Oral History Interview of
Ted Hartman

Interviewed by: Laurie Lawson
June 26, 1997
Lubbock, Texas

Part of the:
Healthcare Interviews

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Transcript Overview:

This interview features Ted Hartman as he discusses the medical field and how it has changed over the time that he was a medical professional. In this interview, Hartman recounts briefly his time spent in service during World War II, then moves on to discuss his medical profession and the Texas Tech Health Sciences Center.

Length of Interview: 02:16:45

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Lubbock Texas, Healthcare, Texas Tech, Nursing

Laurie Lawson (LL):
This is Laurie Lawson interviewing Dr. Ted Hartman for the Southwest Collection in Lubbock, Texas on June 26, 1997. [Pause in recording] I'm not mechanically inclined at all. Okay. Dr. Hartman, if you don't mind, I think the best place for us to start would be to ask you to give us your name, full name, when and where you were born, and maybe a little bit of biographical information.

Ted Hartman (TH):
Okay. My name is James Theodore Hartman. I was born on June 13, 1925, in De Ridder, D-e-capital R-i-d-d-e-r, Louisiana, and we lived there until I was ten years old and we moved to Iowa, where my father accepted a position on the faculty at Iowa State University in Ames. And we grew up, I grew up, in Ames, Iowa, and graduated from high school in 1943. Was able—I started university that summer, but was called into the service after six months of university and was sent to Camp Roberts, California, where we had basic training in field artillery.

LL:
What branch?

TH:
In field artillery.

LL:
Okay. Okay. I'm sorry.

TH:
Of the army. Excuse me. I'm sorry. Yeah. Field artillery of the army. And then, because I had taken an examination, in which—I guess it was something like an IQ examination, but a lot of us in high school took that. A lot of us, seniors, in high school took that examination and you expressed an interest in either the navy or the army, if you got sufficient grades. Well I had expressed an interest in the army, so after basic science, I was sent to University of Oregon for three months and was supposed to have been there nine months, but toward the end of three months, we were told that the army needed us back in the army, so to speak, and was—all of us there were then taken to, by train, to Camp Cook, California, where we joined the 11th Armored Division. The 11th Armored Division was tanks and I was assigned to a tank company and gradually became a driver of the tank of the platoon sergeant. After training there for some six months, we were sent to England. Went over in a big convoy. Stop me anytime you don't want to hear all this.

LL:
That's fine. No, that's wonderful.

TH:
And we were—went to Southwest England to prepare our—our new tanks came and we went to Southwest England to prepare them for battle in Europe. We left England, the 11th Armored Division left England. I was the tank driver and crossed the English Channel in landing ship tanks. And landed on—not in the battle because the battle had already moved eastward, but we landed on the beaches at Cabourg. And then, just as we landed, we were told—that was in December of 1944—we were told that the Germans had gotten a major breakthrough in the Ardennes area of Belgium and that instead of us being sent to a relatively secure little area in Southeast France, we were to go to the battlefield. We engaged in a forced march. Passed through Paris on New Year's Eve and reached the field of battle. Spent one day to get our tanks ready after travelling three hundred miles, which is a major length for a tank. It's a big thirty-three ton vehicle. And got our tanks ready and went into battle and we fought in the Battle of the Bulge and had many experiences there, some harrowing, under General Patton. We were ambushed in a town one night that the Germans still held and we didn't know that and we went through the town and it ends up, we got on the other side and found that they were between us and where we should've been and we had a number of experiences like that, but came out all right. And then, I was in—I became a tank commander, then, a little later and we fought through, to the Rhine, after the Battle of the Bulge ended. We fought through the Rhine—to the Rhine—and then crossed the Rhine on pontoon bridges, those air bridges, you know? And then, when the war ended, we were in—had gone through the edge of Czechoslovakia and were down in Austria, the farthest east of any American troops, our particular division was. And we met the Russians there. And the war, we met—just as the war ended, we met the Russians at that point and we stayed there for a couple of months and then were—I was transferred to a different outfit because they were going to close out the 11th Armored Division and I spent the rest of the time until—that was May of '45—and I spent until March of '46 at Nuremburg, Germany, and then came home and resumed my education at Iowa State, where I got a degree. A Bachelor of Science degree. And then was accepted for medical school at Northwestern University in Chicago. Went to medical school there, was graduated in 1952. [Audio interference] Interned at the Charity Hospital in New Orleans, which was a great experience. And was accepted for an orthopedic surgery residency at the University of Michigan and I went back up to the North and completed an orthopedic surgery residency at the University of Michigan in 1957. And upon completion, and I was married during that. Jane and I were married in 1954. We had one child at that time, when I finished residency, and we went to England, where I did a fellowship under the professor, Professor Truvada, at Oxford University for a year. We lived in the community and enjoyed that very much. It was hard work and living conditions were very different in this country, but then came back from there and joined the faculty at the University of Michigan. Stayed on the faculty there until 1961, and at that time, joined the staff of the Cleveland Clinic in Cleveland, Ohio, as a staff member. Orthopedic surgeon staff member at the Cleveland Clinic and was in that position until 1967—'68, excuse me. When I accepted a position as associate professor of orthopedic surgery at Northwestern University in Chicago, and chairman of the

Department of Orthopedic Surgery at Cook County Hospital. That's Chicago's big charity hospital. We had—we had a hundred and sixty orthopedic beds, which is very unusual to have that many orthopedic beds. Many hospitals aren't even a hundred and sixty beds, but we had a hundred and sixty orthopedic beds and residents rotated to that hospital or doctors in training for orthopedic surgery rotated to that hospital from various of the training programs there in Chicago. While I was there, I was contacted about a new school, a new medical school that was going to be started on the campus of Texas Tech University and asked if I would serve as a consultant originally, to help determine how the school would be developed and what type of curriculum we could have. I came down here and was very impressed with what was going to be and very impressed with Lubbock, even though the tornado had been here just a year before that and left its mark. So when I was offered a position as Chairman of the Department of Orthopedic Surgery at Texas Tech. Then, it was just Texas Tech University School of Medicine. Later became the Texas Tech University Health Sciences Center. And we moved here and began the activities necessary to be ready for an entering class a year later. Came here in 1971. And we entered our first class in August of 1972, but that was an extremely busy year preparing for various types of programs that needed to be done in order to educate young physicians. And at that time, I also began to practice orthopedic surgery in the community because there was no university hospital and one of the things that impressed me was that Lubbock had a very high quality of the practice of medicine in general at that time. Medical schools usually enhance that sort of thing, but to come to a community that already had a very high quality of medical practice turned out to be an important thing because many of those doctors that were practicing here when we began the school assumed positions teaching at the school because of their experience in practicing and also, of their interest in helping teach young doctors. We began our preparations for starting then, the medical students, but beyond that, we began our preparations for getting ready to have residency programs for training of the graduates of a medical school like that and the various specialties, family medicine, internal medicine, orthopedic surgery, all of the things that make a complete medical school. And it was during that time that we got prepared, got our materials all ready to apply for approved residency and they have to be approved by a national organization. They call it Residency Review Committee. And we submitted our application. Didn't hear anything. This, one of these tells about that. Didn't hear anything and didn't hear anything and so I finally found out, by calling different people in that office, that our application was still there and nothing had been done with it. I happened to have worked with the chairman of the Residency Review Committee in several ways prior to that so I called him to ask him about this and to see what might be done, and within three weeks we had notice that we were going to be inspected for our residency program that the—sort of the executive secretary, the full-time person at the Residency Review Committee for Orthopedic Surgery, had decided that it wasn't possible that there could be anything like that occur out in West Texas, and so she put it in her bottom drawer. Well, my friend was able to reverse that and we, then, were inspected and we were approved because we had everything that was needed to begin an orthopedic surgery residency.

LL:
That's amazing.

TH:
It really is. And thank goodness we knew some people that could be—that could help us in a situation like that where it was hard to find out where our application was in the first place.

LL:
It could've just said "indefinitely."

