JUNIOR LEAGUE OF CEDAR RAPIDS

ORAL HISTORY PROJECT

INTERVIEW WITH J. Stuart McQuiston

CONDUCTED BY Carolyn Wellso

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Dr. J. Stuart McQuiston was born in Pittsburgh, Pennsylvania in 1904. He was married and widowed twice and raised one son. In this interview, we learn about medical school at the University of Pennsylvania-Philadelphia and Internship at the Mayo Clinic during the late 1920's and ealy 1930's. Dr. McQuiston tells about his selection of Cedar Rapids for his practice during the middle 1930's and shares his observations on how medicine and its practice have changed since those early years.

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CW: If you could give your name and birthdate.

McQuiston: This is Stuart McQuiston and it's kind of fun. I spell it Stuart, but occasionally I get mail Stewart; and I suppose it's finicky, but maybe it's from an old historic viewpoint. There was supposed to be some great relative that would tear the letter up and not open it if it wasn't spelled correctly, but I think we can't afford that approach at this time.

Anyhow, I was born in Pittsburgh, Pennsylvania, in 1904, and my parents were working people. Neither my father nor mother had a college education. My father was in wholesale drygoods, and my mother was, early on, a secretary. But I was the last of three children, all boys, and I must say that there were no family connections or M.D.'s. I can't find one yet that was an M.D. So how did you become a doctor? Well, apparently I was sick and the doctor came and said this and that and the other thing, and when he left I said "I guess I want to be a doctor" like every kid does. But I think what happened is the family kept repeating that story so frequently that I finally became convinced I wanted to be a doctor and proceeded along those lines, period. In high school, actually, I was selecting courses in those years leading to a medicine career, basically to get into school. Comes college, I went to Allegheny College in

Meadville, Pennsylvania, and again selected courses to get into medical school. And I must say it was an entirely different ballgame then than it is now. I had visions of going to Harvard, but I understood from the catalogs that you had to have four years of Latin and I couldn't barely squeak by two, so that eliminated Harvard pretty quickly. Then we inquired around, and I settled on choices University of Pennsylvania in Philadelphia or Jefferson Medical School in Pennsylvania or Johns Hopkins. Johns Hopkins at that time was mostly, to me at least, a post-graduate education and therefore was a choice of Penn or Jeff. Perhaps I talked to ten people that went to Penn and only seven or eight that went to Jeff and elected Penn. I had a slight difficulty getting in because they required a certain amount of English and I was going in on three years of college and getting your college degree at the end of your first year of medical school. But after due correspondence, I convinced them working on the school newspaper, etcetera, that might be equivalent to whatever was deficient in the language arts.

Medical school was a standard four-year course, and there were about a hundred and twenty in the initial class. And they were not easy. They said that if you kind of looked at one side or the other of your seatmates, one of them wouldn't be back the following year. But I think this is mostly to scare you a little bit. If you want an anecdote, this is kind of cute: The first course you get is on osteology, that is the study of bones, and so we were given

disease that you read about you figured, say, maybe I've got that. But you finally survive, and then as you get into the third year then you become what were known as "clinical clerks." They give you a white uniform--that was your status symbol. Anybody with a short white uniform was a clinical clerk, and you did see patients in clinics and rounds, etcetera. There was a kind of a joke the year that I was in because everybody kind of figured if you made it through the junior year, why you were going to graduate "if you just hang in there" because the fourth year was pretty much clinical. Well, they flunked about six or eight juniors who had either dropped out of medicine or were able in some way to repeat the year or something, and you never saw a group of students in that year that studied harder than we did in the senior year when we were supposed to be coasting a little bit.

We had our good times and bad times. There were the usual worries about the courses that didn't seem to catch on. They used to call... the dermatology course was run by a Dr. Stokes, and he was so tough that we called it "Stokes' riding academy." We all knew a little dermatology though when we got through.

