HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Roy Payne

Interview conducted November 21, 2006

by

Matthew E. Simek

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[Begin Track One.]

?: I am actually rolling if you want to head slate this.

SIMEK: Sure. This is an interview with Dr. Roy Payne. And today's the twentyfirst of November, 2006. Keep wanting to say 19. This interview is at the OMA on Corbett Avenue, still at the Corbett Avenue address. And let's see, made possible by a grant from the Oregon Medical Education Foundation. And Matt Simek is the interviewer, and very pleased to be here with you.

PAYNE: Yeah.

SIMEK: We start off, as we typically do, we start off a little bit with your history. And tell me a bit about your history. Where you were born, and your early days, and what it was like in pre-war.

PAYNE: I was born in Portland, Oregon. And did grade school and high school here. Uncle Sam paid my way around for several years after high school. I didn't find anyplace I liked any better than Portland, so I came back here and did my pre-med at University of Portland. And then medical school at the University of Oregon Medical School.

SIMEK: Was there a sudden defining moment when you realized you wanted to be a doctor, or did it come on slowly?

PAYNE: No, this was just grade school. Somewhere along in grade school, I decided I wanted to be a doctor. And that was my focus from there on out. I knew it in grade school, high school. Knew it in the army and told my buddies that I was headed for medical school. Came back to Portland, did my college, and then medical school, and then residency at Providence Hospital in Portland.

SIMEK: Tell me about your folks.

PAYNE: Well, my father was a physician. He graduated from University of Minnesota in mining engineering. He bought a whole lot of mining stock that wasn't any good. After I got married, I got my mother's stack of mining stock, and none of it was worth a damn. But then he went to medical school. Now at that time, he was married and had a child, which was extraordinarily unique for that period of time. Most of the medical students were not even married.

After he finished his medical school, he went to Los Angeles and had one year internship, which made him a specialist. He then came up to Portland, joined a large firm and acted as their radiologist. Eventually the firm broke up, as they had a tendency to do. Surgeons' egos got in the way of cooperation, and that broke up. Dad decided to go with one group, but went into private practice and practiced independently for the rest of his life.

SIMEK: Now what period was that?

PAYNE: Well, that was 1917 when he came back and wanted into the group. And then I can't tell you exactly when the group broke up, but by the time I was old enough to know what was going on, he was in private practice.

SIMEK: In 1917 or, well, you weren't born until later. But your first observations of being a doctor, what did being a doctor mean to you based on the experience of your father?

PAYNE: Well, one thing was that he was pretty much in charge of what he did. He was independent in how he practiced. He didn't have, he wasn't complaining about his boss because he was the boss. And he did house calls. He did hospital calls. He was greatly respected wherever he went. And really, I think, enjoyed what he was doing. So that sounded good to me.

SIMEK: Good role model.

PAYNE: Yep.

SIMEK: So was he, like so many doctors complain about, was he always gone? Was he the absentee father because he had given his life to medicine? Or was he, did he have a-

PAYNE: Well, I didn't see him as much as my friends saw their father, I know that. But on the other hand, he was never distant from me. We always got along well. So I never had a feeling that I was, I loved my father and I loved what he did, and I loved to be with him.

SIMEK: Did you get to know any of his patients?

PAYNE: A few. Occasionally on his house calls he'd take me in with him, and talk to his patients and come out. And I knew some of them because I'd go up to the office and sit around waiting for him to go home, or waiting till my mom came and got me, or things like that. So I had some exposure, but not a lot.

SIMEK: And their regard for him.

PAYNE: Oh, yeah.

SIMEK: This was the, I suppose, fairly early days of radiology.

PAYNE: Yes, it was. He had the wildest machine you ever saw. It was, he had taken over from a chiropractor. His office was, he had taken over the office from the chiropractor. The chiropractor had the actual machine. And it had sparks and gaps and made loud noises. And it was a monster that zipped and zapped. And you really respected that thing.

Actually, after he died, my mother asked around if anybody wanted it, and nobody wanted it. It was junk. By the time he died, it was just no longer a functioning unit, and it was junked.

SIMEK: A museum, perhaps.

PAYNE: Yeah, well, maybe, yeah, I suppose.

SIMEK: What it would be like to have one of those now. So this was, I assume, a fairly high dosage radiation.

PAYNE: Mm hmm.

SIMEK: Did he use it often? And, if so, was there any kind of negative effect on him?

PAYNE: Well, he died relatively young. He was fifty-five. These changes that show up with the X-ray overexposure and other physicians I'm acquainted with usually happen later, in their seventies, by that time. I'm sure my father would have had trouble. He used the gloves, the appropriate gloves. But I'm sure it would have showed up eventually if he lived long enough. Cause it was a lot of exposure on their old fluoroscopy machines.

SIMEK: I remember reading one doctor on the coast who assisted another doctor who used radiation, X-rays, quite a bit. And his hands were already so burned that he couldn't do it anymore, so this other doctor was his assistant.

PAYNE: Yeah. Well, we had that in Oregon City. We had a physician who burned his hands. When I was an extern in medical school, fourth year student, I went out to Oregon City Hospital to work. And they had me taking X-rays. And the first X-ray I took, I walked in there and I said, "Where are the gloves?"

And they said, "What gloves?"

And I said, "Lead gloves."

They said, "Oh, we don't use those." Of course, that's the same doctor that years later showed up with his hands badly burned, and cancerous growths on his hands. They didn't use them. I did. They had the gloves for me the next time I was there, and I never would touch them without it. But in those days, they thought that was a wussy thing to do, try to wear lead gloves. Got in your way of feeling what you were doing.

SIMEK: [laughs] Okay. What were you saying about your father being a specialist?

PAYNE: Yeah, because he had an extra year of training beyond medical school, which was quite unique. So he was grandfathered into the specialty of radiology, and grandfathered into the specialty of internal medicine.

SIMEK: Because he had four years instead of three?

PAYNE: He had five instead of four.

SIMEK: Five instead of four. So he was practicing then, about the time you were born, his practicing was getting pretty close to the Depression.

PAYNE: Oh, yes.

SIMEK: So how did he fare through the Depression?

PAYNE: Well we did really very well when I look back at it. We were never hungry. He had a car that ran. And was able to pay his life insurance premiums. We were not wealthy, but he did all right. And a certain amount of practice was in the Italian community. And we always had three types of wine available from his patients. One of them was the top notch stuff, and that was table wine. Another one was cooking wine. That wasn't as good, but it cooked just fine. And the third one, of course, they opened up and left for vinegar. We always had all three of those available.

SIMEK: In thinking back on life in Portland, in pre-war Portland, what comes to mind in terms of what was really different then from what it is, or what it was, post-war or today?

PAYNE: Well, I think that we were not confined as much. Currently Portland is trying to keep from spread. And they're trying to infill all these communities with housing in the spare lots. Well at that, my early days, when I went to school, grade school in the morning, I think we passed twelve houses in six blocks that I walked. And of course now, it is just absolutely, totally filled in. And I think that this crowding thing is just a natural growth of a community that's filling in. I don't think there's anything exceptional about it.

SIMEK: Any idea what the population was when you were born?

PAYNE: Forty million.

SIMEK: And it's four times that now, roughly. You mentioned something about the government sent you around all over. What was that about?

PAYNE: Oh, it was two years in the army. I was trained as a draftsman and sent into Philippines and Japan. But I read aerial photography for a couple of years. That's all.

SIMEK: Anything exciting?

