Oral History Interview of
Robert "Bob" Carr

Interviewed by: David Marshall
June 24, 2014
Lubbock, Texas

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Transcript Overview:

This interview features Robert Carr. Carr talks about getting out of the Navy and attending Texas Tech. Carr also discusses his interest in pediatrics and his career in medicine.

Length of Interview: 02:11:49

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David Marshall (DM):
The date is June 24, 2014; this is David Marshall interviewing Dr. Robert Carr at his home in Lubbock, Texas. And this is the second in a series of interviews, we talked last time about your childhood, and we talked about high school, and World War II, so let's pick up there when you were discharged and began your medical career, and your training. So can you just begin right there?

Robert Carr (RC):
Okay, when I was discharged from the Navy, then I came back to Tech and registered again and in fact that's where I met my wife that year. And I was in there for one year, and then they called me from the Navy—now this is where I'm getting confused.

DM:
That's okay.

RC:
Just a second.

[pause in recording]

DM:
So tell me about when you were discharged then from the military, and began your studies at Southwestern.

RC:
Okay, well I already had of course graduated from Lubbock High School, and then when I came back after the war, then I was discharged in Chicago from the Navy, and they sent me by train to come back down to Lubbock to be discharged, to go return where I joined. And then I enrolled back in Texas Tech, because I'd only had about two years of college—one year at SMU and one year at Tech. So I enrolled again at Tech. And when the enrollment period—and of course I was an older student, as a lot of the people were, the men, because they'd been to the war just like I'd been. And so I was out there looking at all the freshmen girls, and in a long line of freshmen there was a cute little girl that I saw named Betty, and I wanted to meet her but I didn't do it at that time.

DM:
What was her last name by the way?

RC:
Her name was Betty Jean Sullivan, S-u-l-l-i-v-a-n. And so anyway, what happened is that that

very same night, two other guys and I were putting out some fliers for the Methodist church welcome program we were having down there for new students, and we were planting them around the grass at Texas Tech, and we saw three little girls come up to us, and there were the three of us boys. And what had happened is that one of the girls had been there at freshman convocation, and one of the girls had taken all her money that she had for tuition and put it in her purse, and then had dropped her purse somewhere along the line in the building. And it was the old agricultural building, so they asked us if we would help them, because when they went back up to find them, the doors were all closed, so they had no way to get in there. And she was frantic, because all the money for tuition and everything was there. So we said, "Yeah, we'd be glad to help you," and they thought it was alright, because after all we were putting up signs for churches. And they figured we weren't going to attack them or anything you know, so one of the guys went around, was able to raise a window, and got back into the auditorium, and found that her wallet was right there where she'd dropped it.

DM:
Oh good.

RC:
So he brought it back out, and we asked them then would you ladies like to go with us to have a coke or something? And they looked at each other and agreed it would be okay. So we got in the car, went over there, and that was how we began. The next day I saw Betty, she was standing in a line to get tickets for something, I don't remember what it was, but anyway I decided I would go up and say hello to her again, because I was kind of smitten by her at the time. And so she said that she would go with me and so we got together then after that, and that's how we learned to like each other. So it started in the line, and she said, "You always came back to me, because I was up in the line, and you wanted to crash the line up front." And I said, "Well, you're probably right to a great extent." So anyway, we did that. Then after we got there and I got registered again, as I had mentioned here before, the Texas Tech had a ruling that if you had a hundred hours, you could then apply to medical school. And if the medical school would accept you, then they would go ahead and let you go back to medical school without graduating from Texas Tech. And after the first two years, of medical school, and they would automatically give you a degree from Tech. And they would count you for the other twenty hours that you hadn't gotten at Tech. So that was good, and so I applied and was accepted to Southwestern Medical School.

DM:
Okay.

RC:
Now Southwestern Medical School was a very young school at the time, and they had just been built with old Army barracks, there wasn't any brick schools or anything like that at all. It was

put behind Parkland Hospital in Dallas on Oak Lawn and Maple avenue. And so we started among the first people that enrolled there, not the first class, but probably the second or third. We had forty-five medical students from all over Texas and one or two outside Texas that started out. We graduated with about forty-two or something like that, so we all did pretty well there. So anyway, we enjoyed medical school, Betty and I had married at that time after I'd been in medical school for a year.

DM:
I have this as 1948, does that sound right?

RC:
Yeah that'd have been probably about 1948.

DM:
Okay.

RC:
And so—or 1947, might have been too—but anyway, right in there, and she convinced me that I was very lonely, although I didn't think I was. But she was here at Tech and I was there in Dallas. So we finally decided to get married, which we did, and the best thing I ever did. And anyway, so I went ahead and graduated from medical school at Southwestern Medical School in 1951. After graduation, at that time you were almost like a slave, because you went to the medical schools and the teaching hospitals, which were really the best ones in the nation—paid you very little, in fact some had no salary at all, you just came and worked for them. At Parkland, which is a real well-known hospital at that time in Dallas, I worked there. But people that went for internship there got twenty-five dollars a month, and then I decided to go to Colorado, to the University of Colorado Medical School in Denver, because it had mountains around it, and I knew I was probably going to come back to Texas, and I thought it'd be nice to be in an environment that I wouldn't be in the rest of my life. So we went there and stayed there for a year at that time, and really did enjoy it, it was a nice thing we had, we had nice people we were associated with. And I got some awards while I was there too. Oh, one of the things too, didn't mention about cost and so forth. I did receive when I got into my residency the next year at Texas Children's Hospital, I received seventy-five dollars a month there, so I got an increase, quite a lot, from the amount I was getting in Colorado.

DM:
Do you remember what that amount was?

RC:
In Colorado I think it was about fifty dollars or something like that a month.

DM:
Oh okay, still more than the other internship.

RC:
Yeah, it was fifty dollars in food.

DM:
Oh.

RC:
So my wife and I ate at the hospital most of the time. And she became pregnant middle of the internship, and the funny thing about it is that we don't have enough money to buy meat and so forth, so we would always eat at the hospital the days they had steaks there, so she could eat some too, because I couldn't take anything home to her. And so that was real nice, we enjoyed it for a year, and because we knew we were coming back to Lubbock, so— And also my residency, after I got through with my internship, which was one year after my graduation, then I had a year internship, then I had two years of residency. And the second year of my graduation, I got a hundred and twenty-five dollars a month for that. And as you can see, the months there it never did increase very much. But along with what the government gave me, and along with what Betty got by working all the time, we were able to get by.

DM:
That second year you were chief resident?

RC:
In the second year I became chief resident.

DM:
That's why the money went up over that period.

RC:
That's right, it went up a little bit. But also, during that time too, Mead Johnson, which is a big company for children's drugs and so forth, awarded twelve scholarships over the entire United States to be giving to what they said, "outstanding residency." And they awarded me one that I got a thousand dollars a month for—a thousand dollars total I think it was, divided, given over the years' time. And anyway I got that, which also helped to add a little bit of money to the pocketbook.

DM:
There are several things I want to ask you about that chief residency, but before we do, can we back up just a little bit, I had a few more questions about Southwestern Medical School.

RC:
Okay.

DM:
Can we go back there just a minute?

RC:
Yeah.

DM:
I wanted you to talk a little bit about the GI Bill. You were on the GI Bill when you were first living in those wooden army barracks I believe?

RC:
Yeah, yeah.

DM:
And something I read that you had written a while back said that they paid a hundred and five a month, does that sound right?

RC:
Yeah that's probably right, a hundred and five.

DM:
Okay.

RC:
Now but they didn't do anything but gave you tuition and some book fees.

DM:
Oh.

RC:
But as far as living outside, which we did, we were able to find an OPA, which is an Office of Price something from the government, which wouldn't let people raise rents on soldiers and sailors, and so we got what we would consider the second-rate apartment for forty-five dollars a

month. So that's how, again, we were able to make it with Betty working and not having much rent, and getting food at the hospital. And mother and daddy gave us a car. So with all that we were fixed until we got out, and then the residency with that little extra money we got from there too.

DM:
Maybe you better talk about that first apartment. I saw a little bit about that, it sounds more like a third-rate apartment.

RC:
Well, it was nice for us. It was okay.

DM:
Okay.

RC:
It was up on the second floor in a nice part of town—well, that's the second one we had.

DM:
Okay.

RC:
The first one we had was over near Baylor Hospital. It was this second floor of an old house over there, big old mansion house type of thing. We lived on the second floor, they had converted it into an apartment up there, and the only way you could get up there was by stairs that they built on the side of the house, that you went up with a handrail to get inside.

DM:
Okay.

RC:
They did have a porch on the outside, which is what I liked, that you could sit out sometime. But it was so hot out there in Dallas all the time, you could hardly do that. But it was nice to have the view. It was right across the street from a fire department that was always on call, and then Baylor was a block away.

DM:
Okay.

RC:
Had ambulances that went by there all the time. In fact as Betty and I have laughed about many times that we would have ambulances going by us so much, that we had a fire across the street from us, and with ambulances and fire trucks and everything, and we slept through the whole deal. Didn't even know they were there until the next day. It was an apartment that was really very nice. We knew we had to have one, and we didn't have enough money for Betty to come to Dallas to look for one. So it was during exam time and she asked me if I would go out and rent the apartment. So I found this place and it was the only one that was reasonable at all, but the kitchen was just a room that had a little stove in it, a gas stove, that you could cook on. And it had an ice box, and I mean really an ice box, that you put ice down into, which meant that enough water would come out of it in two hours that you had to empty it, or it overflowed. So we never got to go even to a complete show, because we'd have to go—shows were usually two or two and a half hours, and so we just emptied the water before we left, and then hurried back to get there before it ran over very much.

DM:
Now this was the shared bathroom apartment wasn't it?

RC:
A shared bathroom—you had to get your water to drink out of the bathroom, out of the bathtub, and bring it in in a bucket in our area to drink for water, and cook in and so forth. But of course we were newly married and we didn't know any different, and what the heck. So we enjoyed it very much. Finally though, Betty began to tire of that, and we were able to find, maybe after six months of living there or so, able to find an apartment over near on Oak Lawn, in that area there, that was fairly nice.

DM:
Okay.

RC:
And it's the one that had the [OPACS, Office of Price Administration and Civilian Supply] limitation of forty-five dollars a month or something like that. But now to get back to that apartment, which was very nice, it had the screen door, screened in porch on the outside. It had windows, but all the windows were very leaky, and anytime it rained, which it didn't do that much even then, it leaked in. But otherwise it was okay. The only thing is the wind blew a lot there, and it would just come right through the window, and so we had a bedroom, we had a porch outside, which we sometimes slept on the porch and then we had the bedroom and the living room in there. So it was nice enough, it was a lot of fun, and again being young and newly married it didn't make any difference anyways.

DM:
Well before you got your car, how did you get around—could you walk to the hospital?

RC:
No, it was a little too far, but we had a friend of ours that when he was in medical school—he had lost his leg in the war, and the Army, or whatever service he was in, gave him a car to get to medical school. So he would come by and pick all the rest of us up and take us to medical school.

DM:
Okay.

RC:
Take us home. Then whenever we got the car from my daddy, of course we'd just use that one.

DM:
Okay.

RC:
Yeah.

DM:
Now I think it's interesting that the government paid the GI Bill for your schoolwork, but didn't help at all during an internship when money was really—

RC:
Ah, but you see it didn't have to have at that time even an internship. There were several people from my class that graduated with me—they went directly out into practice.

DM:
I see.

RC:
They didn't even take any sort of extra training. Those were the ones that were going to go in with an established physician, or somebody that they could learn from him too. But you didn't have to have any extra training after medical school at that time.

DM:
That was kind of like an apprenticeship then, you attach yourself to a practicing physician, interesting, okay. Alright, can you tell me some of the anecdotal accounts, some of the stories—I

know that you've written about dissecting cadavers, and I know that you've written about testing urine and interesting things like that that happen there in that first year or two at Southwestern Medical School.

