INTERVIEW WITH THOMAS MUDGE
MARQUETTE, MICHIGAN
JUNE 16, 2009

SUBJECT: ST. MARY'S AND ST. LUKES—MARQUETTE GENERAL HOSPITAL

START OF INTERVIEW

MAGNAGHI, RUSSELL M. (RMM): Okay, interview with Dr. Thomas Mudge, Marquette, Michigan. June 16th, 2009. Okay, I can call you Tom?

MUDGE, THOMAS (TM): Yes.

(RMM): Tom, the first question that I ask everybody: what is your birth date?

(TM): Birth date? May 24th, 1920.

(RMM): Okay. Could you give us a little of your background, where were you from, where did you grow up and kind of how did you get into medicine?

(TM): Okay. I was born in Negaunee, 1920. My dad was a general practitioner and I guess medicine was kind of predestined with him as a person I kind of admired and wanted to follow in his footsteps. So after going to North Western for three years, I went to the medical school, I graduated from the medical school, interned at Addleston Hospital Association. Whereon, I was in the service, as all of us were that passed physical, because that was World War II. Following that, I came back to Chicago and I was at the Cook County hospital for six months as a surgical pathology resident. I wanted to go into surgery but with the influx of people getting out of the service, the number of residencies was limited so there wasn't an immediate opening so I had to wait about six months. Which I spent there at the Cook County hospital and it was very worthwhile. Then I had three years at the August Anna Hospital as a resident in surgery, following that a year at the Leigh Clinic in Boston and then I came back to Chicago and back at August Anna where I was on the staff with Chief of Surgery Nelson Percy and was his assistant until recalled into the service not too long after the Korean episode. I was in the service, this time, for a couple of years and on my return I moved to the bay area of California. I was the director of the surgical program at the Highland Elemena Hospital. It's a county hospital of about seven hundred patients. I was managing the surgical training program at the same time I was on the staff at the University of California.

(RMM): Was that in San Francisco?

(TM): No, that was in Berkley and Oakland, across the bay. Following that, we turned to this area and thinking maybe we would return to this area thinking I would maybe give it a year. I knew I was drawn to the area because I grew up here and the hunting and fishing and all that from my youth was something that I enjoyed. I was concerned about the level of practice that one would find in a rural area

after one is exposed to specialist medicine, you feel a little vulnerable to go into an area that might be predominantly general practitioners and you worry that their expertise in internal medicine or even pathology or radiology were low. You hoped they weren't and I wasn't prepared to make this my life decision to stay here but I was gratified to see how they had progressed and that the radiology department was excellent, the pathology was excellent, and there were a core of three internists, so I didn't feel vulnerable to having to be a general practitioner myself, although, the training I had in general surgery was very broad in the sense that we didn't super-specialize. I had training in gynecology, in orthopedics, in urology, and even some in neurosurgery. So coming back here was not replete with total coverage, and I'm thinking particularly neurosurgery. We had no neurosurgeons and it was required by us to evaluate head injuries or then decide to fly them out or get them out of there where they could see a neurosurgeon or a neurologist at least. In the winter the roads were shut down, the planes weren't flying and the evacuation was interdicted. We did have to do what we had to occasionally after a head injury. That is do a tri-final, make a whole in the skull and that releases the pressure from a clot that had formed and that was really not very technically difficult. It was something that the Egyptians did, and the Peruvians, and the South Americans. In this day and age, or that day and age, 1960, it was still a kind of anxious time for us and we were more than happy when we finally did get a neurosurgeon and we were relieved of that concern.

(RMM): So you came back in what year?

(TM): 1961.

(RMM): So you were going to come back for one year?

