heart surgeries. I've had a replacement of an aortic valve fourteen years ago. And last September I had a three-way coronary bypass. Personally, I'm exceedingly grateful for the technology and the skill and facilities that made that possible and extended my life. But from a point of view of society, I'm not sure that it's all that good. That it's an undiluted good.

The changes that have taken place, the emphasis that's been placed on health in advertising. The drum beat of threats about your cholesterol and your erectile dysfunction and your mood changes and your restless legs and dry eyes and all of that that bombards us all the time on the television represents money, anxiety, diversion of attention and resources from things where it could be so much more beneficially put. And I don't know where the end of that is. So if I could go back and vote whether cardiac defibrillators, monitors and resuscitation techniques should be invented, it would be really tempting to vote no, even if it cost me these last 14 years.

I know that sounds like a weird thing to say. But if you look at it one way, we're exactly where we were when I started. That is, the doctor's duty is to do his best for the patient, do everything that can be done for the patient, to help the patient to understand and accept that everything has been done that can be done. Help the family to accept that. And then accept the inevitable. And that's exactly where we are now, except that it comes twelve years and $500,000 later. You know, we've extended life expectancy partly by medical care, not all by that. But the diversion of attention and money into healthcare at the end of life with less and less to gain with each passing month, you know, the life years that have been added to me by my last cardiac surgery was quite a lot less per dollar than my previous cardiac surgery. Which was quite a lot less per dollar than when I had my appendix taken out 60 years ago.

So if you look at it from the societal benefits, then we've got to ask some serious questions. If we look at it from a personal point of view, it's obvious that I wanted to have this done.

But it dawned on me late in life that there are, just by being born, one has a built-in conflict of interests. There are two of me: there's me as myself and there's me as one

of us. And a lot of times, the interests of those two are in serious conflict. We struggle with that a lot of different ways.

SIMEK: Politically as well as economically.

MERRILL: Yeah.

SIMEK: So the politics of medical care, we have so many different ways that we're struggling with this now politically. How do you distribute limited dollars to the healthcare of the majority. We have the Oregon Plan. And your views on the Oregon Plan are what?

MERRILL: Yeah, I think John Kitzhaber had it nailed right on the head when he pointed out that rationing of healthcare is going to happen one way or another. We can either do it in an organized, deliberate, rational, compassionate way, or we can just let the rationing fall by those who can get it, fine, and those who can't, oh well. The people who have too little money to pay for healthcare themselves, but too much income to qualify for public assistance with it, are pretty much stuck. They have to, their only recourse is to go to the emergency room, which is required to give them care immediately, at least. Where they go from there, they fall back into the cracks again. And even the people with money enough to pay can't always find the avenues to get what they want. So the rationing of healthcare has got to happen.

In war for centuries, that's been called triage. You take the people who aren't critically in need of care and tell them to get on down the road and out of the way and wait until we can get to you. You take the people who probably won't survive no matter what you do and you give them some pain medicine, try to make them comfortable, and go away and leave them. And devote your energy to the people in the middle where your services can really do some good. And so when it comes to cosmetic surgery, transplants, lots of back surgery and back care, psychiatric or pseudo-psychiatric care. You know, mental problems, drug problems, there's so much that can find other ways of surviving. But how to distribute the available money among all of these different problems is tricky, and rationing of healthcare is one way to do it.

And the other thing is that I think the insurance industry has taken, has diverted and co-opted so much of the healthcare dollar that that can't be sustained and tolerated, and we've got to find another way. And one of the ways is so-called single payer system, which basically means probably a government-run medicine. And socialized medicine has gotten a really bad ring to the world. And yet we've got a lot of that now, subsidizing all sorts of private entities that provide healthcare. Subsidizing the alternatives. Well, I get tangled up in the thought processes when I get to that point because what's politically feasible, what's socially, let me say not, what's best for the society, best for our big community, is not clear now. And some adjustments need to be made because it's just getting to be worse in some respects all the time. Even as the quality of healthcare, the potential benefits to the sick and injured person, keep improving.

SIMEK: Let's pause here for just a minute. What's our time left on tape?

We have about ten minutes left.

MERRILL: Jumps and bobbles here, but—

If you want me to stop, I'll stop.

SIMEK: Yeah, hang on. I guess [unclear] is going to be about the same way.

Rolling.

