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HOUSE CALLS

THE EVOLUTION OF MEDICINE AS TOLD BY CLARKSVILLE PHYSICIANS.

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"The changes in medical care I've seen over the last 40 years have been miraculous."

— Dr. James E. Hampton, Internal Medicine

Through personal experience and first hand accounts, we'll take you through a history of medical care as seen through the eyes of several Clarksville area physicians. From the days of house calls and home births to present day, state-of-the-art technology, these dedicated physicians have seen it all. Here are their stories.

Preview: American Medical Practice Since the 1800s

During the 1830 to 1860 period in the USA, lay practitioners treated ailments with herbs and folk remedies, while formally trained physicians were somewhat disregarded. Family medical care, for the most part, was attended to by the women in the family.

At the time of the American Civil War, 1861 to 1865, hand washing was not a normal practice, and germs and bacteria were still not understood. Blood transfusions, x-rays, antibiotics, sterilization, vitamins, vaccines, and wonder drugs all came after the Civil War. Most bone fractures and all wounds of the joint meant amputation by physicians wearing dirty, bloody clothing or aprons, working with unwashed hands, and using unsterilized surgical instruments. There was little anesthesia other than alcohol or some opium. It is truly a wonder that most of those amputations, estimated at 60 to 75 percent, were successful. In the Federal armies, sickness and disease accounted for seven of every 10 deaths. Death rates for the Confederates are merely estimates, but some think that for every man killed in battle, three died from disease.

Living in close quarters took its toll with no knowledge of how to deal with body waste, typhoid fever, yellow fever, and measles. Many died of pneumonia and dysentery. Only one out of seven could expect to survive a wound.

In the 1860s and 1870s, Pasteur and Koch greatly influenced and impacted preventive therapy based on bacteriology. By the 1890s there was some control of water and food-borne illnesses. Regulation of the milk supply dramatically reduced infant mortality. In the 1890s the germs responsible for tuberculosis, cholera, typhoid and diptheria were identified. By the mid-1890s laboratory tests were available to diagnose these diseases. Urine analysis had been available long before that. The syphilis spirochete was identified in 1905 and the Wasserman test for syphilis became available in 1906.

In the 1800s physicians often did not cooperate with others in the profession, and there was little supervision. But from 1902 to 1904, the Tennessee Medical Association grew from 386 members to 1,097. In the early 1900s the American Medical Association grew so rapidly that by 1920, 60 percent of physicians were members. Unity and coherence were now being achieved. Organized medicine began to function efficiently, and medical schools were better supervised, requiring a minimum standard for medical education. Physicians were now respected and regarded as experts in their field. As time passed, more women and minority students were accepted into medical schools.

By the late 1800s, Pasteur developed a rabies vaccine. Diptheria antitoxin appeared in the mid-1890s. Typhoid and tetanus vaccine became available around 1900.

Even though ether was available in 1846 for anesthesia, it was not widely used, and major surgery of the abdomen was not very common until the early 1900s. The advent of x-rays in 1895 was a major turning point in diagnostic equipment. From that time on, surgeons could operate earlier and more often. Throughout the latter half of the 1900s, the development of more and more radiological equipment made possible more accurate diagnosis of many diseases. Along with these improvements, radiology made possible many options for treatment that before had not even been dreamed of.

Along with all the changes in medicine and surgery in the late 1800s and the early 1900s, hospitals became much more efficient and trustworthy, and the nursing profession became a respected, honored and necessary profession.

It got to the point in the early 1900s that physicians could understand and explain many of the diseases, but lack of successful therapies may have promoted the patent medicine business. Sulfa drugs were discovered and used in the 1930s. Antiseptic surgery with suitable anesthesia became available.

Insulin was the first hormone identified (late 1920s), and it won for the doctor and medical student who discovered it, the Nobel Prize (Banting and Best).

In 1928 Fleming discovered penicillin, but it was not readily available until 1946. During these years, scientific medicine began to develop more and better medications. Through the fall and winter of 1953-4, nearly two million children in the USA and parts of Canada were immunized with Salk vaccine to prevent poliomyelitis. This was the beginning of the end of polio and had a huge impact on the health of America.

As significant as these facts are, many other awesome improvements in medical diagnosis and treatment have occurred since my birth in 1929, and it continues to the present day. I hope you will find the following reports from some of our more mature physicians (polite word for "elder") of interest, regarding their observations of medical care in the 1930-1960 era. ■

James E. (Jim) Hampton M.D.
November 19, 2003

More details on this topic can be found in the book "The Social Transformation of American Medicine" by Paul Starr, who received the 1984 Pulitzer Prize for this work.

Photos Left to Right:
James E. Hampton M.D., 1951
Sign for office of J.E. Hampton, M.D., Clarksville

My Memories of Medical Care During 1930s Through 1960s

By Dr. Robert C. (Bob) Koehn,
OB/GYN

Written January 2003

Years of practice:
July 6, 1962 – December 15, 1999

My name is Robert (Bob) Koehn and I was born in Los Angeles, California on March 7, 1928. My father was a telegrapher for a brokerage house, which at that time proved not to be the best business to be in. My mother was a housewife and her best skill was being a mother. My younger brother was born in Seattle. Shortly after his birth we moved to Kansas after my father lost his job during the Great Depression. We lived with his parents for about 18 months until he found work with another brokerage firm in Denver, Colorado. My mother's parents died shortly after I was born. Her father had complications of high blood pressure and her mother was a bad diabetic, dying shortly after the time insulin came on the market (insulin became available around 1923 not in a very pure form). I had the usual childhood illnesses, as did my brother, who got quarantined twice for a severe case of the red measles and a second time for a bad case of chickenpox.

When I was in the third grade my mother and father separated, and my mother, brother and I moved to Kansas. A couple of years later we moved to Tennessee. Before we moved to Kansas, my brother had his tonsils taken out in a doctor's office in Denver, and that experience was the event that made me start to think about going to medical school. Because of a poor family economic situation, I had to start part time employment in the 7th grade. It was amazing that my mother, brother nor I had any illnesses and were not exposed to healthcare professionals or hospitals during 1938 to 1948. In 1948, after completing premedical studies at UT Knoxville, I entered medical school at the University of Tennessee, Memphis.

Medical school was a whole new world, and it was wonderful! Within 6 months of entering, financial problems made it necessary to find work to help with room and board and other expenses. I found a job at the Hospital for Crippled Adults, which was like attending a second medical school. I got a similar position for my roommate; and we performed the lab work required by the hospital (we learned that in a few days), changed dressings for all sorts of conditions, made rounds, assisted in surgery, removed casts, etc. (Most of the things we performed were taught to us before we were exposed to these classes in medical school. The orthopedic surgeons from Campbell Clinic were excellent teachers. More than half of the students in my class worked. At that time, some of the medical students found they could work as LPNs doing private duty care).

The first two years of medical school were mostly spent learning human anatomy, histology, embryology, bacteriology, pathology, radiology, tropical medicine, neuro anatomy, biochemistry, pharmacology, how to perform physical examinations, take histories, etc. We had two women in our class, and they held their own really well and graduated with us. My class was cut in half by the end of the second year as the result of students not making the grade or having "nervous breakdowns." Twenty transfer students from The University of Mississippi were brought into the class to keep it at our normal level. At that time Ole Miss had a two-year medical school. The last two years were spent in a clinical environment during which time we saw many types of unusual diseases. I can remember the interns and residents doing everything they could think of to find some penicillin for their patients that needed it. Sulfa medication was fairly easy to come by. Diphtheria was seen frequently, and a lot of children required tracheotomies for obstructed airways. Medical students rotated sitting on tracheotomy watches to make sure the tubes did not get blocked. Medical students, under the direction of the anesthesia residents, gave drop ether to children having surgery. Today, it is difficult to find ether in any hospital because of its flammable nature. Pregnant women with sever pre-eclampsia were given continuous caudal epidural anesthesia, and medical students had to stay with these patients to monitor their vital signs. The emergency room rotation was intense and we took care of many things that today would only be taken care of in the operating room. I could go on and on about the numerous things we were exposed to during the last two years of medical school.

"The emergency room rotation was intense and we took care of many things that today would only be taken care of in the operating room."

During the time I was in school, we had to attend home deliveries both in the junior and senior year. Two medical students and a nurse from the Shelby County Health Department went into the homes for the deliveries. We carried a large leather bag with all the supplies that we would need. The patient and her family would save newspapers to use during the delivery to help keep the bed linens from being so messed up. A lot of the houses in Shelby County, outside of Memphis, were built on poles to keep the house above the backwater during the rainy and flooding seasons. When the water was not up, you could see the chickens and pigs under the house. A lot of the small homes in Memphis had no electricity, which resulted in using kerosene lamps and having no fans or air-conditioning. The small houses were so close that they had to pull all of the shades while we were attending the patient, and it became miserable inside in hot weather.

In the three months between graduating from medical school and starting my internship, I worked for the Shelby County Health Department attending prenatal clinics scattered around Memphis and attending well baby clinics. I traveled to the clinics on city buses, since I did not own a car. The clinics were another learning experience. I gave a lot of immunizations and smallpox vaccinations.

During 1952 I took my rotating internship at the Baptist Hospital in Memphis, and the medical staff was terrific in guiding me through various specialty areas. I was able to learn and perform many surgical procedures. The whole year was professionally an enriching time. During my rotation on the ENT service, the doctor that I was helping perform a tonsillectomy had a mild heart attack and I had to finish the procedure. At the start of my rotation on the chest service, I was given a routine screening procedure that consisted of performing a cut down to start IV fluids on a surgical patient in under three minutes. I passed that and was allowed to do a lot by the end of the month (I was opening and closing chests). If you showed any interest in what was going on during your internship and demonstrated some level of skill, the possibilities of what you were able to do were pretty well opened up.

During the Korean War, I was number one on the draft list from my home county, and I decided to enter the U.S. Air Force. I was sent to Brooks Air Force Base in San Antonio, Texas, where I served as a general duty medical officer and flight surgeon. There were a lot of flights that came in with injured military personnel and people with other problems. Sick call was very busy and a lot of cases of venereal disease were treated – We were lucky to have plenty of penicillin. A few of the older doctors that I worked with had been drafted. One had been a flight surgeon during WWII, but lacked one month completing his required two-years service. It resulted in his being drafted during the Korean War.

In July of 1954, I started a residency in OB-GYN at Fitzsimons Army Hospital in Denver, Colorado. What a learning experience over a period of three years. We worked under well-trained military doctors and had a lot of input from the faculty at the University of Colorado as well as doctors in private practice in Denver. I would say the level of OB-GYN skills was much higher than in Memphis, where I can remember placing babies, which were having breathing problems, into a steel chamber (I was unable to find out what the purpose was or how it worked). When I was senior resident at Fitzsimons, I had four residents and four interns under me; and we were delivering about 350 babies a month and taking care of a huge number of gynecology patients, some of whom were flown in from all over the world. Several years ago, one of the junior residents, who eventually became chairman of the department at the University of Indiana, told me that he had 32 residents and that they did very little compared to what we did at Fitzsimons. He was concerned about their level of skill. While at Fitzsimons we were introduced to the use of three new antibiotics — streptomycin, chloromycetin, and tetracycline. We were not allowed to use chloromycetin very long because one of the medical residents that took that antibiotic devel-

oped aplastic anemia from which she died. It remains a good antibiotic but is almost relegated to use only when everything else fails.