(TM): Yeah, I wasn't sure I was going to stay, but I was totally delighted. Gave up, I didn't renew my California license. I was prepared to spend my practice life here with no regrets. At that time, of course, even though specialization had really taken off after World War II, as you got farther from the big cities, there was not the same concentration of the specialists that you would have in the medical centers. In the Upper Peninsula, we had a lot of small hospitals which were mainly staffed by general practitioners that didn't have everything. Marquette was fortunate to have a core of specialists at that time. There were two arthropods, at least one gynecologist, obstetrician gynecologist, there were two general surgeons, I was the third, three internists, board certified internists, and two pediatricians, and of course the x-ray and laboratory although located here, they were based here, they did a lot of traveling. I think Lloyd Blytho who was the head radiologist, in fact, for a while he had a small plane and he would fly to Escanaba and he would wear his red tinted glasses so he could get off the plane and go to the hospital and do a, not just read films, but do a fluoroscopic examination of the stomach of the colon or the stomach or whatever was required and regular trips to Negaunee or Ishpeming, mainly Ishpeming because Negaunee at that time didn't have a hospital, and Manistique. He did a lot of traveling, and Munising. But that was part of the thing that they had to do to help out the outlying areas that didn't have the volume or the patient numbers to be able to support a radiologist or a pathologist. Those two specialties although base-tier, were shared by other locales. I think in '61, around that time, really you can get a handle on this by looking at the telephone directories of the 1960s or '70s or '80s or whatever, and in '60 I think, they had around 20 specialists in Marquette, only one in Ishpeming although did share the radiologist and pathologist, and the rest were general practitioners. In the next twenty years, the numbers of general practitioners were about equal to the number of specialist in Marquette, but by '80, I think it was almost three times the number of specialists to general practitioners. That wasn't the case

in any other city in the area. Of course part of that expansion was the merging of St. Luke's and St. Mary's Hospital. Prior to that, when I first got here, St. Mary's of course was a Catholic hospital and although St. Luke's thought of itself as a nondenominational, it was the choice of most Protestants. Surprisingly, religion was a very potent force, much more in those days than today. There were women in Ishpeming, let alone Marquette or Negaunee, that wanted to have their babies in St. Mary's because there would be a priest or a nun or whatever. Of course under enough circumstances, if a death occurred, it appeared to be close to happening, last rites were available. And Dr. Perduzzi, who was a general practitioner in Ishpeming, was a good Catholic and he would come down, he had positions at St. Mary's, and he would come down to St. Mary's and deliver the lady who was pregnant.

(RMM): Even though they had a Catholic doctor, they wouldn't have the baby at Bell?

(TM): On occasion. If you were really a very good Catholic you would prefer to have it at St. Mary's, that was very strong. When I started, of course there were no emergency room physicians. Coverage was by the general surgeons and maybe a few general practitioners that did a fair amount of surgery. I'm talking about Marquette. If you were on call, and there was an automobile accident for example, and one car had people who were Catholic and the other car had people who were Protestant. The Catholics wanted to go to St. Mary's and the others wanted to go to St. Luke's. Well if you were the person on call, that particular incident might cause you to feel like a ping-pong ball, going from one emergency room to the other, and back and forth to take care of these people.

(RMM): So if you were on call, you were covering both hospitals?

(TM): Yeah. I would be on call for the surgeries, for the city you might say, in surgery. If even it's just a banged finger, that's surgical. If there were generalists they would take care of it. You found yourself, I think, that that was the biggest headache, you might say. It got so constant so every time I was on call, I'd be saying not another trip in. But anyway, it also meant that medicine couldn't grow like it might in Marquette at that time because everything cost money and new things were coming out. I was a member of Rotary and at the end of the year we would have money that would be generated through a pancake breakfast or this movement or that so now we are having as to what to do with that money. Where is it going to go? Somebody would get up and say you know, St. Mary's needs a ten thousand dollar addition for their radiology department because their present equipment is not really working as well as it should. People would nod and say yes, and then somebody would say, what about St. Luke's? It would be either way. If you said either way St. Luke's needs something and people are saying that'd be a good thing, the other felt they had to have the same thing over there. There was this polarity that you had to live through to experience. It doesn't exist today of course. We don't have just one hospital. And actually, the Ishpeming hospital, later the Bell Memorial hospital, had more equipment, better, new, and more equipment than the two hospitals here because they had the Cleveland Cliffs. They only had one hospital and the Cleveland Cliffs had a very good program as far as health for their employees. My dad was a Cleveland Cliffs physician, as was whoever else was in Negaunee, whether it was Pain or McIntyre. They are all salaried by the Cleveland Cliffs Iron Company and that meant the patient, the miner and his wife, and his children, I don't know if it extended beyond that, but they had very good coverage. And certainly that was true in Ishpeming as well. That being the hospital for the Cleveland Cliff patients or the miners and their families, they were able to get money for things that we didn't have. And there was a period in radiology in which there three radiologists, I think Bilytho, Carter, and then Ericson. Doug Ericson was born and raised in Ishpeming. His dad was a general practitioner when I