SIMEK: Okay. When you consider your entire life to date, has it brought you more happiness? Are you happier now than you were when you were in high school with pumping water and bathing in an old [unclear] can?

MERRILL: No, I often ask myself this question because technology has advanced so much during my lifetime. And so I have to ask myself am I happier now than I was when I was in high school, for instance. When we lived in a house with an outhouse and a pump in the kitchen that you pumped by hand, and hauled drinking water from town in a cream can and took a bath in a tub that we pulled into the kitchen from the back porch once a week or whatever. No, I'm not happier now than I was then. I was happy then. I'm happy now. Would I want to go back to using an outhouse and foregoing the hot and cold running water? No. I like it the way that I have it now. But at that time, I didn't miss it. So the fact that I enjoy it now is a learned thing that is a consequence of, not cause of, the technology.

In other words, there's an old saying that necessity is the mother of invention. But I think it really is the other way around, that invention is the mother of necessity. That everything that's invented eventually becomes a necessity to some people. And that transition to necessity is, of course, accelerated and aggravated greatly by advertising.

SIMEK: So for example we were talking about the invention of the drug is the mother of necessarily having it?

MERRILL: In the matter of drugs, yes, yes. You could apply it there, too. Although that kind of goes both ways. Engineers now are able to take a particular bacteria and fiddle around and find a drug that will probably be lethal or cause that bacterium to be sick. And so they can do that. But things like computers, like television, you know, it's invented. And then uses are found for it. And then people become accustomed to using it in those ways. So the uses become addictions, become necessities. And the same is true in medicine.

So when I look back to when I started in medicine, or even halfway into my medical career, when I'd been in practice for 25 years, well, 20 years, there was no

cardiac monitors, no defibrillators. That was just beginning to be invented. Now it's taken for granted.

But was I unhappy before that because I didn't have them? No. I never yearned for a cardiac monitor, for a defibrillator, because it never occurred to me that it would be possible. So I didn't miss it. So as I said, we're back to the same place we were then. We do what we can and we settle for that and we consider that good enough.

So further inventions just lead us father and farther into now unimagined possibilities which almost certainly will be increasingly costly in various ways. You know, subtle and not economic, not necessarily economic ways. So I'm really uneasy about the unquestioned, unfettered accelerating development of technology of all sorts, medical and otherwise.

SIMEK: And the resulting question, who will pay.

MERRILL: Yes. Yes. And is this cost effective. The only way, a lot of things now are considered cost effective only because the costs are so narrowly defined and everything else is called externalities. You can't worry about the water that you've polluted and the carbon that you have blown into the air and the wreckage that you've left behind where you've dug out the coal or the things because you can't quantitate those in dollars. So you have to eliminate them from the calculation.

SIMEK: One of the most intriguing and far-reaching research projects of recent years has been the genome. How do you see that's going to change the fundamental nature of medicine?

MERRILL: Well, when I first heard the first reports about, even before the genome, the human genome, was completed, there was a lot of genetic engineering going on in other organisms. And my prediction was then, and I say it even more emphatically now, that the genetic engineering capability is a deeper more hazardous disastrous mischief than the splitting of the atom.

SIMEK: With potential for good?

MERRILL: A little bit. A little bit. But the potential for harm, I think, is greater. By that I'm not saying that eating vegetables that have been genetically engineered are going to make me sick. No. But the whole nature of the natural system, the character of the natural life system, has been altered in ways that are totally unpredictable. Of course, it alters itself in unpredictable ways all the time anyway. But we have augmented that in ways that are so easy to imagine as catastrophic.

You can see little examples of it everywhere now. Like up in Canada where my brother lives, they raise a lot of canola. And Monsanto has engineered a strain of canola seeds that's resistant to herbicides, to Round-up. So they call it Round-up ready canola.

So you can plant your field of canola and wait till the plants start coming up a little bit. Spray it with Roundup and it kills all the weeds, so you've got pure canola coming up.

And so, what's the downside of that? And Monsanto patents the process. They have a patent on the seed. When you want to plant Roundup-ready canola, you have to sign a licensing agreement with Monsanto that you will sell the canola for consumption, but you will not save any for next year's seed. You will not sell or give any away to anybody else. It can only be used for making canola oil or something.

And so the farmer next to this big canola operation didn't like the idea. He always saves canola seeds for the next crop. So he plants it. Somebody knocks on his door halfway through the season and says, "You're in violation of Monsanto's requirements. You've got Roundup-ready canola growing in your field."