Fitzsimons was a huge military hospital, and at one time there were over 2,300 patients in the hospital. The chest service was large, and there were about 100 open chest procedures performed monthly. There were a lot of tuberculosis cases and other types of pulmonary diseases. At the same time there was a fairly large patient population with polio that were in iron lungs. It was interesting that some of the doctors working on the medical wards refused to sign the loyalty pledge to the United States, which resulted in their being denied an officer's commission and in being maintained in the rank of private.

After my period of residency training, I was sent to England with the U.S. Air Force and was privileged to work with a U.S.-trained OB-GYN and an Irishman who trained at the Hammerschmidt Hospital in London in OB-GYN. I had seven British midwives working for me (all were trained nurses), and they were great, even though they worked only as labor and delivery nurses. I do not know of any of them that went back into midwifery. A lot of the midwives in England did home deliveries, and they went to the patient's homes using bicycles as their transportation. They carried their bag with supplies, and it was interesting that they were allowed to carry a Trilene inhaler to use for analgesia (this is no longer available). We had a British civilian who worked at the hospital as an anesthesiologist and on the weekend he worked for the British government following the nurse midwives into the home sewing up tears from the deliveries. The Air Force hospital was near Swindon, England, which had a population of 80,000. The socialized scheme of medicine allowed one trained person in OB-GYN to work in the area. I became acquainted with two other trained men in OB-GYN, and they had to work as general practitioners in the Swindon area, since there were no slots open for them in England. This type of situation led to many well-trained doctors leaving the country!

In 1962, I was sent to Sheppard Air Force Base for two years where I had four doctors helping me (three of whom had minimal training but were bright doctors). It was like directing a residency program, but all of us learned a lot. Dr. Ayers, an urologist, was on the NASA team at about the time they were conducting sub orbital flights, and some of his stories were interesting. During my time at Sheppard, we were able to treat a lot of oncology patients, and my training at Fitzsimons came in handy.

I moved to Clarksville, Tennessee in 1962. Entering a private practice was an eye opener, but Dr. Bill Wall was a big help. He was the first fully trained OB-GYN in Clarksville; and prior to his coming, pediatricians, surgeons, and general practitioners performed all of the deliveries (this was phased out in a few years). Prior to Dr. Wall's and my coming to Clarksville, almost all obstetrical patients were given general anesthesia for delivery. One of the older doctors gave his patients rectal ether in oil for analgesia during labor. All of this and many more things changed for the better. Some times these changes met resistance, but the changes were implemented. Dr. Wall and I saw the vast majority of indigent maternity patients which resulted in seeing many unusual complications (in the military service all dependents had access to medical care, and it was unusual if they did not take advantage of this service). The cesarean section rate in the early 1960s was in the range of four percent (it is now in the range of 24 percent).

After moving to Clarksville I was called on to do many things outside of my specialty field – the result of a small medical staff and no emergency physicians. Both at night and on weekends, since I was in the hospital with patients in labor, I was called upon to help the general surgeons to see patients in the hospital when the nurses were unable to locate their attending physician; to see patients in the emergency room when their private physician could not be located; and to deliver babies when their private physician could not be found.

The malpractice crisis started to come into being in the late 1960s. Many advances in the practice of all areas of medicine and surgery have taken place over the last 40 years and have made for better care of patients. Despite the malpractice crisis, the introduction of TennCare and Medicare and the problems with insurance companies, taking care of my patients has been a rewarding career and experience. ■

"We had to attend home deliveries. We carried a large leather bag with all the supplies that we would need."

"It is difficult for young physicians and medical students to understand how we practiced medicine without ultrasound, CT scans, MRIs, arteriograms, and the... laboratory tests [now] available. Tests that would take two to three hours 30 years ago can be done in a few minutes today."

Dr. Alton Ruether Boyd,
Family Practice

Written December 2002

Years of practice:
June 19, 1967 – January 1, 1999

After graduating from Austin Peay State College in 1954, I thought I was leaving Clarksville for the last time. Little did I realize that I would spend half of my life here. As a medical student in Memphis in 1964, I met Dr. Harold Vann who was doing a year of pediatric residency. We stayed in touch, and while I was an Intern at Baptist in Nashville, Drs. Jim Hampton and Charlie Trahern visited me. Harold had told them that I planned to go into general practice but had not yet decided on a place to practice. They encouraged me to set up practice in Clarksville because it was desperately short of physicians. After looking at several other locations, I settled on Clarksville for two reasons. First, the medical staff here was the most congenial and cooperative group I had found anywhere. Second, I was starting in practice after only one year of post-graduate training and knew that I would need the assistance of multiple specialists. Clarksville had an unusually high percentage of specialists for a city its size in 1967. After I made my decision to practice here, the next step was to find available office space. Dr. Jim Hampton was moving from downtown to a new office near the hospital. This left a vacancy at 106 South Fifth Street. The building had been a residence but was converted into two offices downstairs and an apartment upstairs. I was told that the office had been occupied in the past by Dr. Ed Atkinson, then Drs. Charles Trahern and B.T. Iglehart, then by Dr. Hampton and by me. In 1969 Dr. Tony Montgomery moved in with me. When we moved out in 1970, Dr. Reginald Lowe moved in. Can you visualize examining rooms with 14-foot ceilings? The rent was $105 per month with heat furnished. When I moved in, I brought with me an air conditioner that I had bought from another medical student for $25 in 1964. When I moved out in 1970, I sold the air conditioner to Dr. Lowe for $25. In 1967 there were about 10 physicians in offices downtown.

When I arrived in 1967, the west wing of the fourth floor of the hospital had just opened. A bed in the four-bed ward on 4 west (room 419) cost $19 per day. A semiprivate room was $21. While most of the medications we used then are obsolete today, they were greatly advanced over what was available thirty years before. One winter evening after I had checked the patients I had in the hospital with pneumonia, I said to Dr. Jack Ross, "I do not see how you treated patients with pneumonia and other serious illnesses twenty years ago." He replied, "Back then, 25 percent of the patients with pneumonia died." More because of penicillin than my skills, all eleven of the patients survived. It is difficult for young physicians and medical students to understand how we practiced medicine without ultrasound, CT scans, MRIs, arteriograms, and the vast number of laboratory tests available. The speed with which lab tests are done today is a great help in rapid diagnosis.

"When I arrived in 1967, a bed in the four-bed ward on 4 west cost $19 per day."

Dr. Harold Vann,
Pediatrics

Written in 1996 for Presentation
to Leadership Clarksville

Years of practice:
January 1958 – January 1995

Tests that would take two to three hours 30 years ago can be done in a few minutes today. All this advancement in technology comes at an increased cost.

The thing that brings back pleasant memories of those bygone years is the different personalities of the physicians. Almost every morning when I would see Dr. Fount Russell he would greet me with the same statement, "Reuther, I want to tell you a joke I heard yesterday. It is the funniest joke I have even heard." Practical jokes were played frequently by Dr. Russell and Dr. Troy Walker.

In the late sixties and early seventies, there were no Emergency Room physicians. We had to see our own patients when they came in after office hours. Many people appeared there and said they did not have a regular physician. When this occurred, and it was usually several times a night, we were required to see them. I was frequently irritated by the patient I had to get up and go see at two or three a.m. I would ask who their regular doctor was. The all to frequent answer was, "Dr. X in Trenton or Elkton, Kentucky, but he doesn't doctor at night."

One of the big differences in practicing medicine in 1967 and 2002 is the doctor/patient relationship. In 1967 the insurance companies had less influence on this relationship. Then a person went to a certain physician because he was recommended or was available. They were free to go to a different doctor if they did not like the first one. Today a person goes to a physician because he is a name on the list of their insurance company. The doctor/patient relationship is also affected by the number of physicians in a group. In 1967 the largest group in Clarksville had three physicians. Most physicians were in solo practice. This meant that a patient would see the same physician most of the time, was comfortable with him and looked upon him as a friend. Today a patient will see so many different doctors in the same office that they never establish a comfortable relationship. ■

I have lived and worked in Clarksville since 1958 and feel a need to review for you some of the history of the economics of medical practice. I have only recently begun to understand them.

I came from Fort Campbell where I did not worry about the cost of medical care, but I was introduced to precertification by the late Judge Hudson. Neither he nor I knew the term but he knew the concept. When a patient of mine who could not pay for his care needed hospitalization, I called the judge who asked appropriate questions. Yearly he asked the county court to appropriate enough money to cover such expenses.

Since then there have been five trends that have led us to the present crisis in healthcare financing.

1) In 1958 about 90 percent of medical expenses were paid by patients out of pocket. Soon hospital insurance caused most patients to ask their doctors to put them in the hospital for tests and even checkups. As the insurance companies became wiser, they paid for outpatient tests. Most illnesses we hospitalized in the 1960s are now treated at home. Now the hospitals are filled with patients who are much sicker and more expensive to treat. The cost of going to the hospital is now terribly expensive. Most doctors do not know how much of the insurance companies or government's money they are spending on a particular illness.

"In 1958 about 90 percent of medical expenses were paid by patients out of pocket."

2) The technology explosion has been the most costly item in health care. In 1993 I had outpatient tests at our local hospital at the cost of $2,500. The cost of the equipment to do the tests on me is around $2.5 million not counting the costs to pay highly trained technical people required to operate them. This expensive equipment is usually outdated before it is paid for.

A short list of the many technical advancements:

- Most two-pound premature babies now live.
- Most childhood meningitis can now be prevented by immunizations. The immunizations needed during the first 18 months now cost $300. In 1958 we included the cost of immunizations in a $5 checkup.
- Most surgeons know when and where to operate with the aid of MRI technology.
- Each day in the U.S. many kidneys are transplanted.
- Oral antibiotics are now used to treat illnesses previously requiring IV treatment in the hospital. The great advance in laparoscopic surgery costs just as much and can now be applied to people who were too sick to have surgery previously. So the total cost is a lot more.
- All the technological advances cost $900 billion per year. So we spend an average of $3,600 per year for each of us.

3) The average age of our population is increasing each year, so as we preserve the health of older people, the more care we need. Our organs wear out as we get older. My parents are 87 and 88 and in the last two years each have been in the hospital one week for illnesses they would not have had 20 years ago. During 1993 my mother had a carpal tunnel syndrome operation as an outpatient at the cost of $2,500 with equipment that was not available 10 years ago. We spend most of the money per person during the last three months of our lives.