PAYNE: No. The only thing exciting about it was years later, when I went down to check on some property in Louisiana, the folks gave us the runaround. We were checking on a piece of property down there and the clerk at the county handed me a map and said, "There's where the property is, and there's no streets on it."

I said, "No, that's not the property. You handed me a bad map. Give me the right one."

He says, "Okay," and he pulls out the aerial photography. And here's the property we were looking for that had a street on both sides. That came in handy then, but not much otherwise.

SIMEK: So you had no medical connection in the army.

PAYNE: Not the slightest. Nope.

SIMEK: And of course that would have been between wars.

PAYNE: Fortunately.

SIMEK: So when was that? You would have been-

PAYNE: '46 to '48.

SIMEK: So between World War Two and Korea.

PAYNE: Yep.

SIMEK: So then you finished at U of O Medical School.

PAYNE: Yeah.

SIMEK: And this was just a general pre medicine.

PAYNE: Yeah. This was a regular school. At that time it was a little different than it is now. They were sort of graduating puppy dogs and Boy Scouts: loyal, truthful, caring, and so on and so forth. And they were not focusing on research and research monies at that time. It was a kinder, gentler arrangement. And we had eight hundred apply when I got in, and eighty-five of us were taken. Now there are several thousand applicants for the hundred that they take in, or hundred and twenty, whatever it is this year.

SIMEK: Your course of study was what?

PAYNE: Just general medicine. The specialties came later. But everybody went through the general medicine. We had a few electives, but generally speaking it was across the board. Whole curriculum's changed now. I have no idea what they're running now, but it has been totally upgraded twice, at least, since I graduated.

SIMEK: The faculty at the school at the time.

PAYNE: Yeah, most of the people giving us lectures when I went through were volunteers who had a practice downtown. Came up to the medical school to volunteer their time to teach. Give lectures and so on and so forth. The heads of the department were probably more often than not full time employees. But most of the lecturers and the teachers were volunteers from downtown. That's totally changed. And it was starting to evolve soon after I got out of medical school.

SIMEK: And that would have been in the late '50s.

PAYNE: '53, '55.

SIMEK: Oh, okay.

PAYNE: I graduated in '55.

SIMEK: And then you had your residency.

PAYNE: Then I had my residency in Providence Portland. Internal medicine.

SIMEK: What was Providence like at the time?

PAYNE: Well, it's kind of interesting because eventually they upgraded it or expanded it, whatever you want. But it was built in about '41. And I think they were building it for war, because they had walls on them that were twelve inches thick cement. Because when they went to go building, they had to tear those walls out. And it was just a godawful racket, tearing that hospital apart to put additions and what not. But it has totally taken over the whole area, whereas initially it had just been the hospital and power plant and parking lot.

SIMEK: Change in the, reflecting a change in the medical care.

PAYNE: You bet.

SIMEK: Who were some of the key figures in Providence when you were there?

PAYNE: Oh, Dr. Osgoode was a hematologist, and an outstanding national personality. And we had lots of wonderful doctors. Dr. Hans Haney is an internist. And just a lot of real nice people practicing.

SIMEK: Was Tom Miller there then?

PAYNE: Tom came after. Tom came later.

SIMEK: Well it seemed to me he started practicing around the mid '50s, also. But then he didn't go to there till then. Now so you were in residency, and then you broke out onto your own.

PAYNE: 1959. Went into private practice by myself. Stayed in private practice by myself for seven years before I took a partner.

SIMEK: What was it like being a sole practitioner?

PAYNE: Night and day. Night and day. And of course, I was not very clever about this, because I went out to Oregon City to do some practice. I read electrocardiograms in Oregon City. And so every night I ran out there. And I lived in Northeast Portland at that time, and had patients in Providence, and consults in Oregon City. So that meant starting out in the morning going to Providence. And then going to the office, and then going to Oregon City, and then coming back to Providence, and then going home.

SIMEK: It's tempting to ask; how did this affect your family life? Did you have a family at that point?

PAYNE: Oh, yeah. Yeah. Well, they survived. We're getting along just fine.

SIMEK: Now this was your beautiful roommate Anna?

PAYNE: We're doing all right. Nothing broke up over it. But we did move closer to the hospital. Well, actually I moved closer to my office. And we tried to cut down and make it better wherever we could.

Now, see, I didn't play golf. Since I didn't play golf, all that time was devoted to Anna, you see. So there's a trade off on this sort of thing, you go along.

SIMEK: What was it that made you decide to give up your solo practice?

PAYNE: Fatigue. Night and day. And if I were to leave town, I had to have a doctor that took care of the EKGs in Oregon City, and a doctor that took care of my

office in Milwaukie, and a doctor that took care of my patients in the hospital. And usually I was behind on doing my charts, so usually I had to spend the whole night before I left getting caught up with charts so I'd have admitting privileges. So it was just a huge effort to get out of it at all.

SIMEK: So after seven years-

PAYNE: Either get a partner or quit. Do something else.

SIMEK: And?

PAYNE: Got a partner.

SIMEK: Who was?

PAYNE: Bill McCarthy.

SIMEK: What was he like? And how did you find him?

PAYNE: Good point. One of the residents, I was educational director for three years after I got out of my training.

SIMEK: At Providence.

PAYNE: Huh?

SIMEK: At Providence.

PAYNE: And one of the residents, one of the doctors that went through, I tried to recruit for my practice. And he said, "No, I won't come, but my partner in medical school is about ready to go into practice." So he sent him. And we got along just fine and took off. So he sent me his classmate from medical school.

SIMEK: Now he was also just, not just, he was internal medicine, also?

PAYNE: Yeah. Mm hmm. Yeah.

SIMEK: So a family practitioner, internal medicine. And did he develop any specialties or particular interests?

PAYNE: Well, he did have one at the time. He did some isotope studies for Portland Adventist Hospital for a couple of years until an Adventist came along that could replace him. But he did do that for a while, especially the study of the thyroid gland. SIMEK: Now that was one of a couple of different particular interests. I think you were telling me that another one was an outgrowth of the Korean War.

PAYNE: Yeah. One of the physicians at Providence had served during the Korean War. He's a urologist. And he had done the kidney dialysis during the Korean War. And when he came back, he set up to do dialysis at Providence. And he needed an internist to help him with it. He did the surgery parts, and I did the internal medicine part on dialysis.

And I did quite a few of those for the next few years. And then eventually they trained a nephrologist to come along and replace docs like me. And that made good sense, because they were much better trained. They knew the things that were available. And I was through doing dialysis.

However, I kept involved because we had a Kidney Association of Oregon. And I was on their board. And then we did a selection process, because these were all home dialysis. And we did a selection process to get the patients who were best suited for home dialysis, that could accomplish it at home. And so we did that for a few years.

Eventually Medicare took over on paying for dialysis. And once that occurred, there was no selection process. Because they could do in hospital dialysis with payment from Medicare. So we didn't have to stretch every dollar as far as we could. In-home cost

sixteen thousand dollars, but took a lot of work for the patients. In-center dialysis cost thirty-five or forty, but was a lot less work for the patients and their families.

SIMEK: Now any idea what the equivalent of that would be today?

PAYNE: No, I'm sorry. I don't have any idea now.

SIMEK: That was a lot of money then.

PAYNE: Yeah. Oh, it was a whole lot of money. Yeah.

SIMEK: And did we say who that doctor was?

PAYNE: Which one?

SIMEK: Who was doing, the urologist?