TH:
Yeah, it could've if we hadn't really pursued it. So we were approved and have had an approved residency in orthopedic surgery since 1975. And of course, at that same time, many of the other programs, many other departments and specialties were making their plans and getting approval for their residencies, but our first residency at the medical school, logically, was the residency in family medicine because we were going to be in the small, rural communities. We were going to be educating a lot of our graduates to go into the small, rural communities and this was going to be a very important feature of this particular school. Although, we were going to have the super specialty, sort of, areas, those were not going to dominate like they do in the big cities. These, we were going to be primary care oriented. Very definitely. And for that reason, the legislature had—when it established the legislation, which set up the school, set up to have units of the school in Amarillo. Not only in Lubbock, but in Amarillo and El Paso and then in the Permian Basin, which later, was decided—it was decided later that that would be in Odessa. And those are the communities that the school is in to this day. During those early years, we did our hospital practice at Saint Mary Hospital and at, to a limited extent, at Methodist Hospital. Methodist Hospital, the administrator at Methodist Hospital was very leery of having medical students and residents there and really made it quite difficult for us to try to do teaching there. Whereas, at Saint Mary's, Sister Marie, who was the administrator of the hospital, very much wanted to see the medical school utilizing the facilities of Saint Mary Hospital and she did everything in her power to support the development of the medical school and we then graduated. Our original plan, wherein most medical schools, or except the first year class from individuals who have a bachelor's degree in science, a lot of them at that time. And then, the medical school is a four year program after that before you begin a specialty training program. Our original plans were to go year round. Instead of being four, we would be a three year school and we began that way and we did graduate our first class in three years, but we found that there was far too much information to try to teach in that brief a period and we really had to extend it to four years, which we did, I think, after the second class graduated and after that, we maintained the four year program. In orthopedic surgery, the physicians, the orthopedic surgeons in the community, all joined together in helping us make plans for teaching the students and also for teaching the residents when we began the residency and we had—we had just really strong

support from most of the orthopedic community through that time, which I personally felt made it a much stronger program because these were individuals who had practiced and who knew what medical practice was like and what you needed to know when you were going to be an orthopedic surgeon. So I was very grateful to the orthopedic community for coming together in such a strong fashion to support us in getting started at the school.

LL:
So you took people with a BA and then they did their four year training here. Did they do their specialty training here as well?

TH:
Many of them did. They could go other places, but many of them would stay here and do their specialty training too and our students were recognized very early as being very good clinical doctors. Knowing how to care for patients. Not research doctors, but real doctors who really saw patients as people and understood how to take care of them and this holds to this day as far as the reputation in the school among the various other medical schools where they go to train. We hear this, every year, we hear several times about them—the impress—how impressed many of the other programs are with the knowledge that our students have in the way of taking care of patients.

LL:
Why do you think, as far as just patient care or relation—doctor—I assume—I—my tongue is tied. From the conversations I've had with other doctors in the past, they seem to say something similar about the doctors out here having a better rapport with their patients. Why is that, do you think?

TH:
Well I think it's maybe the type of individual that lives here in the first place. I was very impressed from the very beginning with the openness and the ease of communication with the people that lived in this area and the trust that they had in their physicians. A thing, which didn't exist in a lot of places in the north and east. You know? And I think that that's part of it. That ease of communication and evidence of caring, then, from a physician was very quickly accepted by the people who lived in this area and I think that's probably one of the things that draws the type of physician that we get, is that they recognize that these people are real and they're up front and they're open.

LL:
So it's the trust that inspires the physician?

TH:
I think so.

LL:
More than the physician inspiring the trust?

TH:
Yes, I think so.

LL:
That's interesting.

TH:
And then, eventually, I think the—

LL:
Becomes a two-way.

TH:
Yeah, eventually, it's a two-way thing, but it would be hard to find a community of Lubbock size that had finer medicine than Lubbock has today. And, of course, a lot of that has improved over these last twenty to twenty-five years. It's not that the school is the reason for it, but I think the school being here attracted a lot of physicians that might not have wanted to come otherwise because of the continuing education capabilities and a lot of physicians like to teach and where that opportunity is available, they take advantage of it.

LL:
So essentially, you're saying that the school probably played a large role in the building of the community since—medical community?

TH:
I think, yes. Yes, I think it did.

LL:
In terms of the types of physicians, that it brought in the different types of specialties and things of that nature? Or the quality?

TH:
Both. Types and quality. You see, Saint Mary Hospital is about—is over three times as large as it was when the school first started here. Methodist Hospital is almost four times the size it was and

there was no university hospital at that time and here, these are all thriving institutions. I think largely because of the ingrowth of excellent patient care capability.

LL:
You said that the quality of medicine here when you first came here was high and that that was unusual prior to the building of the school. Do you think that the patient—the rapport with the patient was a large part of that? Or was there something else that lead to the high standard?

TH:
I suspect that the rapport with the patients was part of it, but there began to be the realization and the acceptance by the patients that you could get any quality of care here. Any type of medical care needed here in Lubbock, which was not true actually when the school was started. It isn't the school brought all those people here that are here today giving the very special types of care, but the school encouraged those people to come by being here. Do I make sense?

LL:
Right, right. Yeah. I guess I was—there seems to be something about this community. I don't know if it was the geographic placement or what that prior to the coming of the medical school, seemed to lend itself to a high quality of medical care regardless of whether or not the breadth of, you know, the types of physicians or the types of treatments that were available. What was here seemed to be of extremely high quality and I don't know if it was a geographic thing. It was just enticing for someone to practice here when they had all of these little outlying communities or what? Was it just a natural place for it to spring up?

TH:
I think. I think the—I think it is a natural place for that to spring up. The people, the general population here, although perhaps not sophisticated, knows what good medicine is. They know when they're getting good care and when they're not getting good care and I think they were willing to accept other people coming in that were good. We don't see a lot of people practicing here that are not good physicians. They're just not here.

LL:
Still.

TH:
Uh-huh. Still. That's right.

LL:
That's interesting. Did they open—you said you began concentrating just on family medicine. What about clinics? Do you open clinics in the outlying areas or how did that work?

TH:
We did not open clinics in the outlying areas at first. We were trying to get organized. You know, to have a place to teach from here to begin with and we had our first clinic activity in Thompson Hall on the main campus, the academic campus, and converted that. It was gutted. It was a dormitory and it was gutted and converted into clinic office building type of thing and we were able to have all of our faculty in there in those early two to three years. Actually, the medical school building itself that we're in now was completed in 1978, I believe, and only one-third of it was completed. One of the things that did occur with us is that as the school—as the concept of putting the school here on the campus of Texas Tech came forth, nationally, for any medical education project, if state or local money would provide one-third of whatever it would cost, the federal government would provide the other two-thirds. Just as we were getting started here, the federal government retrenched and stopped putting up their two-thirds and so we had to reorganize what we were doing and what we were planning and one effect from that was that with the money that the state legislature had set up for our medical school building, we built the entire structure, but we only finished off one-third of it because that was all the money we had. We would've used federal money for the other part of it, but we didn't have that so we finished only one-third of it and very slowly as money has been available we have completed other areas in the medical school building.

LL:
That's been, what? Twenty years?

TH:
That's been twenty years.

LL:
That's fairly rapidly for that kind of a—

TH:
That is. You're right. It is.

LL:
That kind of money.

TH:
We felt pretty cramped at first when we moved into one-third of the space that we were expected to be able to function in, but it worked out and then the—

LL:
Now, is that just for the Health Sciences Center part or does that include the hospital, as well? The University Medical Center?

TH:
The hospital, it included it too. The same situation and the county put—built the present hospital for twenty-one million dollars and [Recording cuts abruptly].

LL:
Just wait a few minutes. Okay. We're talking about the hospital and the Health Sciences Center.

TH:
The hospital was affected in the same way because it was anticipated that there would be a major segment of the cost of building the hospital provided from federal monies and that did not happen. The county had—was able to sell bonds for twenty-one million dollars and they constructed a building for that value, which is the size it is today and it really was then and is a very up to date hospital.

LL:
They're still building everyday over there.

TH:
Yes, they are.

LL:
We've had a number of people of comment on the—what they were fearing was a tendency to—let's see. How was it? To build empires rather than to actually offer what they saw as—their idea of quality healthcare. What do you think of that assessment?

TH:
There's probably a little bit of that in it, but many of the things that they're doing in the way of building today, for example, are pretty essential. For example, we—the faculty really—they had the clinics in the new medical school building, but they didn't have a place where they could see separately, private patients. I don't mean that to sound snobbish, but it began to occur that the legislature cut back on its funding and the physicians at the medical school had to increase the amount of money that they were bringing in to help support the school and that has continued to the extent that today, about 30 percent of the money that's needed for running the Health Sciences Center comes from the state and the other 70 percent comes from state patients now.

