

Oral Memoirs
of
Robert Capehart, MD

An Interview
Conducted by
Clinton M. Thompson
November 8, 2016

Development of the Tulsa Medical College:
An Oral History Project

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The Development of the Tulsa Medical College Project was conducted by the Schusterman Library at the University of Oklahoma-Tulsa from January 2016 to June 2018. The project focused on the history development of the Tulsa Medical College, which later became the OU-TU School of Community Medicine. The project consisted of 28 interviews with former and current employees of the University of Oklahoma-Tulsa.

Robert Capeheart was the first chairman of the Department of Family Practice at OU-Tulsa.

Clinton M. Thompson was the first Director of the Tulsa Medical College Library and went on to become the Director of the Robert M. Bird Health Sciences Library at the University of Oklahoma Health Sciences Center.

Alyssa Peterson was a Medical Librarian at the Schusterman Library.

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Robert Capeheart, MD
Oral History Memoir
Interview Number 1

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THOMPSON: This is November 8, 2016. Would you like to introduce yourself?

CAPEHEART: I'm Robert Capeheart.

THOMPSON: Okay. Would you like to talk about your education?

CAPEHEART: I went to the University of Tulsa. After I graduated from high school in Muskogee, Oklahoma, I went to the University of Tulsa and pursuing a degree in chemical engineering. And then I saw that the space age was coming in, and I thought that engineering would do well in the space age, and so I elected to go to OU, but I came into contact with medicine at that time, and I thought space age and medicine would go well together, so I entered the University of Oklahoma in an MD/PhD. And that—I graduate from OU, went to, came to St. John's as an intern. After internship I went into the Coast Guard, was stationed at CDC and Topeka, Kansas. And while I was at Topeka I was able to spend half time at University of Kansas Medical Center in the Department of Gastroenterology. And then following my two years there I went to—I pursued a residency in general surgery, completed that. And then I went up to Michigan for a fellowship in colorectal surgery. And then I came back to Tulsa and went into practice. That's what I've done. That's been the only job I've ever had.

THOMPSON: And you practiced at St. John's the whole time?

CAPEHEART: I practiced at all the hospitals.

THOMPSON: At all of them. Okay. Okay. Your involvement with the college, the Tulsa Medical College?

CAPEHEART: Shortly after the College was started on paper, they had a difficult, as I understand it they had a difficult time identifying a chairman of the Department of Family Practice because Tulsa was very, very, very anti-GP [anti-general practice]; it was extremely

anti-GP. The—at that time there were no family physicians. The major hospitals would not even allow a family physician or a general practitioner to make rounds socially and see the patient's chart. They were persona non grata. And they had no privileges except at—a few of the older gentlemen had privileges at Hillcrest. There was a group of GPs that started a hospital here in town called Doctors' Hospital. And that basically was about the limit of it. Oh, I think there was one or two very old GPs at St. John's, but the hospitals here were very anti-GP. They were not just anti, they were hostile. And they could not—they had some people come in to interview for the thing, and they saw the cold shoulder that general practice, and thus going in to family practice, was receiving.

And one day Bill Thurman came to see me and asked would I assume the chairmanship of the Department of Family Practice. And I told him that I'm not a family physician. The—I'm a surgeon and I know how to teach. And he offered me the job. And I told him I would take it with some provisos. One is he could set our budget. I didn't care what our budget was, we would get the job done with whatever he paid us, or gave us, which I'm sure that pleased him because he was always finding budgets. And the second thing is I wanted to be able to have a major power in the power of appointment to the department because as I understood my role would be to one, hire a core faculty; number two, to develop a core teaching curriculum; and number three, to break family practice into the big three hospitals. And so, my first job was to get the faculty. First person that I identified was Les Krenning. He was in the military at that time. And then the next person I was able to identify was, it was either Les Walls or Roger Good, one or the other, I forgot who the second, but let me say it was Roger Good, I don't know, it could have been Les. But then I identified Les Walls. He was up in Canton, Ohio, and he came down. And then the fourth person I believe was Gene Harrison or Silvie Alfonso. Gene was here in town. I found Silvie down in Florida. And anyway, that was our first faculty.