PAYNE: Oh, that was Dr. Charles (Katlow?)

SIMEK: And he had experience in Korea?

PAYNE: Yeah, he did the dialysis in Korea. He used a more primitive dialysis machine called a cough kidney that was soon replaced by a different system at Providence. A lot simpler system.

SIMEK: Seems to me, I remember (Harold Lafruit?) talking about when he was a public health officer in Korea, and about the problems with hemorrhagic fever.

PAYNE: That's it. Kidneys shut down. The red cells were disrupted, and the hemoglobin and contents of the red cells shut down the kidneys.

SIMEK: Was this a viral disease?

PAYNE: I can't tell you. I'm sorry. I don't know that.

SIMEK: Let's see. Now you had to make some choices about who got the kidney and who didn't. I mean, who got the–

PAYNE: Dialysis.

SIMEK: -dialysis and who didn't. And a lot of people think that you become inured to death or to morbidity. How did you feel when you had to turn somebody down?

PAYNE: Well usually we were in a position to really objectively observe what was going on. And to objectively know whether these patients could handle the problem, or the project, or the work, whatever you want to call it. So it was not a terribly difficult decision to make in most cases. Sure there were some that were very difficult. But basically, most of them, you could either do the job or not. And that helped, that helps because it wasn't a matter of comparing things that are equal. It was trying to find things that were, trying to separate things out that were not equal.

SIMEK: It's not like later on with the Oregon Health Plan to try to decide who got an organ and who didn't.

PAYNE: No, this was financial. I agree. But this was whether or not this technique was appropriate for this individual. And was not the same kind of thing as whether you could pay for the transplant or not, or pay for the bone marrow transplant or whatever.

SIMEK: Now even today, dialysis is not a permanent solution.

PAYNE: No, no, no, no, no. Now, the only, the best solution is kidney transplant. And those came in while I was doing dialysis. And I think the first successful ones were probably the medical school. I don't remember exactly. I know that they took over the transplant program and ran it for years. Some of the other hospitals wanted to have their physicians doing transplants as well. And I think they do now. But when the kidneys

were very, very scarce – well, they're still scarce now – but when the initial program began, why it was down at the medical school. And they had done considerable research on preventing rejection. So they were right up there with the leaders.

SIMEK: And that was the real key, wasn't it? Rejection.

PAYNE: Oh, yes. Preventing rejection was the huge key. The mechanics, the mechanical part of transplantation had been well resolved. But the rejection was a big problem. They could put the kidney in, but if the body rejected it, it would die. It didn't do any good.

SIMEK: I remember hearing about that in my early years, when they were trying to do the same thing with the first heart transplants. How to prevent the rejection.

PAYNE: Absolutely. Same story. Same story. Yeah. But medical school and the VA, I think, were both very actively involved with learning how to prevent rejection.

SIMEK: At what point did nephrology become a specialty? You mentioned that that has been-

PAYNE: Well, that would be, I think, somewhere around, probably around 1968, somewhere in there. I can't tell you exactly because I didn't take the necessary training to

become a nephrologist. I was going on my practice with (Katlow?) during my residency and immediately after. But I did not take the necessary training to be a nephrologist.

SIMEK: So did you continue on with Bill McCarthy?

PAYNE: Yes. I retired first, and now he's retired. The practice built up to five physicians, and has been maintained at about that level since. Five or six.

[End Track One. Begin Track Two.]

SIMEK: But you developed another specialty, as it were, early on. What was that?

PAYNE: Geriatrician. Now we didn't know what a geriatrician was, because that word has never been invented before. But when I first went into practice, the (LaVue?) Manor administration came down and said did I want to be the doctor for this retirement home. Well, this retirement home was a brand new phenomenon. It started in 1955. It was '59 when they came down and talked to me. But it was started in '55. And it was the first in the nation of high rise retirement homes. The Methodist Church initially started investing in this, and then they backed out. And the people who were developing it went to the builders, what's the word I want, not the architects but the contractors. The administration went to the contractors and said, "Why don't you dig our basement, and we'll sell this thing."

So the contractor came out, put a hundred thousand of his own money into digging the basement for this retirement home, and they immediately oversold it by 100 percent. It was a success from day one. And as soon as they finished one building, they went to the next, because it had already been sold.

But they needed someone interested in taking care of old people. And it sounded pretty good to me. Now we didn't know what Alzheimer's was. That was a word that was invented long afterwards. We didn't know what senility was. We didn't know why these people were so confused when they got old. And there's a whole lot of other information that we just didn't have when I went into practice.

But it developed over the years like all the rest of the specialties. More and more information became available. They developed words like "Alzheimer's." They developed techniques for replacing hips and knees, and all sort of heart transplants, not transplants, because we didn't do any of those. But all sorts of heart surgeries. Cataract surgeries that have become routine, standard, are developed over the years. It's been very interesting work in geriatric. A lot of interesting things have happened.

SIMEK: Any conditions that were just a mystery to you? That just confounded you and frustrated you?

PAYNE: Well, let's go back to my dad's day. He felt very bad about sitting beside a patient's bed and watching him die from pernicious anemia. They had absolutely no idea– well, that's not true. They had no way of combating pernicious anemia. And during his practice, they found Vitamin B12. And by the time I got to practice, you gave the patients a shot of B12 once a month and they didn't have pernicious anemia. Nobody died from it. Didn't even get anemia anymore, because Vitamin B12 took care of it.

And of course there's been a lot of those things that developed over the years. The cataract surgery, as I said. The people who first off lost their lenses and had to wear the big bull's eye glasses. And then eventually the business of taking the lens out and putting in a plastic one to take its place. And the joy of being able to read that was lost to your cataracts. So that's one example. It goes on from there.

Medicines. Starting out when I was starting out with diuretics, mercurial diuretics that were not very effective. We used them, but they weren't very effective. Then along came a medicine called hydrochlorothiazide. And it diuresed them. And it's gone on from there ever since, with stronger and stronger medicines that take care of heart failure. Irregularities. Pacemakers. For a while there, we didn't have a cardiologist come out to Milwaukie Hospital, which was called Dwyer at that time. So Bill and I wound up being the pacemaker implanters. And we put pacemakers in for a few years until the cardiologists decided maybe they did want to come out and take care of our patients. So we very readily gave up the pacemaker placement.

But all of these advances, it's just been unbelievable the advances that have occurred over the years.

SIMEK: Doctors don't carry a black bag anymore.

PAYNE: Actually, I did, because I needed to have the necessary tools to look in the eyes, ears, nose and throat and that sort of thing. But it's only a little one. This big, instead of this big. We had a doctor come up to us in medical school and talk to us about black bags. And he brought his bag up there. He was a family practitioner. And he brought this thing up and started unloading it. He had a full surgery setup. He could do appendicitis on the kitchen table, which he did occasionally from out of his black bag. Mine got down to the point where we had a hammer to test reflexes and some to look in ears, nose and throat and take a blood pressure, and that was about it.

SIMEK: That brings up an interesting question. What about in, when you were first practicing medicine, did you have any experience with rural medicine versus urban?

PAYNE: Well, no. Not really. I pretty much stuck to urban practice throughout. The hospitals in Oregon City, the first time I, there are two of them. One of them was a Hutcheson hospital. And the first time one of the doctors asked me to see a patient there, I went out there. And they had to have help getting a patient from the second floor down to the first. So I helped carry the stretcher, and we took the patient down the steps. The reason I was there is because I was tall and could hold the bottom up level, and the guy

(we had him?) drop his, and we could carry him down the stairs. That hospital closed fairly soon after I went in to practice. But we did have some of that type of thing going on.