Incidentally, talking about finances, medical school cost $500 a year, and that was pretty steep. But it sure was relatively cheap compared to what the charges are now. I don't know... I can't give you a current quote, but it is

I was in the reserve for ten years, so I had ten years' seniority and a really old army number. And that army reserve training was worth some bucks because the pay in the army wasn't as great as it is now, just like everything else. Well, that's enough on medical school, I think. Let's move on to internship.

This is a new deal, too. You selected any one of a number of hospitals, and if the hospital was any good, they didn't pay you a dime. If they were paying very much for residents--we were peons... if they paid anything, probably they had to pay them because they couldn't get anybody to come there. So the criterion was, "What do you get?" Well, I got seven uniforms, and as a going-away present a fountain pen flashlight. I interned back in Pittsburgh, because this was my home, at West Penn Hospital, and there was a large number of beds. I can't tell you how many--maybe twelve hundred. But I can still remember another anecdote, if you want it: When... incidentally, ninety percent of us were unmarried and ten percent were married, which also gives you a little bit of the economics of the times. I graduated in 1929, so I'm interning in 1930. The services were covered; we were on "A" service, and then if somebody wanted to sign up, "Well, I want to sign out. Will you take my calls?" "Sure, what are you doing?" "Well, I'm on O.B.," or "I'm on Nose and Throat," or something, and so you covered the calls from that department. About the time the third guy asks you to sign out, he says, "Oh, by the way, I'm covering so and

so and so and so." So I remember one night I ended up that the last one I was covering for was the emergency room, and we had an automobile accident that came in. It was really a head injury, but mostly I guess scalp injury of a severe degree. We called in the resident surgeon and then took the patient up to the operating room. I had a real nice ring, a family ring with a diamond and a sapphire. So I got up to the operating room, why you had to get into what we called "jumpsuits" or operating uniforms. And when I got in there, I was scrubbing before the surgery and I noticed the ring. I took it off and put it into the operating gown, and I didn't miss it until the next morning. So I went down to the laundry to see if they... they had already picked up the uniforms, it wasn't in the dressing room. If it wasn't in the laundry, why, I figured somebody found it and took it. So I called the police, and they said, "We'll check the local pawn shops. That's the standard procedure." When you do that, you are dealing with police; so the police reporters check the police records. So the headline comes out the next day, "Doctor Loses Ring While Operating." (Laughter) Which maybe I just plumb lost it in my uniform, but that isn't the connotation of the newspaper article.

I had, at that time, a Model T Ford. In fact, my dad said he'd help me buy it for $75 to go to senior year in medical school, and I brought it back and it was stolen. Every time it was stolen, I lost part of it. The first time the top was gone; the next time the windshield was gone. So

it was pretty well stripped down when I'd get it back, but it was kind of fun.

It was a one-year rotating internship, which most of them were at that time, and we don't have that now. You elect a specialty, whether it be family practice or a sub-specialty of cardiology or gastroenterology or oncology--that's dealing with malignancies. But this was a rotating internship in a period of one year. Well, I wasn't sure what I was going to do after internship, and it was at the time of the Depression. As I say, this was 1929 and 1930, and we got our spending money by giving transfusions--blood, which they paid pretty well for in those days. I had... as a matter of fact, I never graduated from medical school. We finished our course and then there was a month between that and internship... [glitch on tape] wrote or called and said, "Why don't you come on out and visit for the month between jumps," so I paid somebody five bucks to go to the graduation ceremony and stand up when they called my name, and I subsequently got my diploma by mail, I guess. But on the way to California, I had a friend who was at the Mayo Clinic, Ed Grenearson by name, so he said, "Well, listen, why don't you stop by the Mayo Clinic?" And I had seen him on vacation, and to me the Mayo Clinic was some place out there in the hinterland, probably with Indians on either side, but I managed to come back by way of Rochester and visited for three or four days. And in the process, I was thoroughly impressed, and I visited with young Chuck Mayo