was a kid. He would go very frequently he would go to Ishpeming because he had that feeling for the hospital and that community and ultimately an interest in treatment. Radiology can be divided into two areas, diagnoses and treatment, treatment meaning radiation for cancer and tumors, which came along later. Initially it was x-rays and making a diagnosis. But later, treatment and the people that were coming in new, like Ericson, he was much younger than Bilytho and Carter, was interested more in treatment than the diagnostic part. They said Jim Carter and Lloyd Bilytho said let him do it if he wants to do it. They had equipment for treating up in Ishpeming before they had it in Marquette. In other words, they were ahead of us. Well, the surgeons in particular were frustrated here in Marquette because this back and forth and both hospitals were underfunded. You couldn't really get everything you needed unless you might have purchased it yourself. Jim Lyons, an arthropod, he had I bet five big suit cases of instruments. He wanted to have every instrument you might need and if he'd go up to Bell or up to Ishpeming, those instruments all had to be lugged up there. It was just a big deal. Well, anyway, when I got back here in 61, and I think it was '63, I was made Chief of Surgery at St. Mary's. I had very good report with the board, in fact, Harland Larson, who was head of the board, wanted me as his doctor, even though I was a specialist, we still did a certain amount of ordinary medicine. A couple of years after that, I don't have the years exactly right, I was Chief of Staff, I had my year or year and a half at St. Mary's so now I was Chief of Staff at St. Luke's. At that time, and this might be 66, don't pin me on that date, Raymond Clevinger was our representative for this district. In Washington the Congress in the year before or previous year before, had, recognizing the escalating cost of medicine, said one think we've got to do is try to avoid the duplication that's occurring. If we can figure out a way to do that, I think it will be helpful for everyone. So Ray Clevinger came back, he was an incumbent running for office, and one of the things that he really caught on to was this bill that promised funds for any two hospitals in a close physical location if they would eliminate duplicating the same thing. It's a bigger problem than it sounds, but at the time it sounded good. Clevinger really grabbed it and decided to run with that and make it part of his program to run for re-election. Because of my relationship with St. Mary's and then my relationship with St. Luke's, the meeting that Ray Clevinger had with the two boards occurred within the basement of the Northland Hotel. They asked me if I would moderate because they felt I was acceptable to both boards. You couldn't have the president of one board of one hospital do it because they felt that that was a conflict of interest. I can remember going and driving down there and remembering this is the greatest thing happening. I'm not going to be jumping back and forth, there's not going to be one emergency room. It's going to be better and bigger and we won't be bouncing back and forth. Well, Clevinger said, "I can promise you, the city of Marquette, a million and a quarter," which was big money in those days, "if you will eliminate the duplication of services." In other words, one hospital had the emergency room and the other had the obstetrical ward. But when you get beyond that it gets sticky. Who's going to have surgery? Who's going to have internal medicine? Surgery was still considered, you know, a higher form of treatment by a lot of people. So the result was the two boards sitting there, Clevinger could have been speaking Chinese. That was the reaction. Both board presidents got up and said something but didn't say anything really. In all fairness to them, they were representing their constituency. I mean, that's the feeling of these people. As a result, when Clevinger ran for election, he very closely lost. But it was Marquette County that dumped him, and this is the county of the biggest numbers and here is where he took his nose drive because he was promoting something that neither side wanted. Neither one could see the value of that. They both wanted their own hospital. I don't know how many years…I'm not sure what year it was that it merged.

(RMM): '72.