RC:
Yeah I told you the story I think about the cadaver that walked up the hall? Told you what I was scared to death about?

DM:
But not on the record.

RC:
No not on the record, okay.

DM:
No, do you mind telling that story?

RC:
Yeah, well it was a very interesting story, because medical school then was nothing but these wooden barracks. And they'd been used so long, that the floors were always noisy. When you'd walk across them, they'd stretch away from the other board and make a noise or a squeak or something like that. And it was just a one floor with several buildings jutting out from a main hallway.

DM:
Okay.

RC:
And so one night I decided to go back to medical school to study something up there. I don't know why I did that except that sometimes the guys—I lived in a fraternity house at that time, Kappa Sig—no I'm sorry, it was Phi Beta—and so I decided to go back up there to study. So I got there, and you went down this hall and then they have just sometimes a long hallway extending down in the other direction. Ended up in the classroom, but there were some little offices before you got to that area. So I came down one of these buildings, and then went in one of these small offices along this long hallway, and I was sitting there reading, and all of a sudden I was aware of a sound that went swish, and a swish, and a swish, and a swish—and I thought my gosh, what is that sound? And I was there by myself and it was dark except for the room where I was. The cadavers were in the next building up from me, and that day we'd finished taking off the legs of our cadaver that day, studying the muscles and things like that. And I thought my gosh, the thing that sounded most like to me is that cadaver, who we just put a sheet

over him, an oil sheet. He was swishing, swashing up the hallway, and I thought this is that cadaver coming after me for taking his legs off. You know at night and having done what you just did.

DM:
Sure.

RC:
Oh boy, this is something—reasonable thinking was not something you did at that time. So anyway, I listened, I listened, it got closer and closer, and I thought well there's only one way out of that room, that was the door that led out to the hallway where that noise was coming from. And so I just got to get out of this room. So I opened the door and looked, and it got right up to my door, and I said well I got to get out. So I opened the door and there was the janitor, he was mopping the floor out there, swish, swish, swish, back and forth. And I surprised him to death, because he didn't know I was there, and I was very glad he was the one that was there, and nothing else. But that was real funny too.

DM:
Nice to find a rational explanation for these things.

RC:
That's right, but that was the scariest thing I think happened to me in medical school for sure.

DM:
Can you tell me about some of the other jobs you worked, I mean the times were kind of tight apparently, you were—

RC:
Yeah, well in the summertime you were off three months—

DM:
Okay.

RC:
Which was good to do, because it gave you time to relax and everything—but on the other hand, three months without any income, what are you going to do? You've got to make some payments and everything for next year, and all this other stuff. So what Betty and I did, she kept on working, but I was able to get a job at the only job I'd had experience in, here in Lubbock was working at the Furr's food stores. And I was a grocery stock stacker. I handled eggs, farmers would then bring things in, trade them in for food and so forth, and I would check to be sure it

was all good food and so forth. So anyway, so that's the only experience I'd had. So I finally found a little place, and I tried to get a better job—in fact one year I'll tell you what I did—but the first year, I was able to get a job in a little grocery store where they made home deliveries. So I got in there, and they would let me have a car, and they paid me a little bit of money, and I worked twelve hours a day, except for Sundays, and then they would pay me a fair amount of money that I could then contribute to the household expenses. But that was fun, because I enjoyed meeting people on deliveries, and doing what I did. Another time another year, either the first or second year, I got a job as a sitter, hospital sitter.

DM:
Hmm.

RC:
And because you were a medical student, everybody thought you knew a little bit about medicine. So they thought well—I'd got on this list of people that were available to sit with people at night in the hospitals, because they didn't have a lot of nurses that would do that. And I was just a babysitter is really what I was. So I went there and did that, but it was awfully hard. I noticed I saw a lot of sunrises in Dallas, going from sundown to sunrise, where I was fighting to keep my eyes open. Because there they were supposedly sleeping, and I was helping them with them to go to the bathroom and things like that. But anyway, I saw many a night end in Dallas when I was doing that all one summer. And that was pretty good pay, because they paid you pretty good there. The other summertime job I had, which it even reinforced my idea to be ever this again, was a book salesman, door-to-door book salesman. And I got a job—the book was called *Book of Knowledge*, it was an encyclopedia at that time. And what they did, is they sort of sucked the people in, because you went up to the door, knocked on the door, and then you'd ask them some questions. You'd ask them if you could ask them some questions, and most of them were fine about it, nice about it. And then the last question was do you know anything about the Grolier Society? The Grolier Society was the publishers of the encyclopedia that I was selling. And they would usually say no, of course nobody had ever heard of it before. And then I would use that to say well I'd like to just talk to you a minute more about the Grolier Society. And most of them, "Fine, okay." Only thing they just had kids around that were making some noise, and they were not going to go anyplace anyway. So I wasn't very successful at it, but those that I was successful at it, I kind of regreted because they were usually people that didn't have any money, the living room furniture was really boxes or something like that maybe sitting in there. And they're the ones you tried to make feel guilty, because if they didn't get it, their child was going to be uneducated, and if they really loved their children, they would go ahead and accept this bill they were going to give to them. And it was a bunch of books; it was about twelve, eighteen books. But you had a low payment every month, not very much, and it was one of those deals you tried to suck them in.

DM:
Yeah.

RC:
Well I did that for several months, but it just gnawed at me every time I sold a place, didn't sell but three, or four, or five, but whenever you did that, it made me feel terrible, because these guys could have used that money for something else a lot better than buying an encyclopedia for the kids, who might be just two or three years at that age anyway. So that was another year that I did. Then of course when I got out of medical school then I was a doctor in all ways, and then there was a twelve month year working in the hospitals, where you were the doctor that was there. But those were odd things, I ended up at that time encouraging my desire to be and to remain a doctor. And was never sorry that I was a doctor, ever.

DM:
And apparently you had some opportunities, even that early on, to be a doctor, because I think your first deliveries came somewhere in this time period.

RC:
Oh yeah, yeah.

DM:
Can you talk about those?

RC:
Oh yeah, in Dallas they dependent a lot upon the population. For example, the deliveries, you got them a delivery system, where you were on the OB/GYN, they put you for maybe six weeks on the outpatient deliveries. And so that a person would call you and maybe didn't want to come to the hospital, or maybe didn't have enough money to get in the hospital, and they wanted to deliver at home for whatever reason they wanted to. Then they would send a nurse and a doctor out, and deliver them at their home. Well that'd have been real nice, because most of these people, because they didn't have any money, they lived in little shacks. One of the first ones I ever went to, the family lived in the chicken shack they had just made a little bit waterproof. And so we delivered the baby in the bed that had a mattress that had been depleted of all its springs approximately ten years ago. And also in the middle of that room was a television set. The television set at that time—in our fraternity we had a ten inch screen. Well they had probably one of the biggest ones being made at the time I guess, fourteen, or fifteen, or sixteen. They had a big one like that in a cabinet, in a walnut cabinet. And over it they had built a second shelter, put a tin over it to keep it when the rain came in the roof, it wouldn't hit their television set. So I thought that's really something, because here I've got to come out to their house and deliver the child for nothing, and they've got this TV over there. But they enjoyed it, and the whole family,

probably the whole neighborhood would come in and watch it at times. But that was kind of funny. That was down in the territory that Bonnie Parker and Clyde Barrow came from, that same area.

DM:
Oh.

RC:
And then other things as far as my internship, let's see—Oh, when I was doing my residency, another interesting thing happened with me in the hospital. I may have told you something about this, but I was chief resident as I told you, and that meant I was in charge of all the residents, which you had about ten or twelve at the time, of assigning them where they went.

DM:
Okay.

RC:
And being sure that things went well, and I was kind of elevated to a teaching position too, gave lectures and so forth. And so anyway, they assigned me to Parkland Hospital in the summertime whenever I was there—Overton Texas Children's Hospital—to go there, because they had a branch there. Well that was the year that they had the biggest polio epidemic in the whole nation, was that year. And they had so many people, that they actually remodeled a big part of the hospital into just one big gymnasium-like room, so they could put all the iron lungs in one room, and have people that would be there, if they could be helped over here, helped over there, rather being individual rooms that you didn't know when they were being helped, or needed to be helped.

DM:
How many beds were in that area?

RC:
Well in that, I imagine there were probably thirty or forty iron lungs.

DM:
Oh, wow.

RC:
And then they had their people that did not have bulbar polio, that was the bulbar victims. The ones that got it in the spine, up here in the bulbar area, that controls the breathing. If they got it there, then they couldn't breathe on their own, and they had to be helped to breathe, and that's

what the iron lungs were for. And had to be watched very, very carefully, because you were their only source to getting oxygen, and suctioning their tubes in their necks and things like that. So anyway, I was in charge of all this area—I was the doctor in charge of this area, along with a bunch of residents, and private doctors that came in too. And it was a really a wild thing as I talked about in the talk that I gave. At night it became almost eerie and even scary, because you'd have all these lungs that were making all the noises of the air being exhausted out of the iron lung, and then the next breath being taken, breath out, breath in. And with the nurse, with nothing but a little thing like over there by you, that sort of bent over, had a light like that over each person like this, so they were under a light all the time so the nurse can see them. And had a nurse every head of each one of the tanks, and then had orderlies all the way around to help the nurses and so forth. And then we had to be ready in case there was any trouble with the electricity, because all these were electric machines, and they could be done by hand laboriously, for maybe ten or fifteen or twenty minutes, before you changed to another person. So if the lights went out, the electricity went out, every one of these people would die unless they had somebody cranking the air in and out you know.

DM:
Did that happen?

RC:
So you had to be ready for that. Never did happen thank goodness.

DM:
Oh good.

RC:
And but we were all prepared for that, and it was a wooden floor so again it squeaked, and people walking across the floor made noises all night long. And these little lights up and down the whole gymnasium area, and then people walking around, nurses talking and whispers, doctors coming in and out, checking machines to be sure they were running all right, things like that—it was an eerie type of thing. The responsibility was just nothing like I've ever had before.

DM:
Did anyone ever improve to the extent they could be taken off the iron lung?

RC:
Yeah.

DM:
Okay.

RC:
They did. Now polio, when it came on, the bulbar might come on immediately or it might take a day, or two, or three to show up. It might end up just being nothing but paralysis of the legs, or might be a weakness in the arm or leg, but it might involve everything, it might involve bulbar up here, might involve the whole spine. And there was no treatment for it, the only thing was Sister Kenny, a lady nurse that came from Australia came to talk to us one time, and she was the first one to try to do something to relive the pain that these people were in. Because the muscles spasmed and things like that all the time. So she came, and showed us how to take these woolen blankets, and put them into washing machines, and get them real hot, and then wrap the limbs with that, because it relieved the spasms—gave them some relief from all the pain that they were having. So that odor came—woolen blankets, if you've ever been out in a woolen blanket, or woolen anything got wet from the rain, and then it begins to smell. Well this had that aroma all the way through that all the time, because they were washing blankets, getting them hot, and then washing them again, getting them hot. And but see she came and told us how to do that, so we did that too.

DM:
The patients in iron lungs, it was a bedpan situation, because it was a—

RC:
Yeah, you had arm things that you'd work through little arm things that kept the pressure inside. So you could never take them out, unless you had some other way to aerate them, and you could do that maybe for a few minutes with a little hand one up here, but it wasn't very good.

DM:
If they had this program on the spine, how did they get better, how did—

RC:
Well it spontaneously—just like getting rid of the flu or something like that. That didn't mean it ever came back, because some would be paralyzed say in the arms, and never get their arms back. But a lot of people who are paralyzed in the legs never did get to learn to walk again. Or if they did, it was only with help. The only ones that we really worried about dying of course would be those that were their brain was not telling them to breathe. And that's the people that had the bulbar polio.

DM:
I believe you talked about hearing the iron lungs being shut off.