who also went to the University of Pennsylvania, and he was about three years ahead of me. That would be the son of Will and Charlie Mayo and a very good friend of Ed Grenearson, whom I was visiting. So I put in an application. I didn't expect to get in, but what the heck! I didn't know what I was going to do anyhow. Things were pretty tough, and I might try to do some medicine. Well, I go back home and I'm interning and my mother was one of these doting mothers. I told her I'd stopped at Rochester and had applied. So she promptly went out and told her friends, "Well, you know, Stuart's going to the Mayo Clinic for his post-graduate training." And the word came back to me, and I said, "Mother, you can't say that because there are about five hundred applying and about twenty-five are accepted. So don't put out that stuff." "All right, all right," she says. But later on I hear, "Say, your mother tells me you're going to the famous Mayo Clinic when you finish internship." Well, this was getting a little tough, so I finally decided the only way I could cure my mother, and she sure didn't... "Mother, I've decided I'm not going to go to the Mayo Clinic. I'm going into practice here with Clarence Inger," my roommate in medical school who also is from Pittsburgh. Oh, she was so disappointed because "What will I tell all my friends?" "Well, I don't know. You've told them, that's your business." Well then, a little later on, I was accepted and I said, "Now, Mother, you can tell

them I'm going to the Mayo Clinic because I have an acceptance letter." I don't think she ever got over that, but that was the only way... proud mothers, you know, they just can't resist bragging about their kids. And I, of course, basically was pleased about getting accepted, and there weren't very many... many applied, but not everybody got in.

CW: It was a big deal. What was it like?

McQuiston: The Mayo Clinic had just... if any of you have ever been there, it is a tremendous medical establishment. It was a one-industry town, if you want to call it that, because that's all there was was medicine. And the other ancillary activities were related to the Mayo Clinic. It wasn't until after we had left there an industry came to town so that it then became a two-industry town, because this was industrial. I'm not sure whether it was I.B.M. or not, so I'd have to check that to be sure. But anyhow, it was a one-industry town and everything related to the clinic. It was divided into services. In the first place, you were known as a "fellow" at the time, that would be comparable now to a resident, and it was a three-year program. You were on a service for six months, and I recall I was on a thyroid service to start with. We made rounds every day, and that's when thyroids were very common. It was the advent of iodine about that time that made operating on hyperthyroid people--that's too much thyroid--safe, and they had a list of ten or twelve every day. So our job was to work them up. Then you graduated to... you moved to other services. If you were in a clinic on the floor was called...

you were a fellow on a medical floor if you were in medicine; I was in medicine, others were in surgery. You were in a diagnostic floor and you saw the incoming patients, and then after your history and physical, the records were reviewed by the consultant--he was a staff man--and then ordered off a number of tests. Then a review date was given and the staff man was there to give the personal touch. And he would kind of repeat the exam, or if you had a finding, he would check that finding and was there to actually then determine the diagnosis and the treatment. My early on medical program was with Dr. Brown and Dr. E. V. Allen. And E. V. Allen was one of my favorite people, and I must say that probably he introduced me to psychosomatic medicine early on and it has probably influenced my approach to treating patients in that I feel that the psyche has so much effect on the soma that if you do not listen and do not get the history of problems that the patient is coping with, in which the symptoms may only be a manifestation of tension. And as we say, the stomach is a barometer of the emotions, so that everybody didn't have ulcers or everybody didn't have ulcerative colitis. They had a tension anxiety state. And as Stewart Wolfe , who was recently here as a speaker, indicated, they have very, very excellent tests confirming the fact that stress can raise cholesterol, raises sugar, changes the acids in the stomach and the circulation in the stomach, and also will change blood vessels like in migraine--which is a dilation of blood vessels in the

head and then a constriction so that you get almost like mini strokes on one side with a very severe migraine--but basically all predicated on nervous tension or perhaps some foods, like chocolate. But to go back, Dr. Allen was a strong believer in this, and I can remember one incident... Am I too verbal?

CW: No, no, it's fascinating.