And he says, "What? I don't, either. I planted my same old canola seed."

"Nope. You've got Roundup-ready canola here."

"How do you know?"

"We took some samples from your field and tested them and they're Monsanto canola."

Whether this was wind that blew pollen across, whether birds dropped a seed or something, his field contained some of it. Now he's in violation. Monsanto sued him. They said, "You have to either sign the license agreement, pay us the fee, or destroy your crop completely."

So he refused. He sued Monsanto, or Monsanto sued him to force that. He counter-sued Monsanto for contaminating his crop because he's got stuff in it now that he didn't want in there that he didn't plant. And Monsanto won the suit.

But the Roundup-ready canola is off and running in the environment, wild and free. And the same thing has happened with other plants. In India, Africa. So the—

SIMEK: And African bees is another example.

MERRILL: Uh, I'm not sure about the African bees. I know they're moving northward. But I don't know if that's directly a genetic engineering problem. But the most--

SIMEK: The hybridization of two bees.

MERRILL: Yeah. That's a natural process. And it may have undesirable consequences, but it does—

SIMEK: It happened at a university.

MERRILL: Pardon?

SIMEK: It happened in a university in South America.

MERRILL: Oh, okay.

SIMEK: It was an intentionally bred—

MERRILL: Okay. I had forgotten that part of it. I did hear that.

SIMEK: But yeah. So—

MERRILL: Like most of the salmon that you buy in the market now is farmed salmon. A lot of it along the British Columbia coast. And a lot of that salmon has been genetically engineered by putting into it a gene from a sea perch from the Atlantic Ocean so that the salmon instead of being anadromous going up to freshwater and coming back and taking four years to grow to adult size, it now grows to this adult size in the pen in 18 months. And then some of those salmon escape into the Fraser River and here and there up and down the coast. What happens when they interbreed with wild salmon. Or the hatchery salmon that have replaced a lot of the wild salmon. Nobody knows. But the possibilities are really totally nauseating to me.

SIMEK: So you look at the human genome project and you say it has the potential to eliminate diabetes, or the potential to eliminate cancers or the potential to adjust this or eliminate that. And those can only be good. But then—

MERRILL: Or we think it may have that potential, but we know for sure that it has the potential of informing the insurance companies which people they should not insure because they are likely to develop diabetes, Parkinson's Disease, etcetera, etcetera.

SIMEK: So the, so anything that relies on the goodwill of human beings is inherently flawed.

MERRILL: Yes. Yes.

SIMEK: So we shouldn't count on it.

MERRILL: There's lots of goodwill in human beings. It's one of their most remarkable and admirable traits. But it's not universal. And it's not only a matter of goodwill. I mean, unintended consequences. You can never do just one thing.

SIMEK: Yeah. The yin and the yang. I remember, too, in studying the constitution, that the framers of the constitution were all too well aware of the potential in human beings for evil or for--

MERRILL: Mischief.

SIMEK: Mischief, untrustworthiness when it comes to power.

MERRILL: Yeah. Or just for error.

SIMEK: And so the requirement of the constitution for separation of powers and checks and balances exactly for that reason. And anytime the potential for error or for mischief is available, such as in the genome, you think that error is likely to come about? Or some error is likely to come about that will be untenable.

MERRILL: Well I think the probability that humans will be cloned is almost 100 percent.

SIMEK: In spite of prohibitions?

MERRILL: Oh, yes. Yes. I mean, I can think of several other things that are or have been prohibited that happened anyway.

SIMEK: There were several things we haven't dealt with yet. And I know that there were going to be more than when we get together later this evening, we're going to say oh, we forgot about this and that. And one of them is, you've known some outstanding characters. In other doctors and politicians and other people in general that you've met through your medical career. And so maybe we'll get to some of the cases toward the end, since they might prove to be the most amusing. But of the other physicians and medical people that you've known, who were some of the most meaningful to you through their positive influence on your or just because of who they were or what they did?

MERRILL: One that comes to mind is Robert [Reif?] Robert Reif was the chief surgical resident when I was in my internship in surgical residency at Santa Clara County Hospital. He was in about his fourth year of residency, so we got to do quite a lot of things. But he was, he was the guru, the mentor and the disciplinarian as needed. And so I think that he influenced, to a large extent, my attitude toward my responsibilities as a doctor.