LL:
And like, you're talking like the Medical Office Plaza? Patients that come into there?

TH:
Yes, and so the Medical Office Plaza, then, was built by the University Medical Center so that there would be a place where private patients could be seen, who would be willing to pay for their services and expect to be in a little nicer setting than in our clinics.

LL:
All of the physicians who see patients in the Medical Office Plaza, are they all connected with the teaching facility?

TH:
Yes. Yes, they are. They're either full-time faculty or they're clinical—what are called clinical faculty. But they're all connected to the teaching and then one of—the building that's going up right now, which is the west most wing, is going to house the library, which is—has been out of space for their book storage now for ten years. We've had to store a lot of things out on the eastside of town.

LL:
We how that is.

TH:
Yes. [Laughter]

LL:
Yes.

TH:
And so that's what's going to be in this new building that's being built is the library. I understand there's going to be an auditorium and there is no auditorium over there. There's a room which will hold about a hundred and thirty people, but there's no real auditorium and so that would be very useful to have a real room, an auditorium, which you could hold a lot of functions that we cannot now hold over there. And then another part of that building is going to be occupied by a health man [?], which is the name of the structure that we began. The telecommunications project that we began as Mednet [?] [0:36:45]. That is expanding and going to provide more services to the rural areas out through West Texas and they need more space to be able to broadcast. They sent continuing education programs to satellite, for example, that are picked up now and about a hundred small rural hospitals out around West Texas, so that the

doctors can get continuing education. The nurses can. Hospital administrators can. The dieticians can. Just all sorts of continuing education can go to satellite from over here.

LL:
And there will be interplay question and answer time?

TH:
Yeah. Now, the question and answer is over telephone line, but the main program itself comes in on video.

LL:
That's amazing.

TH:
Yeah, it really is. [Pause] And that was one of our—the Mednet [?] [0:37:53] project was one of the, I think, one of the major accomplishments. And I realize I have a certain prejudice in this because I was so closely associated with it, but in order to—we have talked about our real mission at the medical school being to go into the rural communities and provide services to the rural communities out through West Texas. And we had done a little of that, but not as much as we would've liked to have done, but the distances were the real problem. And so we—several of the individuals at the medical school, and I talked over possibilities of different things that we might do that would take us out to the rural communities. One of the things was the continuing education program that I mentioned. How nice it would be because in some communities, there's one doctor and there are not extra nurses so they can't leave town to go to a continuing education and yet, in order to continue your license, you must have a certain number of hours in continuing education every year. So we began to talk about things that we might do that would be useful to the rural communities and we developed the idea that we would do the continuing education programs and that we would, if we could work it out, we would do something in the way of consulting. Have the family doctor in a rural community present a patient over a video to a doctor here and get help on how to treat that patient. We went to Washington several times and met with then Senator Benson and explained to him what we believed we could do if we had some funding. Senator Benson grew up in rural South Texas and he knew very well what rural was. And so, at that time, he was chairman of the senate finance committee and in the Omnibus Budget Reconciliation Act of 1987, there was a two million dollar grant to the Texas Tech Mednet [0:40:46] Project, which had to be matched by the school, right? But that was a major item because the school didn't have that much money to spare, truthfully, and we could only use the federal money in certain ways. We could use it for salaries, but we could not buy any equipment with and what we had proposed to do was very equipment intensive, but we were able to work out ways in which we could purchase equipment and continue with our plans for putting this thing in place and we began our project in 1989, and getting the equipment for sending

programs to satellite was the most expensive item because we had to install an uplinked satellite, which, at that time, cost a quarter of a million dollars, but we were able to do it. We were able to find the funds in various places and put it together. Today, there's more than one uplinked satellite over by the medical school building. Those programs were doing well until about two months ago when the satellite that they were using disappeared. To this day, they don't know where it is and time is so difficult to get on satellites that they have not been able to get back on with their programs, but they will. But back to the original, we then learned that we could go over telephone lines to do consultations and we visited a number of rural communities and decided that if we could connect from our system here to Alpine and to Fort Stockton, we could show what you could do in the way of consultations over the video where the doctor in Alpine or Fort Stockton presented the patient over video to a specialist of some type here and we got ready and got our equipment in place and had a lot of help from AT&T and from Southwestern Bell. The phone lines were very expensive because to do this required twenty-four long distance lines each way.

LL:
Goodness gracious.

TH:
Because of the breadth, you know, the picture too was required that much breadth of bandwidth. But we did work that out and with some special planning by some of the people that understood a lot of the electronics, we were able to convert analog into digital and digital into analog so that we could transmit taking the least space, but when we got to either end, we could show a full picture with full action and it worked well. The first consult we had in 1991, the doctor in Alpine, was presenting a patient, who had been operated on here at the Health Sciences Center and had a colostomy, the question was whether or not the colostomy could be closed. Whether the function could occur if the colostomy was sewed back together and it was determined very clearly from that video that the colostomy could be closed. That the man could function well after this was closed. Just as we were finishing that consult and the surgeon here was the one that was answering that consult. Just as we were finishing, the doctor in Alpine said, "Could you get a neonatologist for me to talk to?" He said, "I've got a little two hour old baby who's in real severe respiratory distress and I'm not sure what to do next." So we went out quickly and found Dr. Miriam Myers, who was head of neonatology here at that time. Miriam came and sat in front of our camera and saw Dr. Lukey [?] [0:45:51] in Alpine. Dr. Lukey presented the situation. He presented the laboratory findings. Presented an x-ray over this video from Alpine, three hundred miles away. You could see the lung have pneumonia up in one corner of it of this little two-hour old baby and while we were talking, while they were doing the consult, they got some more blood and did some more blood tests to see what was happening and the baby was getting worse. And so, Dr. Myer was able to tell—the neonatologist here—was able to tell Dr. Lukey in Alpine, sort of in cookbook fashion, what to do step by step and within two hours, the baby was

stabilized and could be transferred by family car to the hospital—to the neonatal unit down in Odessa. That thing took off because of that consult, which none of us would've predicted. We would have no idea.

LL:
The first one.

TH:
It was just so spontaneous. Yeah. Just unbelievable. And that thing took off and within a year, we had done a hundred consultations with those people in Alpine.

LL:
Goodness gracious.

TH:
On all kinds of conditions. One thing it did was it made it possible for many of the patients in Alpine to stay in the hospital in Alpine. Not be transferred out somewhere else. The hospital in Alpine had been having a very hard time because people didn't want to stay there. Patients didn't want to stay there when they could go off somewhere else. Well that changed and the hospital stabilized financially and the whole medical situation in Alpine turned around in a major way because of this.

LL:
Not only quality wise, but economics.

TH:
Economics, right.

LL:
Economic impact of something like that.

TH:
And of course, staying in the hospital in Alpine is a lot less expensive than staying in the hospital in Lubbock. And with the family doctor being able to have contact like that through video, he was able to do whatever needed to be done in the way of treatment.

LL:
What kind of cost is that to put on the patient?

TH:
Well actually, it didn't put any cost because we were not allowed—the federal government would not allow us to make any charges for the services that we provided, the specialists provided, over the system. We, and to this day, will not allow. But that's kind of coming around and our most recent state legislature passed some legislation, which makes it necessary for Medicaid, at least, to reimburse for the consultations over the system so it's coming of age, in that regard, but this is what? Six years later and the efforts to get the reimbursement, which was an essential issue, the efforts to get those had not been successful until now.

LL:
So we're talking a partial reimbursement by Medicaid to the hospital itself?

TH:
Right. To the hospital and to the physician.

LL:
Okay.

TH:
And the hospital part will help pay for the equipment then, you see? And the medical school now gets some money from the legislature to run the equipment system. So the whole thing is sort of coming of age and it's interesting. This was the first project like this in the nation and there are, somewhere in the neighborhood, thirty projects like this now all around. Georgia has very advanced with it. A lot of the states have programs like that now.

LL:
One is to wonder once this first consultation had gone off and it apparently went so well, what Senator Benson thought of the whole thing after he had?—

TH:
He was as proud as he could be of the whole thing.

LL:
I can imagine.

TH:
Yeah. He came back to see it several times. To see it in action. And he was really pleased at what he saw happening.

LL:
Amazed.

TH:
Yeah, yeah.

LL:
That's really incredible.