McQuiston: ...one incident where this woman was just sure she couldn't eat this and she couldn't eat that and he said, "What's the worst thing you can get into?" He predicated this on the basis that: We listened to your story, we've had X-rays and stomach examinations and studies of your gastric acids. We used to put this tube down your stomach to test the acids, which was no picnic. But I said, "We've found this to be entirely within normal limits. Now, tell me, what's the worst thing that you have to eat that you can't handle?" "Well," she said, "nuts probably are the biggest offender." So he sent me over to the local drug store and I came bag with three little bags full of peanuts. So we all sat there and talked for half an hour while we ate peanuts, and he said, "Now, here is my home phone and here's the office phone, and if you have any trouble, which I know you won't because I know you need the reassurance that your stomach will handle peanuts just as well as mine, call me if you need me." Well, she didn't call, so she came back in another day to get discharged and she was so thrilled that I remember getting... I didn't get the letter, probably

Dr. Allen got the letter in three months that said, "You don't know how much I appreciate the visit because I've been able to enjoy food I haven't had for ten years just because of your advice about the functions of the stomach under stress and emotion. Incidentally, my stress problems that you advised me about have ironed out so that the two tie together very nicely." But these kind of incidents were impressed on me, the psyche and the soma, and I think it makes you a better doctor if you listen. I suppose that's... in those days we didn't have any antibiotics, we didn't have any magic medicines, all we had was T.L.C., tender loving care, and we had plenty of time to listen.

All right, so time goes and the standard stay at Mayo Clinic was three years. I remember Dr. Louis V. Wilson was the director of post-graduate medical education. We had the usual talk to the graduates, and I remember this distinctly that this one year he said, "I am very pleased that the young men at the clinic, meaning the 'fellows,' are staying longer now." He said, "I find that they are staying three years and (we'll say) three months." And he took that as being quite a compliment to their interest and study and preparation for practice. But then the next year when he gave the same speech, he said, "I notice that the 'fellows' now are staying three and a half years. Now I thought about this during the year, and the conclusion I have come to this year, it's a little cold economically outside and the umbrella of the Mayo Clinic may have something to do with

it." Incidentally, about economics, you'd be interested to know that I got paid $66 a month, which as Will Mayo said, "If you think this is a salary, it's the poorest salary in the world. But if you think of it as an opportunity for learning, you won't starve." And then the salary on the second year was raised to $76, and the third year it was supposed to go to $83 or $86. Well, the Depression hit the medicine at the Mayo Clinic and we never got beyond the $76 range for the rest of the time we were there.

As I said, ninety percent of the fellows were single and only ten percent were married, and we finished our training and then it was an election of where to go. The selection of where to go, and I must say I came to Cedar Rapids originally and I can probably tell you why. I came down with the boys to look at an Iowa Homecoming game and stopped in Cedar Rapids. We had a date with some gal from Coe, and it was raining and we went on down to the game the next day and it was great. And I thought later on, you know, if Cedar Rapids looked so good on a rainy night, it might be a pretty good place to practice. And so the selection of where to go, these factors came into it. What size town you went to--and I didn't figure I'd go back to Pittsburgh and take care of my starving relatives who didn't have a dime, and it was a big city to break in to--so somewhere between fifty and a hundred thousand would be an appropriate community. And I remember visiting on this one night when we reviewed the place, Ed Foust told me that if

you could survive six months you would make it, and this was true. We were looking for a town fifty to a hundred thousand and one that withstood the Depression pretty well, and Cedar Rapids fulfilled that. And furthermore, I must be frank, I thought maybe some of the Mayo name would sort of brush off, rather than going down to Lakeland, Florida, or somewhere else, and I came down here. But I didn't know anybody.