One time when I was early in my surgery residency, I had off every other evening and every other weekend, every other night. From five o'clock until seven the next morning, I was free to go home to my wife and baby. And every other weekend.

So I'd had a long night in the ER and a hard day in the clinics. And was hanging up my jacket in the dressing room, ready to go home. And Bob Reif was sitting on the couch there and greeted me and we smiled and said hi.

And I said, "I took out two tonsils this morning the way you showed me, two sets of tonsils the way you showed me. And that woman that we looked at earlier this afternoon that we thought might have a bowel obstruction, her pain is gone. She seems to be settling down okay. And I think the bowel, the obstruction, if it was, has resolved itself. So I'm on the way home."

And he said, "That's great, Ted." He said, "Did you get her history and physical written on the chart?"

And I froze in my tracks. I said, "Well, I was in the surgery clinic all afternoon and I figured I'd do that first thing in the morning."

He said, "But Ted, that's not the way it works." He said, "Once you sign up for this job, you know, your responsibility is to the patient and to finish the work before you quit." He said, "You know, Al [Ribici's?] on call tonight, right? So if something happens with her tonight and there's nothing on the chart explaining what's going on, he's going to be in a hard position." And he said, "That's not the way it's supposed to be done."

So I said, "Yup, I guess you're right."

So I put my jacket back on, went upstairs, wrote up the history and physical exam and learned a lesson that stuck with me for better or for worse from then on.

And one day on Thanksgiving Day when my wife had made arrangements for us to go and have Thanksgiving dinner with an old friend of her family who was widowed and was going to cook us a Thanksgiving dinner, I was getting all ready to go. And we were headed out when the phone rang and one of my patients had just gone into labor at the hospital. So there was Bob Reif's ghostly form grinning at me from the corner, you know.

So I had to go and deliver the baby. And while she was delivering, another patient came in in labor. And we eventually went after all, about two-and-a-half hours late. But you pay a price for signing up for this job in that form.

In later years, there was quite a time when I had a partner. And we exchanged calls at night. When we left the office, we'd flip a switch on the phone and all the calls would go either to his home or to my home, depending on whose night it was. But back in those days, I didn't have that. And many other times, I haven't had that. So. Yeah. You pay your nickel and do what you have to do.

SIMEK: Other doctors who have been a particular influence on you?

MERRILL: Oh, yes. I have to think back to my old teachers. Dr. Philip Smith. He was the histology professor at Columbia College of Physicians and Surgeons. And he was kind of gruff and didn't talk very much. And yet when you asked him a question or any problem to him, he had such a sweet, fatherly attitude toward the students, and tried

to do everything he could to help us out and point out our errors in gentle but unmistakable ways. So he's one that I remember fondly.

SIMEK: Any Oregonians?

MERRILL: The doctors that I've worked with in John Day, they've all been memorable. Lee Harris was an interesting doctor. Had some different views on medicine and people and so on. But he did a lot of good work. And he and I worked in the same office or opposite ends of the same office for several years in the '70s. Bill [Stahl?] is one of my colleagues. I worked with him in John Day for eight years, in my second time in John Day. And then I left for the emergency room. And a year later, he left for an emergency room. And about six years after that, we both ended up in the same little clinic, walk-in clinic in Clackamas, doing low, low intensity, non-critical medical care. He's still a good friend. Takes me camping every summer.

SIMEK: How about unusual patients?

MERRILL: Well, unusual incidents. My surgical training and my, and Howard Newton's surgical training didn't include chest surgery. But one day we were in the office in John Day and a station wagon pulled in there. A bed had been rigged in the back, a mattress in there. And there was a man lying on the mattress. He was talking and looking around, but lying quite still. And his friend that came with him lifted up a bandage on the man's chest and there was a hole there with air swishing in and out whenever he took a breath. And he explained that he'd been in a mill, a sawmill, in Long Creek, and he reached into the gears to clean sawdust out of the gears with a stick and a cog caught the stick and drove it back into his chest, put this hole in there.

So it was a small opening, so it looked like something could be taken care of by one person under local anesthesia. So Howard Newton went up to the hospital in Prairie City with him, and I went back to work in the office. And about 45 minutes later, I got a call. "Dr. Newton needs you up in surgery right now."