TH:
Well it was extremely rewarding too, for the whole thing to unfold this way and you wouldn't even know, but the consults that have been done since then. I mean, of course, that's the basis for today's prison healthcare, you know? They're doing consults. They go to satellite and back, but the prisons in West Texas go to satellite and are brought in here to Lubbock to the medical school here for the consultations for all the prisoners so they don't have to haul prisoners great distances with, you know, extra guards and this sort of thing. It was a very expensive proposition for them.

LL:
I can imagine.

TH:
To move prisoners to where they could get some sort of specialty care, and this takes care of a lot of that.

LL:
I've heard so many comments about technology and the advancement of technology actually in many cases taking the place of the relationship between the doctor and the patient that we were talking about before, but this seems to be something that maybe moves things a little bit in the other direction. High tech.

TH:
Well, yes. And see, we saw this. We did. Every patient that we did a consult on, we had fill in a questionnaire and virtually, every one of those said they believed that they couldn't have had more effective care and a better feeling between them and the doctor, even though it was three hundred miles away over the system like this.

LL:
Just that feeling that someone has taken the extra step to put the technology there so that you can, rather than just going into an office and having a test and disappearing.

TH:
And we encouraged the families to be with the patient when they were on a consult and this did a great deal because it helped educate the family for one thing, but it also allowed the families to participate if it was appropriate. For example, there was one man we were seeing that had a bad hand infection, a rancher down near Alpine, and he was going to need some real excellent care and we were interviewing—or the doctor here was doing the consult and asked him if there had been any change in his sensorium, a realization of what's going on around him, and he said, "Well no, there hasn't." And his wife said, "Just a minute." She said, "Yes. There really is." And she said, "I think I just have to speak—step in and say something." And this answered because it was expected that this kind of infection was going up his arm and that there would be some systemic affects from something like that and this added very much to the consult to have the wife speak up at that time.

LL:
I've often wondered why there isn't something more like that in the medical profession—practiced in the medical profession in general because I know when we do these interviews, people come in and they have all these wonderful stories that are very valuable to us, but they think that what they have to say is not important and so they're like, "Oh, well you know." And it's the same thing. You know, you go into a physician's office and they start asking you questions and you're thinking and you're thinking, "Well, not really," because all of those little things that have come up are things that you think are going to be minor and if there's someone else there to help you say, "No, that's not true," or "No, don't forget to tell them about this." You know?

TH:
I'm going to see—I think that little girl, the first baby, may have a picture in here. I don't—I guess not. Southwestern Bell did. One of their publications had her picture in her Easter dress four years later.

LL:
Wow. I bet that was quite a boom for those companies to be involved in something like that.

TH:
It was. Yeah.

LL:
Yeah. Quite a little thing to put in the scrapbook.

TH:
Yes, right.

LL:
That—the point I was making a while ago about the comments that technology began to take the place of the relationship between the doctor and the patient. What do you think of that idea in general? That concept?

TH:
Oh, I think it is true, in general, because instead of—it has encouraged the physician at times to depend on an x-ray and not to depend on examining a patient in the same way that he or she would've examined the patient before the technology and I do think that's detrimental because there are a lot of things you can see and feel and hear if you're examining a patient with great detail that the technology won't take the place of. Although, I will have to say now, the video consult—one of the finest neurologic exams I've ever seen was done over this video system. Over the Mednet system [0:56:34], where the neurologist here helping the family doctor in Fort Stockton, show him the various things that he needed to see to help her. She, the family doctor, had thought that there was something wrong neurologically and that it was not an alcohol problem, for example, but there was this question and so this examination went with great detail and the neurologist here was able to instruct her on how to do the next test to show him certain things and this went on for about an hour, but at the conclusion, the family doctor's suspicion was correct that there was a neurologic problem that was going on and that was—that was a really important issue, I think, that technology didn't obstruct. In fact, it enhanced it in that particular instance.

LL:
Yeah. That's really interesting. What—

TH:
I didn't mean to get off subject.

LL:
Oh no. It's—I think it's fascinating. What, as far as technology, well and other things as well, what other types of improvement, advancement, can you think of that—in just since you came here—that have made great differences in medical care?

TH:
Well, the CAT scan was not available when I first arrived in town. I mean, not just here. It just wasn't available and we were able to get one of the first CAT scans out of—outside of the small—outside of the large cities here because of all the medical activity in Lubbock and the same is true of the magnetic residence imaging. Lubbock is unusual for a community its size to have those sorts of services available and those are available now and they weren't there when—think when—1971, for example, and '72. Operations are sort of the same, but the total hip has

really, for example, has really been a major advance in orthopedic surgery. We had hip operations, but we didn't have anything that was even close to being the excellent operation that the total hip replacement is now. And that's only been—see, that's been in this relatively short period of time. And the total knee is the same story. There have been other joints replacements, but none of them have been as good as those two. But I guess, with you bearing weight on your hip and on your knee, carrying your weight of your body, maybe that's one of the reasons there's been particular emphasis on trying to do something about bad joints in those locations.

LL:
Yeah. My grandmother had a knee replaced and it was amazing how quickly that she got past that.

TH:
Uh-huh.

LL:
What about—what kind of changes have you seen in the education of physicians just between the time that you were educated and today? What was the way the—

TH:
Most of our education, about 90 percent of our education when I was in medical school in 1948 through '52 was in the hospital. That it was seeing patients in the hospital and there has been a major change in that over this period of time. In fact, that was one of the embassies in the startup of the medical school here at Texas Tech was to teach on an outpatient basis. To teach about patients who didn't have to be in the hospital, but who still had a disease problem that needed to be treated and needed to be examined and monitored. And so there's been a great emphasis to see patients other than in the hospital over these last twenty years and we were at an ideal, sort of, point here time wise to be able to do that because the other medical schools didn't have clinics or they had very few and here, we were able to build a building that was filled with clinics so that we could teach the young physicians how to see patients who didn't have to be in the hospital, but who still needed medical care.

LL:
So essentially, with the exception of the limited space to begin with, this medical school has been on the cutting edge from the very beginning.

TH:
That's true. It really has. And there's been a great emphasis on primary care over the last twenty years, gradually growing. Well, we began as a primary care oriented type of medical school so all of that is fit together.

LL:
That's a great step ahead.

TH:
Yeah.

LL:
Have you seen in any changes in the goals and ideals for lifestyle on the part of physicians since you began?

TH:
Yes. Oh. [Pause] I don't ever recall when I was a medical student or when I was a resident or my early years of practice that we ever talked about money much. We just assumed, and I think, rightly, that it would fall into place. And there is an awful lot and I hear this from doctors eating in the dining rooms of the hospitals, for example, that the major topic at the table is the finances today. So that's a major change and I think actually with the managed healthcare, there's a major cutback in the income of positions. Some of them are decreased by as much as 30 percent now, over even two years ago. Maybe this is too sensitive.

LL:
Oh, no. No.

TH:
Okay.

LL:
This is one of the questions that we have on the list.

TH:
The part—I have no concern about decreasing the position's income because—[Recording cuts abruptly]

LL:
Okay. You were talking about—we were talking about changes in lifestyle and the emphasis on money.

TH:
There's been—physicians have always had, I think, comfortable living, but in more recent times, there's been a real emphasis on materialism and material things. It's been my impression that this is, in general, not true with—or has not been true in the past—with individuals in academic work

because physicians in academic work would generally have an income about half that of physicians in the community and this has been true right along, but one of the things that really brought this money issue to the front was Medicare, surprisingly enough, because a lot of people complained about Medicare payments and how they were inadequate. But before Medicare, and I was in practice before Medicare came into place, we took care of many people who couldn't pay and it wasn't a concern. It just, you know, it was part of what we were doing and part of what we were expected to do and Medicare came in and anybody over sixty-five years of age would have their healthcare provided and the hospital and physician would both be reimbursed for their efforts in taking care of the patients in that age group and that's the first time that money seemed to be a major factor in the practice of medicine was after that came into place.

LL:
An expectation.

TH:
Yes, right. Right. And of course, that's reversing now with managed healthcare with the income of virtually every position decreasing relative to what it has been say, five years ago or so. Mind you, I think that the income may still be quite good, but maybe not as much as it used to be. The part that's concerning is the—with the changing of healthcare thing and the HMO's [**Health Maintenance Organization**] and other types of managed healthcare. Is it—I personally have some concern that a patient may not get all of the care that a patient needs become some business organization has decided that they won't spend that money to get an x-ray or to have them see some sort of super specialist about some particular problem and that's a concern. I think that's a concern among a lot of us today that patients may not get as good of healthcare long term, as we've been able to offer in past years.