The Oregon City Hospital was a unique small hospital. It had been run throughout the Depression. The lady that ran it was a doctor's wife, and she kept that hospital going all through the Depression. I think they got paid in a lot of chickens and corn and vegetables, but she kept it going. Pretty amazing. Anyway, that's a kind of urban practice, not rural, really.

SIMEK: It just occurred to me that somebody in rural practice maybe had to have not just a large bag but a suitcase, maybe a trailer or something, to be prepared.

PAYNE: Well, they didn't have that. They just didn't have those tools. They didn't take X-ray machines with them. They took what they could carry, and it was in one or two black bags and that's it. If you didn't have it there, you didn't have it. But on the other hand, they sure weren't doing open heart surgery, either. They didn't take gall bladders out; they drained them. That sort of thing.

SIMEK: I hadn't heard of that. Well, but that brings up an interesting, what are some of the techniques that have changed so much just in your career?

PAYNE: Probably the big items are progress in managing blood pressure, and heart failure, and surgical interventions. I don't do surgical interventions and never did. But having them available to my patients has made a tremendous difference. The ability to have someone who can take care of abdominal crises. And vascular surgeries. All of these things have become available since I went in practice. Open heart surgery. Coronary bypass. It goes on and on and on. The ability to care for these patients has just spread out and out.

The decision on life processes near the end is a huge problem. Because we have all of these wonderful things. And we can put an airway in and keep them breathing, whether their head tells them to breathe or not. We can put pacemakers in, the heart can keep going whether it's strong enough to pump blood or not. We can keep it running. The decisions that come up at the end of life have been altered dramatically. Instead of saying, "Yes, Mary's dying of pneumonia and it will be over in two days," we can put them in the hospital, pump them full of antibiotics, put a tube down their throat to breathe, do everything for them, and make them live a lot longer. Maybe not better. But all of these things have come about.

When I first went in practice, we did not have intensive care units. And we had to develop, these came out of Minnesota, I believe, the first ones. And we had to develop code cards. Now it's a big business. But in those days, we had to make our own. And we had to decide what medicines were going into our code cards, and what numbers we

called out over the PA system, and who went when we called it, and what the techniques were to help.

Did this at Providence, and worked with this as a resident, and then in practice. Then one time I was out in Oregon City and had a code occur. A patient died. And I threw her on the floor and was doing chest compressions and breathing for her. And I collected the whole hall full of people, watching what this crazy doctor was doing to this lady. She was dead and here I was, pushing on her chest and breathing for her. Totally new concept to take to the rural hospital. Obviously, she died.

But on the other hand, then we had a cart start being placed out there. And we built special rooms at Providence. And eventually special rooms were set aside in Oregon City and the Willamette Falls Hospital. And these things spread out and progressively developed.

SIMEK: Well, I was thinking about that as you were talking about the geriatrician part of your practice. And how with the cardiac interventions and the orthopedics, you can replace almost every joint there is now.

PAYNE: Right.

SIMEK: And all these things. Is it just extending the life of people in these facilities? Or is it actually improving the quality of their lives?

PAYNE: Well, the first place is that if you break your hip, it's terribly painful. And you want to do something that stabilizes the hip so it won't hurt. The old days, you put a patient into a cast. And they died in the cast. They couldn't move. They couldn't exercise. There was just no way. They formed clots in their legs and they died of pulmonary emboli.

Once you could start putting pins across the fracture to hold it still, then you could start moving the leg, you could get them out of bed and you could get them active again. So it relieved pain, and it helped in rehabilitation and getting them back up and going again. So this was a, if nothing else, was a comfort measure to do this kind of surgery. And war wounds for the individuals involved with trauma, of course, you had to learn to pin and stabilize those injuries. But in the geriatric system, there's just all sorts of comfort measures that maybe involve very refined techniques.

A lot of patients developed valvular heart disease early on in the practice, before rheumatic fever was pretty well taken care of by antibiotics. Antibiotics didn't treat rheumatic fever. It treated the infection that caused the rheumatic fever. And so pretty much rheumatic fever went away. But there are still a lot of bad hearts out there, and a lot of patients that were disabled due to their heart failure, that could be helped with surgery or with the medicines that developed over time.

High blood pressure became a treatable thing. I first went into practice and the reserpine that we used probably caused near as much trouble as it did help. But we were very limited on what we had for high blood pressure. And now you can control almost anybody's blood pressure with medicine. There are things available to do it. Multiple choices. And if they can't take one, they can take another. I took one blood pressure medicine that made me cough. Quit that one, take another one, you know.

SIMEK: So the technology, and certainly the pharmacology, have both changed enormously.

PAYNE: Oh! Just fantastic!

SIMEK: But now I'm wondering, going back to once again what you were talking about in the difference between your internal medicine practice and your geriatrician practice, what were the differences and the challenges in doctor/patient relationships in each of those? They were, I would imagine, quite different.

PAYNE: Well, one of the things was that in the geriatric patient in the office, particularly, they took more time in order to talk to them so you'd understand. Typically we were trained that there's one patient and one disease and one treatment. And you don't mess with the rest. You don't worry about anything else. That's your patient, that's his disease, and that's the treatment for it. And then we get into geriatrics, and there's a patient, he's got twelve problems, and you've got all of those twelve problems to address without intermixing them and making them worse with your treatment instead of better. Because what helps one makes the other worse, and so forth. So there's a whole different perspective in caring for the geriatric patient from the pediatric patient. With one disease and one treatment sort of thing.

A major, major shift along those lines as you get up in age. I think that, I think that trying to deal with Medicare now is, doesn't recognize that. I think that the insurances and what not, Medicare, Medicaid, look at the complex patient as something with simple answers. And it just doesn't work that way. It makes it much more difficult. Much more time consuming. Those of us that went into geriatrics found that we had to spend more time with our patients, because they had more problems and more treatments that you had to integrate. So it's one of the drawbacks of the practice, because you can't turn them out as fast. It just takes longer.

SIMEK: And then, of course, it takes longer to do the paperwork.

PAYNE: Well, that's a given for everybody. Pediatricians have the same problem that the geriatricians have with paperwork. It's all a new world in the paperwork.

SIMEK: Who were some of the people you admired most in the medical community in Oregon?

PAYNE: Well, of course, Howard Lewis. He was something special. He was the head of the medicine department at the medical school. And he was our teacher in physical exam and other medicine at the medical school while I was there. And he was just an outstanding person. Now he had gone into private practice in Hood River or someplace like that, and switched to the medical school. And at the medical school, he had a lot more time to talk to patients and loved to do it and did a wonderful job. I'm not sure that Hod could do as well out in the boonies where he didn't have so much time, but he was a wonderful physician.

And then for the guy who takes care of office patients, Hans Haney was one of the outstanding physicians. He ran the outpatient department at the medical school when I was a volunteer up there. And he was a wonderful guy.

We had wonderful surgeons. I never knew any of them real close. Anytime I was in surgery, I was on the outside, holding a retractor. They didn't do much with the internal medicine guys. These are some of the people. Osgoode, the hematologist, was outstanding. And of course, oh, gosh, I can't think of his name right this minute, right off the top. Public health doctor.

SIMEK: (Harold Ostrude?)

PAYNE: Hmm?

SIMEK: Ostrude.