RC:
Oh yeah, it was one of those things that we had two people that worked there that died while I was there. One was another resident, a doctor. Real nice fellow, he was there, just exhausted himself trying to take care of everybody. But he caught it and he died first two or three days. And then we had a nurse that also caught it. Because you see we didn't know how people caught it at that time. We thought it must be obviously person to person, because there's so many catching it from everybody else. But we didn't know it came from spittle as you talked, we didn't know whether it came from bowel movements that might have been contamination, the air contamination and so forth. We didn't know whether it was the water you were drinking, we didn't know whether it was when you went swimming, or whether just crowds that you could avoid. So we had all the schools, everybody were told not to meet in any crowds over four, five people, so that they wouldn't catch it. And we also tried to do everything we could do about not getting them exhausted, to get plenty of rest, eat good, take liquids—just simple things like that is all we could try to do to prevent it. But everybody came in sick in that time to Parkland, you almost had to almost do a spinal tap on them to see, because the signs might be very obvious, but you wanted to make sure it wasn't meningitis that you could treat, or something like that, bacteria. It was a terrible, terrible year.

DM:
Did it change you? I mean you were around these tragic lives more than most people are.

RC:
Yeah.

DM:
Did it haunt you at least for a while, did you get used to it?

RC:
You got used to it. But never entirely, because you always had kids that—Like for example, one of the first patients I had when I came to Lubbock in 1954, was a guy, a little boy about six or seven years old named Gregory Hannibus [?], I'll never forget it, and he developed bulbar polio. And we didn't even have but one iron lung in Lubbock at that time, so we got the iron lung there, the fire department had to bring it out, they maintained it and brought it out. They did have chest respirators, but they didn't help if you were having very much trouble at all—they didn't move the air enough. And so they brought it out for him, put him in it, and we saved his life. But he never did get over the bulbar part, never could breathe on his own, was completely helpless, paralyzed from neck down. And we kept him in the hospital as long as we could at West Texas Hospital, and then we took him home, and then I would make house calls down there to see him, to be sure he was doing alright. But his mother and father were just saints. They took care of him and kept him alive. He was an inspiration, he really was.

DM:
How long did he live?

RC:
Oh probably several more months afterwards.

DM:
Okay.

RC:
But usually what happened, is they usually got clogged up, developed pneumonia, and that's what carried them away in the end. So I don't remember with Gregory what he had, but I think that's what he died of.

DM:
So do you think you came out of this experience a different person?

RC:
Oh yeah.

DM:
Okay.

RC:
It made me a much more—sympathetic I guess is the right thing, for not only to people that had these diseases, but those that did not. I remember another little child that I had during my practice that had a liver tumor that had a big growth on his liver and so forth, that now we could save by having a liver transplant. But that age, we didn't do anything; we'd just keep him comfortable. And he lived for many months before he died. So all those people like that really made an impression upon me.

DM:
Things have certainly changed for the better in your lifetime in the medical world, haven't they?

RC:
I have a talk that I give about how the medicines that we had then. At that time, we had the penicillin, which was found during World War II, we had sulfa [sulfonamide], which has been used before, and then we had streptomycin, which we found later helped a lot as far as tuberculosis, but which if you gave too much of it would make you deaf. So it was always complications with these things too. And that's all we had. If you think about, I don't know how

many antibiotics they have now, must be variations at least a hundred, two hundred, and there we had three. So, and penicillin can only be given by shot and by mouth. You couldn't give it in a liquid because it deteriorated too rapidly. So we got one of the companies in Dallas to make a product which they still make, it's called Syrpalta. It's just a real sugary, sweet type of thing that tastes really good. And you could take some of this really bitter penicillin powder, and hide it in there and give it to the kids, and they'd take it that way. But they would swallow, it was just so bitter, from plain penicillin powder you know. That's just another thing to show you how things have changed.

DM:
Well there must have been some excitement about these miracle drugs coming out, antibiotics, but when did you start to hear about the problem of people's systems becoming dependent on antibiotics, or learning to fight antibiotics, the overuse.

RC:
Well, of course you were either allergic or not to these medicines. An allergy could take the form of just an upset stomach, or diarrhea and so forth. People couldn't take penicillin because it caused so much diarrhea at the time. Or if you were allergic to it, you could break out in a rash. And if any of these symptoms got bad enough, you could never give them penicillin again. And of course the first variations usually that drug companies would decide to do, is they'd make a variation, still a basic, basic penicillin molecule, but they'd tie chemically a little different up here, like amoxicillin, which came after penicillin. If you're allergic to penicillin, you're allergic to amoxicillin, because it's the same medication, just changed a little bit. So yeah, some of the first—I don't know, you might read the story sometime how penicillin was found and since this is a trying to give a history to you of myself, sometimes it's interesting to read how penicillin was found as a result of contamination that occurred on a—professor in England, that he left some penicillin that he was working on, to look to see if he could find something that would kill the bacteria that he had in the petri dish, to see if it might kill it. And he came back the next morning, having had to leave in a hurry, and didn't cover it over. And the janitor had come by and swept that night, and some of the penicillin mold on the floor had gotten on his thing, and he noticed that there wasn't any bacteria living around this antibiotic that he'd gotten on this mold that got up on this test that he did. Well that's how he then said, "Well maybe we can use that." So that's how he found it, just because he was careless and left a petri dish with the bacteria unfolded up there on the top.

DM:
It's an incredible story.

RC:
It really is, and then a lot of other things were established in that manner too. Among the first

penicillin recipients was a guy from St. Mary's Hospital here in Lubbock. He was a janitor there, and he caught a bone infection, and they couldn't clear it. And the doctor told him—I don't remember who the doctor was—told him if he'd get some of this new penicillin that they've just been letting some people have just experimentally, they would go ahead and they'd get it. So the lady who was in charge of [Phone Rings] St. Mary's Hospital—Betty will get it. [Pause, second ring, Picks up phone and hangs up.] The lady that called from the hospital called Franklin Roosevelt, and talked to him personally, and told him that we had a fellow here that—and she was a Catholic sister, so I guess she got in to him because of that too.

DM:
Yeah.

RC:
But she told him that she had an employee that they told her that they saved his life with his bone disorder if they could get penicillin. So he established and sent to her this real precious penicillin, and it cured his—he was one of the first people in the United States to get penicillin, was at St. Mary's Hospital.

DM:
Have you ever seen that written up, like was it in the newspapers in Lubbock?

RC:
It was in a story about St. Mary's Hospital, yeah.

DM:
Oh I see.

RC:
I had heard it from her, but she wrote about it in a story there too.

DM:
That is amazing. Hopefully they—

RC:
Of course the reason they didn't give it originally was the fact that they did these tests and found that it worked real well with petri dishes. But that didn't mean even the human body can tolerate it. So they began to get all these people back from the war who had terrible injuries with infections, who had pneumonias, which carry people away real easily at that time, because they were sick and ill anyway. And so they started giving to them, and what they would do is they'd take the penicillin and like they would give maybe a thousand units. And now we use millions of

units at one time, but they used to use a thousand units and inject it in a person, and then they wanted to be sure it didn't kill him, because they didn't know it wasn't going to kill him. And then they would use that, then they'd get his urine, and there'd be enough of that active penicillin in his urine when they got the penicillin they'd give that to him again, what was left. So the penicillin was extremely—because you had to make it by overnight at least, or longer, in order to get the penicillin to grow in these petri dishes. They didn't have any big vats like they have now where penicillin is made. So but it was just wonderful, because to have something like that that you could give people that cured them. I always told people when they asked me why I went into pediatrics, well there's two reasons—one I had a lady professor that I admired very, very much, her name was Dr. Gladys Fashena, and Dr. Fashena—

DM:
What's that last name?

RC:
F-a-s-h-e-n-a.

DM:
Okay.

RC:
Gladys is the first name, and she was my professor in pediatrics at the medical school, and I admired her so much, because she was so smart and so that's one reason I came back to work at her hospital under her.

DM:
Okay.

RC:
And she was the one that appointed me chief resident the second year. But anyway, what was I going to say about that, it was—

DM:
You were talking about penicillin.

RC:
Oh yeah, well anyway she was the one—and I don't remember what it was, I'm sorry.

DM:
That's okay, and then you said something about the two reasons you went into pediatrics.

RC:
Oh well that was one reason, was because Dr. Fashena. I always told her that, and she was very appreciative. And the other reason was—I remember now—I used to tell people, I said taking care of babies is kind of like looking at two cars. If you have a car over here that's twenty years old, and they bring it in to get it fixed, you probably are going to fix it, but it probably has a bunch of stuff wrong with it. It's never going to be like new again. And yet if they bring a child into me, he's only been here maybe two weeks, or maybe two years, and everything's new about him. So he'll only have one illness, usually, and if you can get him well from that, then the other things will take over, and you get back to normal again, you see? That's why I didn't want to go into what they called "old age medicine," things like that that old-aged people get. So that's why I enjoyed pediatrics.

DM:
I'm glad you said that, that's a great explanation. And you had already had some experience delivering babies though.

RC:
Oh yeah.

DM:
Can you tell me about the one, the Volkswagen, and those first two—

RC:
Yeah, in the medical schools, they would, again, obviously have to get professors with a student to deliver, or at least a higher resident in to get in and get the approval of the person that they were going to deliver, it was kind of sometimes hard to do. And so when I got out of medical school, I delivered about, oh twenty children I guess, by myself, twenty infants. And I thought well that's not very many, I don't know whether I could do this on my own now, without somebody telling me how to do it. But anyway, I got up to Colorado General Hospital, and there were people there from Mayo's, and some of these big, big—Duke University—all these places that you'd heard about, and I got to thinking when we got an OB/GYN, these guys probably really know how to do this delivery stuff real good. Well it turned out most of them had delivered maybe one or two at the most, because they had so many people in their medical school, and ours was a small one, that everybody wanted to get their own deliveries. So the guy that was in medical school, he didn't get on any of the deliveries unless everybody else wanted him to.

DM:
Oh.

RC:
So he might get one, or two, or three, so he had very little experience, and I had a gob of experience. So that was real interesting. Now this other deal you're talking about was my first delivery. Even as a medical student I was a senior, in OB/GYN. And I was over at a hospital over at Baylor and it had a— Florence Nightingale Hospital for women, and they had an OB hospital there. And they would send us over there to get extra work, and study and so forth over there. And we'd spent some time there doing that with the doctors. And so one night I was on call, and it was a busy night. They'd talk about the full moon being out. Well the full moon was out that night, there were people coming, and all sorts of people with babies to be born. And so for all the deliveries they had three or four doctors there, but they were busy with deliveries. And so they called me from down below. I was up there as a medical student, I was just helping the other doctors, and they said, "There's a lady in the parking lot that you need to come down and see about." And I said well let me see if other doctors can come down. Well they were all busy right in the middle of deliveries, so they couldn't leave. So they said, "Why don't you go down and find out about it, and let us know." Well I walked down there, and it was a little Volkswagen, one of these original Volkswagens with very little room in it in the first place. And the lady was in the back seat with her legs over the front seat, and she was fixing to deliver it. She couldn't even move, she said, "I can't get out of here."

DM:
Oh.

RC:
And I certainly couldn't get her out. And so the baby just delivered right there in front of me, and I just helped the baby be born, and my first delivery therefore was in the back seat of a Volkswagen out in the parking lot of Baylor Hospital, all by myself.

DM:
Oh boy, one of the Beatles, one of the little Beatles, the small Volkswagens?

RC:
Yeah.

DM:
Oh wow, oh goodness. And then there was another one in an elevator?

RC:
Yeah, that was after I got to my internship.

DM:
Okay.