I came down and I had a letter of introduction to Morris Sanford, and this was from a shirttail relative that was on the staff at the clinic, Dr. Sanford. And he said he runs a bookstore and stationery, so I went in to see him and I said, "Say, I'm thinking of coming to Cedar Rapids and I'd like to know what you think." "Well," he said, "would you like to meet some of the businessmen in town?" And I said, "I sure would." So he arranged a luncheon and we had... this was over on... Killian's had a tearoom, I think it was upstairs at that time. But he had a luncheon, and at the luncheon were A. L. Killian; Arthur Poe of Quaker Oats; Sam Miller, who was John Miller's father from Armstrong's; and Morris Sanford. So we kicked around the possibilities here, and they said, "Well, I'll tell you what. This community has survived the Depression pretty well, and if you go halfway, they'll meet you halfway and you'll be accepted." With that in mind, I figured we might as well try it; so I came to town with a second-hand car and we found a place to live out at the Carlton Apartments and set up shop over here

consultations. Incidentally, Dr. Wolverton was here. Dr. Wolverton was an internist, and he and I were the only internists in town and the town was 56,000 people. Now we have fifteen or eighteen internists and the town is 120,000. But things have changed a great deal over that period of time. I was here eight years and the war came along, and we all volunteered to get in the service in 1942. I said to Dr. Wolverton, "Now listen, you're ten years older than I am [glitch on tape]... make it, why then you can try it." Well, I'd been in an automobile accident in 1940 with a broken back, and I didn't know whether I could get in or not. But I went down and they said, "Have you had any symptoms for two years?" I said, "No, I haven't had any symptoms. Hell, I was in a plaster cast two years ago, and I sure didn't have any symptoms when I was in that cast." They said, "O.K., you're in." And so I got in, and poor Ben, he had to stay home and worked harder than I did. My first assignment was out to Colorado Springs, and this is a real country-club assignment. We worked at Camp Carson. At four o'clock we'd knock it off, go out to Broadmoor, play nine holes of golf, and then go downtown for dinner and then come back and see a fifteen-cent movie. But this didn't last very long because Dr. Hench, who was the chief of the medical service, had collected a group of Mayo men who were running this hospital, and Ed Allen, my friend originally in Rochester, was the Seventh Service Command medical consultant. He came out and said, "You've got too many...."

I was board certified at that time. No, I wasn't either. Yes, I was. I was board certified in internal medicine. And he said, "You've got too many board certified men here. I'm going to take McQuiston and send him down to Salina, Kansas. We're opening a new outfit down there, a station hospital." So I went down there, and they didn't even have the hospital finished, and I ran into a flu epidemic and the kids came into the wards with fever. I had to ask them to bring their mess kit along because they didn't have dishes to go around. So the country club medicine didn't last very long. Salina was not bad, but it wasn't very good either. Then I was transferred to Cheyenne, Wyoming, where the wind blows so hard it rings the doorbells and there's lots of cottonwood trees and they cover the ground. I was there until discharged, so really I fought the battle with the Seventh Service Command. For some reason they didn't send me overseas. The last six months in the army were pretty terrible. We had nothing to do, and that's hard to do. Nothing to do is the worst thing in the world. But we finally got out and came back to Cedar Rapids.

But I had an advantage at that time in returning. In the first place, the patients... poor Dr. Wolverton was worn out trying to keep track of them, and they were delighted to see doctors come back to town. So we were busy immediately. But that is what prompted me to start a partnership, and I had the late Dr. Hunting join me. And then we gradually added others until we had five men in the partnership. It

was a good medical partnership, and now that I have retired the younger men, usually ten years down the line as we had them join us, are continuing to practice medicine. While I was there, there was no turnover in any of our partners except for the loss of Dr. Hunting by death. There was the fun--we had consultation-type internal medicine practice. The internist then was different than he is now. We didn't have so many sub-specialties. We were general internists, and now the men are so well trained that they look after diabetes and coronary heart attacks, whereas those were the things that we were called in on as consultants. It probably is better, because no one can keep up with all the advances in medicine that have occurred since we started. I'll take a breather for a minute.