PAYNE: Ostrude came later. Ostrude was wonderful, but this was a guy that was ahead of Ostrude, and I can't remember his name right this minute. But he was wonderful. He taught us what whooping cough sounded like. And he stood up in front of the class and he coughed until he turned blue. Then he goes [gasps air in] takes a breath in.

Well, that was stuck in my head. And when I got out into practice, I spent one month covering another doctor who took a vacation while I set my office up. And I did a locum tenens, taking care of his practice. And I was sitting in there, talking with the nurse, and I heard this cough out in the office. And this kid coughed and coughed and coughed and coughed and coughed. And I thought, that's whooping cough! And he coughed and coughed and then [gasps air in] got this big breath in, then sure enough, there is a small sect, religious sect, outside of Oregon City that refuses to get vaccinations. So these kids get whooping cough. And doctor's lecture stuck right there. Boy, he showed us what it was, and that's what it was. Yeah. He was outstanding. Sorry I can't haul his name up right this minute.

SIMEK: That's all right. What a great story. Were you ever tempted by things like surgery or other specialties?

PAYNE: Well, doing the dialysis was a lot of fun. That was a specialty which I was very soon replaced, but it was a lot of fun while I was doing it. And geriatrics, I enjoyed. I enjoyed taking care of these people. They were very grateful for what I did for them. I didn't need other things, particularly. As I say, we put in pacemakers for a few years until the cardiologists came out and took over. That was kind of fun to do that. But I wasn't tempted to compete with the cardiologist once they decided they'd come out and see our patients again.

SIMEK: And you didn't have to have your patients asleep before you could get along with them.

PAYNE: Yeah. [laughter]

SIMEK: Well, let's switch gears a little bit now and just go to your political career. When did you become an activist?

PAYNE: 1965.

SIMEK: What happened?

PAYNE: Well, I debated this guy, I can't remember his name, but I debated this guy on Medicare. He was all for Medicare, and I was against it. I was on the side of the American Medical Association. And we had this community debate someplace out in Oregon City, in a community hall of some sort. And I thought I did a pretty good job. I had my arguments, my ducks in a row, and I thought I really did a pretty good job with this.

Then I read about it the next day in the paper. And he already had his publicity release, or his informational release, that he handed to the reporter that was there. And it just cut me to ribbons. Now he quoted me as saying things that I didn't say, because he'd already written it when he got there. He didn't need to have, he just was quoting some of the arguments against Medicare, whether I said them or not. So he just beat the daylights out of me in the newspaper, which was a very educational thing.

About that time, they invited me to be a member of the legislative committee at the medical society. So I was involved there. Then Ann and I both got involved with, oh, I think Mark Hatfield's run for Senate. When he was governor. I think that was probably the first one that we got involved with.

I did the unit, what's the term, I can't remember the term. It was an elected position as a committeeman. And then I was on a central committee for Clackamas County, and then I was chairman of the Central Committee for Clackamas County. Republican Central Committee of Clackamas County. Then we were involved in various other campaigns. Anna was involved, interestingly enough, our son went out on strike at the high school, which really upset us a great deal. That's no way to win friends and influence people. So she got involved with a friend, and they taught this one group of kids how to pass a bond issue with door to door canvassing and the whole schmear. And she taught these kids along with her friend. And they won the next bond issue that came through. She was, when I was chairman of Central Committee, she was my organizer. And so she helped me with that.

SIMEK: You had one son?

PAYNE: I have two sons and two daughters.

SIMEK: So on the legislative committee of the medical association, what was your first real challenge that you recall?

PAYNE: Well, we did a lot of work. We read a lot of bills and we argued a lot about what we should do, and so forth. The big challenge that I ran into while I was involved was the rapidly increasing premiums for medical liability. It got to be so bad that we would be losing doctors if we didn't do something about it.

So we put a big campaign on in 1975. We worked very hard with the legislature that year. I was the president of the medical society. And we did get a number of important things through. We did not get a limit on awards, which is what we wanted. But we did get a lot of other things. The definition of informed consent, several other issues that we did get through all right. Definition of death, so that there wouldn't be a question about harvesting organs. Not the suicide thing. This was, how do you know a patient's dead? And we got that through the legislature.

SIMEK: It's interesting to hear that. I remember one person who was an expert in the history of science said that you can trace the evolution of human progress by their ability to measure smaller and smaller amounts. So it seems like sort of the same way. At some point, that definition of various key events, you'd say, "That person's dead. That person's alive." But at some point, it has to be more refined than that.

PAYNE: That's right.

[End Track Two. Begin Track Three.]

PAYNE: -find ways to define it. And they have to be put into law because this is not the practice of medicine. This is the practice of citizenship. So if the medical school, the transplant doctors at the medical school came to me and said, "We need a definition of a death." And so we sat down with several other states' definitions and worked out a definition that we took to the legislature and got passed. Tom (Coony?) and I worked on it. SIMEK: I want to come back to that. In terms of definition of death for the purpose of harvesting organs and looking at the history of medicine, the definition of brain death, is that the same thing? And that determines–

PAYNE: Mm hmm. You can define it by cessation of cardiac activity or brain function. Either one will define death. How you word that works out. Our definition eventually we came to a point where there was a consensus meeting throughout the country, and they came up with a definition very close to the one we had passed. We took maybe two or three words to change ours, to fit with the consensus decision.

SIMEK: Again, Oregon is the leader.

PAYNE: Well, actually, we were like number three along the line. There were a couple others ahead of us.

?: Okay. We're at the one hour mark.

SIMEK: Okay. Do you want to pause here?

?: Well, yeah.

SIMEK: How did your situation work out? Did you postpone your-

[End Track Three. Begin Track Four.]

?: Dr. Payne, how's your last name spelled?

PAYNE: P-a-y-n-e.

?: P-a-y [pause]

SIMEK: I'm going to take off my sweater. This is an interview with Dr. Roy Payne on the twenty-first of November at the Oregon Medical Association, 2006, at the old building in Portland. And the interview is made possible by a grant from the Oregon Medical Association Foundation. This is tape two of two. And the interviewer is Matt Simek. And did I forget anything?

?: No.

SIMEK: But it's much more cool without my sweater on. All right. We had some things that we wanted to get back to. And one of them was, let's see, where did it go, in the 1960s, I forget how he was involved with this. Refresh my memory about Drake Willock.

PAYNE: Okay. One of the things I had intended to bring up when we were talking about dialysis was that in order to accomplish the dialysis away from the hospital,

there had to be special machines created. And Dr. Drake and the engineer Willock developed a home dialysis system that had bells and whistles that warned of potential and impending difficulties. Pressures and leaking tubes and whatever they could establish for warnings for the patients taking care of themselves in their home. And these machines went through an evolution. And eventually Drake and Willock sold out to one of the large pharmacies, pharmaceuticals.

But anyway, for a number of years, Oregon was unique in having this home dialysis system that was developed here and was very successful, and was a pattern for others throughout the country. And we were able to have these patients do this at home and manage it themselves.

SIMEK: It sort of raises my curiosity about the number of times doctors and engineers form teams. I remember when we were interviewing Al Starr–

PAYNE: Yes.

SIMEK: -that his-

PAYNE: Starr-Edwards.

SIMEK: –engineer Edwards was the one who really designed and built the valve. And Starr was the one who implanted them. PAYNE: Right.

SIMEK: So that combination is very intriguing to me, how engineering marvels and-

PAYNE: Well, it takes a certain give and take in order to do that. Being a physician talking to an engineer is difficult, because you have two different basic languages that you have to meld some way so you can be mutually on the same subject, having the same knowledge. And it's quite a feat. I don't think there's a whole lot of these things that are this way.