RC:
And again, I was, by that time, had delivered quite a number. And so there was a black lady that came in, sweet lady, and she came in and she was as big as a toad, and she was delivering. And she had waited pretty long, so I knew it wasn't very long before the baby's going to be here. And the OB area was up on the third floor, and so I was in the emergency room, I was in charge of the emergency room. So I decided to go ahead and go with her up on the elevator. So the nurse and I and two or three people that was accompanying her, plus the lady that was having the baby was on the stretcher, and it was a small elevator anyway. But we got everybody around appropriated, just kind of standing up straight, so they wouldn't interfere with anything else. And she says "Doctor, I've got to have this baby." And I said, "No, we're going to get there in just a minute, don't worry about it, just on the third floor, we're going to get there." "Doctor I can't wait any longer," and that little baby just shot out, and I caught it so it wouldn't kill itself hitting the floor. But as I've laughed about so many times, I don't know how many people—we had one more on the third floor than we started with on the first floor so. That was kind of funny too.

DM:
Well the way you put it in one of your papers was certain number of people went in the elevator, one extra came out.

RC:
That's right, that's right, absolutely.

DM:
Did you just carry a scalpel with you, how did you handle the umbilical cord and all that?

RC:
Oh yeah, well we were there soon enough, and no, I didn't make—but usually what they did is they would have all the equipment as soon as we got up there. In the meantime, I'd could hold—clamp with my fingers to keep the blood from flowing out that way.

DM:
Okay.

RC:
Yeah, or we'd just not cut it—if it didn't break, I'd just let it stay there, which sometimes they did in regular deliveries anyway, to get more of the blood from the placenta into the baby.

DM:
I see, okay. So how many deliveries, since that time, since your first deliveries, how many?

RC:
Well, deliveries myself I imagine probably not very many, probably all told maybe fifty or sixty. But as far as being present, they had a law at the time when you came in and started practice here in town that if it was to be a C-section—which they didn't do very many of initially when I first came here—but if had a C-section, they would like to have the pediatrician there to handle the baby after it was born, which usually was not necessary, because the baby came out crying. So anyway, so I guess I got a few more that way, but most of mine were just being present at deliveries.

DM:
How many do you think you were present for, did you ever keep a count?

RC:
Oh I don't know, yeah, and especially seeing soon after they were—I had them always come in for a one-month checkup with us, saw them there. But I would always check them in the nursery immediately after the delivery.

DM:
Okay. Now did you do cesareans yourself?

RC:
No.

DM:
Okay.

RC:
No, I didn't want to be a surgeon, I didn't have any desire at all to do that. In surgery, what you do in medical school is that you're way down the totem pole, and when they ask you to assist in surgeries as a medical student, you know all you're going to do is to go in there and hold clamps, to pull the tissue apart so the doctor can get down inside. And they didn't do microsurgery or anything like that at all, so you had to stand there and you couldn't move. The doctor would slap your hand if you moved or anything, because you might pull something out of position or do something, so you just stood there mobilized, frozen, for the length of the surgery, which in some surgeries took four, five, six hours. You might change hands very slowly, warning the doctor you're going to do it first before you did it. But you didn't move, you didn't come back sit down and come back. And so I decided I was never going to do surgery.

DM:
That didn't sound thrilling.

RC:
Of course I did suture of lacerations and things like that, which didn't take very long, but.

DM:
You mentioned something about full-moon deliveries, are there certain cycles, or are there certain lunar cycles that make a difference?

RC:
Well, we always laughed about that, I don't know that that really is so. But yeah, I think that excitement in a mother, like if there were to be a tornado coming in or bad weather, or something like that like being in a car wreck that seems to make the hormones change a little bit, and make the mother ready to deliver.

DM:
Does adrenaline induce labor?

RC:
Adrenaline, yeah.

DM:
Okay.

RC:
Yeah.

DM:
Okay, that's interesting, very interesting profession.

RC:
It is , it really is, it always was, yeah.

DM:
And a world that most of us don't really think about, but you right in the middle of it all the time.

RC:
It was very good, I enjoyed it so much, I really did.

DM:
Well, now after your stint as chief resident, you went into practice, private practice I believe is that right?

RC:
That's right, and that was in 1954 I came to Lubbock. And I had a choice to stay in Dallas, I had to doctors there that wanted me to come into practice with them, and then the medical school, Dr. Fashena, who was the head of the department, wanted me to come out and teach at the medical school. And so I went out and looked at that, and I knew about it pretty much, but asked her what my duties would be, and one of the things she said, "Well in medical school you have to do a lot of research. You'll not only be a doctor, but you'll also be a researcher." And I just didn't have any appetite for that, do research and so forth. And yet I knew I would have to, because that's what actually the medical school had been set up in Dallas for, was doing for a lot of research. So I said, "Well Dr. Fashena, I don't know. I don't know Dallas, it's such a big area, I'm just not used to Dallas, living here the rest of my life, and it's growing so fast and everything." I said, "I think I'll see about going back to Lubbock." And I told Betty, I said, "At least in Lubbock, the streets run north and east, south and west, and they go straight." They did all then, not so much now. But they grow straight, and said, "If I'm making house calls"—and at that time we did make house calls—"if I'm making house calls, I can be over there to their house in ten or fifteen minutes, and be home in another ten or fifteen minutes. And here in Dallas, you get calls from all over Dallas." You may have to, like going making rounds, if you have hospitals that you have patients in at Parkland, then you have at the new medical school, and then over in Oak Cliff they have a hospital over there, Methodist, and the doctors I was going into practice with possibly went to all those hospitals. Well, if they did, they had to go to those hospitals twice a day, morning and night, and that was before and after they went to the office. And if they had an office full of people, and they saw—average doctor I think saw about thirty or so odd, maybe a little bit more, per day—and if you did all that all day long, and then you did these going to two hospitals twice a day, just the travel time alone would eat you up. And I said I don't know that I want to spend that much time. She said that's why you out to come out to medical school, because you've got your hospital right here, and you can go ahead and take care of that, you'll have residents to help you and so forth, too. But anyway, I decided, and then the other thing is like the east and west streets. So anyway, I came back and I talked with Dr. Overton, who had been my doctor. And he was still in practice out here at Methodist. And I said, "Dr. Overton, I'm getting out of medical school, I would really like to see if you would be interested in having me come in and work in your practice here, either ultimately looking to be a partner, or something like that someday." And he said, "Oh Bob", and he was sweet, and as sweet as he could be, he said "Oh Bob, you don't want to go and practice with me. I'm going to go out of practice here in the next year or two I'm sure. You want to go with somebody's that's young and vigorous, and practiced medicine like you wanted him too. I have a friend here in town, Dr. J.D. Donaldson, and J.D. is a wonderful individual, he's fair, and a good doctor, and conscientious, and

everything. So I'm going to send you over to see him. Not that I wouldn't like you, and if I were twenty years younger, I would have you come, but I just don't feel the safety is fair to you." So I went over, and then J.D.—I went into practice with him.

DM:
Okay, and how did that go?

RC:
Went very well, we never had any great arguments. We later on decided that I had an idea that I wanted to build a clinic, or an office away from the hospital, and he was at that time in the adjunct annex of the West Texas Hospital. So we decided, I talked him into going out to 26th & Avenue Q, which is where the children's clinic was, and talked him into going out there and building it like we wanted it to be. And it was not like an office-type thing, it had two waiting rooms, one was for well, one was for sick, to keep the children separated to keep them from giving each other everything. It had a little play area out there with a little riding horse and a couple other things that the kids could play in. It had little holes in the wall, they could look and see the traffic out there on Avenue Q. It had some grass to play on, trees around it, I had a room that I set up for adolescents, because I was interested in seeing adolescent people. I was the first doctor to have an adolescent room separate and apart from everything else that they came in. A lot of the kids I saw of course had older brothers and sisters, and the mothers would call me and say "Well I know he's fifteen or so, but we didn't never seen another doctor, could you see him?" And I'd say, "Sure." So I decided I would go ahead and have an adolescent room, which they would enter by a different door, not even come in the front door. They would enter by another door, register, and then they could sit out there, and I had books and things like that appropriate to them.

DM:
Okay.

RC:
I later on had pinball machines that were put in one of the rooms where they could come out, spend some time playing pinball or something like that out there. No gambling stuff, but I mean pinball machines.

DM:
They don't feel like they're with the babies.

RC:
Yeah, that's right, they felt like they had their own doctor. And I had a room, examining room, with the regular adult table and things like that in it too. I had one of the ladies that [Clock strikes

three] here in town, who—I know her name any other time—but she was one of the people involved— I took care of her kids. And she came over and painted the walls, and in the teenage room we painted two adolescents talking on the telephone.

DM:
Oh.

RC:
And in the baby rooms, we picked flowers, and birds, and bees and things like that in the three children's rooms. And then we had tables that I designed myself that could walk up little steps to get up on the top, and they could lie up there, more to my height so I could feel their tummies and everything without any trouble.

DM:
Okay.

RC:
And they weren't scared at all looking like a doctor's table and everything.

DM:
It wasn't too clinical, sterile.

RC:
Yeah, it wasn't too much at all.

DM:
Yeah.

RC:
And we always wore jackets and things like that, so we wouldn't frighten them. We didn't wear the doctor's coats, we were always in jackets, that they looked like nice things, so they liked that.

DM:
Did you have any patients you had as children, and then through adolescence, who wanted to continue with you when they were adults?

RC:
Oh yeah.

DM:
Okay.

RC:
Quite a number. One of them was a fellow that came in—I'll tell you two instances—one was a fellow that came in with his child, and I'd seen him when he was a child, but now he was an adult and had a child, and he asked them up front if he could be seen too because he had a sore throat, and he didn't have any other doctor, and, "Will Dr. Carr still see me today?", so I told him sure. And then I had two people that came in, one had some people refer to me that were adults, one was Junior Miss America, and she came in to see me, because she had trouble and I had—well one of the big country singers here in town that still comes here occasionally, that came in with a sore throat and I saw him, just as a favor to a friend of his. He was singing here in town and had a sore throat and everything, so he came into get some medicine from me.

DM:
Wow.

RC:
But this Junior Miss America I thought she was very nice, I enjoyed seeing her. But yeah and then I had one that I put in, she came in and registered under the regular name she usually came in, and she was sick enough that we had to put her in the hospital. So I called out and went out to see her that night after I put her in the hospital, and they said, "We don't have a Miss so and so", and I said, "Well I know because I called down here and got her a room and everything, so she's bound to be here." So I said, "Let me call and see if I can call around." So I looked around, and Mary, my nurse, I called her and she said, "Oh yeah I bet she registered under her married name." And I said, "Married name?" And really she had, and she hadn't told me she was married, she thought I probably wouldn't see her, and that's what she told me when I went in under her married name, there she was.

DM:
Okay.

RC:
So I had several that did like that.

DM:
It sounds like you're building was very patient and friendly, and it brings up another point—just I think everybody's experience is, you sometimes have a doctor that is very good bedside manner, very compassionate, others that are very clinical. Did you recognize that a lot among the—

RC:
There's some in town today that I can tell you who's clinical, and who's not. The clinical ones are usually smart as whips. But their personality is such that they just don't project very well. And I always got too involved with my children, although I tried not to. In fact I told Bobby, my son, when he went into orthopedic surgery, now one of the things you want to do is never lose you empathy for your patient, but on the other hand don't get wound up too far in them, because some of them are going to die. And you can't just live your live worrying about the ones that maybe you couldn't help. And worry about what could I have done? Because for the first two or three years before I went into retirement and wasn't having any patients in the hospital any longer, I can remember waking at night almost every night, worrying about patients that I thought I had in the hospital. And when I was in practice, I would worry so much because am I doing everything I need to do, is there another test I need to do, is there another question I need to ask, are they doing as well as they should—things like that. I would just worry myself to death about it. And that continued, in my dreams I would make up cases, and worry about that all night long about this case that I had. And I'd wake up in the morning, think boy I'm glad that wasn't real. But no and that was part of my enjoyment. I enjoyed that, to get some kid well, some little child well, or teenager come in with a broken clavicle, and fix that. Things like that—those are the things I missed about medicine. And even now, it is not at all unusual to go someplace where there's several people and somebody that will walk up to me. We went out to the Firehouse Subs the other day, and a guy walked up to me, and I don't know how old he was, but must have been forty-five, fifty. But he said, "Dr. Carr, I was your patient whenever I was young, do you remember me?" And of course I never do because they look so much different, but anyway we talked, but I always appreciate their doing that you know.