4) The yearly official definition of poverty has defined a larger and larger percentage of the population as needing financial assistance with medical costs. At this time 50 percent of the babies born at Clarksville Memorial Hospital are covered by Medicaid. A family of three with an income of $20,000 is approved by Medicaid for the pregnancy and all expenses for the first year of the baby's life. People whose expenses are covered by a governmental program have no incentive to save on medical expenses and are therefore prone to overuse the services. All insurance plans that do not require co-pays encourage the same overuse.

5) The expectations of most people from medical science have become unrealistic. We expect to use tobacco, abuse alcohol and other drugs, eat all we want without exercising, and have sexual freedom without paying the price in suffering or in money. We know how to prevent AIDS, yet we expect medical science to produce a vaccine, which will permit us to ignore the known preventatives.

The greatest contributor to poverty at this time is teens becoming pregnant. That sets them back economically and psychologically.

All of these trends have contributed to the crisis.

Is there any hope? Yes! We need to approach the problem of the crisis at many points such as:

- Limiting the use of each new technology until its cost/benefit is well proven.
- We need to face the fact that much of terminal medical care serves to prolong misery. We can remedy that by looking at benefits of procedures. We can use capitation to pay for "care" and not procedures.
- We must be careful that defining someone as poor does not interfere with the wise use of his limited funds. We need to assist the poor but never take away their hope and their freedom to overcome economic difficulties.
- We need massive TV and school education on the details of improving our health. This is the great opportunity for the government.

The philosophy we use in changing health care will determine the outcome for years to come. ■

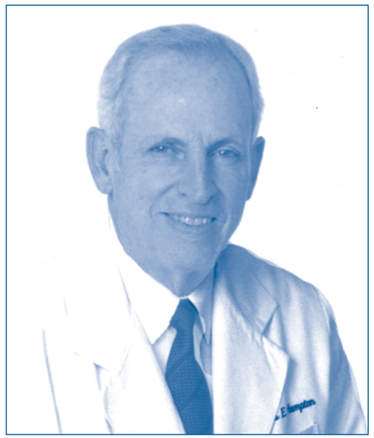
Dr. James E. (Jim) Hampton,
Internal Medicine

Written in January 2003

Years of Practice in Clarksville:
January 1963 – July 1987,
1995 to present

Presently working part time at
Public Health Department and
Good Samaritan Ministry

Missionary Physician to South Korea
1987 to 1994



"In 1929 Dr. W.T. Pride's bill to my parents for my birth was $125."

I was born in Memphis, Tennessee on June 22, 1929. In October of that year, the stock market crashed and The Great Depression was on. Dr. W. T. Pride's bill to my parents for my birth was $125: $100 for labor and delivery, $25 for induction and episiotomy. There was an additional charge of $25 for circumcision. Doctors in those days did not have to pay malpractice insurance. My mother had a prolonged labor of over 24 hours, and it was such a horrible experience that she made it known she would have no more children. Nowadays she could have had a Caesarean section earlier in the labor and saved her some of the trauma.

Jobs were scarce in the 1930s; soup kitchens were set up in many of the larger cities to feed the down-and-out folks. Many could not afford medical care and when they got sick, plenty of them died.

My father worked for the Pullman Company as a conductor on the sleeping cars on the L&N Railroad. He was on the "extra board" which meant he was called to work if he was needed. Since few people had money, there was a decrease in train travel and especially in the use of the more expensive sleeping accommodations. When he was working (rarely), he was sometimes consulted by a traveler about a medical need. His treatment for earache was to put ice water in the ear. He said it worked well, but I've always wondered what folks did about the dizziness and nausea that occurs when cold water is used in the ear.

Let me tell you about his remedy for a severe asthma attack. Around age three or four, I developed asthma. The only medicine for asthma then was ephedrine, which helped, but it made the heart beat fast. If you took enough of it, you felt like running around the block but were too short of breath to do so. It could also interfere with sleep and make your hands tremble. Each summer my family went to Clay, Kentucky to visit my grandparents on their 200-acre farm. I slept in a "feather" bed. I would not recommend these sleeping accommodations for an asthmatic. One night I had a bad asthmatic attack. Dad got some Vicks Vapor Rub, melted a teaspoon full of it, and made me swallow it. I vomited up my toenails, but the asthma attack was over. I cannot stand the smell of Vicks Vapor Rub to this day.

In 1934, at age five, I came down with pneumonia along with the asthma. The doctor was consulted and I was treated at home with a sulfa medication, the only antibiotic we had at that time. Penicillin did not become readily available until the 1940s. Of course, I was at bed rest, and my mother faithfully put the large sections of cloth all around my chest and put mustard on them. These warm mustard plasters were acceptable treatment at that time. Pneumonia was the big killer then, but the Lord must have had other plans for me. As a sickly child, it was good that I had a mother who was a Registered Nurse. She graduated from Baptist Hospital in Memphis in 1923, five years before marrying my Dad.

On one occasion, I had a bad earache and since my physician was unable to help much, Mom took me to the Eye Ear Nose & Throat Hospital in Memphis. After about five seconds, the doctor said, "It's only swimmer's ear. Put some vinegar in the ear canal." Mom mixed five percent white vinegar with an equal amount of rubbing alcohol, began putting it in my ear, and it was soon well. Recently I got swimmer's ear again and made three trips to the ENT doctor who prescribed some costly ear drops to clear it up. Now I carry a dropper bottle of the old vinegar and alcohol solution with me when I swim and use it to prevent infection. This mixture is sold today as "Vosol Otic". It is effective because vinegar is acetic acid, and most germs and fungi do not grow in an acid environment.

One day during childhood, I was outdoors watching the neighborhood kids at play, propped up on my forearms on the lawn. A very young child was also outside, and somehow he had in his possession a pair of manicure scissors. Apparently he thought it would be good idea to cut the grass with those things – near my right elbow. Soon I experienced a sharp needle-like pain; he had stabbed me with his dirty scissors. By nightfall, my elbow was the size of a softball, warm, and painful. Eventually, we made a trip to the emergency room where an infected elbow joint was diagnosed. I was not very happy as they gave me a local anesthetic and opened the elbow to drain a large amount of smelly yellow pus. Again my mother used her nursing skills as she put my elbow through a full range of motion repeatedly twice each day. The mother of the young child who had injured me lived near enough that she could hear my screams each time we went through this routine. I'm sure she felt bad about it, but not nearly as bad as I did. There were no physical therapists in those days. If my mother had not done this painful therapy, I would have ended up with a frozen elbow joint. Even with all that, it has never been quite normal. I enjoyed playing tennis, but after one set, my elbow would start swelling and I would have trouble getting a fork to my mouth for several days. Ask me, and I'll show you my one-and-a-half-inch scar.

During this period of financial hardship, my father took the cash value from his life insurance policy and bought some Raleigh products to sell. In the mornings, Dad would fasten chicken cages on the back of his old Ford car, load up the Raleigh products, and make his rounds in the country. The Raleigh Company may not exist today, but a competitor, Watkins products, had a similar advertisement stating, "Today we offer a complete line of gourmet specialty foods, botanical personal, and home-care products, and, of course, tried and true medicinals." There was a need for such things in those hard times, even though there were exaggerated claims about what the medicinals could cure – leprosy, tuberculosis and such. The farmers' wives loved the vanilla extract, home care products and especially the medicinals. They had no money to pay for them, but they would barter with Dad, and he would accept chickens, eggs, or other fresh farm produce as payment. Mom selected what she could use, and Dad took the rest to the grocery store. The store owner was glad to get the farm produce, and Dad would again barter for butter and other foods we needed. After the trading was done, the store owner would give him a little cash to boot. Dad took the cash and bought more Raleigh products, and the cycle was repeated many times. Everyone was happy.

In the 1930s, children had to be very careful or they ended up having their tonsils removed. After only one or two sore throats, off you went to the hospital for a tonsillectomy. My wife and I both had tonsillectomies in early childhood. How different it is today!

In the 1930s-1940s era, my Aunt Mary, one of the prettiest women in our family, developed a mental illness. My retrospective guess is that she had some type of depression, either unipolar or bipolar. She was hospitalized several times and was given electric shock therapy to the brain; she was never was the same afterwards. She took various medicines off and on after that. The treatment of these disorders has greatly advanced over the years, and today there are very effective medicines for them. Primary care providers are now able to manage treatment for many of these patients.

In the 1940s-1950s era, my redheaded cousin Ann developed schizophrenia. Her treatment for this devastating illness had very little effect, and we watched in dismay as this lovely, kind, and vibrant person's life fell apart. People with schizophrenia spent much time in the mental hospitals of that time. In the past few years, with new medications, psychiatrists have been able to bring people with schizophrenic disorder back to a normal state of mind within a matter of days – a true miracle in our time. Since 1960, most of the mental hospitals in Middle Tennessee have closed because the need for them is much less.

From 1947 to 1951 I attended Vanderbilt University on a Naval ROTC scholarship. My family could never have afforded to send me there had it not been for that scholarship. I am very grateful for the wonderful opportunity. I had passed the required physical exam in Cincinnati, Ohio, but during my senior year my blood pressure became elevated. I failed the final physical exam for naval officers and was discharged from the Navy during the last half of my senior year.

James E. Hampton M.D. and Staff,
Circa 1985

Following graduation from Vanderbilt, I went on to the University of Tennessee School of Medicine in Memphis. It was there in 1953 that my blood pressure reached the point where my physician decided I needed daily treatment. I was given phenobarbital, the only medication available for high blood pressure. It didn't help appreciably, but I just didn't worry about it anymore. The only other option was a strict rice and fruit diet.

The first medicines to be developed for high blood pressure were the thiazide diuretics, pills that cause the passing of salt in the urine and loss of excess fluid. I started taking this medicine around 1954-55 when it was new, and it is still a fine medicine. A recent Medical Journal article states that it is probably the medicine of choice as the start-up treatment of hypertension. At one time in my life I was on three different types of medicines for hypertension. This may explain why I have already lived nine years longer than my father did.

From September 1951 to December 1954, I was in medical school and I loved it! Tuition was $250 per quarter and I bought used textbooks. I lived at home and my parents were able to pay my school expenses by then. I graduated with no debt. These days most medical students graduate with debt of more than $100,000.

In medical school we went 12 quarters straight, with one quarter off at the mid-point to prepare for the Basic Science portion of the Tennessee Board of Medical Examiners Examination to obtain a future medical license. Most of us worked as "externs" during that off quarter. I went to Oak Ridge, Tennessee to work at the hospital there. During that three-month period, I rotated through all the medical and surgical departments. Living quarters were in the hospital, which was convenient. Everything was going well until I helped to deliver a woman in labor who also had mumps. About two weeks later, I developed mumps! I was quarantined to my room for more than two weeks. It was quite embarrassing to get a childhood illness while I was moving along the path to be a physician. There was no immunization for measles or mumps at that time. Amazingly, we did have BCG vaccine to help prevent tuberculosis, and all of the medical school class received it. If it was successful, a positive tuberculin skin test developed; mine never did. Oh, well! Externship was a good learning experience.