Now there's a whole lot of instrumentation that the physicians develop with engineers to use. The catheters that are used to study the heart valves, and the catheters are used to study the circulation of the heart, and so forth, always have to be processed through both the implanter, the one who's using them, and the engineer who creates the necessary tools to make them. And so there's always this collaboration one way or another. But I think the Drake Willock and the Starr-Edwards are outstanding examples of it rather than totally unique.

SIMEK: And the pacemaker.

PAYNE: Pacemaker, well there's your engineer doing his electrical thing, and the doctor implanting it and using it.

SIMEK: And now the pacemaker defibrillator-

PAYNE: Oh, yes.

SIMEK: –which I guess was an unheard of thing. In fact, it's amazing to me how many places you now see public use defibrillators. And that that's something that an ordinary person can use is just astounding when you consider where it came from not very long ago.

PAYNE: Not very long ago. My experience was the gentleman across the street who had a heart attack. And the daughter came down and got me and we went tearing up to his house and started the necessary chest compressions and breathing for him. Ambulance came and put him in the ambulance and we did chest compressions and breathing down to the hospital, and got him in the emergency room. And hit him with his defibrillator and he came out of it. He was a little dinghy for a while because he'd had some cerebral anoxia, but he wound up okay. Went back to business and did his thing.

And the next time he did it, my wife was available. So she went tearing up, and she beat on his chest a little bit. And the paramedics came, and by that time they had a portable defibrillator. So they defibrillated him right there and took him to the hospital. About that time, his insurance company figures probably he needs to be studied. So they did pay for him to have his heart circulation studied, and did the necessary surgery to relieve his obstructions. And he's gotten along for a long time after that. He eventually died. He was in good shape for a couple of years, anyway.

SIMEK: I sort of think from the other side of this, if there is another side, thinking about Mother Nature, seeing all the progress being made and say, "What am I going to use now? They've taken away this tool, they've taken away pneumonia, they've taken away fibrillation? What am I going to use to end people's lives?"

PAYNE: You sort of get the feeling that there is a time when there are multiple system failures. The head doesn't work because you're demented. You're deaf. You can't breathe because you smoked. Your heart's barely getting by. And your kidneys are just barely getting by with the diuretics you're taking. Somewhere along the line you're going to trip, and that's it, because the whole stack of problems falls down on you. Just multiple organ system failure. And it's going to happen no matter what you do. We haven't figured out how to get out of this alive yet. Probably won't.

SIMEK: Yeah. Is MOSF a standard term? Multiple Organ System Failure?

PAYNE: Yes. I've never abbreviated it, but yes, it's multiple organ system failure.

SIMEK: Well, there were some other things that you have been talking about that I was curious about. And one of them was the idea of the nursing homes. That's not exactly, I thought it was a fairly old thing, but apparently not.

PAYNE: Well, there were homes for the aged. And they were either religious organizations or fraternal organizations, or government installations, such as our home for the poor. Or private, where we warehoused people that were no longer able to live independently and be at home. And they were not associated, particularly, with medical care. They were places where these people lived and died, but the doctor didn't go see them there very often, or ever, sometimes. And it was hard to get to the doctor's office, so they just didn't get much care.

Medicare came along, and they knew about these places where people were stored. And in their wisdom decided that those would be a good place to send patients that no longer needed acute hospital, but couldn't go home. So long term care eventually evolved. There have been many terms for it along the line, besides long term care. There's assisted living, oh, all sorts of things. I won't get involved in that. But anyway, acute care graduated to nursing home care. And then the rules were developed that everybody had to fit into. And so the private warehousing had to improve to a point where they would qualify to get federal funds. And the religious organizations sometimes had to reduce their level of care to survive. Get enough money to survive as an institution, because they liked to treat them as if they were in the general hospital and

they weren't, they were in a lesser level of care. And then the fraternal organizations fitting into this, too.

But these skilled nursing homes then it were by Medicare defined by a care outlet to be paid for by Medicare. That's gone through a lot of evolution over the years. Initially if you had a heart attack, you got ninety days in the nursing home. And if you had a broken hip, you got ninety days. If you had pneumonia, you had thirty days. Well, that's all gone now. They have a whole different system of evaluating. I had a broken hip and I wound up in the nursing home for, I think, eight days of convalescent, and then went home. Whereas when it first came in, why, I might have gotten ninety days of nursing home care. But that's an evolutionary process, where they limit access to save money. And it works.

But they required that a physician be involved with a patient. And so this created a whole new definition of physician services. And it was an administrative position, so you were paid for your time by the nursing home, not by the patients. And this was medical director for a long term care. That came in about, let's see, Medicare came in in '65, and that came in around '70, where these nursing homes were required to have a physician's service on administrative level. And so I was involved with that for a number of nursing homes.

SIMEK: This is going back quite a bit farther than that. There was some point where the idea of a hospital struck terror into the hearts of anybody who had to go, because it was a place to die.

PAYNE: That was true when I went into practice. That was true in 1950whatever, during my residency and when I first went into practice. I had this problem with the patients in the retirement home that I talked about, LaVue Manor, convincing them to go into the hospital, because that's where patients die. During my residency, I had a patient come into the, go to the medical ward with a heart attack. He was thirty-five years old. The wife said, "I'm going to go downtown now. I've got him in the hospital. I'm going to go downtown now."

I said, "Well, this is a heart attack. You have to worry about this a little bit. He might die from this."

And she says, "Oh, okay," and took off.

And of course, two hours later he sits up in bed and he dies. This is before we had these intensive care units. Before we had our code system set up. And here's this guy, thirty-five years old, dying of his heart attack. Just, boom. That's changed. And there's a whole different system available now, with all sorts of support system. And that has changed over the years. And they were afraid to go in, because that was where they died. Now we have the same problem, because patients don't want to go in nursing homes, because that's where patients die. They don't mind going to the hospital. They've got Medicare, and most of it's paid for. But they don't want to go to the nursing home, because that's where patients die.

SIMEK: And they figure they'll come home from the hospital.

PAYNE: Right. Yeah. They're going to come home. They've got intensive care units and all sorts of goodies in the hospital that are going to send them home. Big change.

SIMEK: How do you see the change continuing on? Where do you think medicine's going to be in so many years hence?

PAYNE: I don't know the answer to that. I have no clairvoyance whatsoever. I know that they are going to continue with scientific advances. The typical thing is a replacement for blood. They're going to find a way to replace blood so that it can be stored. And right now, it's still toxic. They're using a form of hemoglobin now in the battlefields. And there's some bad side effects with it. So it's still an open subject. But they will learn how to have a substitute for acute blood loss. There's a whole lot to be learned about viruses and how to control them, keep them from changing over and over and over again to new viruses. Learn how to block them. There's a whole lot of things

involved with aging that are going to be worked on as we go along. So there's lots of opportunities out there still.

SIMEK: Later in your career, you saw the advent of the human genome project.

PAYNE: Yes. It didn't mean a thing to me. No, it really didn't. I suppose it should have. Multiple members of my family died of hereditary disease. My mother, my brother and my sister all died of a hereditary disease. So the genome study should have been very important to me, but unfortunately it was sort of what's going to be in the future, and not something that I was involved with. But you're certainly right. That's going to change a whole lot.

And of course, the stem cell changes that will be brought about when they know what they're doing with it. Right now, I don't think they know very much about what's going to happen with it when they have an opportunity to study it.