So I made that 13 miles in 11 minutes and got into the surgery there. And everything was okay. He had the patient on the operating table and anesthesia screen up there. But he didn't need a general anesthesia. You know, put in some Lidocaine around the wound and cleaned up the edges and was getting ready to repair it, and he saw that the clavicle had been fractured and a little piece of the clavicle had been pushed backwards. Still joined to the sternum.

He reached in and pulled that piece of bone up forward where it belonged. And all of a sudden, the whole wound filled up with blood. And he put his finger up there, under there, where the bone had been pressing. Pressed on that and the blood, the gushing, stopped. Suctioned out the blood and got it all cleaned out and tried to see in there. But it was on the back side of the sternum where you couldn't see.

So he tried to, he moved his finger a little bit and all of a sudden whoosh, there's the blood again. So that's when I got called.

At that time, and when I got there, he had his finger on that spot. And he explained to me what was going on. At that time, our blood bank, we didn't have a blood bank in the hospital. We had no storage facilities or source for stored blood. But our blood bank was a card file with names of people who had agreed to serve as donors in emergency situations. So we had maybe 30 or 40 names in this file with their blood types on them.

So we had the lab techs started calling in, or the nurse start calling in [glitch] and the lab tech cross-matching blood. And first one that laid down to give blood was the nurse anesthetist. Because anesthesia wasn't being used, so she turned that over to another nurse. She was the right blood type so she went and laid down and gave a pint of blood. And then, by that time, the patient's family had arrived. So the patient's mother-in-law, I think, was the second one to give blood. And they just kept coming. There was a forest supervisor and a schoolteacher. And people just kept coming in. He got seven pints of blood while he was on the table there.

We finally managed by feeling and blind clamping there to get that blood vessel clamped. The clavicle had torn off the internal mammary artery right where it goes down behind the sternum from the subclavian. And it's a vessel about the size of a matchstick. So we got that tied off. Things cleaned out.

While we're doing this, I looked over the screen, the anesthesia screen now and said, "How are you doing, Cory?"

He said, "Pretty good, Doc."

So we went on working. Pretty soon, Cory's voice, "How you doing, Doc?"

"Pretty good, Cory."

So we finally got it under control. And then we were getting ready to close it up and see this little drip, drip, drip of kind of a milky fluid from the upper edge of the wound. The thoracic duct. Carries all the lymph fluid from your entire body. Your legs, abdomen. Left arm. Most of your torso. And dumps it into the left subclavian vein, right there behind the clavicle. And this thoracic duct, just a real flimsy little tube, size of a toothpick, had been ripped off. And it was just dripping there. And we didn't know what to do about that.

So I had seen the thoracic duct in the anatomy lab in school, you know, many years before. But had never had occasion to see it since then. So I kept watch on that and slurping up that fluid while Howard went to the phone and talked to a surgeon in Portland that he knew, Marvin [Lacey?], I think it was, and asked him what to do about this. you

know, should we tie it off? Should we try to bring it to the outside and let it drain? Should we try to attach it back to the subclavian vein, which obviously would be impossible.

He said, "Tie it off. It will be fine."

So we did that. It was fine.About a month Cory still had his clavicle fracture, which was getting better. And another month, he was back to work at the mill.

But that was the state of our emergency blood supply at that time was what salvaged the situation.

SIMEK: My goodness. That brought back to mind when my dad said that he had rheumatic fever as a kid. And he said he's got some Irish in him. And I said, "Dad, you're Czech."

And he said yeah, but when he had rheumatic fever, it was an Irish fireman who laid down on the table next to him and gave him blood. (Merrill laughs) Vein to vein. And that, I guess that's what they did in the '30s.

MERRILL: Yeah. Yeah.

SIMEK: How about the other quick draw expert?

MERRILL: Oh, yeah. There was a fellow who was in his upper teens, I think 18 or 19, from over in Long Creek came in one day. Had a gunshot wound of his leg. And it went in the outer side of his leg about a third of the way down his calf and came out near the ankle. First he wouldn't tell me how he did it, you know, it's just an accident. But he finally confessed he was practicing fast draw and the gun went off before it got out of the holster.

And this bullet hit the peroneal nerve where it goes around the fibula, the outer side there. That's the nerve that controls the muscles that pick your toes up, that lift your foot up when you take a step. So he had foot drop that never went away. He ended up with kind of having to lift his foot higher and kind of flip it or make a flapping movement to take a step.