In the early1950s, Salk Vaccine, named after Dr. Jonas Salk of Pittsburgh, became available on a large scale. Through the fall and winter of 1953-54 close to two million children across the United States and parts of Canada were involved in a field trial, and the effects of crippling polio soon began to wane and then almost disappear. While I was a medical student, there was an entire building in the hospital complex filled with "iron lungs" — machines that helped some polio sufferers to stay alive when the virus affected their breathing mechanism. It is rare nowadays to see anyone with this dread disease. Immunization has been a big development in my lifetime.

When I was working as a medical missionary in South Korea (1987-1994), I saw an old iron lung in a hallway near the emergency room. It was different from the ones we had used in Memphis, as there was no opening for the patient's head to be on the outside. Upon inquiring, I learned that an American physician who had worked there had altered the machine so that it could be used to treat carbon monoxide poisoning which was a major cause of death in the wintertime. Many Korean homes, especially the older ones, are heated by a system where warm air from charcoal fires is forced through pipes in the flooring. When a crack appears in the pipe or chimney, carbon monoxide seeps into the rooms, poisoning the occupants. If the victims could be transported to the hospital in time, they were placed in this iron lung where oxygen was pumped into the chamber under pressure until the problem was corrected. Ingenious!

Here is a story about heart failure and edema (excess accumulation of fluid in the body). On Cardiology Rotation during medical school, we went to Heart Failure Clinic each week. African Americans, who have a high incidence of hypertension, made up a majority of the patients we treated. If left untreated (and we really had no effective treatment then), the heart weakens and fails as a pump. Fluid accumulates in the legs, then in the abdomen and lungs. Many of our patients had as much as 20 pounds of excess fluid in their body. All we had to give them was large ammonium chloride pills. After taking two of them, four times a day for three to five days, we could get them acidotic (excess acid in the body). We then gave an injection of mercuhydrin (a mercury product) that caused the kidneys to malfunction temporarily, and over the next few hours they spent a lot of time in the bathroom getting rid of all that extra fluid. A few years later, the first of the stronger diuretics, furosemide (trade name of Lasix), became available and this probably shut down the Heart Failure Clinic.

As a student, for additional medical experience, plus some salary, I worked every fourth night in the labor and delivery area of St. Joseph Hospital in Memphis during 1953-54. One night I was called to the parking lot where a woman in labor arrived at the hospital just a little too late, and the nurse and I delivered the baby in a nice new automobile!

Upon graduation, I entered a rotating internship at the University of Oklahoma Hospitals in Oklahoma City. It was 1955, and the pay was $50 per month, plus a room in the Intern / Resident Quarters, laundry services, and meals. As a part of my internship, I gained quite a bit more obstetric experience. The OB-GYN resident told me not to awaken him unless it was an emergency, and who was I to argue? One night I delivered four sets of twins!

Shortly after arriving in Oklahoma City, I met the cutest student nurse named Barbara and within six months we were married. Having no savings, I borrowed $1,000 from my dad so we could get married. I hoped the money would last us about two years. We had planned to buy simple gold rings, but Dad was adamant that "the Hampton women wear diamonds," so there went $300. How did this relate to medical care in the 1950s? In 1955-56 there was a severe shortage of nurses throughout the country. To deal with that, the nursing school offered a 40-hour nursing course to medical students. I was an intern, but I applied anyway. Graduates of the program worked as nurses on the hospital wards in the evening or night shifts. My intern's salary of $50 per month was totally inadequate, even with the loan from my dad and free meals at the hospital. Our apartment rent was $60 per month. I decided to take the 40-hour course. Subsequently, I would work as an intern during the day and as a nurse on the night shift, sometimes on the same ward. I really got to know the patients that way, and it gave me a real glimpse of what nurses contribute to the medical care system. Even after I became a resident in Internal Medicine, I continued the practice of nursing at night. I had received a 50 percent pay raise and took home $75 a month then. But the money I earned by nursing still came in handy. It is nice to know that the intern and residency pay scale is more within a living wage amount these days.

Barbara became pregnant with our first child during that first year of residency, and she also developed Infectious Mononucleosis, for which she was hospitalized. At that time, we knew very little about this disorder and not much about the side effects of medicines on pregnant women and the developing baby. The intern assigned to the service treated her with one of the mycin drugs, which had no effect on the illness, but it did have a negative effect on our son's teeth, causing them to be dark gray. When he was 25 years old, thanks to improvements in dentistry, we were able to get the teeth capped, and he was much happier with his appearance.

From 1957 to 1959, I worked with three physicians in a Native American Hospital in Claremore, Oklahoma. We all gained much experience in that 70-bed hospital dealing with all kinds of medical practice – obstetrics, surgery, pediatrics, and internal medicine. I had one and 1/2 years of residency in Internal Medicine under my belt. One in our group had some pediatric training, and all of us had completed a rotating internship that included obstetrics. This broad background proved to be valuable in my medical practice later.

It was our opinion that Native Americans had gallstones until proven otherwise. There was always a long list of patients waiting for gall bladder surgery. Initially, we had a local family practice physician who came to the hospital to help us do surgery, but as time went on, we did the most common surgical cases ourselves. We had no anesthesiologist. Today surgery is much easier and safer with good anesthesiologists. We gained a lot of experience in doing spinal anesthesia. To perform gallbladder surgery, we would inject the needle into the lower back and position the patient so as to achieve numbness up to the right nipple level. On the left side, the numbness level needed to be lower so as not to interfere with breathing. The procedure usually took one and 1/2 to two hours. Patients were given a few breaths of nitrous oxide if they seemed to be experiencing pain; we were convinced that our Native American patients tolerated pain better than we Caucasians. Surgery patients stayed for several days to recover.

In 2000, forty-five years later, my gallbladder began passing small bits of "sand" into the common bile duct. It was quite uncomfortable, and one day it occurred while I was seeing patients here at the Montgomery County Public Health Department. I turned pale and sweaty and must have looked awful, for the nurses were ready to put me in an ambulance. I went to see my doctor, and the ultrasound confirmed the diagnosis. What a great invention ultrasound is; we would have loved to have it in the 1950s. Dr. Bill Steely did the surgery, Dr. Joe Holt kindly put me to sleep, and the laparoscopic procedure took 54 minutes. I was home four hours later. There have

been terrific improvements in surgery in the last 40 years.

At the Native American Hospital, we soon got to thinking that we were experts in spinal anesthesia. With a primipara (first baby) we would give the mother a "saddle block" in which we injected an anesthetic into the spinal canal with the patient sitting upright until the lower parts were numb. In those days we mixed the anesthetic with a heavy concentrated sugar solution so that the combination would go south and deaden the appropriate areas. One day a medical person of questionable intelligence told me that I didn't need the heavy sugar solution in the mixture. Upon hearing that, I used only the anesthetic on a nice young lady. In a short time the patient stated, "I'm having trouble breathing!" and the chest area was becoming numb. We breathed for her for about two hours, had a nice baby, and all turned out well. But it was a real learning experience. I certainly appreciate the expertise of anesthesiologists and anesthetists.

In 1959 after this two-year stint with the Public Health Service, Division of Indian Affairs (as it was known then), I returned to Memphis to complete my Internal Medicine Residency. From 1960 to 1962, I joined with a large group practice in Murfreesboro, Tennessee. By this time, Barbara and I had four children. Her blood is Rh negative and mine is Rh positive. Two of our children were Rh negative. Through an error of some kind, and unknown to us, Barbara's blood tests in Murfreesboro reported her as Rh positive. Leaving Barbara in labor, I drove to the Nashville airport to meet my mother who was coming to help out. She missed her plane and the next flight arrived three or four hours later. The four children were with me in the station wagon, hungry, crying and irritable; and I, of course, was the calm, loving, and compassionate father.

When we arrived back in Murfreesboro the phone was ringing as I entered the door. The nurse explained that the delivery went well but that the baby was becoming jaundiced and they could not understand why. I told her that my wife and I have the Rh discrepancy. All immediately swung into action, and the baby had an exchange blood transfusion, getting rid of all that bad Hampton blood. That child is our lovely and healthy daughter Becky, who is now a mother of three sons. Today there is an injectable immune globulin called RhoGam that helps prevent blood from hemolyzing (disintegrating) in babies born to Rh negative mothers and Rh positive fathers.

At the time we moved to Clarksville in December of 1962, there were only 20 physicians on the hospital medical staff. In the interest of good will, I went to each of their offices and introduced myself. Now, with 150 doctors on the active medical staff, plus others on the advisory staff, it is difficult to even know who they are when you see them in the hospital. We used to have a meeting every other month with the hospital staff and hospital administrator, Carney Wright, who kept things interesting with his presentations.

Upon arrival in Clarksville, I rented an office on Fifth Street near Franklin. This was in an older building where Drs. Tom Iglehart and Charles Trahern practiced medicine before I arrived. My wife hung the drapes and brought in other accessories, and it looked very nice when we got it all going. I was in solo practice of Internal Medicine for 24 1/2 years and started out with one employee, adding a nurse after a short period of time. Through the years, other faithful staff members were hired as needed. Now, with all the Medicare, TennCare, multiple insurance forms, and government regulations, a solo physician needs several employees. As a result the solo physician is a rarity, as most have gone into group practices.

In the 1960-70s most of the medical staff belonged to the Tennessee Medical Association and the Montgomery County Medical Society. Some even belonged to the American Medical Society. The local Medical Society met every other month for a dinner meeting, and we usually had an interesting medical lecture of general interest. Almost all the physicians attended these monthly meetings; one month the Hospital Medical Staff met and the next month, the Medical Society. The physicians knew one another and some were close friends. Today we have no Medical Society Meetings and few of our physicians are members of the Society or the Tennessee Medical Association. Now the hospital staff meets three times per year with no attendance requirements except that there be 1/3 of the members on the roll to act as a quorum to conduct business. Recently a business meeting of the hospital staff had 39 physicians present of the 41 required to do business.

In the 1960s, some of us were still making occasional house calls. Many physicians hated doing this, because it required a lot of valuable time, and there was no way you could charge a fee appropriate to the amount of time it took. The house calls I made were for the elderly and infirm and cancer patients who had a great deal of trouble getting to my office. It was an interesting experience to keep the House Call Bag filled with what instruments might be needed plus a few simple medicines. I resisted house call requests when it seemed the patient might need some further testing to make a correct diagnosis. Overall, I enjoyed seeing patients and their families in the home and getting to know them a little better. Another two to three decades later, this service reappeared in the form of home health nurses.

Daytime and early evening Emergency Room calls were a difficult aspect of medical practice, especially when the calls came for non-emergencies (things that could have been taken care of at the office that day or the next). This was a topic of frequent discussion at our staff meetings both in the past and now. We had no full time Emergency physicians until recent years.

Night Emergency Room calls were a different matter. We had some good nurses

"I would work as an intern during the day and as a nurse on the night shift. It gave me a real glimpse of what nurses contribute to the medical care system."

who shared the load. One of them was Mrs. Marjorie Graham, LPN, who worked the 11 p.m. to 7 a.m. shift. She handled most of the non-emergency patients herself and did an excellent job. Those who were more complicated were referred to a physician's office the next day. If she called you in the middle of the night to come to the hospital, you knew there was a true emergency. I could rely on her assessment of the situation, and this physician hurried right on over. At the age of 80-plus, she has made two annual medical mission trips to Brazil. We all love "Mother Graham".