LL:
How does that work, for instance?

TH:
Well the—in many HMO's, for example, and in some of the managed health care schemes, a patient has a primary care doctor. That primary care doctor is payed, generally, is payed a certain sum of money every month for every patient that is assigned to that physician. There's also a reserve fund, which is set up, which that physician will participate in if there's any money in that reserve fund at the end of a year. A year, for example, it's just—some go different time intervals, but a year is sort of the way they tend to go. So if the primary care doctor refers that patient to an allergist, the care for that allergist, the payment to that allergist must come out of that reserve fund so the more the patients get sent to different specialties or for different—for x-rays, or for other things that may not be as necessary, the less money is going to be in the reserve fund.

LL:
Sort of like a cooperative situation.

TH:
That's right. So at the end of that time, there's less money in that reserve fund or there may be less money in that reserve fund to share among the primary care doctors and that's a real concern. It isn't that anybody's trying to withhold care, but there's this sort of unconscious feeling that you need to be more cautious about sending a patient to a specialist or sending a patient for a special x-ray or something like that.

LL:
And for someone who is not—who doesn't hesitate to attempt to take care of those sorts of things themselves might need to [Inaudible 1:10:12].

TH:
Right. Well see, right now, allergists are finding a very hard—and I use that just as one of the specialties—allergists are having a difficult time because their patients, number of patients, has dropped significantly and yet, in some respects, with a complicated allergy problem, it's far less expensive to send the patient to an allergist and get the thing settled and under—treatment underway—than it is for the primary care doctor to continue trying to treat and not refer the patient and then, ultimately having to refer the patient and there's a fair amount of that right now. Allergy is one, I think. Dermatology's another where there's a tendency not to refer the patient. And this is just in general. It's not a criticism of primary care doctors. It's just sort of the system that got set up.

LL:
The way things are.

TH:
And my personal belief is that business doesn't have a place in medicine, but this is business. Setting up funds like that, you know, and that sort of thing.

LL:
It seems, on that particular note, that it hasn't just been the HMO's and the insurance companies, but I hear many, many people in the healthcare profession lamenting that the hospitals themselves are operated more and more by businessmen who have no experience in healthcare whatsoever. And what I worry that places run—for instance, I have a number of friends in laboratory work. Well, in laboratory personnel, we try to keep a high standard ethically, but many times, they are pushed to sacrifice that for the bottom line, which is the dollar.

TH:
Yes, and that is going on.

LL:
The profit margin.

TH:
There's no question. That's going on. That's worrisome because the laboratory person, many times, is the one that picks up the very piece of information that you need to treat that patient and if they get pushed to not provide some of that, then you lose out on having a valuable piece of information.

LL:
Someone was telling me recently that there was a push and that it's already begun in California to replace all of those medical technologists and MLT's [**Medical Laboratory Technician**] with generalists, who will just be trying to push the button and read the result and totally get rid of these professionally trained people. And that the people in California are keeping up their education, awaiting the day when the hospitals are going to be in trouble and need them back.

TH:
They are going to need them.

LL:
Because just reading that result is positive or negative is not all that's needed.

TH:
That's not the whole story.

LL:
Right.

TH:
Yeah, right. I just can't tell you how many times an alert technician in the laboratory can identify things for you that no piece of technology's going to do. I've seen them find a gas gangrene's organisms in something that we least expected it and I don't believe the technology—a piece of technical equipment would necessarily do that, but it's been this extra sense that the technologist brings.

LL:
Maybe looking for something else.

TH:
Yeah, right. Right.

LL:
That's scary.

TH:
It is.

LL:
That's a scary thought. What—can you think of any individuals who have been instrumental? That stand out for you in the bringing about of the med school and advancement of the situation in the med school? Somebody?

TH:
Well yes. Of course, Governor Preston Smith was such a major factor in that. But you know, another person who worked with Governor Smith a lot, who is now deceased is Bill Parsley, or was Bill Parsley. Bill was in the state legislature at one time and then became the, sort of, he couldn't be called—he was not allowed to be called a lobbyist, but he represented Texas Tech—Texas Tech Medical School in Austin to the legislature. And Bill did a great deal of the leg work in getting legislatures to understand what this school meant and what it could be and a willingness to vote on it, vote favorably on it. And so I really, I do have tremendous, or have—I've always had tremendous respect for what Bill Parsley did in those years and how he understood how to do all those things that would help the school come into place. Now, locally, Dr. Brandon Hall was extremely important in helping develop the attitude locally of supporting the idea of a medical school. And you know, the—so many of the practicing physicians. I won't start naming because I'd leave out some who ought to be there, but so many of the practicing physicians in Lubbock wanted this thing to come about and were so supportive of it. And, of course, the community was. For them to vote a bond issue to build a hospital was a very major thing for a community this size back at that time because the community really did not have that strong an obligation. The way things were set up, they did not have that strong an obligation to provide medical care for patients who couldn't afford it. Now, they do. They have—I mean, it's an established issue with major funds provided for that. But early on, it was not nearly as strong a set up for providing indigent healthcare. So the community, at large, really has to be given great credit for realizing that this was a next step beyond for the community. And, of course, it has been a good thing. Look at the economics of the healthcare system here in Lubbock today. It's just one of the very major employers.

LL:
That's for sure. What—could you briefly explain, in [layman's] terms, what orthopedic surgery entails?

TH:
Orthopedic surgery is the examination and treatment of problems with the muscles and the bones and joints of the body and it, oftentimes, is—does not entail surgery. In fact, it is thought that about 75 percent of an orthopedic surgical practice is not surgical, but is examination and treatment with physical therapy and other sorts of means and that only about 25 percent is a surgical approach to a particular problem. Orthopedic surgery is interesting to me because there are so many manifestations in orthopedics of various disease problems in the body. Orthopedic surgeons see many problems from a person with diabetes, for example, or Cerebral Palsy, or having had a stroke, various kinds of the arthritis problems show up and are dealt with by the orthopedic surgeon, in addition to the rheumatologist or the family doctor.

LL:
So you get to pretty much, as my grandfather would say, stick your finger into a lot of different pies?

TH:
Yes, you do. Yes, you do. And you have to be prepared to—open to recognizing that it isn't just the bone that you're concerned about at that point, but that there's something else going on there.

LL:
But the whole.

TH:
Right.

LL:
When did it become—when did the need arise for orthopedics as a specialty rather than just something that the general practitioner took care of?

TH:
About the time—the need for orthopedic surgeons began to develop about the time of the First World War, somewhere around 1917, when in England, actually, with the battle injuries that were brought back to England from France, they began to realize that there were specific problems related with the various fractures and wounds that they were not taken care of as well as they might and that they began to specialize in that area. And the British were really the first and strongest along that line. It kind of grew bit by bit, but the Second World War is what really

brought it forward for the very same reason. There were so many various kinds of injuries that had to be cared for and so often, they were of the muscles or of the bones or of the joints and again, the British, along with the Americans, began to be the leaders in those areas at that time. The British continue to be strong in orthopedic surgery.

LL:
What was it about it that attracted you personally?

TH:
When I was in the first—I had thought I was going to be a family practitioner—and when I was in the first quarter of, or first semester, of medical school, every Saturday morning, we had a conference where they presented patients and on the mornings when the orthopedic surgery doctors presented their patients. I saw such a direct relationship between the patient's problem and the anatomy that we were learning about at that time, they just fit so well together and I thought, that tells you if you know the anatomy, that tells you how you're going to try to treat many of these problems in orthopedic surgery. That's really—that's the time at which I became very interested in orthopedic surgery and it's really never changed since then. It's sort of, if it's clear cut, you know? Nebulous, I don't do well with, but if I can see something of a design and it fits together like anatomy, that's easy to handle and so I've never had any question that I wanted to do that.

LL:
Very satisfied?

TH:
Yes, yes. It's been a very interesting career.

LL:
I've heard a number of people refer to what they call the "Golden Age" of medicine. What does that term mean to you?