(TM): '72, I was thinking about ten years. It took about ten years of red ink on both sides to force that issue. It wasn't public opinion, it was just money. We can't keep losing and losing. So they merged, it was a godsend. Up until then, a doctor in Houghton or Escanaba or Munising, or Manistique, you wouldn't send anything to Marquette, you'd send them to Green Bay or down to Ann Arbor or to Milwaukee. We were just one of the groups, you might say.

(RMM): The smaller hospitals?

(TM): Yes, everyone felt the same. Actually it wasn't true, we did have more specialists here, then the merger came and then the influx increased. That's when you saw the development of Marquette General into a medical center instead of a regional hospital. Unfortunately for Clevinger, he was devastated by the loss and left the area and went to Ann Arbor to practice, I talked to him once for some reason or another, but he really felt he had been blindsided by the loss here. Of course, he was right. The duplication isn't good sales, but the community wasn't ready for it. They hadn't seen the red ink or whatever it was. Maybe we became more tolerant of other views. I'm saying red ink because that's always a factor. When I was a teenager, my parents were Protestant and if I were to date a Catholic girl, they'd be worried. Because our children would have to be baptized in the Catholic Church and they worried about that, as ridiculous as that might sound today, religion played a much bigger role in people's decision at that time than we can really conceive in the present circumstance.

(RMM): I've gotten this sense not so much from the interviews but more from knowing the general history of Marquette, Marquette was kind of divided. South Marquette was the Catholic end of town.

(TM): Yeah, that could be too. You know, you'd go to your closest hospital. The battery in my hearing aid, I just put a new one in, I'm going to just change it.

(RMM): Just to recap because the recorder was off, you saw that tension than, that Catholic-Protestant…

[END SIDE A]

[BEGIN SIDE B]

(RMM): Okay, were you involved with the combination or the process of bringing the two hospitals together? Did you play any role in that as a physician or was it all done by the boards?

(TM): I don't feel I had much input there.

(RMM): So it was just sort of something that finally, the red ink forced the issue for the two hospitals?

(TM): Yeah, of course, when you have one hospital as Marquette General is the hospital, events occur, of course, that change the situation. In other words, with Al Hunter coming on heart surgery, well you got to have a bigger room with this and that to support that, you got to have an upgrade in your intensive care, all these things tend to grow and specialization increases. The specialization part is very expensive. As I in the past have argued with my engineering friends complain about the cost of medicine, I say it's the engineers. They are inventing a new MRI every few years that cost an extra

million bucks. The two things have gone together. Everything is so expensive. As far as the actual merger, I don't remember being in the planning of the hospital.

(RMM): So then did the two close? Did one close completely, or did the two kind of work together?

(TM): Actually, St. Mary's played a role in areas that were valuable and I'm not sure if it was in the early thinking or not, but they had the substance abuse ward, in other words, alcoholics were brought there for care, so there were areas where it was used as an institution to supplement.

(RMM): it was more of a satellite? St. Luke's was the center?

(TM): St. Luke's, or Marquette General was the center, yes. Really, I think the board of St. Mary's worried about that from the beginning. I think they were visionary enough to see that if they merged, it was going to be St. Luke's hospital, with small letters saying St. Mary's over here. I don't say that it happened that way because both boards were on the Marquette General board, it was a merger of the existing board. It was an attempt to make this physical building compatible with the boards and the people they represented. So I think it that was very worthwhile. In the emergency room, as I say, the idea of having one emergency room was wonderful. But on top of that, having emergency room physicians was an even bigger step. Or at least a very complimentary step because that meant that there was somebody there and you didn't find yourself being in your office with patients waiting and somebody from the emergency room says this or that or can you come over and take care of it.

(RMM): Oh, so that's how it'd work. You'd be in the midst of taking care of patients?