In the 1960s many of our hospital staff physicians smoked cigarettes. After all, wasn't Clarksville known worldwide for its tobacco? Today, very few of our physicians smoke. That should say something to those who still are ruining their health with cigarettes. It used to be acceptable to smoke in most rooms of the hospital; now Gateway Medical Center has a virtually smoke-free campus.

Many of the great diagnostic and technological improvements in the last four to 50 years have been in the field of radiology. While I was playing handball one day, I had sudden severe pain in the right lower back and leg. Later the pain became disabling, and a myelogram confirmed that a disc had ruptured and which one it was. The procedure required a lumbar puncture with injection of iodized liquid into the low back, which involved some risk, though small. Today, a Magnetic Resonance Imaging (MRI) study would have been done instead. Surgery was successful and the pain was relieved.

In the early years of medical practice, keeping up with advances in medicine was a real chore. I would have to go to the hospital medical library to get the latest information from medical journals. The journals I subscribed to were frequently in an unread pile at home beside my chair. Textbooks were the main reference books, but they quickly went out of date. Eventually we started receiving a yearly edition of the Physicians' Desk Reference that keeps us informed about all medications. Now it quickly becomes obsolete.

Today, my handheld Personal Digital Assistant (PDA) is complete with my To-Do list. On it is a reminder to "review medical journals" on Thursday and Friday of each week. If I fail to check this as done, it keeps appearing daily. Therefore, each week I access "Medical Consult" on the computer and review recent editions of journals pertinent to my medical practice. I use ePocrates, a program that has nearly all the current medications in use, listed by drug or class, with adverse effects, cost, etc. It is updated every time I hook the PDA into its cradle and thus to my computer and the Internet. The Palm Pilot, as it is frequently called, also has a complete medical textbook in it that is updated five times per year. Instant retrieval of medical information today is a real miracle as compared to the "good old days."

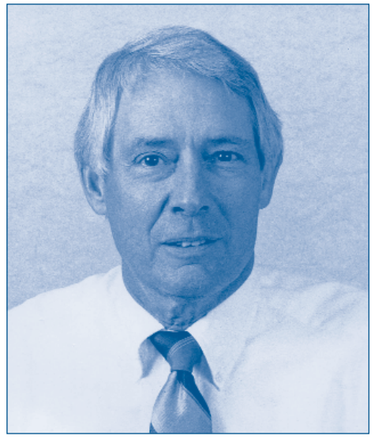
Before Medicare was created in the 1960s, physicians were paid on a fee-for-service basis. Malpractice insurance premiums were very reasonable. If a physician wished to treat and care for an indigent person free of charge, there was no problem to do so. We could easily spend more time with a specific patient who required more attention. When I started medical practice here, there was a minimum number of government regulations and requirements. We older physicians refer to those as the "Golden Years of Medicine." Physicians and medical office staff reading this will realize that there have been major changes in recent years.

The changes in medical care I've seen over the last 40 years have been miraculous. As our family celebrated Thanksgiving recently, and as the host was praying before the meal, I said a silent prayer of thanks for all the wonderful medicines and the very helpful diagnostic modalities, and other improvements in medical care that we have today. ■

Dr. John F. Wright, Jr.,
Anesthesiology

Written January 2003

Years of practice:
1965 – Present (Part Time)



"Today it would take an 18-wheeler to make a meaningful house call."

I was born October 26, 1935 in Nashville, Tennessee. My mother, like all women, was in love with her obstetrician. Just before entering medical school I worked with my mother's obstetrician's son who was also an obstetrician. Junior had a loose screw, which made me wonder about my mother's judgment and thankful for being alive and well. My mother allowed that Junior came from the shallow end of the gene pool.

Before age 10, I was quarantined with scarlet fever. All this meant to me was that a sign was on my home's front door that meant I could not go outside and no one could come in. In the 6th grade I was bitten by a dog and came down with a terrible illness, which puzzled our doctor until I had almost recovered. He then said that I had Tularemia, or rabbit fever. These illnesses were all handled with house calls. Today it would take an 18-wheeler to make a meaningful house call.

My tonsillectomy and adenoidectomy was preformed in the Medical Arts building, downtown Nashville, about 8th and Church. I remember going round and round, seemingly forever, as someone smothered me with an ether mask. This was surely not informed consent on my part and I don't know how my mother and I were talked into this procedure. And then, as if to make up for it all, I was taken home in an ambulance!

Somewhere along the line I had two separate accidents requiring the repair of fingers. The most severe was done in the doctor's office and cost $49. This took my mother forever to pay on a monthly basis and was $15 more than our house payment. So far as I know, there was no insurance back then or it was not affordable for poor folks.

My mother had an appendectomy when I was nine years old. She was in the hospital for a week – doctor's orders. Everything at home came to a standstill until she recovered. I was a lousy nurse.

We did not go to the doctor unless it was absolutely necessary because of money, even though payment plans were very flexible. And if you went to the hospital, you opened your Bible as well as your wallet because there was a good chance you were going to die.

A few of my schoolmates were killed or crippled by polio. Going to the crowded swimming pool was equated with the risk of going to war. After comparing the benefit-risk ratio, most kids still went swimming.

Of all the afflictions I suffered as a child, poison ivy was the worst. Calamine lotion and the electric fan just didn't cut it. It lasted 14 days without treatment and two weeks with treatment. A big dose of Prednisone would have sure been a blessing.

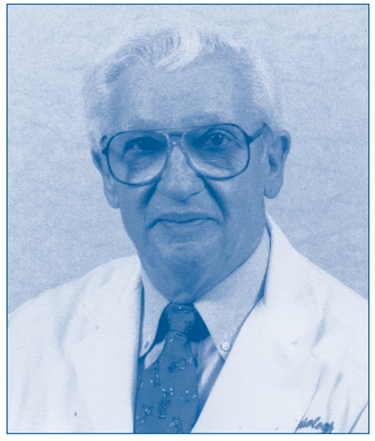
"Of all the afflictions I suffered as a child, poison ivy was the worst. It lasted 14 days without treatment and two weeks with treatment."

Medicine has greatly improved since my childhood. We can make every patient comfortable and cure most. A lot of problems and illnesses are self-inflicted. We can prevent or cure most of these illnesses if patients would heed our advice. It seems ironic that the great advances in medicine have vastly improved the patients "lot" in life but the doctors have not fared as well. ■

Dr. B. Tillman Hall,
Anesthesiology

Written January 14, 2003

Years of practice:
July 23, 1962 – Present (Semi-Retired)



My first medical memories date from the summer of l933. I was five years old, living with my parents and a younger brother in a small town in West Tennessee. I had the misfortune to break an arm after falling from a board fence. My father took me to see Dr. McCrea, a general practitioner whose office was located halfway between our town and the county seat. Two things were special about Dr. McCrea – he had an x-ray machine and he had studied in Vienna, Austria. I never knew whether he studied for five years or five days! While gently rubbing my arm, he announced to my father that I had suffered a green stick fracture and the arm would have to be completely broken to heal properly. In a flash, he snapped my ulna and radius (the forearm bones) over his knee with a loud "crack!" He commented on my stoicism, which he mistook for the fact I had nearly fainted. He then re-x-rayed and placed my arm between two balsa wood splints, wrapped it with Nugauze and placed it in a sling. He pronounced my arm healed, and dismissed me some eight weeks later.

My mother was trained that summer along with a neighbor to be the official health department person to oversee the spraying of the throats of all in the children in our town (population 150). This was a program for the prevention of infantile paralysis. It consisted of spraying the throats with an atomizer containing a weak solution of "carbolic" (a phenol product). This was done three times per week until the first frost appeared. This treatment was probably ineffective but was administered with care and compassion. Also there were no cases of polio in our town that summer. Some 17 years later, as a medical student, I saw my first iron lung respirator in the children's hospital at John Gaston. This huge device had been developed to treat the many cases of polio that attacked the muscles of respiration. The patient was placed inside a large cylinder and sealed with only the head outside. A motor would alternately create a vacuum and positive pressure causing the patient to passively inhale and exhale. There was a large lever attached to the bellows and manned by teams of medical students in the event of a power or mechanical failure.

My father was a merchant and ran a general merchandise store. Among the items he sold were many "patented medicines" used for the treatment of medical ailments. These were available without prescription and included Vick's Vapor Rub, Groves's Chill Tonic, Smith Brothers cough drops, Black Draught, Lydia Pinkham's tonic, Carter's little liver pills, Castor Oil and Ex-lax .

I entered University of Tennessee School of Medicine in July of 1950. The school was on a quarter system and we went to school year round. It was possible to finish Medical School in three and a fourth calendar years. My class was small, 36 members, and half of them were married. I eagerly anticipated the study of medicine. Everything was new and exciting. I never felt I was "called" to practice medicine but I was certainly happy to be there. Our class quickly bonded and became one extended family. During the clinical years, I saw many unusual and interesting cases, to include tetanus, typhoid, and polio. Many of my professors were exemplary role models and a few could be classified as eccentric. I always felt confident when working with patients. Early on I read a quote from the great physician Sir William Osler, "Listen to the patient, they will tell you the diagnosis". This confidence many have come from the fact that I had been in the military service with a command responsibility prior to returning to college. We were required to take an academic break between our 2nd and 3rd years of Medical School. This was called the "6X" quarter. Students did many and varied things during this period and I chose to work in the Pathology Department at the University. We did autopsies with full anatomical and microscopic tissue reports, all supervised by senior staff physicians. At the end of this three months period our class took the first part of the Tennessee State Medical Licensing Examination.

On the obstetrical service, I was allowed to participate in home deliveries.

"I received no pay but was richly rewarded by the clinical experience of a training program in geriatric medicine."

"We made six to 10 house calls per day in addition to our office practice. We served the whole county and took our families on call with us many times."

Seconal, APC and "five minutes of reassurance" were our only pain relievers for the women in labor. The home delivery team consisted of the Public Health nurse, a senior medical student and a junior medical student. This program was discontinued when I reached senior status.