TH:
What it means to me is particularly the practice from somewhere, perhaps in the mid-sixties up to about 1990 and in the mid-sixties, we begin to get different antibiotics, we begin to get ways to do cardiac catheterizations. We begin to put in total joint replacements and all of those things were really improving the capability of the physician in helping the patient and all of that. That kept improving with various research—all that came from research. There's no question, of significant research being done mostly by medical schools and much of it sponsored by the National Institutes of Health out of Washington D.C. by the federal government. But all of that really kept improving until business began to get interested in making money out of medicine.

That's when the managed healthcare began and I think that sort of began to close off those golden years. The patient confidence. The patient belief in the physician. The physician dedication to the patient. That physician-patient relationship was a very precious thing and that, through most of my career, existed and it was the patient could talk to you about anything. Any personal problems. Any of those things. And those, you kept private. And they didn't hesitate to discuss those issues with you.

LL:
The doctor, the bartender, and the hairdresser.

TH:
That's right. That's right. [Laughter]

LL:
Yeah.

TH:
Oh my. But a lot of that has changed and is changing. Now, maybe—maybe things will reverse after. It appears to me that business interest in medicine has occurred because they see a way to squeeze money out of the system that is profits for the business and so they cut back on their reimbursement of the hospital. They cut back on their reimbursement to the physician. They cut back on a number of tests that can be taken and you can only do a limited amount of that before real patient care begins to suffer and so when real patient care begins to suffer, I don't—I believe that the business will no longer be interested because there's not—they can't keep cutting things out after that so they've made their money out of it and I really believe that in several years from now, business will be out of it, pretty much, and medicine will start returning toward what it was. That's a hope, also, of course.

LL:
It's my understanding that the way this occurs is that you make a diagnosis and based upon your diagnosis, they give you a list of X types of treatments or tests that you can order. Who—for instance, in orthopedics, would it be an orthopedic guy on the other end who is making out that list or is it someone who's familiar with your field at all?

TH:
It's often someone who's not familiar with the field at all and that person has a list of things, which perhaps an orthopedic surgeon has helped develop and perhaps not, but that individual has a list of things which are liable and if it's not one of those, it's not liable. The other day, my wife was seeing the gynecologist and she wanted her to get a blood test and, which was fine. The only thing was part of it was a hemoglobin and white count, and the insurance company didn't pay for

that because they said her condition didn't indicate that was needed. That's the basic part of medicine is you know, a white count and a hemoglobin.

LL:
So what you're looking at is a gamble on the part of the patient that the physician they're seeing is making the correct diagnosis in the beginning. Is a very good diagnostic physician because if you have something this difficult to detect, you could have to change diagnosis a number of times.

TH:
Yeah. Right, right.

LL:
And maybe end up in really bad shape before it's actually found.

TH:
And that's true. Yeah. That's a good evaluation of it.

LL:
Or use up a significant amount of your lifetime insurance. You know, if you're limited to a hundred thousand dollars of lifetime benefits. Goodness gracious.

TH:
And I am also concerned. I know Congress keeps talking about a medical savings plan, like an IRA [**Individual Retirement Account**], you know? Or retirement IRA, but the medical savings plan, they will agree that you don't pay taxes on say, five thousand dollars a year, and if you don't spend that going to the doctor or going to the hospital, that you get to keep it. Well, the concern there is that there are a lot of people that don't know what they need medically and so they may not spend that money in order to be able to keep it.

LL:
Similar to the reserve fund.

TH:
Yeah. And it's kind of concerning because a lot of people simply don't know and I'm not being critical of them. They don't know. They don't have a way of knowing what they need and what they don't need like that.

LL:
In that kind of situation, you'd have that reserve fund inhibiting with the same patient on two

different points.

TH:
Right. That's right. Yeah.

LL:
Could you comment for a moment on changes and concepts of nursing services over the years?

TH:
Yes. There have always been and still are dedicated nurses and there are some who consider it as a job, not a profession, and I think that's been true since time began. Although, there has begun to be so much paperwork required of the nurses that they don't get to spend as much time nursing, doing nursing, as they have to spend trying to keep track of the records and that's really a difficult thing for the nursing staff. There are still a lot of excellent nurses who just don't—are not allowed to take the time to be the excellent nurse because they have so many of those other little things, paper and record keeping things, that they have to take care of.

LL:
My mother is an LPN [**Licensed Practical Nurse**] and has been for a number of years. I frequently heard her mention an individual and say, "They're one of the best patient care nurses that I've ever seen." And I've always found that kind of unusual because it seemed to me that that's the whole idea behind nursing and why would someone who is good at it be someone who stands out?

TH:
Well yes, you're right. And I do think that in my earlier career, most of the nurses were excellent patient care nurses. They cared and they taught me a lot. I'll tell you, they taught me a lot about what to do with patients and how to pay attention to certain things about patient's comments and very sensitive because they were good patient care nurses.

LL:
Seems that as time passes, nurses, at least on the RN side have more and more responsibility placed upon them. Not just for paperwork, but for other things as well. Things that it used to be the physician.

TH:
That's true. They do. Yeah. For example, in the little town of Presidio, which is south of Alpine about a hundred and twenty miles, there's no—this a town of about five thousand people—there's no physician. There are two nurse practitioners who are really superb and they're connected by this video system that we started over at the medical school to the family doctor in

Alpine so they can communicate, show patients to that doctor and in years past, a nurse would not have been allowed to assume that kind of responsibility, but here's Presidio, five thousand people, no position and the nurse practitioners are really very good.

LL:
What has been the impetus behind that change?

TH:
The real impetus is the fact that if there weren't nurses or physician's assistants assuming those kind of positions, there would not be people there providing health care to those—to that population group in Presidio.

LL:
Because it's such an unattractive, theoretically, unattractive place for someone to set up a practice.

TH:
Right. It's really sort of the _____ [1:36:00]. It looks it. ***[Audio cuts abruptly].***

LL:
Okay. We were talking about concepts of nursing services. One of the things that I was mentioning my mother making the comments. One of the things that struck me was she frequently makes the comments about the nurses that they get in from the Philippines. About how excellent, how excellent they are in patient care and I wonder if it has something to do with the fact that still being considered at least partially a third world country, if maybe it is that lack of technology standing between. If maybe they have more training and more experience in just the basic everyday stuff rather than the mounds of responsibility placed upon them.

TH:
Well I think that's probably part of it. Another thing that I've observed is most of them trained—did the nurses training—in a Catholic hospital, and in a Catholic hospital where the sisters were very active and knew how to take care of patients and taught them how to take care of patients. Through the years, I've known many of those Philippine nurses who are really excellent nurses. They know what's happening with their patients and they give superb care. It's an interesting phenomenon.

LL:
I guess a lot of the nurses who come in from other countries go through Catholic hospitals. Receive their training in Catholic hospitals.

TH:
Yes. Yes. Because I think that's one area that the Catholic sisters particularly—and I'm a Presbyterian Protestant, but I have great respect for the work that they've done in carrying health care to third world countries and teaching people in those countries how to do the things necessary to provide good health care.

LL:
We were talking. You've mentioned Medicare and Medicaid a number of times. We talked about all of the ins and outs of that. Was Medicare something that you were in favor of in the beginning or was that something that you were not really pumped up about, so to speak?

TH:
I had personally believed that we needed to have some system available to—particularly, to pay for the cost of health care of individuals over age sixty-five when they couldn't afford to take care of it themselves and I don't mean for the physician because before Medicare came, physicians took care of a lot of those patients, but many of those patients couldn't afford to be in the hospital so what do you do? And I think Medicare provided a real area of support that could allow people who could not afford to otherwise get the best medical care to get that health care so I have pretty much been a fan of Medicare all along. I guess I always have a little reservation about the government running anything, but who else would do that?

LL:
Well that's the question I always ask. You know, I understand the problems and the perspective of a lot of the people that I've spoken with, but when I ask, "What would you see as a viable alternative?" They always want to go back to the old way where the doctor treated the patient without receiving payment after just having stated that today's physicians were more interested in monetary issues. So the question that comes up is do you really believe that physicians in this day and age would go back and be willing to treat indigent patients with no payment whatsoever?

TH:
Many wouldn't. I will tell you, for example, that in Lubbock, about eight years ago, the—there were two physicians that were willing to take care of pregnant women who were Medicaid type patients. One physician was the medical school, it's called a physician in that sense, and the other one was one of the doctors in town. There were twenty obstetricians in town that wouldn't care to see those patients and wouldn't see them. So I do not believe that it would be possible for us—for people like that, to receive care if there weren't a system in place.

LL:
If they're not willing to take partial payment then they certainly wouldn't be willing to settle to no payment.