(TM): Yeah, and even though we were only a few blocks away, we were in favor of getting emergency room physicians. At that time, and this is the early '70s, I don't know how elsewhere it was in the country, but certainly here, the idea of a specialist in emergency room medicine had really evolved. Very often it was a man that had taken his training and maybe he had taken his internship, and wasn't decided on whether he wanted to go into medicine or obstetrics, or whatever, or maybe he had bills that were pressing. He took a job as an emergency room physician. He didn't have any specific training as an emergency room physician. And that's become a specialist situation just like any situation. Just like any specialist. If you think of all the variety and types they are going to see, whether it's poisoning or early trauma, or whatever, they have to be right on the ball. That goes for the ER as far as ambulance people, etc. We'll say 1973, I'm not sure but around that time, the first emergency room physician was hired. He had been with Northern as a university physician for patients but because he was over-religious, if a girl came in with something suggested sexual activity he would ask her to get on her knees with him and pray to help her get through this crisis. The university didn't find that, well, he was a great guy, a good doctor, but it was not that role that they had hired him for. But others followed. So the hospital room was concerned because they knew the emergency room physicians didn't have a lot of specialized training. Nelbert, who was the head administrator of the hospital, came to us, which was surgical associates Dr. Bennet, myself and our partners. He wanted us, we accepted this, to take the responsibility for the management of the emergency room. That meant we had to hire three men. 8 hour shifts in other words. If one of them got sick, we, as surgeons, would come in and take care of whatever. It was more of a concern for a surgical problem, like an automobile accident, than someone with a heart problem. I mean, they felt more vulnerable when it came to trauma than when it came to internal medical problems. I think we the surgeons complained the most about being interrupted and

making all these trips. So anyway, we hired them and paid them, we didn't make any money out of it, we just provided the service and were happy to do so because it saved us a lot of trips and time and interruptions at night. Eventually, they developed and became their own bosses and made their own contracts. At that time, the hospital realized these people were trained in emergency medicine and they didn't have to worry about a suit to the hospital because they had working for them competent people. From then on the emergency department became fully staffed and really did an excellent job. I'm trying to think if there is anything more I can add to the period I was most familiar with. Obviously, being named a center was important financially and for a variety of reasons. We were all behind that and contributed it and we gave money to Jacobetti to push this thing for us and he did and we got it. It was a very important step in making this a center. The development in which a program of teaching interns was another thing that was important. Initially however, the staff was leery that this was not a good plan. Actually it was the medical school. This was where Dan Mazzuchi has more input and was very closely involved with that. Having medical students here, training, there was actually a larger number of the practicing physicians against it than for it because they were afraid that after they finished their four years, what if they flunk their state board because they hadn't been adequately trained, so they didn't want to take the burden for the first few years. If you were in a normal medical school you'd have a cadaver and do a dissection. You'd do cystology and basic sciences that we weren't, as practitioners of medicine hadn't conversed with like we do in medical school. What happened was initially the students went to Escanaba and they took their clinical work up here. And then ultimately they took the whole thing. Fortunately there wasn't this failure rate that we all feared. In fact today, I don't know, in the medical schools how much they still do the sort of thing we did. We spent hours looking through microscopes and doing dissections and stuff like that really, if you are in surgery, you learn it all over again for the area you are working in. If you are a neurosurgeon you are concentrating on the brain and all that stuff. A student will tell you you'll forget 90% of what you learn here. Having the school ultimately turned out to be good for the students. It made it very good for them because they had the wide spectrum of really excellent teachers from the various specialties.

(RMM): One area, I don't know if you'd be able to comment on; the pathology department.

(TM): I really don't have the knowledge there that would be good. I just know they expanded and it's been a wonderful thing.

(RMM): In the early days it was kind of primitive?

(TM): Well, that was one of the reasons I was nervous about when I first came. Obviously, if you have one pathologist, he's the only one that's doing autopsies, determining the cause of death, and also he's responsible for tissue analysis, determining whether a patient has a tumor or not. For example, I remember cases where we'll say a breast tumor, you take a biopsy, and it'd take about a half hour to get a result. If you have a patient with a bad heart, being under general anesthesia for an extra half hour was not really that good for her. I remember another case that I was assisting on where the patient had a brain tumor. The neurosurgeon didn't last. This wasn't Birsch, he was a man who came along later. He was a perfectly delightful gentleman and person, but in his training he hadn't had a lot of hands on experience. We started at 8 o'clock in the morning. When we finally got down to the brain tumor, he took a little out, but he didn't want to take too much out because you may remove some of the brain that you wish to save. So he'd send the piece down. We would stand there for a half hour until we got the results on that. He'd say there was still tumor. So he'd take another little piece. I hung in there for I

think 8 hours, I said I think I've had it, I'm exhausted. But fortunately he was just about through, but if it had kept up much longer, I don't know what would have happened. But now I'm sure they'd have come up with the answer much more quickly.