Just to go back and pick up a paragraph or two on the economics of medicine during the early days, during the Depression years, people didn't have Medicare and they didn't have any or very little hospital or medical insurance, so the doctors always looked after the poor. Because if you didn't have anything, well, office calls are $2; if you want to pay a buck, that's fine. House calls were $3, and you might settle for anything. If they didn't have it, you didn't charge them. And now, just to jump into now, if you try to reduce the patient's bill because you don't think he has very much, then the powers that be say, "Well your profile indicates a lesser amount, so we'll pay you officially then a lesser amount because look at all

these reduced calls. We don't care whether they were poor people or not. They are reduced calls, so we'll just reduce your profile." Therefore, the doctors now can't economically reduce their charges because it changes their overall rating that comes from the third-party peers. But the standard fee at that time was $2 for an office call and $3 for a house call, and we all made house calls. The reason was, in the first place we weren't that busy, and in the second place we felt that some of the calls were necessary. Somebody asked, "When did this change?" Well, I think it changed when we came back from the war because during the war there were so few doctors they could not take time to make a house call because this was a poor utilization of time. Because you got out there and if you had a gall bladder attack, there's no point in making a house call and giving a hypo because you know in three hours they're going to need another one and they belong in the hospital. Also, with the advent of more scientific medicine, the house call was simply a matter of history and laying on of hands; and now with the scientific advances, you do need a blood count or a urine test or a blood test of some type to confirm or determine the type of treatment. So let's say that the war was the turning point. And let's face it, the patients were spoiled. When we had time, they said, "Well, come make a house call and we'll talk to you." And Dr. Wolverton just couldn't make all those calls, so they learned then to either go to the hospital or make it down to the office in

some way. It was a real normal transition on supply and demand.

We might talk about the type of practice that you had early on. Let's face it, the doctors were on a pedestal. Whether they should have been or not is open to question, but when they said you had something it was accepted. You didn't question it, the doctor knows best. And the patient said "Yes, doctor. No, doctor. Thank you, doctor." And perhaps this was abused, but we always felt that we were not a god, we were not infallible, that we did make errors, but we honestly did the best we could with the knowledge that we had and the tools that we had to work with. And patients accepted that. This was a general feeling that the doctors were super-educated. Admittedly, they weren't perfect, but they certainly tried their best, and malpractice was an unknown word. We all automatically got malpractice insurance, and it cost $30 a year. Nowadays, the public is suit-minded, and they feel that someone should pay for every disability whether they stubbed their toe on a rock on the sidewalk. The business at that place was responsible. If they have a poor result with a fracture, nobody could make it any better, well they weren't completely returned to full activity, somebody has to pay. The patient never feels or the public never feels that their stupidity or their awkwardness or their lack of attention is ever responsible for any disability, and therefore...

END OF SIDE ONE - BEGINNING OF SIDE TWO

McQuiston: ...did you tell a patient when you finished your examination, and I believe that with my generation there was a changing viewpoint, and the doctor just said you have so and so and he didn't expand on it other than he put a tag on it and sometimes the tag was very vague, whereas when our generation came along, we had a feeling that the more the patient knew the better patient he would be. This kind of goes along with whether somebody had cancer, let's say. In the past the family particularly would say, well, don't tell Grandfather that he's got the bad disease, the cancer, that's just terrible. So we sometimes went along with that. But I'll indicate what happened then is Grandpa was not getting any better and he'd say to the family, "But I don't feel better. I'm weak," and this and that, and they would say, well, platitudes, "You just go along." "I wonder if this doctor knows what he's doing," Grandpa would say. Well they knew what was wrong. "Oh, yes, he's a fine doctor, and he's a great guy and you just do what he tells you and that's the way you should go." Well, what about it? "Well, just do what the doctor...." Well, the end result was that Grandfather thought he was neglected by the family; he had lost confidence in the doctor, and he was in a terrible state of mind because he thought he had something. But they wouldn't tell him, they avoided it, they went around, and so this became a little different. Sometimes only occasionally would I feel that a patient shouldn't be told what they had. But you can always slant the diagnosis in the sense that new