At the beginning of my third year, I was hired by the Shelby County Hospital (the county poor house), to be one of two student externs. An 80 year-old medical director supervised us. There were 500-plus patients divided into two equal segregated wings of the hospital. I received no pay but was richly rewarded by the clinical experience of a training program in geriatric medicine. They did provide an apartment in a converted ward for my wife and son, three meals a day and 65 gallons of gas per month. I owned an English Ford at that time and we were never able to completely use our allotment, thanks to the excellent gas mileage! Our supervision was somewhat spotty, as illustrated by the following example: I had just returned from medical school around 5 p.m. and was summoned by a nurse to a patient's bedside. I quickly made a diagnosis of congestive heart failure with pulmonary edema. I set the patient up in bed, applied tourniquets to three extremities, started nasal oxygen and administered intravenous diuretic. After an hour and a half, the patient was stabilized and I went to report to the medical director. He had an apartment in the hospital, and came to the door in his nightshirt. He carefully listened to my summary of the case and my treatment, then carefully with emphasis said, "Son, it sounds like you have done a wonderful job and I want you to keep up the good work. But please don't wake me up in the middle of the night with every interesting case that you have." I never bothered him again after 6 p.m. If I had a problem, I simply called the senior medical resident at the University. My fellow extern and I made rounds each evening, dividing the hospital between us. We were limited in the number of medicines available for treatment. My request for Phenobarbital was denied, but they sent me a 5,000-capsule jar of Benadryl which I used that for nighttime sedation for the patients. We also held nightly clinics for the ambulatory patients. Our antibiotics were from clinical trial programs associated with the University.

After graduation and internship, I joined a medical practice with Dr. George McCreay in a small town in Alabama. This was a most rewarding association. We had a varied and challenging practice, with surgery, obstetrics, geriatrics, pediatrics, and internal medicine. We made six to 10 house calls per day in addition to our office practice. We served the whole county and took our families on call with us many times. I was never apprehensive when making night calls, as I was always expected and many times someone would appear out of the night to guide me to the patient's home. I carried a bag with all necessary medications and narcotics. I did not do home deliveries. Specialist referrals were available in a larger town, 25 miles away, and in Atlanta, Georgia about 80 miles away.

After six years, my partner and I each decided to return to a residency for further training. He chose orthopedics, and I returned to an earlier interest in Anesthesia. I trained at Huron Road Hospital in Cleveland, Ohio, the third oldest anesthesia residency in the nation. At that time, I felt that anesthesia was the most underserved field in medicine. I became interested in Clarksville on the recommendation of two physician friends. One had been a classmate and the other was my OB resident in medical school. After visiting the town, and receiving a warm welcome from the physicians and hospital administration, I moved my family to Clarksville.

We arrived July 16, 1962 and I administered my first anesthetic on July 23. I was the only anesthesiologist. There were two pediatricians providing part-time anesthesia and one CRNA (certified registered nurse anesthetist). As the operating room was in the process of being renovated, I requested and received piped-in oxygen, nitrous oxide and suction in each of four operating rooms. The medical staff numbered 17 when I joined and under went rapid growth, nearly doubling staff size over the next two years. In 1962 we were still using some flammable anesthetic agents, such as ether, cyclopropane and ethyl chloride. This meant we were unable to use any type of electronic monitoring, or electric cautery. Static electricity was a great danger factor in the operating room where explosive anesthetic agents were in use. We had conductive floors, wore conductive shoes, and the OR staff was required to wear cotton underwear. One EENT physician was insistent that I use open drop ether anesthesia for his tonsillectomies and then he proceeded to use an ancient gooseneck lamp and head mirror for lighting! He relented only after being shown the report of 63 operating room explosions with 58 deaths occurring in 1959. Non-flammable anesthetic agents had completely replaced explosive anesthetics in our operating rooms by 1967. EKG monitoring was introduced as a standard in the OR that same year. Pulse oximetry (to record the heart rate) was not introduced until the 1980s. General anesthesia for vaginal delivery was common when I arrived but had largely disappeared by 1965-66. Some form of regional anesthesia e.g. saddle block, caudal or pudendal nerve block replaced it. The normal caseload for anesthesiologists was 1,200 to 1,300 cases per year.

I shared night call with the CRNA, always being available for help if needed, for two and a half years. In 1965 Dr. John Wright joined the anesthesia staff and we shared night call giving me a bit more free time. We had the opportunity to work with some really talented and gifted surgeons.

Over 40 years, great strides in medicine have placed even greater responsibilities on anesthesia. With these changes, great advances have been made in monitoring anesthetized and recovering patients. Patient safety has been greatly improved with the addition of improved inhalational agents, muscle relaxants, local anesthetics and pre-operative antibiotics. Pain management has been enhanced through the use of nerve blocks, epidurals and intrathecal (injected into the spinal canal) narcotics, and patient self-administered narcotic pumps. I credited the development of the post-operative recovery room with lessening the impact of surgical and anesthetic morbidity for patients.

I still find the practice of anesthesia rewarding and immensely satisfying. One of my great satisfactions is that I am now providing anesthesia to a third generation of some of my original patients. As I reflect on my years of practice, there is not a doubt in my mind that I have practiced in the "golden age of medicine." I have also found that caring and compassionate physicians have great impact on the health and welfare of their patients. ■

Dr. B. T. (Tom) Iglehart,
General Surgery

Written January 17, 2003

Years of Practice:
July 1952 – February 22, 1993

Dr. Charles Trahern and I arrived in Clarksville, Tennesse on July 1, 1952 to establish a general practice of medicine. We had visited this community at the invitation of Mr. Eaton Harrison, who was chairman of the hospital board. Mr. Harrison had called us in Chattanooga, Tennessee where we were working as interns at Baroness-Erlanger Hospital – at that time a 700-bed facility. Charles and I were both impressed by the long-distance telephone call. When we visited in the spring of 1952, the "red carpet" was rolled out and we were treated as kings. Both of us left with the impression that the doctors would like for us to locate here and we did. Clarksville had a population of about 17 to 20,000 people and 17 to 20 doctors. The hospital was a 46-bed facility located where The Clarksville Academy is now. The medical staff consisted of the following doctors: Drs. John Ledbetter, Sam Doane, John Ledbetter Senior, Bryce Runyon, Ed Atkinson, M.L. Shelby, Edmonson, Billy Green Lyle, Frank (Buddy) Malone, Rod Workman, Paul Wilson, Ed Cutter, John Ross, Jack Ross, V. H. Griffin, and Fount Russell.

Miss Olivia Short was the administrator of the hospital. I believe she was called the "superintendent" and she ruled with an iron hand. Miss Emily Wimpy was in charge of the kitchen and delicious food was served. Miss Robbie McCracken was in charge of the business office. Mrs. Fowler was in charge of housekeeping at the old hospital (I think) as she was in our present hospital when it opened.

The old hospital was for white people only. Black people were sent either to Hopkinsville, Kentucky or Nashville for hospital care. The Burt Infirmary, which previously served the black population, had already closed. The doctors' offices waiting rooms were segregated. I think Dr. Trahern and I had the first integrated waiting room in Clarksville, which came as a result of a space problem.

In 1953 a black pregnant lady was sitting on a couch in our waiting room. Her water broke, and the waiting room was flooded with amniotic fluid. She was taken to an exam room. She was in labor. I called the hospital and talked with Miss Short. I asked for a bed, a space, the x-ray table, and then I begged. The answer was no, no, no. Absolutely no. This was against hospital policy. So Dr. Trahern and I with the aid of our two nurses then assembled sterile sheets, gloves and an old army examining table. After giving her a light general anesthesia with open drop ether, the baby was delivered – uncomplicated and uneventful. We kept mother and baby for about three hours, then called a cab and sent them home.

The doctors and their wives accepted us whole-heartedly and were very kind and helpful in every way. Early in our practice we had the office open on Thursday. This lasted a short time, because the population was accustomed to all doctors' offices being closed on Thursday.

In 1952 the steel framework was going up on our new hospital – located in a cow pasture. Mr. Jake Cotham was on the scene as chief of hospital maintenance and watched and helped as the structure was being built.

When the hospital opened in 1954 we had a wing (1 East) reserved for black patients, and we were glad to have it. ■

"The old hospital was for white people only. When the (new) hospital opened in 1954 we had a wing reserved for black patients, and we were glad to have it."

Memories of an Earlier Time

By Dr. James F. (Jim) Bellenger,
Family Practice

Written January 20, 2003

Years of Practice: 1962 – 1997

No antibiotics or non-stick bandages – these are two things that certainly would have made my young life easier. At age four a ruptured appendix with peritonitis followed by an intestinal obstruction nearly did me in. I was not expected to live and then when I did survive and came home, bandage changing was a real problem. I remember being held down on our foldout ironing board to change the bandages. Kicking and screaming, it took both my parents to do the job and in spite of that I developed incisional hernias in the two incisions (A second operation had been needed a few days after the appendectomy for the obstruction). Perhaps if non-stick bandaging had been available back then I would not have incurred the hernias, which necessitated a second operation nine years later.

I remember my dad had some mild asthma problem though I do not recall ever hearing him wheezing. He was given a cigarette with a small amount of some type of medication in the end of it, which would then be inhaled. This medication was of a soft candy consistency. I remember sneaking one of these on occasion and trying it myself. Since I do not recall any side effects from doing this, maybe the medication was very weak.

There were also frequent trips to the doctor for nose bleeding. The cauterization did not stop the bleeding for more than a few days. Finally, on my own, I discovered that using petroleum jelly inside my nose as preventive worked better than anything. I remembered this after I started practicing medicine. I started advising patients to put a little mineral oil or petroleum jelly on a cotton ball, insert it in each nostril for about 5 minutes once or twice a day. This was nearly always effective for the most common nose bleeding.

Obstetrical training has certainly changed in more ways than I know since I ceased delivering babies at least 20 years ago. In medical school we had to spend two weeks at the Chicago Maternity Center doing home deliveries. We would have instructed the patients to have plenty of newspapers available and a pot in which to boil water. We wrapped our gloves inside one another (and maybe put the two we were to use inside a third glove) and dropped them into the boiling water. This was the extent of our sterile procedure except maybe for a sterile pair of scissors to cut the cord. Our patients had been followed at the Center and were always multiparous (more than one child), so we had no problems from than standpoint. The fetal heart stethoscope over the head was used. It was not until arriving in Clarksville that I was introduced to the large, round, heavy, three to four-inch diameter fetascope. Now, for all I know, no stethoscope at all is used. In medical school examination of the pregnant woman to determine how labor was progressing was by rectal examination. It was felt that vaginal examination would not be sterile. Fortunately, during internship, vaginal examination became the norm, at least at that hospital. Again, I do not know how the examination is done at present.

When I arrived in Clarksville in June of 1962 there were, to my recollection, about 30 to 32 doctors. I was the first of a number of physicians coming in the next several months. Our monthly meetings were held in the old library, which was a combination check-in place, library, phone booth, and restroom. Since there were no women doctors at that time, there was no need for a second restroom. This room was the first door to the right when one entered from the front of the hospital that faced Madison Street. ■

"At age four a ruptured appendix with peritonitis followed by an intestinal obstruction nearly did me in. I was not expected to live."

Dr. William G. Lyle,
Internal Medicine

Written January 27, 2003

Years of Practice:
August 1947 – January 1988

"Back then, most of us charged $5 for a house call."

I started in August of 1947 in an office on Franklin Street. I developed cardiographs film in the bathtub and had a four-party telephone line. I had several years at the old hospital except for the year I went back into the Navy (1953 until Christmas of 1954). When I first came here in 1948, before I opened my office, I had a patient at the Home Infirmary (Clarksville's hospital for black patients). I was treating this little boy for a broken femur, although I was not intending to do orthopedics. The hospital was closing and made me discharge him, so I had to finish treating him at his home. All turned out well and he later joined the Army. He was the last patient at the Home Infirmary.