SIMEK: In relating some of these things you've been talking about, for example, the definition of death, and the genome, and various advances, it certainly seems to bring up ethical questions about the nature of human life and what it means, and at what point is it time to let it go, and what point not? And stem cells, it seems like we're getting far into the religious aspects and away from–

PAYNE: I think the religious aspect is a political issue, not a medical one. I don't think medicine is involved with the concepts of stem cells and artificial insemination. I don't mean insemination, but I think that it is a religio-political phenomena that's really not available to research or study. It's emotions and doctrine and things like that are not really the bailiwick of the practicing physician.

SIMEK: I imagine it's difficult for many physicians to deal with belief versus science.

PAYNE: It's been amazing. It doesn't seem to bother them. Doesn't seem to bother the friends of mine that have been affected by this. I can't tell you why, I don't know why, but it seems that they can work this out very well in their own mind, and get along with it just fine.

SIMEK: I wonder how it would be if they confront that in a medical environment. For example, if they're treating somebody who is a Christian Scientist who refuses care. Then I wonder if it would change their views or if they would have a different view of it than when they practice in their own lives. But this is speculation on my part.

PAYNE: Well, it is speculation and we do run into it. I think that Jehovah's Witnesses refusing blood fits in with this very well.

SIMEK: Would they refuse artificial blood, do you think?

PAYNE: Yeah.

SIMEK: Oh, even that.

PAYNE: Oh, I don't know about that. Cancel what I just said. I don't know. I think maybe they'd accept that. Right now it's all tied up with trying to use artificial blood without patient consent because it's necessary in an emergency.

SIMEK: To save their life.

PAYNE: To save their life. It's all involved, and I have no intention of getting involved in that discussion. But they might be willing to accept it. But there are surgeons who are willing to accept them for open heart surgery without using blood. They draw their own blood down, and give them back their own blood later.

SIMEK: And they're okay with that.

PAYNE: They are.

SIMEK: A while ago you talked about the changing demographic of physicians. And I'd like you to expand on that a little bit more. How has the changing demographic changed the nature of the physician as a (?)

PAYNE: I think that one thing about the demographic changes is that the specific information involved with patients is divided more and more and more. So that there are many more pieces to put together. Instead of one patient, well, one god, one patient and one doctor, there are multiple members of the team addressing any one individual, or one disease. Instead of one doctor running the whole show, there are two or three or four individuals. Some of them physicians, some of them extenders, some of them technicians. All involved with caring for this individual as a team.

And I think that the big difference that I see is that medical care will be a team practice rather than an individual practice. If you look at open heart surgery, if you look at transplant surgery, all of these things where, not like the brain, where you only have one guy in there or two guys in there. These transplants are taking one here out and putting one here in. and there's a whole team of people working to do this. And I see this in the care of patients with heart disease and gastrointestinal disease and the whole ball of wax.

SIMEK: Has subspecialization become a necessity or a problem?

PAYNE: Well, everything has its good side and its bad side. Every time that you move one step up, something else goes down a step. It's a balancing act all the way along the line. You need to advance, you need to improve, you need to expand. But it always has its own complications and its own problems. And I think that becoming super specialized you learn more and more about less and less until you know absolutely everything about nothing. And so it is a problem. But you can't progress without it. You can't go up the next step without essentially bumping into somebody.

SIMEK: So the more that you specialize, the more that it demands that you have good teamwork with others, and a good overlap. Do you think that there's adequate attention being paid to inter-physician communication in that regard?

PAYNE: Oh, sure. Sure. Is it successful all the time? No. No. in my own practice, I occasionally ran into a surgeon who wanted to run the diabetic control on my patient that he was operating on. And so we do run into this. And sometimes there has to be confrontations. And Doc, you're not with it, let me take over on the diabetes. But that's rare. That's not often.

Most of the time, the surgeons are glad to have an internist helping with the medical problems. They don't want them butting in on the surgery. They will take them, glad to have help on the medical problems.

SIMEK: Now you're one of those rare doctors who's never been sued. And it seems like more and more in the litigious society, people are willing to skewer their physician. And I'm curious about the attempts of limiting non-economic damages, and how that might have changed the practice of medicine. Obviously it only passed once, but then it was overturned. And how that might have changed the practice of medicine in Oregon.

PAYNE: I don't think that the limitation on non-economic loss changed a whole lot of practice. I think that it changed the law that you practiced under. But I don't think it changed much on how you practice. I don't think that, the example I'm thinking of is there hasn't been a huge increase in litigation cases since the protection was lost. It's just that the awards have gone through the roof. So I don't think there's a whole lot more cases coming in, but I think the cost of each case has gone right straight up, because of the loss of the protection that it provided.

SIMEK: And with it, the insurance premiums.

PAYNE: The insurance premiums, that's right.

SIMEK: Is it your belief or your feeling, your knowledge, that there are very few doctors that generate the vast majority of the cases?

PAYNE: Oh, no, no, no, no, no, no. When we review applications for joining our insurance program, we very, very seldom see a doctor with more than two cases. And sometimes there's reason for that. Sometimes, well, I won't get into all the different manifestations of that. It is not common to have a doctor with a lot of cases. They stand out. They're like a sore thumb. And they're very, they're very prominent problems that you're dealing with when you get one with a lot of cases. There are a number of doctors with one. A lot less with one. A lot less with two. And very few with three, four, or more.

We got one instance where we had doctors disagreeing with each other down in Southern Oregon. And each one would tell the patient that came from the other one that the other doctor did a lousy job and they ought to sue him. So we had these two conflicting doctors damning each other. Well guess what that did to their liability cases? Both of them, of course, went straight through the ceiling, because they were each one telling the other one to sue them. Bad situation. But that can happen. It just isn't very often. They're unique cases when you run into that.

Then you have occasional bad doctors, there's no question. And the bad doctor can run up a whole bunch of cases before you can get him out of practice. But that's really, really rare.

SIMEK: I remember the lines from some of the training materials that said there wouldn't be awards if there weren't injured patients.

PAYNE: Mm hmm. Oh, yeah, there's no question about that. That's a definition of malpractice is that there is an injury, and the injury was caused by the doctor. Those two things satisfy the definition of malpractice. And certainly there's malpractice. There's no question about it. But as I say, it's widely distributed. The ones that we have are quite widely distributed between doctors with one or maybe two cases. But very few that stand out due to the multiplicity of their–

[End Track Four. Begin Track Five.]

SIMEK: Is the way doctors are practicing changing due to the changing nature, I think you said that there was one graduate, one female graduate in your class of '85, and now there's more than 50 percent.

PAYNE: Right.

SIMEK: What effect is that having?

PAYNE: I don't know, but my old office now has two ladies practicing among the five or six doctors, whichever it is now. The division of labor has changed quite a bit with the increasing enrollment of women in the medical school classes. And they handle things, sometimes, differently, because they're willing to share a practice between two of them, so that they're half time doctors. I don't remember seeing a male sharing a practice with anybody on a 50/50 basis. I just don't remember it. It may have happened, but I have seen it with the women since. So there's that kind of change the way women practice.

I think that, from what little I have seen, the practice has changed through less intense dedication to the practice. It used to be there was more tendency to be a member of a group where your shoulders sunk from the heavy burdens of night call and weekend calls and that sort of thing. So there's more tendency to have more time off.

SIMEK: Has the idea of care extenders been a temporary fix? Or do you think it's an effective major component of the medical healthcare system now?