(RMM): Maybe I should have asked this maybe in the beginning. Going back to your origins up in Negaunee, could you tell us a little about your father and his practice in Negaunee and the early days of the 20th century?

(TM): Well, as I say, he was a company physician, salaried, 100 dollars a month. If he did surgery, like an appendectomy he would get money for that. I know that a delivery would be 20 dollars, that'd be a 'that day' thing. Most of what he did was with the salary. They provided an office – his office was in Negaunee, on Keylight Ave. there in the Masonic Hall I think. At one there were three or often two company physicians. They were more in Ishpeming, seven probably. The bulk was in Ishpeming. There wasn't much in the way of private practice because almost all the people were miners or had families or were connected to that. I remember him saying when I was going to medical school that I shouldn't just take an internship, I should take more. He was beginning to realize, like all general practitioners were at that time, the knowledge in medicine is increasing so rapidly that it's almost impossible to keep up with medicine. If you are expected to know everything in pediatrics and everything in obstetrics, and everything in medicine, it's just an overwhelming task. So anyway, my brother also went into medicine, I did too. One that that was different, Ishpeming always had, even though it was just a little bit bigger than Negaunee, they seemed to have a more progressive group there. They had the hospital, the radio station, the Mandarin, the best hotel. I mean, better than the one in Marquette because that's where the people the Anatomy of a Murder were housed. They had the only rotary club. Negaunee was a little laid back, they weren't pushing for anything. Ishpeming was always kind of competing with Marquette. Yet, at the same time, in my memory, in the 30's, Negaunee had three hospitals. One was the hospital on Sears Street, which was managed by two physicians which was not connected by two physicians and was not connected to the Cleveland Cliff company. And then, the Cleveland Cliff dispensary where all the patients went to be treated, initially had four beds upstairs which they used to house people or keep people that were sick. That didn't last very long. There was a Dr. Robins where he had a house where he had a practice. I mean people came to his house. He had two rooms upstairs where they had two beds so you might call up Dr. Robins' Hospital. In those days, a hospital was a bedroom. At that time as I say, in a sense, three hospitals. My calling it a hospital just means that a patient that wasn't well enough to go home would go up and have a nurse look after them. In Dr. Robins' case I don't know if it was his wife or what. I don't know. But, the other hospital was a twin city hospital. I don't know big it was, could house 20 or 50 or something. So a hospital at that time didn't have quite the cache that it has today. Also you have to remember that early on, and of course that's before my time, getting to Marquette from Negaunee or Ishpeming meant going by train in the winter. The road between Negaunee and Marquette was not plowed until I would guess the 20s or 25. I mean, you could get on the train and go if you had to go. Even when I was practicing in Negaunee, and this started 61, my dad was still practicing, and I would go up there and see patients and in fact I was busier up there than I was in Marquette because I was my own person – the son of my dad. So I'd see a patient in his office on Wednesday evening and he had already seen them and maybe determined that they had a gall bladder that needed taken out or something. They'd come and see me. I'd check them out and tell them where they are going to go. And then they'd say, "I don't want to go all the way to Marquette." They wanted to go somewhere close to where they lived. Marquette was still a long ways away from where they lived. Now of course they make that trek without any worry.

(RMM): Was there anything that I didn't cover that you want to add that you remember as being important?