At the old hospital, the Lab was about the size of a large walk-in closet and had only one employee. There was no Emergency Room as such. Most of the nighttime emergencies were treated at home, unless they were surgeries. And of course, no black patients were accepted there. If my black patients needed hospitalization, I sent them to Vanderbilt or to Dr. Brooks in Hopkinsville, Kentucky.

In the Winter of 1948 or 1949 there was snow about four or five inches deep, and I had to go see a patient in Adams. He had been found lying in a snow pile in a ditch. Back then we carried all kinds of things in our doctor bags and I had a spinal needle and did a spinal tap. Driving my car with chains on the tires, I took the sample back to my office and diagnosed him with Bacterial Meningitis. Miss Short would not take him at the hospital, because she said she could not isolate him properly. Vanderbilt wouldn't take him either. So I treated him with penicillin at home and he recovered.

Back then, most of us charged $5 for a house call and .50 cents per mile. I don't miss getting up at 2 a.m. to make house calls. When patients were confined to bed, I'm sure they appreciated the doctor coming by to see them. It was as much a social thing as it was professional/medical visit.

Drs. A. Fount Russell, Bryce Runyon, M.L. Shelby and I flew in Waldo Rassas' (a local attorney) plane to Jackson, Tennessee to get ideas to build our new hospital that opened in April of 1954.

I like to say I practiced during the "Golden Age of Medicine." Penicillin was introduced and other antibiotics followed along fairly quickly – we cured diseases we couldn't before. New procedures were introduced for treating heart disease – I'm wearing one of them right now – a pacemaker.

Dr. Charles Trahern and I opened the first cardiac care unit in the hospital in the early 60s. There was a four-bed ward on second floor and we had an external defibrillator. I'm sure we saved a few people with that.

In 1959 Drs. Tom Iglehart, Charles Trahern, Carlos Brewer, Ledbetter and I built a doctors' office building called Memorial Medical Center. We eventually sold it. (And eventually Gateway Health System bought it, leveled it, and today uses it for parking).

I was never so glad of anything in my life to get rid of the segregated patient wing and waiting rooms in doctors' offices.

I retired in 1988 and later directed this Home Health/Hospice program for several years. Hospice has been a great development for people with a hopeless chronic illness.

I do miss my patients and I see them from time to time. I see the grandchildren of my patients!

I started with the advent of drugs like antibiotics and ended with the invasion on the practice of medicine by government and insurance companies.

In earlier years the doctor was still regarded as a physician, not a healthcare provider. They were trusted friends. Doctors were friendly with one another, and we didn't have two hospitals competing. There was no basis for hostility. We were a close-knit group both socially and professionally. I don't think there was a town in the United States that had a relationship among the doctors as good as ours. ■

Exerpts from

Doctors: Hanging On Through Health Care Overhaul

By Mark Hicks of The Leaf-Chronicle.

Dr. Fritz F. Lemoine Sr. &
Dr. Fritz F. Lemoine Jr.
General Surgery

Years of Practice in Clarksville:
Dr. Lemoine Sr.: 1972 – 1996
Dr. Lemoine Jr.: 1995 – present

Dr. Fritz F Lemoine Sr.

Dr. Fritz F Lemoine Jr.

At the dawn of a new century, a young Clarksville doctor refuses to go the way of his peers and instead prefers to practice medicine the way his father did. In fact, Dr. Fritz Lemoine Sr. turned over his 16,000 patients to his son, Dr. Fritz Lemoine Jr., in February 1996 so the family practice will continue.

In July 1995, the 72-year-old Clarksville physician needed prostate surgery, so his 37-year-old son left his swank Miami practice to help out while his father recovered. "I was in a large practice in Miami. I was successful. I stayed (in Clarksville) because of my love and respect for him and what he built here," Lemoine Jr. said.

Getting to know the people he treated was the appeal for the younger physician and, conversely, the patients' acceptance of him that made the difference.

Growing up he remembered his father taking time to talk and get to know his patients. That carries on. "I know these people's grandchildren, their sons and daughters," Lemoine Jr. said.

That kind of medical care is rare in these days of managed care and health practitioners who see patients rather than doctors (seeing patients).

Lemoine Sr., a Haitian immigrant who started his practice here in 1972, sees insurance companies and managed care as the hand of change that is choking the medical profession. "Medical science is being suffocated by controls," he said.

Need For Profits Hurting Medical Care

Since his retirement, Lemoine Sr. said he's had time to reflect and think about the future of medicine. He sees disparity.

Insurance companies are keeping much of the money they collect, he contends, and are taking medical decisions away from physicians. And those doctors are being portrayed as the reason for the rise in health care costs.

The elder Lemoine thinks people's attitudes toward health care also need to change. He also advocates "health accounts" for medical care to cut out the insurance middle man. "They think nothing will go wrong with them. If something does go wrong, they want the medical treatment cheap. That idea is suffocating progress in medical science," he said.

Lemoine Jr. brings the point home, "You have a guy come to you and says he smokes three packs of cigarettes a day, then he goes ballistic when he has to pay a $5 (insurance) co-payment. He spends more each day for something that's killing him."

Lemoine Sr. is familiar with doctors who don't earn large sums of money. He and his wife, Raymonde, also a retired physician, both earned $125 per month in 1958 when they came from Haiti to Meharry Medical College in Nashville.

According to work visa rules, the couple had to leave the country for two years and when they returned in 1966, he made $17,000 annually and she made $16,000. "We were trying to raise three children on that," he said.

Lemoine Sr. said the majority of his earnings over the years has gone to the education of his children. He said he was $78,000 in debt when his son graduated medical school. He also sent another son, Philippe, to medical school. He is now a cardiovascular physician in California. Daughter Rose is a pre-med student and also plans to attend medical school.

Racism Met With Confusion

Despite his meager finances in the 1970s, Lemoine Sr. still managed to send his children to The Clarksville Academy.

"I remember when I went to The Clarksville Academy, there were only three black kids in the whole school – myself, my brother and my sister," Lemoine Jr. said. He recalled some harassment (there) but usually tried to ignore it as his father had taught him.

Lemoine Jr. said his race has seldom been an issue in Clarksville, but in Miami he felt like a "high-paid servant" for his wealthy patients.

To both, a patient's race is as unimportant as a doctor's race, but some people make it an issue.

"I still believe in the old school — that the patient is your friend and you should be a friend to them." — Dr. Lemoine Jr.

"Some people are taken aback by my race," said Lemoine Jr. "But after they see how I practice medicine, it's not an issue. I still have people ask what race I am on the phone."

His father said he really didn't experience much racism but spent most of his time at Meharry, a historically black college, and associated primarily with his colleagues.

Lemoine Sr. said no racism existed in Haiti and he really didn't notice or understand racism in America until he stopped at a Broadway restaurant in Nashville to make a telephone call in the early 1960s. "They looked at me very strange. I was ignorant of the culture. I was not American. I did not understand everything in American life. It was a struggle to me to understand," he said.

Lemoine Jr. said his mother was the "militant one" when it came to race relations and participated in the civil rights "sit-ins" at white lunch counters in downtown Nashville during the early 1960s. Raymonde Lemoine was head of the Meharry pediatrics department until she retired in the mid-70s to care for her daughter, who had become ill.

Lemoine Jr. said changes in the medical profession have led most physicians to combine their offices into large group practices in order to cut costs. He's experienced the group-practice environment and vows to resist doing such in Clarksville with his and his father's practice "for as long as I can hold out."

"I still believe in the old school – that the patient is your friend and you should be a friend to them. And patients are people, not just an insurance card number," Lemoine Jr. said. ■

Exerpts from

History of Medicine in Montgomery County and Some Personal Observations

By V.H. Griffin, M.D., (1905 - 1996),
General Surgeon

Written Circa 1977

Just as we have progressed from the horse and buggy to the jet age in transportation in the 20th century; we seem to have duplicated it in the practice of medicine. When I graduated from Vanderbilt School of Medicine in 1931, we still had no antibiotics, but great strides had been made in both medicine and surgery. This included the treatment of diabetes, pernicious anemia and many other diseases.

After graduating from Vanderbilt in 1931, I spent four years on the surgical service at the Medical College of Virginia at Richmond. During my third year there, sulfanilamide became available as an antibiotic. It was the first of a long line of sulfa drugs to follow.

I returned to Nashville, and for two years was associated with a doctor there who had a large industrial practice. Times were hard. There were too many doctors in Nashville, so I was looking for a small town in the vicinity of Nashville to begin a surgical practice. At the suggestion of Dr. Fount Russell, who at the time was on the house staff at the Nashville General Hospital, I looked over Clarksville and decided to move here. I am certainly glad that I came to Clarksville and have been very happy since moving here in September 1937. We are all willing to work hard and trying to make a living. How times have changed!!! Times were hard in the 1930s and my move here was one of economics. I had become spoiled while in Nashville during those two years.

"When I graduated from Vanderbilt ...in 1931, we still had no antibiotics."

Photo Left to Right:
Dr. V.H. Griffin, Dr. William G. Lyle

I had the good fortune to operate in St. Thomas Hospital, Protestant hospital, which is now Baptist Hospital, as well as Nashville General; and I spent one half day each week working the outpatient orthopedic department at Vanderbilt.

In 1937 there were approximately 18 doctors who belonged to the Medical Society. This was quite a contrast to the 54 listed in 1850. Many of the doctors lived in the community around Clarksville, such as New Providence, Hickory Point, Thomasville, Cumberland City, Indian Mound, Dover, Erin and Guthrie, Kentucky.

It was a common and accepted practice at the time, that if a patient was referred to a surgeon in Clarksville, the referring doctor had the privilege to give the anesthetic to the patient. Fortunately ether was the most widely used anesthetic at the time, and it was relatively safe. Chloroform was sometimes used but it was very dangerous. Both local and spinal anesthesia were also now available. I did the first thyroidectomy in Clarksville in 1939 under local anesthesia. The patient's husband later became President of American Airlines.

There were no blood banks at the time and if a patient required a transfusion, it was almost a direct method. The blood was collected from the donor in one room and a vacuum bottle, which contained citrate and then immediately given to the patient usually in an adjoining room. I must remind you that at that time, nothing was known on the RH factor, which we now know to be very important.

Tuberculosis was very prevalent in the 1930s and later. The only known method of treatment at that time was rest. If bed rest was no sufficient, the patient was usually referred to Dr. M.L. Shelby, who would then treat the patient by a pneumathorax. This was done by injecting air into the pleural cavity, which then would put the lung on that side to rest. If adhesions were present and would not allow the lung to collapse on that side, Dr. Shelby would frequently request to me to do a phrenicotomy on that side. This was done in the neck under local anesthesia. The phrenic nerve was either crushed or avulsed. This would produce a paralysis of the diaphram on that side thus aiding in the rest process.