DM:
Yeah.

RC:
And I've got a big bunch of paper over here about letters from patients and parents that wrote me thank you notes and everything, I saved all those.

DM:
Oh good for you. Is that something you're going to put in the Southwest Collection?

RC:
Yeah.

DM:
Okay good.

RC:
They can have them, I'm sure nobody else would mind.

DM:
You talked a little bit about Dr. Overton, I got an impression of his personality. Can you talk a little bit more about Donaldson, and also what about Dr. Ellis?

RC:
Yeah.

DM:
Noel Ellis?

RC:
Yeah Noel, N-o-e-l.

DM:
Noel Ellis.

RC:
Noel A. Ellis, middle initial A. Well they were different personalities, although I enjoyed both of them. Noel was a fellow that he belonged to one of the local churches, and so helped our patient income because of course he got all the money for the patients he saw, but he did increase the patient load we had down there, which was appreciated very much. And he was a nice fellow, he never gave me any trouble or anything. One of the things that he did, that I may not ought to say this, but he depended more upon the giving of shots than I did.

DM:
Okay.

RC:
Anybody that came in that had a sore throat or something like that, he always gave a shot. And I didn't think that was absolutely necessary. And J.D. was always fussing at him about it, Dr. Donaldson was. But he was very contentious, he was very appropriate in treatment, except for maybe the giving of the shots when we felt like we didn't need to, the other two. And but he always was available, he took night calls. For the first several years we were together down there, the three of us, we did night calls, house calls at night. And some stories from that are kind of funny there too, but anyway, we did those things. And we would try to have one person off, one half-afternoon a week, and otherwise we'd be there Saturday morning until we saw

everybody we needed to, as well as Monday through Friday. And on Sunday, whoever was on call would go back down to the office to see anybody that was sick.

DM:
Okay.

RC:
So if you needed to be seen, asked to be seen, but it wasn't an emergency you had to be seen right then, we would make appointments for telling them to come in on Sunday.

DM:
Wow.

RC:
And then on Saturday to.

DM:
Y'all stayed busy.

RC:
But we stayed very busy, and people have told me how much they appreciated that, for us doing that.

DM:
Oh yeah. Can you tell me about house calls? House calls are such a thing of the past now.

RC:
Yeah, house calls—I kind of enjoyed them really and surely, except when I was so tired, just so tired that you couldn't do anything else, and I had to make a house call. Or when I had to go up at night, especially for delivery, a C-section maybe, that I had to go up there early, and the surgeon would take a little bit more time to get everything ready, and I'd have to be there maybe two or three hours before I could come back home and go back to sleep again.

DM:
Oh, okay.

RC:
And had to get up the next morning to go to go to work again. Let's cut that off.

DM:
Sure.

[pause in recording]

DM:
Well tell me a little bit more about house calls. For example, how far would you travel on a house call, you had to have some limitations, surely.

RC:
Yeah, well no there really wasn't, because most of the patients that called you of course were people that were your patients anyway. And in Dallas for example, I made one house call to Oak Cliff, but most of the ones I did when I was there, for a two-week span, during my vacation, one of the people that wanted me to come to work with him was a fellow that lived out in east Dallas. I can't even think of that area there, but anyway just on out past Baylor, on out Swiss Avenue. And so—well know, give me a thought back.

DM:
Okay about house calls, the distance?

RC:
Yeah, and well I'm sorry.

DM:
That's okay, but you were talking about well, they were your patients, and then you were talking about some in Dallas, but what about—

RC:
Oh that, I know, the furthest I had to go was over to Oak Cliff.

DM:
I see, okay.

RC:
Went over there for a house call once or twice.

DM:
Okay.

RC:
But now when I came back to Lubbock, that was one of the main reasons to come back, because making house calls, and it was so easy to. And here I had several house calls that were kind of interesting. One I remember they called me one night, and the used to have Milam Orphan's Home out there on the Slaton highway, and they had a home there that they had people that, transients could come in that didn't have any place to stay, and had a large family, they could stay there a night or too, because we didn't have anything but just motels, and they weren't very good either. But anyway, so they went ahead and would call out there, and they'd get to stay a night or two. Well one night they called me from out there, and they said, "Dr. Carr we can't get anyone to come out to make a house call here, and we have a little child here that's ill, and the parents are very concerned about it." I said, "Well okay." She said, "Before you come out, let me tell you they're gypsies, they're an itinerant band of gypsies, and they're nice but you don't want to come in and be shocked and surprised." Well when I got there, and it was during the night, it was two or three o'clock in the morning, and when I got there, then they had a bunch of gypsy wagons and so forth out there in the front. But it was right there, wasn't out in the country or anything, it was just not very many places around it. So I went ahead and knocked on the door, and they came out and they were very nice. And they had the little baby on somebody's lap on the couch, and we talked pleasantries for a few minutes, and there must have been twelve, fifteen people in the room, the living room, and they all had the gypsy garb on with all the jewelry and all this other stuff. And I thought this is an unusual atmosphere, and I asked about the child, how long he'd been ill. Well it turned out that the child was the chief's son—not the chief I guess—

DM:
The head gypsy, whatever he's—

RC:
The head gypsy's son.

DM:
Yeah.

RC:
And that's why they needed to get somebody out there tonight and not wait until the next day. So I thought, "Boy now there's all these people where they're dressed and they're wild people, and if I don't get this kid well immediately, I may not leave this place." So anyway, so I talked with them a while longer and examined child, and gave the child a shot, sat there for a minute until the fever began to come down, and told them what to do and everything rest of the night, gave them instructions as to what to control with the fever, and do things like that. And so then I left, and Betty, I had told her about where I was going, and she was kind of concerned about. I said, "Oh, it's at Milam Orphan's Home, it's right here on twenty-fourth and the highway over to

Slaton." And she said, "Well, you be sure and come back soon as you can." So I said, "Okay", and so I did, but it was kind of alarming a little bit. We'd had not too long before that, one of the gypsy chiefs, another one, another band that came through here with all their garb on and everything that lived on the lawn at West Texas Hospital for about a week. Just put their tents out there on the lawn and everything.

DM:
Golly.

RC:
Because one of the big wigs was sick, and he got well enough for them to leave, but that was funny too just having a gypsy band that was out on the lawn of the West Texas Hospital for a week or so.

DM:
I wonder if anyone got photographs of that.

RC:
I don't imagine so, they're probably afraid to do it. But the other thing, let's see I was going to tell you another story about—

DM:
House calls?

RC:
House calls, yeah, maybe it'll come back to me. Turn that off just a second then.

DM:
Sure.

RC:
Let's see if I can get it to—

[pause in recording]

DM:
Okay.

RC:
I had several children that I had to see more than once, because of their illnesses. One was this

little child I mentioned I think before that had the liver tumor. And I would go by to see him at least once a week, maybe more often. I just went by just as a courtesy call, and just because the parents, it seemed to relieve them a little bit. And then the other was little Gregory Hannibus, the little child that had the polio. And I wanted to keep a tie on him as much as I could. And then of course, house calls then were expected by a lot of people if they called you. Remember, we didn't have any telephone answering service or anything that if they called the doctor, you call a doctor, and the doctor answered the phone. So I would expect that probably until ten o'clock, I would get at least on the average four to six telephone calls after I'd got out of the office, at ten o'clock or ten-thirty or so. Most of the time it would slow down pretty much, but occasionally you would have calls to come in, maybe two or three during the night too. A lot of them you could go and tell them what to do for the temperature, or maybe had the croup [*laryngotracheobronchitis*] or something like that, tell them some things that they could do at the moment to ease the things out. And I always went to see those too, if they needed to. But most of the time it's just giving them some relief and let the parents feel better about it. But some you had to go that were really very ill, you had to go see them and temperature, maybe having a fever convulsion, or something like that that children occasionally had I think more often then than we have now.

DM:
Did you have any parents that called much more often than they should have?

RC:
Well, I really didn't.

DM:
Okay good.

RC:
I honestly didn't.

DM:
Good.

RC:
And I had people I thought call me unnecessarily, but that was because I wasn't the parent. I can say well that's just a croup, or something like that, and tell them what to do. And I'm sure that probably some of them thought that, "Well he should have come out", but most of the time if there was any question about it, several times I remember waking back up after ten or fifteen minutes and calling them back and telling them I'm going to come out and see the child. And

then I'd go out, so I had several I did that, I remember that many times that I did that. Because putting myself in their position and everything, it scares you to death you know, so.

DM:
What about did you ever have to leave Lubbock and go over to Slaton or Idalou?

RC:
Yeah that was one of the things I'd tell you a while ago. Yeah I made house calls, one was a child who had a smallpox vaccination over past Littlefield, a little town named Amherst, or something like that up there.

DM:
Amherst.

RC:
And they put live virus in the area, and if you weren't careful, it could spread—if, for example, a little child started fooling with it, and scratching it, and then scratched over here, he could get a vaccination over here too. And it really wasn't that bad except it looked terrible. And sometimes it would spread if they had a low resistance, it might spread to other areas too, you would get pox lesions all over. So one I went to Amherst, to see a child who had that. The only way that could be treated was by getting some gamma globulin that had extra antibodies against the smallpox and cowpox that they had in the vaccine. And then so you gave that to them. So we sent to Dallas, and they sent a Mercy plane back out to Lubbock, I think. They didn't land in Amherst, because there wasn't a closer field, it was midnight anyway. So they sent a plane out, we gave the gamma globulin to the child while it was there in the hospital.

DM:
Okay.

RC:
And then I did go over several times to Slaton Hospital. I've been over there and given talks at dedications of the Slaton Hospital.

DM:
Okay.

RC:
And when I went over there, it was interesting because they had no pediatricians except in Lubbock, and there were only five or six of them in Lubbock at the most. And I'm sure some of the others wouldn't want to go that far, or out of town. But anyway, I would go over there and

see the newborns, particularly if they were having respiratory difficulty, try to help them. They'd either bring them back into Lubbock if they needed to, although Lubbock didn't have near the things that we have now. Used to if a child had respiratory difficulty, many of them died because they were too young, and their lungs just were too young, were immature. But some died, if you could help them along enough to give them some oxygen and treat them gently and feed them a little tube and things like that until they got stronger.

DM:
I assume some of these house calls were in bad weather?

RC:
Oh yeah, a lot of them were. Yeah, it went out in snow, I've been up in snow several inches. I don't know whether it was high snow, but probably four, five, six inches to get there, and sleet, a lot of sleet that you had trouble getting there.

DM:
Yeah.

RC:
So yeah I had a lot that was in bad weather, and I could understand why the parents didn't want to get the child and bundle them up in that weather, and then bring them out to the office. But after we quit making house calls, then often times I would meet them at the office, because that way it was safer for me. I just felt like that maybe someday somebody was going to conk me on the head and take my money. That was a good way to get me down there by myself.

DM:
Wouldn't it though.

RC:
Yeah.

DM:
Call a doctor, do a phony call and get him there.

RC:
And have him come down.

DM:
So something you wrote said house calls at the beginning of your practice were, what ten dollars, does that sound right?

RC:
Yeah, about ten dollars.

DM:
Three dollars for an office call?

RC:
Yeah.

DM:
That's interesting. Penicillin shots two dollars.

RC:
Yeah, yeah.

DM:
These are things I'm lifting from those stories that you wrote.

RC:
Yeah, yeah, yeah, that's good, that's good. Yeah I don't even remember some of those anymore, so I'm glad I wrote them down so you could look at them.