(TM): Ah, not really. Although, the thing everyone has to keep in mind with specialized medicine, with medicine getting so complex, and with so many avenues to go, it also means there's a parallel in the increase of cost. If you have a group of general practitioners, they're not going to generate the type of fees if you have a specialist. First of all, they won't be able to get the type of surgery. I mean, here I am, I had a knee replacement, I've had a hip replacement, and just recently I've had a cochlear implant, which means putting a sensor into the cochlea for the treatment of deafness. These are the things that were not readily available only 25 years ago. Or not even available at all or maybe not even considered. And with that goes the cost of medicine. When they say they are going to have medicine for all that really poses such financial problems that I don't know where it's going to go. If, for example, they can get to the point where they can eliminate rejection, they can take someone else's heart that has been in an automobile accident, and put it in your chest without the worry of rejection, the procedure they can do, but unfortunately your body isn't, right now with what drugs they have and knowledge they have, won't tolerate. What if they solve that? What is anybody going to die from? Everybody gets a new heart, or wants one. What if they get, I mean when I started practice, if a man got an obstruction and it turned out to be cancer of the colon, you removed the obstruction and put the bowl back together. And maybe when you felt the liver, there were nodules there. Whether you biopsied or not, you pretty much knew that they were spread cancer. That patient was relieved of the obstruction, but you didn't prescribe radiation therapy, or chemo therapy or anything like that. Today the program is just beginning and the cost for that extra year is enormous and the longer everybody lives, the greater the opportunity of more cancers. Cancer goes with age. I can't see how we are going to solve this problem, the curve is just going up, it isn't dipping down or anything like that, it's just going up with new ways to treat this and new ways to treat that.

(RMM): And as you were saying earlier, all the new equipment is added to it all.

(TM): So, it may be we'll have to end up doing what they are doing, or are still doing in England as far as I know, if you are in your late teens or early twenties and your kidneys fail, they'll do a kidney transplant. But if you are, and I don't know if these are the correct ages, if you are in your thirties or early forties, they'll give you dialysis.

[END OF TAPE 1]

[START OF TAPE 2]

(TM): So I guess their system makes sense. Oregon has been at the foreground of trying to keep medical costs down. In almost every other state, if a fetus is born and birth weight is, and I'm not sure where they draw the line, if it's two lbs. or what, they'll just say there is no way we can keep this alive or the chances of keeping this alive and having a sound baby without problems later are not really a good way to go. So that's the attitude that they take in Oregon. But in most places, they say they have the intensive pediatric care, so use it, so even though it takes $50,000 dollars to save this questionable child, if they want to call it a child, is it spending dollars wisely. The whole area has lots of questions that make it very hard for anyone to come up with solutions that can satisfy whatever we feel is good

medicine. And certainly here I'm 89. I don't think the worst thing is dying. I don't want to keep living forever. If I'm unable to reasonably enjoy life, I'm ready to throw in the towel and I think that makes sense. You'll have a family of say five kids and maybe the ones that are closest to this person have been here locally and the ones that have been away maybe feels guilt ridden, you have to do everything, anything new. The oncologist will say with this particular formula or this particular set of drugs we can show that a person will live three months longer. Is that a good choice? If you got one person say do it, maybe tomorrow will say they'll come up with a cure, and the others don't say anything, they don't want to say it. It's got a lot of problems.

(RMM): Do you feel from your perspective because you are older, do you feel that you, well we are kind of getting back to the religious thing, you mentioned it earlier with St. Luke's and St. Mary's hospital. Do you feel that religion is, or maybe it was always there, is it invading the practice of medicine where someone questions someone's actions?

(TM): This one has gone out too.

(RMM): I'll talk louder. Okay, do you feel, we were talking earlier that religion played a role in St. Mary's and St. Luke's hospital and so on, do you feel that today religion is coming in and playing a role in terms of what the physician can do in terms of medical and what medicine can do and is it demanding that more be done than should be done.

(TM): I'm certainly not against religion. I'm seeing, when I was at August St. Anna's hospital, that was a Swedish Lutheran hospital, they had a chapel in there, and I think for a lot of people that was a wonderful thing. At least they could talk to that person much better than the physician could and give them a philosophy or give them assistance in a spiritual way that would make the remaining days or months in their life very more acceptable. I do think there are places where I might disagree, and that's keeping everyone alive at all costs. In a sentence that's about where I would draw the line because that's what I want done. I guess I wouldn't object to it being used more for other people. But everybody, they have to make their own choices.

(RMM): Okay.

(TM): Well that's it I guess.

(RMM): Well thank you, it's been very enlightening – another wonderful, wonderful interview.

END OF INTERVIEW