TH:
That's right. And even there, there was partial payment.

LL:
Right.

TH:
Yeah. Yeah. Well you know, I worked in that English system the year we were over there and I didn't think it was all bad, frankly. It had far less bureaucracy than we've got out of Medicare. The hospital, I was at an orthopedic hospital that was part of Oxford University and that hospital received a certain amount of money at the start of the year to cover its cost for that year and they had to make do, but I never saw anyone suffer from lack of whatever was needed in the way of treatment.

LL:
So the stories we hear about going in for problems with your tonsils and having your appendix removed are not something that you experienced in the year that you were there?

TH:
No, I did not. I was very impressed with the quality of care that the patients were receiving there. That was excellent orthopedic care.

LL:
So what is—what do you think is the reason why there's so much opposition to that and those—who is behind circulating those fears of that sort of system?

TH:
I think a lot of people in this country don't exactly trust their government. Now, the British trust their government. They trust that they will do the right thing and I think, in that instance, they are being provided very good care, but I think a lot of people in this country don't trust the government. This morning's paper gives a good example of that. They have this quote on Medicare and they're going to increase the cost of Medicare of the individual payments that people have to make, especially if they're above a certain level of income, but they didn't have—they had a voice vote—they didn't have a roll call vote. So you don't know who voted for it and who didn't vote for it. I don't trust in that. I may vote against whoever runs. That's really pretty sneaky.

LL:
You know, it's interesting that the headline right under that was about the Roswell incident. People are still up in arms about that.

TH:
Yes.

LL:
Two front page stories.

TH:
That's right.

LL:
In a relatively conservative newspaper.

TH:
That's to say the least.

LL:
What do you think about the state of indigent healthcare today in Lubbock?

TH:
I think—I really believe that the indigent patients in Lubbock, overall, get excellent care. They don't get the fritz of care that perhaps the paying patients get, but I really do believe they get excellent care and I think they are not denied anything that they really need. I'm sure there's an occasional incident when something happens that they don't get something they need, but I believe that that's rare and that anything that they really need, I believe they're getting in the way of care today.

LL:
What about the state of healthcare for HIV infected individuals and particularly in Europe, what kind of precautions does that set up for someone in the field of orthopedics?

TH:
It can be a real problem in the operating room, you know? If any—if you create any kind of a surgical wound in order to do an operative procedure in an HIV positive patient, you run some significant risks because a glove can always get cut or a neck and finger and we probably haven't been as willing to provide that care as perhaps, we should've, but that's such an individual thing. It's hard to legislate that some orthopedic surgeons going to take care of an HIV patient. I

certainly would. I'm not practicing anymore, but I certainly would if I—you know, if a patient came to me and I was expected to do that. I took care of a lot of patients with tuberculosis back in the era when we had a lot of bone and joint tuberculosis.

LL:
Is tuberculosis a blood born disease?

TH:
Yes. Uh-huh. Well it was. It is at a certain stage. It goes from the lungs and then can go out to virtually anywhere in the body, an abscess in the brain or joint or osteomyelitis, ____ infection [1:47:45]. It can do virtually anything.

LL:
So do you think the reluctance on the part of some to treat HIV infected individuals is because of fear or because of—or some other?

TH:
I suspect it's more on the basis of fear. Even though they may not approve of the lifestyle of, at least, most of the people in HIV positive situations, I really doubt that they would decline to give them care if there weren't some fear involved in it.

LL:
It's my understanding that in particular that orthopedic—especially, orthopedic surgeries is a great deal more equipment, as far as saws and drills and things of that nature that might be—

TH:
And spatters, yeah.

LL:
Yes.

TH:
You come out of there with glasses messed up. You know, it's on your face too.

LL:
So it's more than just the universal precaution type situation with orthopedics.

TH:
Yeah, very much so. And we so often—I don't know if I should use that expression—a

significant number of times in the operating room, we do get a torn glove or a nick in the glove from the night and that matters in HIV, you know?

LL:
A great deal.

TH:
Yeah. Right, right.

LL:
Not to—what do you think about—being an orthopedics guy, what do you think about the push on the part of the chiropractic profession to be recognized?

TH:
I really believe that they don't have sufficient education to warrant their being allowed to treat a lot of items now. I think that they can be excellent physical therapists, but their education is not the same as a medical or an osteopathic education. Medical and osteopathic, incidentally, are so close together, you hardly would know the difference, except for the name of the school or the degree after the person's name. But the chiropractor doesn't have anywhere near that in depth of an education and I think it would not be appropriate for them to do more than kind of hands on massage sort of thing.

LL:
What types of medical organizations have you been actively involved in?

TH:
Oh, I've been active in the Lubbock, Crosby, Garza county Medical, the Texas State Medical, the Texas Orthopedics Association, American Medical Association, the American Academy of Orthopedic Surgeons, the American Orthopedic Association, the Association of Bone and Joint Surgeons, which is just one more orthopedic group. I've been active in all of those through the years. I'm emeritus in most of them now.

LL:
What is the mission of the Lubbock, Crosby, Garza County Medical Society?

TH:
The mission of the Lubbock, Crosby, Garza County Medical Society is really to provide a vehicle for communication between the physicians of this area and I really believe it's been quite good at that. The real hitch in it has come with less people belonging to it than have in the past so

that they don't get the communication potential that really it was set up for. But overall, I believe it still does a nice job of keeping peace in the community.

LL:
Keeping peace?

TH:
Well I don't know if that's the word I should use, but keeping people talking, at least.

LL:
Uh-huh. What do you think is maybe the reason that the membership has declined? We're talking a proportional membership, a percentage, right?

TH:
Yeah. There seems to be less interest on the part of the younger physicians today in joining in to organize medicine. I don't know—I don't know that anyone understands why that is so. The—you see, less than half of the positions in the nation belong to the American Medical Association and part of it—I'm sure part of it with the AMA began with its negativism about social security, to start with, and then fought Medicare and the very things that many physicians thought we needed to support, were not supported by the AMA officially and I'm sure that some of the disenchantment began with that. Some of mine did over the Medicare attitude, although I've belonged to it all along. I don't now because I'm retired, but I do—I believe that today's younger physicians are really not as interested in organized medicine and the sorts of communication in which it provides, as we used to.

LL:
You hear so much talk about the power of the AMA and medical organizations in general. Someone commented here a couple of weeks ago about how little power you feel you have when you go before a congressional committee with less than a 50 percent membership.

TH:
Right, right.

LL:
They tend to just kind of brush it aside.

TH:
That's true. That's true. And they know it in Washington, you know? They know that you're not—they're not talking to the real—because there isn't a real leader for medicine today.

LL:
Right. I've heard people comment also on the AMA's inability to discipline the medical profession.

TH:
Been terrible. Now, that's one thing that has come out of organized—I mean, out of managed healthcare is that we have been able to utilize the records and show that certain physicians are doing certain procedures and call them on it and this was done—I worked at Blue Cross. When I retired from medical school, I was medical director at Blue Cross for the West Texas area here in Lubbock and one of the things I was able to do was to name an advisory committee of physicians of—we had twelve physicians and this advisory committee reviewed when we brought in information about overuse of certain procedures or overcharges and things like that, we would bring that to our committee. The committee would look at it and would usually instruct me what to do with it. To say—to talk to the physician and tell them that we're not going—we're going to take them of the managed care list or whatever and that has—that's really the strongest point I can make with managed care, I think, is that we've been able to stop some of the abuse that was going on and it was there. Some of them got pretty upset with me over it, who I talked to, the ones that I talked to about it. By in large, they're a very small group that would tend to do that. As we began to investigate that more when I was there at Blue Cross, I was really impressed with how clean, by in large, the Lubbock medical community was about things like that. There was very little overcharging. Very little overutilization. There were one or two surgeons who would unbundle. You know what unbundle is?

LL:
No.

TH:
Well, if a usual surgical fee is a certain sum, say five hundred dollars, but the—there are code numbers for various parts of that surgical procedure so if you take each one of those separately and add them up, they're worth more than five hundred dollars. So sometimes we get a bill for incision and a scan and another one for approaching a next level and another one for this sort of thing and that's not common, but there was a little bit of that, but by in large, Lubbock is very clean on that. I was impressed. We even had one person not in Lubbock who charged for sewing up the incision that he made separately from the operation. We didn't pay it, needless to say, but there was this effort to unbundle the two, pick out the separate parts, and had to pay attention.