DM:
It seems to me like the money situation has changed fairly drastically, whereas you were paid—I don't know how you would rate your payment in these early days of private practice, but there's a lot of big money in medical practice now, and I'm wondering if that has changed the type of person that is in the medical community. Are there people you think that are getting into the medical community for the money, is less than for the compassion?

RC:
I think there are some doctors that do that because of money, especially surgeons, and neurosurgeons and so forth. I don't know that, but it's my impression that they are. I always felt like that I never turned anybody down because they said they couldn't pay me. I never turned anybody down. And I worked at the Well Baby Clinic here in Lubbock for several years, giving an afternoon every week, and other times if they needed me they'd call at the office, and I'd have them come down to the office and I'd see them there, and never charge them. I didn't charge most of the preachers at our church, I gave nurses a discount, I gave some of the other people that worked in the medical business discounts too.

DM:
Yeah.

RC:
So I've told my son many times I could have been a lot richer person if I'd been a surgeon like you. Because he probably made in what year probably more money than I would make in five. But that was fine, I enjoyed what I was doing, and I was happy to do that, because most people were very grateful, and very nice about it. Some of these I'm sure I'm seeing now, or come up to me and talk to me, are there because I didn't charge them full fare, or didn't charge them anything or something like that. Only when I was much older did I—there were some people who had a habit of just running up the bill, more and more and more, and so I would tell them that they needed to pay me a part of it, didn't make any difference what part, if they'd just pay me two dollars or whatever it might be, that'd be fine, but that I was going to have to go ahead and—since things were going up for me all over the place, I was going to have to go ahead and try to get some of the money back. And some of them paid me over a year's time, others never did and I finally hired a fellow that I didn't like very well, but he was a friend of a friend that had a collecting agency. And he and I went over very carefully what he would do. He wasn't going to threaten them or do anything like that at all. He tried to work out a payment system, and if he felt like I'd never get it, just write it off. And so I don't think there's too many people nowadays that do that. Any other doctor that came into see me, I considered that such a compliment, I never charged them, or their family.

DM:
Yeah.

RC:
And I just thought it was nice that they would come to see me, and had that much faith in me.

DM:
Yeah.

RC:
And so but I kept mine—certainly—again, I may have mentioned some of these things before, but when I quit practicing medicine, I was charging thirty dollars for a visit for a child, a regular visit, thirty dollars. And I figured about several months before I'd sat down and figured that it was costing me thirty-three dollars to see them, so I was actually paying out three dollars to somebody for my being able to see the child. And so I decided that's what the government's going to do to me, because I saw a lot of government children, as I got to the latter part of my practice. But I always was available if somebody wanted me to come to talk, if somebody

wanted me to do the preschool examinations for the kids or something like that. I didn't mind at all, I enjoyed that.

DM:
Okay.

RC:
I gave lectures, took my stethoscope, would go to churches and talk to the kids so they wouldn't be scared of the stethoscope and the other things that we had. Took my otoscope and they'd all look in everybody's ears and everything. But that was a lot of fun, I enjoyed that, I really did.

DM:
Well it's very interesting, I mean the whole career from start to finish sounds like not money-driven, maybe compassion-driven, or interest in humanity-driven.

RC:
Well, I want to paint a picture that makes me—

DM:
But just be honest though, you know.

RC:
But I really didn't care, as long as I had enough money for what Betty and I wanted to do, and to get a nice house like this, and to have a car, and have things like that—that's all I wanted. I didn't want to amass a fortune, and I couldn't have anyway, but I didn't even want to do that, so.

DM:
Let's talk about some of the major changes that occurred in medical practice from the time you began, until the time you retired. We've talked about changes in, for example, penicillin, I mean penicillin and antibiotics. And obviously the house call thing is a thing of the past, but what about other major changes that have occurred, can you think of any?

RC:
Well, I think that the way that doctors are looked at has been changed too. The doctor was considered to be the upper person in the society, and I reveled in that. I liked the attention that I got. I liked people to know who I was—not because of just knowing who I was, but I liked that a lot, you probably can put it in better words than I, but I didn't want to necessarily make the most money, but I wanted to be thanked, and appreciated, and so forth. And I was enjoying what I was doing, and so it has changed, and I can remember in the office, the doctor always wore a tie and a jacket, and really looked like he was just really a nice, clean person, interested in health and so

forth. And nowadays, I never will forget when some of the pediatricians came in, and the things people I'm talking about now are gone. But they would come up to see their people in the hospital resting in their yard clothes, or they'd come back from riding on a horse, they'd come back without taking a bath, things like that. And I didn't think that was right. It didn't fit the picture of a doctor, of a healer. And I wanted to always fit that picture. I didn't try to dress up better than anybody else, but I just tried to dress up as I thought a professional should do. And I think that's changed tremendously.

DM:
What is the standard now, would you say, is the standard—

RC:
Well, for pediatricians, it seems to be that you can—I don't think they ever wear a tie—again, I don't know because I don't go to their offices. But a lot of them don't wear ties. A lot of them wear just house clothes, not anything real big. And certainly, to make rounds a so forth, where again, I wouldn't have gone possibly without putting on a coat and tie, they go up there now with shorts and everything. It's just against my thoughts of what should be done. I think you should be a professional.

DM:
It seems like if there's any kind of a standard dress, it's more like scrubs now, than anything.

RC:
That's right, and my son does that all the time, scrubs and everything. And that's fine, I have no objection for them, but I wouldn't do that. Maybe I would now, but I wouldn't have then.

DM:
But it has changed. It is one of those big changes that we're talking about.

RC:
Yeah.

DM:
Can you think of any other changes?

RC:
Well, I don't know, seemed like—of course, thing is I notice mostly are changes of who examines you. You go for a doctor's appointment, and it's usually a nurse practitioner, and they're very good, I've got to say better than I was when I first started. But it seems like that the doctor may not even know about you. You have the chart in his office, but he's got so many

patients, the government's coming down on him to see more all the time, that that's all he can do. He's not a personal friend anymore. Dr. Kearse, [William O. Kearse, M.D. (1944-2014)] who just died out here was leftover from that, he was a personal friend that I got to know more when I went to see him. Not before I first saw him, but since that time. But he was a grand guy, and then some of these other fellows there in town—Travis Bridwell, Dr. Travis Bridwell, some of the others were the old-time doctors. You see these guys that they're always dressed nicely, very friendly, really remember your name, which I never could do, but they could remember names and so forth. I think that they lost some of the humility about medicine, that I think is so important. And I think, as I say, people can get me to do anything if they thank me for it. So and that's the same way with I would go over and I went out when they had the people come in from the Louisiana hurricane type thing. The typhoon they had down there, and they brought them out here, put them in the college thing. I went out there and signed up to go out there and see anybody that was sick out there for them. Did it for nothing, just because I wanted to. And if I was on the thing about children that we'll talk as you say about later, but the government—I can't even remember what it was called now, but they'd put out the first two or three years of school. The government got people to come bring their kids in, and they'd have sort of like a little nursery school for them. And I would go over and do those things for them, for the government. Flew in some private planes all over this country to take care of these kids, or to get them enrolled, because they'd have to have an examination before you could enroll them.

DM:
Okay.

RC:
So anyway, and I did it, I really think that I was really true to myself when I'd tell people I wouldn't be anything but a doctor. I really did appreciate being a doctor, there were times when I was just burned out, but most of the time it was just something I really did enjoy, and if I could keep my knowledge about me, keep my wits about me, keep my brain synapses working well—which they don't anymore—then I would still be a doctor, as long as I could.

DM:
Do you have any stories of patients that really stand out in your mind, after fifty-five years in the profession. Do any incidents, or any anecdotes just stand out? So if you're talking to someone else for example about, "Well I was a doctor, and oh let me tell you what happened one time." Can you—

RC:
Well I guess the biggest one is that Gregory Hannibus, because I took care of him so long, and he was my first polio patient, and I was able to get an iron lung for him, and kept him alive, for

whatever good that did, I guess for the parents it did. But I guess he was probably the most conducive to my early development as a doctor.

DM:
He must really stand out in your mind then.

RC:
Oh he does.

DM:
Because he's popped up a couple of times in this conversation.

RC:
He was a brave little kid, he never complained, and his parents took care of him so well.

DM:
Yeah, okay.

RC:
He died I think it was not too long ago, maybe two or three years ago, and I wrote her a letter, and told her how much I appreciated Gregory.

DM:
Okay, okay. After your private practice, you were with the Lubbock County Health Clinic? 1992 to 2006, does that—

RC:
Yeah what happened there, I'll just quickly go over some of the things, I had been in practice, it was 1992, and I'd been practicing here in Lubbock since 1954, so that was about fifty some-odd years almost I guess. Anyway, I went home and I'd been up the night before, and probably the night before that, and I'd worked all day, and I'd just came out, I was completely exhausted. And I told Betty, I said, "Betty, you know someday I'm going to fall over dead at the clinic, and they're going to come get me and put me in the ambulance and take me straight to the cemetery, and you and I will never have done anything together very much, take a length of time." Because usually we took one week, occasionally two weeks, but see when I was gone from the office, I had nobody paying me anything, and I had to pay all my nurses. So I couldn't be gone very long. So I said, "I'm just going to go ahead and do something else. So we looked around, and I had heard about this what they call locon tenuns [sic. It's actually spelled "locum tenens"], l-o-c-o-n, locon, tenuns, t-e-n-u-n-s, which was Latin for something, but anyway it means people that worked temporarily, located at a place temporarily.

DM:
Okay.

RC:
And I said, "You know I've heard about this, I think I'll ask. And what they did, is they had big companies, there were four or five of them at the time, usually nationwide, but sometimes region-wide, that they would have doctors who had reached the point where I was, just burned out. And they could go ahead and give the name to them, and if you were a pediatrician, then maybe a doctor over in South Carolina was going to have to have surgery, that'd have him out for a month.

DM:
I see.

RC:
And he needed somebody to keep his practice going, because he was like me. So he would call and tell this company I need such and such, I want this kind of guy, and if you would get me him, I'll put him in my office for a month and pay him salary and so forth. And I said, "You know that'd be fun, I never got to travel that much, but this enabled us to go to a place, and instead of just going in and to say it's Tuesday, we're at Richmond, and Wednesday we're going to go over here, and Thursday we're going to go over here. We could stay someplace for a week, or two weeks, or two months, and that'd be fun to do that." So she said, "Okay, let's do that." So we took the big step, and I sold my practice and joined them, and they got me licenses in six states, and then they'd say, "We have a two months place here, a one month place here." And one of the places that I never went to that I didn't want to was Caribou, Maine. They would always call and want me to go to Caribou, Maine in the wintertime. And I said, "I don't want to go, you told me there was twenty-four feet of snow up there last time I asked you, and I'm not going to be in twenty-four feet of snow." So anyway, we went to I guess all six or eight of the things here in Texas too that we went to, and just stayed, and we stayed in the doctor's houses, or sometimes they'd get us an apartment if we were going to be there two months or so. And we just loved it, it was wonderful, because we didn't make as much money, but we didn't have any night calls, telephone wasn't ringing in the middle of the night to come, we didn't work weekends, didn't have anybody in the hospital except two or three of the places, but mostly it was just outpatient. And it was fun, it really was fun, so we really did enjoy it. And so we did that from 1992 I closed my office, and then we did that from about 1992 to about, oh I don't know, maybe three or four years. I don't have the times, or you probably have it down there, but—

DM:
No, I don't have that.

RC:
Anyway, we did it for three or four years doing that.

DM:
Okay.

RC:
And then after that they sent us to Lubbock, because they were about to lose the doctors here at the Community Health Center.

DM:
Okay.

RC:
And they had no one to keep it open, so the company called and said, "Would you have a doctor come down?" They said, "We have a doctor from Lubbock that'll come down." So that gave us time to come back and get in our house again and everything. And so we did that, and I was ahead of the only doctor down there for several years, and kept it open and so forth.

DM:
Oh, really, okay.