About five or six years later, the same guy came in again. And he had a gunshot in his leg again. It wasn't too far from the first one.

And I said, "Were you practicing the fast draw again?"

"Oh, no," he said, "I know better than that now. I was climbing through a fence and the gun went off."

Okay. I'll accept, I have to accept what he's telling me, because it doesn't change the treatment any. But that was a guy that had a hard time learning a lesson.

SIMEK: Any others ring a bell? (laughs) Or fire a shot, as the case may be.

MERRILL: Well I was a medical examiner for a while. One day I was called down to the Little Max Motel. Early one morning there had been three guys in there. They were hunters. They were coming over for pheasant season. And when I got there, one of them was lying on the floor with a big hole in his chest. And his brother, he and his brother had gotten in an argument. His brother got so upset that he just had to shoot him. I can't remember what the argument was about now. But I could never understand the rationale of that. But he had a full charge of birdshot into his chest and almost out the back. At close range.

SIMEK: So he was finished.

MERRILL: Oh, he was dead, yes. Went right through the center of his chest and took out big blood vessels and part of his heart.

SIMEK: Wow. What kind of advice would you give to people who are contemporary patients now. It can be anything. I mean, in terms of what they see on television, or how they relate to their doctor? What's the best way for patients to get the maximum value out of their medical experience?

MERRILL: Well I guess if they can find it, and they probably can, find a doctor to whom they can feel free to ask questions, and who will be available to answer questions, and who they feel is open and honest in answering their concerns. And then take their concerns to him or her and do the best you can from there. Rather than be guided by television advertising.

SIMEK: So it's back to the doctor/patient relationship.

MERRILL: Then there's a point where you have to, where the patient has to decide for him or herself what steps to take about lifestyle. Smoking, drinking, sleep, food, vitamins, whatever. And if you want to, and exercise. So you have to take some of the blame if things are not going well in those areas.

SIMEK: Expectations?

MERRILL: Well, people have been led to expectations that are way beyond reality sometimes. And everything responds differently, you know. Patients vary so much in their outlook, their world views and their perspective on life and their relations with each other and with other people, you know. You've just got to keep adjusting to that. But seek what help you think you need where you think you can find it and hope for the best.

SIMEK: Last question. What advice would you give to young people today considering a career in medicine?

MERRILL: I've struggled with that question quite a bit. In the past, I've been an eager recruiter of people to medicine. When I was involved with what became the Academy of Family Practice, I've talked to students and residents about that, you know, and encouraged them. I think that I still prefer for myself, and would urge them to consider, at least, family practice, which is not general practice as completely as it used to be, but still is a broad gauge approach to the healthcare problem. Because to me, that's where the enjoyment has been. The psychic feedback from that, psychic payback from that, has been a big part of the rewards from doctoring. You know, I could never make enough money in general practice to justify doing it just for that.

Now it's a little harder to know what to tell people. But the, a trusting relationship between a doctor and a patient, you know, is probably still the core of the healthcare system. It has to be the core of the healthcare system. And anatomy, physiology, haven't changed at all since I started. Disease has changed only a little. HIV wasn't around when I was starting. In fact, the only disease that we tested blood for when I worked in the blood bank as a medical student was syphilis. That was the only blood transmitted disease that was of any frequency at all.

But you know, a lot of things have not changed. And interaction between people is still there to be had. And the best way you can find to have it. And that's where healthcare starts. And it's fun. And if you don't enjoy the preparation for it, you won't enjoy the thing itself

I've had people say, "Oh, you've put in all these years of hard work. You deserve to put your name in lights over your door, put MD on your license plate, show the rewards of your labor."

But that's not the way I see it. The labor was fun just like the labor still is fun. And if I didn't enjoy medical school, I wouldn't be doing what I did the rest of my life.

SIMEK: Thank you.

MERRILL: Thank you.

You know where the end slate is?

SIMEK: Hang on. This interview with Dr. Ted Merrill was recorded on June 12, 2006, at the Geiser Grand Hotel in Baker City, Oregon. This interview was made possible by a grant from the Oregon Medical Education Foundation. Matt Simek was the interviewer. And this is the end of tape four of four, and the conclusion of a very interesting day. Thank you.

MERRILL: It has been. Thank you.

[End Interview.]