PAYNE: Well, it is a major component that will probably get larger because of the partnership or the teamwork necessary to care for patients. My daughter's a nurse, and she is now becoming a nurse specialist, and will be involved with the care and training of nursing in oncology. And will eventually have her PhD in her nurse specialty. So as a member of the team, it's an extender that will be very well trained and will participate in patient care and in the education of other nurses.

SIMEK: I talked to a number of people who I happen to know who are critical care nurses. And they very often, it seems, have advice for the attending physician–

PAYNE: No question.

SIMEK: -that supercedes. And they have a better solution.

PAYNE: Yeah. Well, that's happened since I was an intern. I had nurses telling me what to do when I was off base as an intern. So that hasn't changed since then. That's the same thing.

SIMEK: But you see the same thing in that. You see subspecialization. There was the physician assistant and the nurse practitioner. Now the nurse anesthetist, and the critical care nurse. And this specialty and that specialty.

PAYNE: Yes, indeed.

SIMEK: And that seems to be growing.

PAYNE: Growing. But again, it's a teamwork. It's a team message that we're talking about. A lot of the doctors now are no longer taking care of their hospital patients. They send them in and the hospitalist takes over on them. And the intensive care doc takes (?) if they're in the intensive care. And the teamwork pattern keeps on going. It dilutes the patient empathy and sympathy and understanding and all of that, but it also increases the availability of the physician and the specialty knowledge that he has over being an intensive care doc or a hospitalist.

SIMEK: On the patient side, do you think that the increasing awareness of patients about medical issues has changed the way that healthcare is delivered?

PAYNE: Sure. Sure. But it's probably, I think it's overrated. I think that the ability of the patient to be involved with his own care has increased significantly over the years. But I think the number of arguments regarding this activity on the patient's part is not as strong as it's made out to be. I think that the doctor still sends the patient to the hospital. I don't care whether the patient runs around asking how much it would cost to take appendix out so that they can choose their hospital based on cost. Because when their belly hurts, they don't give a rat's tail on how much it costs. They want to get that belly taken care of, and they're going to go to where their doctor goes. So I don't think that there's that kind of involvement with a patient is as broad as some people think. But on the other hand, it certainly is more.

I'm going to go around and see where I can buy the medicines cheaper than where I'm buying them now, see what I can find. And I think that other people shop as well, instead of going to the local pharmacy because he's a nice guy and he gives me free coffee and we talk about our kids. Which is the way I used to do it.

SIMEK: As an insider, to what do you attribute the extraordinarily escalating cost of medical care?

PAYNE: Very simply that the cost of medical care depends on service. The machinery is improved, and with improvement costs more. There is no raw material that is free to balance out the service cost. And service costs are going up at 12 percent per year, whereas raw materials are going up 3 percent. And we're comparing the cost of living, which included iron and coal and raw material development against a service industry. And a service industry costs more money. It increases faster than the general cost of living. So that you have to pay for increasing cost of service.

Minimum wage. You don't get fifty cents an hour anymore. When I went in practice, the guys that swept the hospital got fifty cents an hour. You ain't going to pay anybody fifty cents an hour to sweep your hospital. It's \$8.50 now, or ten. And all of the services that you're buying have gone up much more than the cost of production of materials. So we're comparing the two things.

And the other thing that's gone up the same way is education. Education is also a service industry, and it's done the same thing as medical practice. It's gone up the same way. Twenty percent here and fifteen percent there. It's done the same thing, because it's a service industry, as opposed to taking raw materials and putting out a product.

SIMEK: I hadn't thought about it that way. Last question. If your son came to you, or your daughter came to you, and for all I know, maybe they have, and said, "I'm thinking about being a doctor, Dad." What would you tell them?

PAYNE: Well, I told my son that he's going to have to work a lot harder than he anticipated in order to be a doctor. And he kind of pooh poohed me, and he went to college, and he found out that he wasn't hitting the grades that were necessary to be eligible to go into medicine.

So he went to another school, he got his grades up a little bit. He went back to his first school, and he graduated. But not with the grades sufficient to get into medical school.

My daughter didn't bring this up until after she was a nurse, and decided she wanted to go to medical school. But by that time, she was too old. They wouldn't even accept her application.

My youngest son was not the slightest bit interested. He's in a rock band and he's a technician, a dental technician. And he's not at all interested. And my youngest child, my second daughter, was not at all interested.

But my second child, the daughter, is a nurse, that is, as I said, into her Ph.D. as a nurse specialist. And her husband's a nurse.

SIMEK: I wonder if it's going to get to the point where somebody says, "Well, I was going to be a doctor but I couldn't make enough money so I became a software specialist."

PAYNE: Well, that's a good point, because there is a concerted effort to reduce a doctor's income by a certain number of people. We did a tour in Europe and some of the Communist countries have the physicians paid two hundred dollars a month, or three hundred dollars a month. And the national income is two hundred and fifty, three hundred dollars a month. So they're at the national income. But they get ducks and chickens, and they get a bribe every time somebody comes in to see them. They pay them a little bit extra for the extra effort they have put into becoming a physician. So they pay more for the doctor than they do the teacher or the butcher, baker.

SIMEK: It seems that the way a person is paid has always been a reflection of how much in demand they are. And if somebody's working on my body, I would want to think I could get the very best possible, which would be indicated by how much I'm having to pay him. And so I'm not sure I'd want to take the lowest bidder, when it comes to a doctor.

PAYNE: That is one way of looking at it. On the other hand, there are other issues that are involved with this. I haven't seen much of it, but there's a new TV program that's *Three Pounds*. And it's a neurosurgeon. And he is an absolute jerk. He insults his patients and the whole thing. But he's a genius with his fingers. And he's balanced by a nice young doctor who's also a neurosurgeon who's coming in to balance the tension out. But if I don't like the guy, I don't care how good he is. And if I like him, he may not have to be the very best, if I can trust him and like him even if he may not

have been the head of his class. They don't all have to be the head of the class to be good docs.

SIMEK: So there's a lot of value in the doctor/patient relationship.

PAYNE: Oh, yes, still. It's being eroded, but it's still a lot of value in it. When I went to school, we had a smaller school. We didn't have all of the big research facilities to pay for. And the docs sort of thought they were turning out doctors that were puppy dogs and Boy Scouts, you know. Truthful, loyal, and all of those things. Now they're up there with all the research facilities paying for the medical school through the efforts of the staff. And it's a little different attitude with publish or perish, even with the medical students, more or less. But that's all right.

SIMEK: Well I know we could talk for hours more. I'm just wondering if there are any key events we missed. Anything you'd like to talk about.

PAYNE: I don't think of anything. I wasn't sitting around thinking about what I was going to say today until you brought this up an hour ago, or two hours ago, whatever it is now. So I don't have anything hanging in the back there.

SIMEK: Well, I've enjoyed it thoroughly.

PAYNE: Good. I'm glad.

SIMEK: And wish we had an opportunity to do this more often. [laughter]

PAYNE: Well, this is kind of fun. As I say, I didn't have to spend any time preparing for it.

SIMEK: Yeah. Thank you, Dr. Roy Paine. It's the twenty-first of November in 2006 at the Oregon Medical Association, courtesy of the Oregon Medical Education Foundation. Matt Simek is your host and interviewer. Thank you, Roy.

PAYNE: You bet you.

?: End of interview, end of tape two.

SIMEK: End of interview, end of tape two.

[End Interview.]