RC:
And then they got another doctor to come in with me, and so it's now just a going concern, with two offices, and two buildings now downtown.

DM:
This is the Lubbock County Health Clinic?

RC:
Lubbock Community Health Center.

DM:
Lubbock Community Health Center, okay.

RC:
Yeah.

DM:
Alright.

RC:
And I got a set salary there, which wasn't as much as I made in practice. But it was advantageous to me to do it, because I knew where I was going to go every day, and at that time they didn't have you take care of the people in the hospital. You'd send them out to the medical school and they'd take care of them out there.

DM:
Was this about the time you got involved with ADHD?

RC:
Yeah, well that's kind of funny too, because when I got out of medical school, I would go back to Dallas quite often for seminars, and symposiums that they had there.

DM:
Okay.

RC:
And they had different subjects that they talked about. And after I'd been out about two or three years, I went to one, and there was a guy talking, and he was going to talk about ADD, or ADHD, which is about the same. And I said, "I don't even know what that is," so I go to listen to his lecture. Well, it was a lecture that a guy gave, that I thought well this guy's crazy, he's talking about children that were out of control, that couldn't do well in school, got in trouble with the law all the time, things like that, and just had a terrible time paying no attention, attention span was so short that they just couldn't learn anything. So I said, "Well, this seems to me that that's not a disease, that's just something wrong with maybe the parents are not raising them right, or expecting enough out of them, or things like that." And then I got to thinking in my practice, a lot of people I've seen in my practice have these same symptoms. I never called it a syndrome or a disease, but I've got so many of them that have the same things, that maybe it might need to be called something like that. So I went back, and when I'd see these kids again, I'd begin to look at them and think about them. And one of the things that this guy talked about was the fact that there now was a medicine that was helping these kids tremendously well. A guy in New York had a clinic, a big clinic up there, a charity clinic, and he was in charge a big bunch of kids that were there—not only sick kids, but well kids, and people that had nothing wrong with them physically we knew. But most of them, he noticed a lot of them were fat kids, and at that time, the disease of the month and the year was being too fat. So he decided, "Well I noticed that when I gave these kids that were so active, and I gave them this Dexedrine, that it calmed them down, and it usually doesn't do that. You give it to anybody that's normal, that acts normal, it speeds them up. But when you give it to children with ADHD, it slows them down, it makes them get back to the normal rate." So he said, "I think I'll go ahead and start up a study of kids, and we'll take these fat kids that are hyperactive, and we'll give them this medicine and see what

happens." Well, he did a year-long study and found that it really worked very well, so he published about it. And I happened to read about it, this guy up there after went to hear him, I read much more about it, and I decided this might be something to latch on to. So I'd watch these kids when they'd come in, I didn't have a separate clinic or anything for it, but I watched them, and I put a few of them on Ritalin, and on Adderall, which are similar-type medicines, and they just did wonderful, some of them. Most of them you could tell where they had too much activity, just because they got back to the normal again. And the mother and daddy would just be extremely grateful, because they were about to get kicked out of school, or they would get in trouble all the time, and they were talking back to their parents, a discipline problem, getting in trouble with the jail, and put in jail and so forth. So anyway, I began to build up people that knew I liked that, and they'd begin to come in. And so eventually, I decided down there, since I was getting a salary whether I saw them and they had ADHD or not. And it took a long time with ADHD children, it took you at least two visits, about forty-five minutes to an hour to see them, and to be sure that you think they had it, and to confirm it with testing. And so then you had to give your medicine, so you couldn't do that in practice, because I was already losing three dollars on everybody I saw anyway. So if I saw fewer, then we wouldn't lose as much money, but we wouldn't have much income. So anyway, I said down there, "I'm going to start an ADHD clinic." So they said, "That's fine, go ahead and do that." So when I got down there, and I was on salary that I'd get whether I saw a child for an hour, or fifteen minutes, I'd get the same payment per time space, so they'd go ahead and see the child down there and set up this clinic. And so I began to develop a clinic—I couldn't see hardly any of the patients. I had a hundred, hundred and fifty kids I was seeing down there.

DM:
Wow, golly.

RC:
The doctors in practice didn't have time to see them, and didn't care about seeing them and so forth. Yet I had the time, and I liked it, so.

DM:
There were problem kids I guess, so people didn't want to deal with them.

RC:
They'd come in the doctor's office, they'd tear up his office while they were there, and they'd not want them to come back anymore so, "Let's go see Dr. Carr. He specializes in that." So anyway, so we got them started on that, and so it developed from being a general pediatrician, I had just an ADHD clinic down there. And I did that until I quit practice, and I quit practice probably about 2005 or six or something like that. I don't remember when it was I stopped from down there, but anyway, it was approximately that age, and then that point I still do ADHD

medicines. Also with Dr. Turnbow here in town is a fellow that does a lot of this too, and I test the children, and then he and I make the diagnosis, then we put a medicine if they need it.

DM:
Okay.

RC:
But for a while it was my opinion that the diagnosis was made too readily—doctors, in order to get them out of the office sometimes just made the diagnosis of ADHD. Because it would help people, most of them, whether they had ADHD or not, but help their activity. So anyway, so they would do that, and they didn't have enough time to see them, and they tore up their office when they were there, and they didn't like them, because they were such a mess to deal with. So I said, "Well I'll just do that", and keep on with Dr. Turnbow out here.

DM:
Okay.

RC:
So he gives me a small stipend and I work with him in the summertime.

DM:
Okay. Well what is your conclusion about all this at this point—what causes this, is it a chemical imbalance?

RC:
Well I think it's a brain problem, I really do think it's actually not just in their head in the sense of the psychological-type thing. I think they're actually the dendrites and the things like that, the neurons in your brain.

DM:
Okay.

RC:
They're in some way not being furnished the right kind of fuel. For example, we do know there are certain things—I can't tell you all them now because it's been so long since I've talked to people about this—but there are certain chemicals in the brain, serotonin, and some of the others—that you need a certain level now. If you don't have enough, or too much, it causes symptoms, and that's how this medicine supposedly works, is it makes that get back down to normal, to what the serotonin ought to be. So I think it is, and why they have something wrong with their brain like this, I think it's because when a child is born, before birth, there may be

things that cause it. Like, for example, we know that a mother who eats a lot of lead in fish will be more prone to have it, to have their children to have ADHD. A mother that has illnesses and doesn't get good nutrition, this will also increase the chances. We know it's inherited, because one or two parents that have ADHD, they're children are more prone. They're not necessarily going to get it, but more prone to have it. So there's certain things, they're either born with it genetically, or they're caused by tiny brain damage in the brain that's causing it. And they know this, because now they can do functional studies to study about the uptake of glucose in the brain.

DM:
Okay.

RC:
And they find that in children who have ADHD, the frontal lobe is right up in here, and the hippocampus, which is right up in there, do not work as well as they do in children who not have ADHD. So now we're beginning to get actually some physical signs of people who have ADHD have something wrong with them, it's not just a psychological problem.

DM:
Is it dietary-related at all, at least in the mother?

RC:
Yes, and what I try to do is to go ahead and I not only—first of all, tried not to give medicine, because that was the one thing I didn't want to do. Because it's going to help them, and if it helps them that much, the mother will have a hard time getting them to continue to take it as they get to be older, or the kid will get sometimes addicted to it, although I've never seen a child that had ADHD that took medicine as appropriate medicine, in appropriate doses—I never saw one that got addicted to Dexedrine, which is we now call speed, same deal pretty much. But anyway, so yes, there's some medicines that will help, there's some things that as they get older, some children improve anyway, whether you do anything or not. The teenagers seem to be able to control themselves better, and I think, again, this is maybe related to the hormonal changes and so forth.

DM:
Okay.

RC:
And I think a lot of times, I think the drugs that teenagers take have an awful lot to do with it now. Even the marijuana, certainly marijuana-like things are definitely causing some of this ADHD.

DM:
Is it something then you see more pronounced in these later generations than you would have seen in the fifties?

RC:
Yes.

DM:
Or can you look back and say, "That child that I remember in the fifties had ADHD." Can you—

RC:
Well yes, I think there's a lot more cases now.

DM:
Okay.

RC:
Diagnosed because doctors are aware of it.

DM:
Okay.

RC:
Much more so, and can pick up milder cases than used to. And secondly is the fact that—again, I forget my second thoughts here—besides that, but there was—

DM:
Well that there is a change in—

RC:
Change in their hormones and things like that.

DM:
Dietary, or something like that.

RC:
Yeah, yeah, dietary.

DM:
Later generations.

RC:
Whenever I saw these children, I would not try to tell them the child was brain damaged, because you don't want to do that, that's not true. In fact some of these children who are real bad, tend to be the smartest kids you ever saw in your life, but it may be limited to knowing about airplanes, or might be over here to knowing about farming. I mean and I think what happened is that in the earlier days, they weren't diagnosed as much as they could have, because there was no reason, there was no disease known as that. And I think that in my classes, I can think of one or two children at least that, looking back, I think they had ADHD, because they were active, and they were kicked out of school, or always getting in trouble or things like that. And I think that probably what happened then—we had a different economy, and there were more individual farm-type things that people could do, and not so much technical work that needed to be done, and you could pull your kid out of school when they were in junior high, without the authorities coming after you, because he was flunking anyway, and having him go to work on the farm and that he'd be a farmer the rest of his life you see. And so he would never be affecting anybody else particularly. He might be considered odd, but at least he wasn't crazy or anything, he's just a guy that never could sleep, he slept ten to two hours a night, like Thomas Edison, some of these others claimed that they'd sleep two or three hours a night and get enough sleep. I think they were all probably ADHD kids.

DM:
It's very interesting, very interesting.

RC:
And but anyway, I think it's more easily diagnosed and perhaps too easily diagnosed, and I think that certainly I think though that now the things that are causing it, the things we're putting in our body—the lead, coming out of the lead gasoline out of the cars—because there's been studies done, there's more ADHD children close to freeways and highways—

DM:
Really?

RC:
Than when they're living in the country, where there's not much gas burned, or fossil fuels burned, things like that.

DM:
Yeah.

RC:
We just don't know, there's just so many different things like that. But I think it's some injury, minute it may be, but minute is causing brain damage, and that's probably what it is.

DM:
Okay. It makes you wonder what other kind of undiagnosed things that we have.

RC:
A lot of the things we do now, we didn't have back up in then. And I just wonder what we're doing to ourselves and to our offspring. They're getting into this, causing some of this Asperger's, which has been so much in the news lately. I think that's probably due, essentially the same way, affecting maybe different portions of the brain than the frontal lobes up here.

DM:
Okay. So you've been very involved with that for a while then. Then also since 2006, you've been a medical sub-investigator?

RC:
Yes.

DM:
And have testified at drug trials, or?

RC:
No haven't done that, because he does that, he's the chief investigator.

DM:
Okay, okay.

RC:
So he's done that some, but no, I don't want to testify.

DM:
So what is your role as medical sub-investigator?

RC:
Well I do testing of the kids.

DM:
Okay.

RC:
And then we go into conference, Dr. Turnbow and myself will sit down and talk about a patient, and see if they're improving. And what happens is, the companies usually are not making new drugs in the sense of entirely pulling out a drug over here from a tree or from the ground or something like that, but what they're doing is that they're taking these drugs that we have that work pretty well, and try to give them a different form. For example, the Adderall, which is amphetamine-type preparation, like speed, we're trying to make it so that you don't get addicted to it. And so we have it in different ways, we have it now in a pill that you have to take it, and when you take it, it's inactive if you just take it, or if you try to snort it up your nose, or you give an IV, like they do speed, it doesn't work.

DM:
Okay.

RC:
It's inactive.

DM:
Okay.

RC:
But once it gets in the pill, and just has the powder goes down your stomach, the gastric juices dissolves that, and it becomes in the activity of the drug occurs in your stomach. So you can't make yourself get addicted to it by shooting it in your arm, or shooting it in your nose, you see?