things are developing such as in leukemia. Childhood leukemia used to be uniformly fatal, and now they have excellent results so that we can say, well, you have so and so but now with chemotherapy and now with high-voltage X-ray, cobalt and now chemotherapy and radiation therapy and combinations thereof have a high degree of success so that you have a much more cooperative patient if you tell them what they have, you give them the facts and figures and how you are planning their program rather than saying, well, you've got a bad disease. We'll give you some kind of medicine and not talk to them or incorporate them in the problem. I think that in the past there was very little. The doctor says, "You've got a kind of fever and it will be better and you just take this medication and let me hear about it." It was always kind of vague unless you had a surgical thing like you have appendicitis and you need surgery.

I suppose some of this was protection, because the families were frequently the ones who insisted that they not tell the relative of a bad diagnosis. I remember one instance where this occurred in practice where this patient had a metastasis to the spine from a cancer of the prostate, and the family kept insisting that he not be told. And it went the route that I have just explained, and finally I said, "You're getting nowhere." And he was very belligerent with his family and everybody else. Finally I said, "You have to tell him what's wrong." So I sat down and I said, "Look, I agree with you that you're having pain, and I agree

with you that you feel like this. And it's very true, because you have a cancer metastasis from your prostate into the bones and it hurts and we are trying to make you comfortable, but this is the way life is." "Well," he says, "I am sure glad somebody tells me what it is." And you know, he became a model patient after that. He accepted the fact. And he became a much easier person to take care of, because he really did know. Patients are able to adjust. This is what human nature has got, a built-in protection. They don't all go to pieces with bad news. They may have some transient emotions of anger, usually at those closest to them, or they go through this cycle that we know about with... but usually it is anger, then denial, then "How long?" and finally acceptance. And these follow sometimes in the usual order, but sometimes they are interchanged and they don't come in any regular sequence. But, basically, the doctors did not use to divulge as much as we did with my age group practicing medicine.

If I may have the opportunity, I'd like to brag a little bit about the Cedar Rapids medical community. When I came here, we had a very warm interpersonal relationship with each other. We had meetings that were fun meetings as well as educational. In fact, we were early on one of the first groups to bring in out-of-state speakers to our Linn County Medical Society meetings. People like Chevalier Jackson, who was a great bronchoscopist, and other surgeons--medical men. And we had as many as two or three hundred

people attending the medical society meetings that occurred once a month during the winter. And then we had also, in medicine, the Iowa Clinical Society and the Iowa Surgical Society; they met about twice a year with interesting cases--sometimes at the University, otherwise at different cities in the state. So we continued early on to be self-educated, and this has changed. Now we have across our desk at least five hundred or more invitations to courses in updates in medicine, surgery, or whatever your specialty might be in some distant community that it is a difficult thing to select which ones you would like to go to. But there's always been the opportunity to learn and improve yourself. And I'm always pleased that the doctors never feel that they have the last answer and want to keep learning what is new. As a matter of fact, they say that a half-life of a physician is about seven years. In other words, if you don't look at any journals, if you don't go to any courses, if you don't study anything, and/or are just out of practice for seven years, half of your knowledge will be out of date, incorrect, or replaced by modern therapy that patients are entitled to receive. So that's why we feel that continuing education is a must, and that's why we think medicine in the United States is probably the best there is in the world. We also think that Cedar Rapids has some very, very fine physicians in all specialties. And if anybody wants to find out about the quality of care, just have them get sick in the East or in the Florida area or the West Coast and then

come back home, and they'll tell you that they appreciate the home-town folks. I picked Cedar Rapids because it was a warm, friendly, thriving community, and I still find that it is warm and friendly. And, of course, economically we're having some question about thriving, but let's hope that this too will pass.