LL:
Unbundling.

TH:
Uh-huh.

LL:
I think I'll throw that one at my vet next time. You're unbundling on me here. This is a seven in one vaccine. Thank you very much.

TH:
Right.

LL:
Can you see any change or any trends that have come about as a result of an increasing number of women entering the medical profession?

TH:
Well certainly an unexpected, I guess, spinoff that would be more women in various of the specialties that you might not have anticipated in years past. As an example, I guess, nationally, in orthopedic surgery, and when I first began practicing back in 1958, there were probably ten women in the nation doing orthopedic surgery and there are a couple hundred today, at least, so that's been one of the changes and this is true in a lot of the specialties where you wouldn't necessarily expect to see a woman in previous years for whatever reasons. I guess, when I was in medical school, we sort of figured that the—we had eight women in our class, so a hundred and twenty eight at Northwestern and I guess we expected them to be in pediatrics or internal medicine or family practice or OB and that was sort of the expected and that, certainly, has changed. Half of the class here now, pretty much, is women and I think that's excellent. Even though you realize that the women cannot, over a lifetime of a career, cannot spend as much time practicing medicine as men can because they are so often involved with taking care of the family in addition to practicing medicine and sometimes, you can't do both, but even so, I think this has been a really good trend.

LL:
As more time passes, more and more we see families wherein if the female is the one making the income, then it's not a problem for them man to stay home and take care of the kids and many men are beginning to appreciate that opportunity.

TH:
Right, right.

LL:
I was wondering, you know, over the years, we've seen—society has tended to see women as the caregivers and men as the bring home the bacon guys.

TH:
Yeah, right.

LL:
If that caregiver perception of women has translated into—has moved over into the medical profession, i.e., do women tend to be, as a rule, more adept at the patient care aspect that we were talking about before? Or has that been a fallacy to think that way?

TH:
I don't think it's a fallacy. I think women are much more sensitive to, even unexpressed, concerns of a patient. I've watched this and it's been interesting to me. Men just don't have the same feel of certain situations that women do. I think that's very healthy for a practice, for the women to be able to practice medicine and utilize that extra sense and I don't know what it is. I don't think any of us know what it is. One of the finest plastic surgeons that I'm aware of is a woman today and I think it's because she is so dexterous with her hands, more so than a big handed man.

LL:
Yeah. I could see how that might be the case. So in a sense, that extra quality that we don't know what it is that women tend to possess, or the majority of women—let's put it that way—has helped to move maybe some of this technological move away from patient care, has helped to move some of that back, at least in certain areas.

TH:
Right. It's helped to at least bridge some of that harshness, I guess, that we might've gotten out of technology.

LL:
That's an interesting idea. As a senior in the medical community, what kind of advice would you give to young people that are interested in making medicine their profession?

TH:
It's a fascinating career. It takes patience to complete the education necessary to practice medicine, but it's a very rewarding, emotionally, career and if they would be willing to take care of the patient and let the finances fall into place, that would happen. They wouldn't need to worry about the material things. The necessities would come and I believe that. Years ago, I

think that's the way we saw it happen and it did very well. But I would certainly encourage them still because I think the difficulties that we see with medicine today in the HMO's and managed healthcare are going to sort of fade or get less intense than they are right now.

LL:
Out of necessity.

TH:
Yeah. Out of necessity, yes. I think the patients are ___ [2:06:02], for one thing. They are a lot more numerous than the doctors are.

LL:
Yes. Yes. Yeah. Yeah. We have patients who are pretty much out of something to do, I guess.

TH:
Yes.

LL:
But it seemed to be the case, though, they could always come up with something, I guess. Looking at your career in its entirety, if you had the opportunity to go back and start again, is there anything you'd do differently?

TH:
Not really. I've enjoyed every step of my career. It's changed as we went along, you know, from pure patient care to managing of an orthopedic department and then to working in the medical administration and then to the Mednet [2:07:10] project, but every bit of it has been very interesting and each, rewarding in its own way. I doubt—I can't think of anything I would like to change.

LL:
Is there anything relative to the medical community in Lubbock or your personal career or medicine in general that you feel that we need to discuss that we haven't covered?

TH:
[Pause] Well I'm not thinking of anything right offhand.

LL:
A way to—one way that I sometimes ask that as if we were—[Recording cuts abruptly].

TH:
Both have some question about what will happen with the Methodist-Saint Mary merger and what that means to medicine in Lubbock and the purchase of practices by the hospitals and I guess none of us know. None of us have a way of knowing what that means long term. I just have kind of a gut feeling, I guess I could call it that, that the physician's practices are going to revert back to an individual practice or phenomenon. That's my belief of within several years and that there won't be all these hospital owned practices and that the hospitals are hopefully going to be less money making oriented and let it fall into place just like I hope the physicians will. Probably, the one thing that has bothered me about medicine in the last several years is the real heavy greed, I guess I'll call it that. It just doesn't belong to medicine and maybe with a little time, some of that will pass away and we can resume. Of course, the young people getting out of medical school today will not have ever known a different type of practice than they're going to see whatever that's going to be. But I think just a good feeling with patients is going to teach them that they can practice medicine and not worry about the material aspect so much. That's probably the thing that bothers me the most about medicine, but it isn't just medicine. You know, it's the world.

LL:
Right.

TH:
It seems like everything around us is this way.

LL:
It's—this is not really what I'm supposed to do, but I'm going to do it anyway. We were talking the other day about, you know, those of us who are graduate students in history, about the sixties and what was the impetus behind the sixties movements and one of the fellows who works with me, who is extremely conservative politically, he just spoke up and said, "Well I don't think that today's youth are nearly as bad as my generation," considers the baby boomer generation, "and that the impetus behind the sixties—that the problem in the sixties was not necessarily drugs and just free whatever. That the problem was," he's a military historian. He says, "Right after the Second World War was when we began to equate our military power with our moral superiority and the idea that we did so well in the war because God was on our side and that connected political power with religion." So that—he thinks some of these children who were raised in that situation were brought up to see their religion and their spirituality as connected with the government. As there being, in many ways, an intertwine, and then when Vietnam and things like that came along, they began to see what they call, "depocracy," and it made them, "Look, well if this is not my spiritual life then what is?" And they began to look because the things—the watch words that they use—things like love and Jesus and things of that nature were things that came from that spiritual teaching. They just no longer saw it where they were. They were

looking for it somewhere else and it seems to be that same cycle that goes—you know, we're talking moving from the old ways in medicine, the patient care stuff and totally away from that, but still claiming to be into patient care and what the next generation is going to bring. If they're going to see that difference and is it going to take an economic extension? You know, we build the empire so far that the pilings fall out from under it and we're forced economically to go back. Is it going to be another generation who says, "Wait a minute. This is."

TH:
Was the Depression a good thing for us? That sort of idea. And are we going to need that to regroup and put ourselves right? You see, I think Russia today is—the average person in Russia today from all I read is going through a lot of the same connections of religion with the government and the way that you mention that it was happening back in the sixties and because they hadn't known it another way.

LL:
As historians, we look at Hegel's dialectical process and the idea of the thesis and the antithesis and you must have both before you can arrive at the synthesis to something that everyone can live with and we tend to shy away from that as being something that's too simple of an explanation, but it seems so often to work in that way that you must have the two extremes before you can come to the middle ground.

TH:
Well that's true and we certainly do. In America, we do the pendulum from one side to the other, seems pretty much routinely.

LL:
Along with the medical changes, we work in the situation with women. The women being homemakers to women being, "I don't want anything to do with homemaking," to women moving back to that center and here, we're saying women may be the start of that bridge. The way that works together is really interesting.

TH:
Well you know, through history, that's really not true. The women have really been the central root, it think, of what's happened. You read about the women. The importance of the women on the ranch here and yet, many of the men would never have agreed that that was true, but the stability of the whole situation says that was true. There's—I've been trying—maybe you know—I've been trying to remember a good many years ago, someone was talking about a monument to women out in—I think it's in Sacramento. It's in California. That part of California. And on the monument, it shows—it's a pioneer woman—and on the monument is

inscribed, "If you would see the real monument to the frontier woman, look at the people about you." That's really fascinating to me. Are you familiar with that at all?

LL:
No, I've never heard of that, but that's an interesting inscription. [Laughs] Why don't we turn this off?

End of Recording