DM:
Okay.

RC:
So we're helpful that way. We're also having patches—the other thing is that parents go so that they had to watch their kids so much, because when we first had the medicine, you had to take it two or three times a day, which is very hard to remember, and so they didn't get it regularly. So now they have pills that last twenty-four hours, or they have a patch that's just like a Band-Aid, that you put on here on the hiney, and it absorbs itself gradually over twenty-four hours.

DM:
Okay.

RC:
So we're finding different ways to give it, different, safer ways to give it. And we're trying

different variations of the drug, we're taking Guanfacine and some of these others that don't work too good, seeing if we can rattle the chemistry around—and I don't know anything about chemistry—but rattle that around a little bit to make it so it becomes much more active.

DM:
Okay.

RC:
So those are things we're trying to do.

DM:
Yeah.

RC:
It's not that we're trying any new drugs to get them addicted to—we're trying to give them things that they don't get addicted to. Come in.

Betty Carr [Robert's wife] (BC):
Now, did you ever tell your story about the—

[pause in recording]

DM:
I'm down to just a couple of questions here. One of them is we're going to go back a little bit, I think it's a really interesting thing you mentioned in one of your papers, and it is how you became interested in the medical profession in the first place. It was something about watching the procedures of doctors Dunn, English, and Hunt, while you were a registration clerk at West Texas Medical Clinic. Do you remember that story?

RC:
Oh yeah, that was a very interesting story, because my friend and I ran the registration desk over at the West Texas Clinic for Dr. Hunt, Dr. English, and all the others. And I asked my friend, Ray Cox was his name, C-o-x, and I asked him if he would like to come up—Dr. Hunt—or Dr. English both invited me up to watch some procedures, some minor procedure, and they got the okay of the patient to do that. And so they picked out a person that was going to have an appendectomy. And they made arrangements for us to come up, and they used to have a little step that you stepped up on, and had a handrail in the front of it, that you could look over the shoulders to see into the surgical field. And so we'd start out, and my friend Ray was just all excited about it. He thought this is going to be fun to see an actual surgery take place. And so they got the nurses in there, and it was just kind of a small room. Probably no bigger than half of

this, and with the nurses, and with the two doctors, and with Ray and I up by the wall, they started cutting and the blood kind of spurted a little bit, and then I looked over at Ray and Ray had fainted on the floor, just fallen without making any noise, just fell on the floor, and I was still grasping onto the rail. And so the nurses couldn't help, because they were scrubbed, and the two doctors couldn't help because they were scrubbed and doing the surgery. And I think the anesthesiologist obviously couldn't help. So it was up to me to wake him up, and let him sit up, and then take him outside. And I remember after he got to feeling better, and got out in the air, I asked him, I said, "Do you think that you're going to be a doctor now?" And he said, "No, I'm not going to be a doctor." And I said, "Well I am," and turned out to be that, because he got to be a bookkeeper that kept books for Methodist colleges up in Arkansas and so forth. And I of course went on to become a doctor.

DM:
That's a great starting story, how it all began.

RC:
Yeah.

DM:
Looking back over all of this, what are some of the real triumphs in your career, and maybe some of the tragedies as well? You've mentioned the one patient, the polio patient, but any other thoughts?

RC:
Well there are a couple bad things that happened that almost changed my life. Soon after I came out here, I was—well, it must have been about a year or so after I'd been here—and I was working very hard, and our office at that time was right on the other end of the block from West Texas Hospital. And I was elected head of the medical group at West Texas Hospital, chairman. And so what we did was we didn't have an emergency room then there at that, except for just an empty room with a bed in it, and then another room that had a bed in it where they could do a little bit of suturing and so forth. And so when—oh gosh, here I go with my memory again.

DM:
That's okay, pause it a minute?

RC:
Yeah pause it.

[pause in recording]

RC:
And this one happened there at the West Texas Hospital emergency room, which as I said, were just the two rooms very sparsely furnished. And they—gosh, I even wrote it down here—one of the episodes, I remember very much, because of the fact that as a result of being chairman of the medical group at West Texas Hospital, we set up a routine that since we didn't have a large enough emergency room to have a regular doctor, that the people on call would come from their homes if they needed to. And one night I was on call as the one for the dentist—oh you're going to have to cut it off again, I've got to go to the ba—

[pause in recording]

DM:
Alright.

RC:
So whenever the emergency room people had to be seen, they would call the doctor down from home. And the nurse down there, which would see them first, called me and told me that there was a little new baby, a small baby that had come in, that seemed to be in very much distress, and that I needed to come right on down. So it was in the middle of the night, or the beginning of the night, and I went down there as fast as I could, and when I got there there was a little child wrapped in a real dirty blanket, the mother and father obviously were destitute, and so I talked with them, and they said that the child had been sick for about three or four days. And I could see it really was having trouble breathing, and color was a little bit on the bluish side, not very much but a little bit. And so I said, "Well we've got to get this child in the hospital." So I call the administrator, and he had to okay all admissions to the hospital, because at that time, if a person could not pay for the hospital, then nobody paid. And we were having a lot of trouble down there with a lot of people coming in that would get medical and then never pay their bill. So I called him and asked him permission to get the child admitted, and I think at the time also we were also to limit down there with the beds. But anyway, so he said, "No we can't admit the child, does he need to be admitted immediately?" And I said, "Well, I think he could probably go out to Methodist," which said they would accept it, if we didn't take it down there. And so he said, "Well why don't you go on and sent him to Methodist?" So I called the taxi back that they'd come in, and I went out and got the child, gave it a bit of oxygen, and he seemed to revive and come around pretty good. And I paid out of my own pocket I paid the bill for the taxi to take the child from West Texas Hospital over to Methodist Hospital, so they'd be sure and go, and I told the taxi driver—do not go any other place, even if they say they want to go home, don't do it. Take them to the hospital, and I will be over there following them right soon as I finish some paperwork. And they had a doctor at that time in the emergency room at Methodist. So anyway, I waited a few minutes, just a little bit of paperwork, finished up what I did in probably ten minutes or so. And then I got in my car and followed out there, and when I got there, the baby

had died in the ambulance just before it got to Methodist Hospital. Well it was a surprise to me, because I didn't think it looked that bad, although it was certainly needing some treatment, and some oxygen, but that it had been four days the child had been having this much trouble. And I said, "Well what did we do?" And they said, "Well, the ambulance reported the child as being D.O.A., dead on arrival." And there happened to be an *Avalanche-Journal*, or a paper reporter that was there—skip the *Avalanche-Journal* part. But paper reporter there, who heard about this and wrote an article the next day on the front page about big as this, three by five maybe something like that, about a baby was refused admittance to West Texas Hospital, and then died because the doctor did not show up at the Methodist Hospital, and it died in the taxi. Well, very inflammatory, and obviously if I'd read I'd be mad at the doctor too. I never saw the parents again, or anything like that at all, but anyway, it was all taken care of and I signed the death certificate and things like that, as I needed to do. And then this came out the next morning, and I had two or three people call me and cuss me out. Condemned me because of the fact that I would not see them because I would not get any money from seeing them. And I said, "I went down to the emergency room, and I knew they weren't going to pay, I paid the taxi, I got them out there, just that he didn't arrive in time, he was that ill, and I didn't asses that as good as I should, but that was the only thing I did wrong." And so in the little news briefs about a week later, they said that the autopsy would be done for the cause of death to be determined. Well I already knew it was pneumonia, and so it wasn't going to die in the next two minutes. When I was saw it, it'd already been going on for four days. And anyway, so when I read the paper about three or four days from there, instead of this front page editorial almost, they had a little news brief back in the back saying that the determination has been made that the baby that died at Methodist Hospital on such and such a day, had pneumonia, autopsy was completed, and no problems. And so, but it was just about this big, where this other one was this big. And I came home and I was so depressed.

DM:
Yeah.

RC:
I told Betty, I said I think we just ought to quit. The offered me a job at the medical school, with a good salary, and I just can't take people accusing me of something like that, when I really am doing the best I can, and whatever I can do.

DM:
And all the success stories aren't mentioned.

RC:
Yeah nothing was done at all about anything else. And the big thing was the big story on the front page, and then the little news brief back on the back page, or something like that, all the

way back hidden in the paper. And I didn't have too many, I only had two or three that called me and talked with me. One or two letters from people, that again thought that the paper implied that I wouldn't see them because they didn't have any money and it was all my fault.

DM:
Golly.

RC:
But that was one thing, the other thing was that I worried and almost quit practicing medicine, was that when I was in Denver, I was in charge of the emergency room there at the Colorado General Hospital. One night, girl came in that had a cut— She had a cut up on the forehead up here, where she'd fallen. And it required several sutures, and we had a suture tray and everything all set up, that I told the nurse to get it set up, and I'd suture it up right then. So anyway, we got it, and I put in medicines—and they had medicines then just in medicine glasses. One was a medicine to deaden it, lidocaine, and the other was a medicine that [Phone Rings] the ointment Mecuricome. [Picks up phone, a lady's voice begins to speak and phone put back on the receiver] And so with the Mecuricome, you could tell therefore the difference of the two, and that it wasn't anything that you need to be concerned about. So I got the Mecuricome, and did that over the thing to clean it, and then I got the other one, and I had a syringe and it was just a clear watery-looking liquid. And then I put medicine and filtrated all the area so it wouldn't hurt or anything, so I could sew it up. And while I was doing it, she seemed to have more pain, she was I think now recalling, she was very apprehensive about the suturing.

DM:
I see.

RC:
And she seemed to have a lot of pain more than I thought she should have, and I kept telling her it's going to be okay, it's going to deaden it a little bit quicker. And so we waited until we were able to finish up. And then the funny thing was that afterwards. I got to thinking now I know that this other did have some Mecuricome there, because of the color it was, but was this other, was it really lidocaine, medicine to deaden it, or was there something else that the nurse put in there that looked the same, looked just like water.

DM:
Because there's no labeling system.

RC:
Yeah, and if she complained that much, maybe it was water, I didn't know.

DM:
Yeah.

RC:
And anyways, I worried about that for the next several days, thinking well until she comes back I'm going to worry about this. So she came back about a week later, to take out the sutures. Looked great, no problem, because the problem would have been if it was something else besides the lidocaine, it wouldn't have deadened it, and it did seem like it did as good as it should. And it also might have caused a lot of sloughing, where it would kill the skin around it, and then there'd be a terrible scar up there. And she was a pretty little girl, high school girl or something like that, college girl. But that's the other time that I almost quit medicine and started doing horseshoeing or something like that.

DM:
You know what, there's so many things that could go wrong.

RC:
Oh yeah.

DM:
It's a frightening prospect.

RC:
Yeah.

DM:
And then besides all of the medical practice, there's the business aspect.

RC:
Yeah.

DM:
I mean there's a lot weighing on you.

RC:
Yeah, yeah, medicine is interesting, let's put it like that.

DM:
Yeah.

RC:
And my son once told me he didn't want to be a doctor, because one of the things, I had to read too much. Because I always had a habit of coming in and sitting down here at this desk, and start reading, and might read until ten o'clock or so, you know. And I think he does the same thing now, but anyway, and then he later told me that that was one reason, but the other reason that children never could tell you where they hurt, and they cried all the time.

DM:
Oh.

RC:
So he decided he didn't want to be a pediatrician, and asked me if that would make me feel bad, and I said, "No." Well there she is again.

BC:
That was your daughter, she's on her way home.

RC:
Okay.

DM:
And I'm finished here, unless you have anything else to add today.

RC:
No not really.

DM:
Okay.

RC:
Those are the two main things that I remember that really we almost quit—and I always said, "We," because Betty and I were in this thing together like you said.

BC:
We had our sixty-sixth wedding anniversary last week.

DM:
Wow. Okay, you ready—

DM:
So anyway, yeah, I'm finished, yeah.

End of interview