It has been a pleasure to visit over the tape, and I can only say that I am retired now. I get to talk every once in awhile on positive aging; in other words, I think that if one retires and sits down and does nothing, he promptly withers and dies. But I have tried to keep involved; I'm on boards and committees, which keeps me interested and makes me enjoy what I am doing even though I am not in the active practice of medicine. Thanks a lot.

END OF TRANSCRIPT

INTERVIEW TOPICS
CEDAR RAPIDS: THE EARLY DECADES OF THE TWENTIETH CENTURY

I. PERSONAL LEAD-IN QUESTIONS

1--When were you born? Where?
15-16--How long have you lived in Cedar Rapids?
--What are your parents' names?
1-3--Where did you go to school?
--Are you married or single?
--Did you raise a family? How big?
1-26--What has been your occupation (career) during your adult years?

II. COMMUNITY TOPICS

A. Technology in the Community

1. Transportation
--Railway travel (Union Station, trips to Iowa City on Crandic)
--Trolleys (the Interurban)
7--Horses and First Automobiles
--Mud roads and the seedling mile
--Hunter Airport and the first planes
--Cedar River (ferries, floods, dams)

2. Communications
--Newspapers
--Radios
16--Advertising
--Telephones

B. People in the Community

1. Amusements/Recreation
--Motion Pictures
--Cedar Rapids Parks
--Dances
--Carnival Week
--Chautauqua
--Community Theater
--Little Gallery
--Symphony Orchestra
--Circus
--Greene's Opera House
--Amusement Parks (Alamo)
--Camps
--Community Centers (YWCA, YMCA)

2. Famous Characters
--Cherry Sisters
--Grant Wood
--Carl Van Vechten (<u>The Tattooed Countess</u>)
--Marvin Cone

3. Lifestyle
   --Life before air conditioning
   --Winter Activities
   --Holidays (Memorial Day, July 4, Thanksgiving, Christmas)
   --Clothing
   --Toys
   --Saloons/Taverns
   --Farm Life

4. Family Life
   --Household Help
   --Women's Roles
   --Childrens' Activities/Behavior
   --Sunday activities (Church life, Sunday Blue Laws)

5. Ethnic/Minority Life
   --Immigrants (Czech, Greek, German, etc.)
   --Indians
   --Segregation of Blacks
   --Jobs Available

C. Organizations and Institutions in the Community
   1. Education
      --Cedar Rapids Schools
      --Coe College
      --Mount Mercy College
      --Cornell College

   2. Government
      --City Services
      --Streets/Roads
      --Relationship with Marion (Courthouse Dispute)

   3. Medical--13,19,24-25
   8-9,10--Hospitals (Mayo Clinic)
   12-13,21,22-24--Patient-Doctor Relationship
      --Broken Bones
   5,10-12,23--Polio, TB, Debilitating Diseases
   20--House Calls
      --Home Delivery of Babies
   2-5,6,8,13--Medical School and Internship

4. Business and Economy
   15--Local Factories (Douglas Starch Works, Quaker Oats, etc.)
   --Local Brewing Companies
   15--Retail Businesses /Department Stores
   --Professions
   --Banking and Finance
   --Restaurants (Greek Restaurants in 30's)
   --Businesses that no longer exist (old groceries, drygoods, icehouses)
   --Farmers Market
   --Mills on Cedar River
   --Buildings Erected
   --Manual Labor/Types of Jobs
   --Companies (Labor Unions, Strikes, Pay)

5. Attitudes/Values
   --Children/Discipline
   --Sex/Petting
   --Charity
   --Divorce
   --Work
   --Working women, Voting Rights for Women
   --Patriotism (World War I)

D. Historic Events in and Outside the Community
1. Catastrophic Events
   --Clifton Hotel Fire (1903)
   --Douglas Starch Works Explosion(1919)
   --Bank Closings (1933)
   --Lyman-Stark Building Collapse(1913)
   --Public Library Murder(1921)

2. National Historic Events
   --Womens' Suffrage
   --World War I
   --Roaring 20's
   --Prohibition
14,15,19--Great Depression
17-18--WWII