Beginning about 1939 a great change was taking place in Clarksville. Once a quite sedate town of 12,500 in 1937, it began a rapid growth, due to the building of Fort Campbell and the large influx of people that arrived here because of it. There was also a tremendous change in the practice of the doctors who were here at the time.

Dr. W.R. Dixon of Nashville, who was in charge of procurement and assignment of M.D.s for the military in Tennessee, did not take any doctors out of Clarksville for the military, because of the few doctors that were here at the time and the rapid growth of the area.

Those of us who were here became very busy and had to do all types of GP, which included pediatrics and obstetrics. How thankful I was for the course in obstetrics that Dr. Whitaker had just completed.

Those were hectic days – so different to what they were when I first arrived here two years previously. Dr. Jack Ross and I are the only M.D.s living, to attest to those times. Many of us were working 12-14 hours per day, besides answering night calls.

I did not come to Clarksville to do OB, but was forced to do it. I will never forget the day that I met Dr. Roland Macon in the hall of the old Clarksville hospital and told him I was going to take OB patients. I also told him that I would not do any home deliveries and would charge at least $50 for all my deliveries. He looked at me very sternly and said, "Young man you will starve to death." I survived the time and continued to deliver babies until the arrival of Dr. William Wall in December 1957. He was the first M.D. specifically trained in OB/GYN. When I stopped doing ON I had delivered 2,007 babies in Clarksville.

I am going to divert here and tell you one incident that occurred to me shortly after moving here in about 1939. At that time I had my office on the second floor of the Masonic building, which

stood at the corner of Third and Commerce Streets. There was an elevator, which lead to the second floor. At the time an elderly French gentleman by the name of Mr. Isadore Bashrack lived in the room down the hall from my office. One night I received a call from a service station asking me to see a lady with a very severe backache. I said sure and send her to my office. When I arrived there I was surprised to see a gypsy female accompanied by two gypsy males. I was a little frightened to say the least. After treating the patient, it is needless to say that I received no money, but was glad to get back home alive. The next morning as I started for the elevator, I met Mr. Isadore. He said, "You had some rough customers here last night," to which I readily agreed. He went on to say to me that I had no need to worry, because he was standing at my back door listening to every word that went on in the office. Had anything unusual occurred, he was ready to act, because he had a hatchet in one hand and a gun in the other. How I wished I had known this at the time.

By now a large number of sulfur compounds were available as antibiotics. During World War II, the British used penicillin for the first time. The first dose of penicillin given in Clarksville, was by Dr. Bryce Runyon to Mrs. Smith, the mother of Mrs. Ersula Beach, in 1943. At that time Mrs. Smith was very sick with pneumonia. Mrs. Beach tells me that her mother was much improved in 24 hours and went on to a complete recovery.

Unfortunately, the first minutes that I could find of the Montgomery County Medical Society were dated November 20, 1946. However, when I came here in 1937 the Medical Society was meeting regularly and doing well. The Society met monthly and usually an out-of-town doctor was on the program, most often from Nashville.

From the minutes of the Medical Society beginning in November 1947, we can learn much about the improved medical practice, as well as the economy of the time. At that meeting there were 22 doctors present for the dinner which was held at the Women's Club, at the location where the First Federal Bank now stands, and according to the secretary the cost of the meal was $22.50 total for all present. At that meeting a well-known surgeon, Dr. L.W. Edwards of Nashville, gave a paper on the "Management of Duodenal Ulcer."

At the meeting on January 15, 1947, Dr. Oscar Carter presented an excellent paper accompanied by slides and a motion picture of transurethral resection of the prostate. This completely revolutionized the treatment for this condition.

At a meeting at the hospital on September 17, 1947, Dr. Charles Ransom discussed the "Clinical Aspects of the Rh Factor" from a paper prepared by Dr. Douglas Senord who was unable to attend. At meetings to follow some subjects discussed were "Over-treatment of x-rays, certain skin conditions, also Drug Reactions, including sulfa drugs, penicillin and many others.

A called meeting of the Medical Society was held February 11, 1948 for the purpose of discussing a letter received from the Chamber of Commerce regarding integration of the hospital. It was the concensus of those present that there was an urgent need for this, and felt that steps should be taken immediately or as soon as possible to fulfill this critical need. This conveyed to the Chamber of Commerce.

In a letter dated October 12, 1948, to the American Red Cross, it states that the Medical Society had voted in favor of the Blood Bank.

Under date of April 15, 1949, the Medical Society received a letter from Mayor William Kleeman stating that "there was a strong possibility that funds in the amount of $1,200,000 might become available to Clarksville and Montgomery County to purchase a site, build and equip a 100-120 bed modern general hospital." He requested the Society to render an opinion on the project. At a called meeting of the society, the above was unanimously approved and letters written to Judge A.H. Broadbent and to Mayor William Kleeman.

At a meeting of the Society on October 19, 1949, Dr. Gant Gaither, of Hopkinsville, gave a talk on Gastric and Duodenal Ulcer. At the same meeting Dr. R.M. Coleman, a radiologist from Hopkinsville, was introduced. Dr. Coleman would become our first radiologist and would serve on a part time basis even after the new Memorial Hospital was opened in April of 1954.

At the time there were 23 doctors in Clarksville and 22 belonged to the Medical Society which continued to meet regularly with informative programs. During this time Memorial Hospital was under construction.

January 12, 1954, Mr. Stacy Johnson, Administrator of the New Memorial Hospital, and Mayor Paul McGregor met with the Society. Mayor McGregor notified the Society that the Memorial Hospital Board, had elected the entire Medical Staff of Clarksville Hospital to serve on the staff at Memorial Hospital. The last meeting of the Medical Society to be held in the old hospital on North Second Street was March 9, 1954. At that meeting, Dr. Ed Cutter, Chairman of the Floridation Committee, recommended the acceptance of the City's Floridation Program, and it was passed unanimously.

Electrocardiography was in its infancy at the time, but before moving to the new Memorial Hospital it was available at the Clarksville Hospital and in several doctors offices.

The Public Health Service of Montgomery County, according to Mrs. Lottie Bradley, who was Secretary of the Department from 1922 to 1942, was first organized in either 1920 or 21. The first office was in with the Chamber of Commerce, which at that time was located as Second Street just back of the present Civic Center. It moved from there to the second floor of the Courthouse and then later in the basement of the Courthouse. A Doctor Stewart was the first M.D. with the department but stayed here only about a year.

Dr. F.J. Malone became Public Health Officer in August 1924 and remained as such until his death in 1953. Shortly after arriving in Clarksville, Mrs. Malone tells me, there was as outbreak of typhoid fever. Dr. Malone became very busy giving typhoid inoculations and trying to run down the cause of the outbreak. It was found to have been spread by milk. A distributor in New Providence, was boiling his bottles, but was then rinsing them in a spring. It was found that the contaminated spring water was the source of the outbreak.

In the early years of the Health Department it was very busy during examination of school children, as well as trying to quarantine contagious diseases. Homes where there were cases of diptheria, scarlet fever and several others, signs approximately 1 1/2 x 2 feet in size were placed on the front of the house and remained there for about three weeks. During this week the children were quarantined from the community. Mrs. Bradley also tells me she recalls at least one case of smallpox.

During World War II, Dr. Ed Cutter, and officer in the Public Health Service who was stationed at Fort Campbell, was in charge of the V.D. Program there. He used the Health Department on Main Street as his headquarters. He would later become the head of the Health Department in Clarksville.

Dr. Malone died in 1953 and later his son, Dr. Frank Malone, would become Clarksville's first urologist.

Dr. Mack Green became Health Officer here in 1956. He had just retired as a Brigadier General, after serving 31 years in the Medical Corp. of the Army. He continued as Public Health Officer for Montgomery County, Stewart and Houston Counties until he retired in 1966. Dr. Green was followed by Dr. Ed Cutter who had been in private practice here after World War II.

The new memorial Hospital opened in April 1954, at a cost of $2.5 million, and was considered one of the most modern hospitals in this part of the country at the time.Mr. H.D. Pettus died in 1947 and it was through the generosity of his will that paved the way for the construction of Memorial Hospital. The remaining portion of the cost of construction was shared by the U.S. Government, under the Hill-Burton Act, and also State, County and City Governments.

A picture of the Medical Society at that time revealed that there were 19 doctors, three of which lived quite a distance from the hospital, leaving a net of 16 actually practicing in the hospital.

With the opening of the new hospital it seemed as though the practice of medicine took a giant step forward. We now had an Emergency Room, or area to treat acutely sick and injured, something we had never had before. The hospital was divided into four services, medicine, surgery, pediatrics and obstetrics. There were 100 beds open for all races. There was the nursing department, headed by Mrs. Frances Hayes (now Warren), the dietary department as well as x-ray, laboratory, oxygen therapy, pathology and record facilities.

Some M.D.s by now had taken special training and were giving anesthetics in surgery. Later trained nurses were used in this capacity, and then Dr. B. Tillman Hall arrived as our first anesthesiologist.

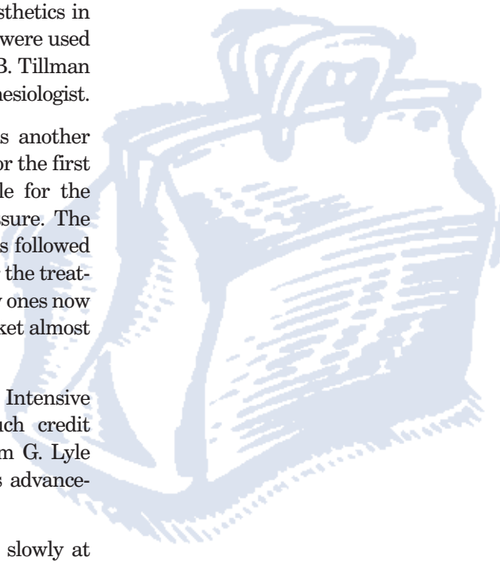
In the early 1950s there was another break-through in medicine. For the first time a drug became available for the treatment of high blood pressure. The name was Rauwofia. This was followed by an armada of medicines for the treatment of hypertension and new ones now still seem to come on the market almost every week.

In the early 1960s the first Intensive Care Unit was opened. Much credit must be given to Drs. William G. Lyle and Charles Trahern for this advancement.

The number of doctors grew slowly at first, then rapidly. There are now over 60 doctors, not only skilled in the basic specialties, but many in the subspecialties. The quality of service had increased with the quantity.

Many additions have been added and much money spent on the hospital since it opened in 1954. It is impossible in the scope of this paper to enumerate all the services offered as well as the equipment located at the new hospital both for diagnostic purposes and treatment. I understand there are now plans for the construction of a free standing one-day outpatient service building to be attached to the hospital at a cost of several millions of dollars.

Looking back over the years, I think what impresses me most and the most advancements as far as surgery is concerned are three things: (1) The discovery and manufacture of antibiotics. (2) The advancement of anesthesia. (3) Advances in cardiovascular surgery. ■



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