The school had two persons that were involved with the department very much. One was—I'm getting Alzheimer's—was—who were the two gentlemen we talked about earlier? Alexander.

THOMPSON: Leeland.

CAPEHEART: And Lapolla.

THOMPSON: Lapolla.

CAPEHEART: And Lapolla was very, very, very instrumental in all of this. And so that's where we started. They built a clinic, a family practice clinic. When I first came to this department, the family practice clinic was a room about, a building about the size of this room; and it was up at, I believe it was on the corner of Queen and Sheridan, up in North Tulsa. And the attending was a gentleman by the name of Williams, Dr. Williams. And everybody in the, when they made the

decision to build a family practice unit out at what became known as the Marina, people in the private community were thinking that this will be built in North Tulsa and take care of all the indigents, but wiser persons prevailed and there was a unanimity among those of us that were involved in that that why put it up there where you have a patient population that cannot help support it, put it out east where there were no physicians, but those were good, insured American Airline employees, people working in industry, what have you, middle class neighborhood, and they did. I don't know what the finances of it was out there, but I'll be willing to wager that it paid its own way. The, there was some political problems that arose because our patients out there had good insurance, and people in the specialty departments at the University, especially surgery, Frank Clingan—is Frank still alive?

THOMPSON: Yes, I believe he is.

CAPEHEART: The—I know his son's still here. There were several people that really wanted our surgery patients to come to the department, but at that time our family physician residents could not go into Hillcrest, could not go into St. John's or St. Francis because there was just, in their opinion at that time, interpreted by myself and others, is they did not want family physicians in OB or in intensive care unit or in surgery. And my attitude was that Oklahoma is a rural state, and that young men and ladies coming out of this department will not be practicing in Tulsa or Oklahoma City, they will be practicing in Gotebo and other places that require some sophisticated knowledge on how to diagnose, how to take care of problems, et cetera. Not that we're, we desire them to be obstetricians or invasive cardiologists or surgeons, but we did want them to be able to take care of patients at their location. So, for a period of time—so I had a problem in that I had to get my patients, I say my patients, the patients of the residents into the hospitals for care, and if you sent a patient over to Hillcrest to go in surgery, the family physician resident was not welcome. And so, I made a decision that caused me to be a very unliked person by many people and a very liked person by other people. The—so I contacted Walter Wilson, Dr. Walter Wilson who I knew from over at osteopathic, and Walter in the osteopathic community at that time had the same degree of prominence and leadership in the osteopathic community that C.T. Thompson had in the MD community. And I asked him, “Could we admit patients to osteopathic?” In other words, we wouldn't be admitting the patient, but we would refer the patient, this patient needs a gall bladder, refer to you or one of the persons on your teaching staff, and they be allowed to come in and go make rounds with you, go to surgery with you, learn from that patient. And they said yes. And so, for a period of about a year, we admitted patients to osteopathic, and it really hit the bank account of the specialists. And as more than one time in the, if you go back in the, if there was minutes made of faculty meetings, if there were minutes I don't know, but there were several instances where in the faculty meetings this was a subject that they wanted to change that. A family practice, general prac—family physician surgery patient needs to go to general surgery at the University; and I got called in before some board, I don't know what it was, but a bunch of people that was concerned about this, and I said, “When my

residents can have a good experience with their patients in whatever hospitals you want us to go to, they will go there. But as long as they are outsiders, we send them and their money to osteopathic.” And shortly after that, St. Francis, St. John, and Hillcrest opened their doors to family practice. The, that made me very much a persona non grata to several people, but also, it also made me a hero to other people. So, it was a good thing.

The, I was able to hire Roger Good from Scottsdale. And Roger was, one of the things I wanted in all of our residents, correction, one of the things I wanted in all of our family members, I did not want a weak community medicine, preventative medicine type person as head of the program because we are a rural state, they need to know how to take care of heart attacks, they need to know how to diagnosis pancreatitis, they need to know how to care for pancreatitis, they need to take care of everything. And I didn’t want anybody that would take a backseat or walk behind a specialist; I wanted somebody what would walk equal with them. And I found that in Les Walls, and I found that in Roger Good. Les Krenning is not so much—Krenning is basically, he’s a very nice guy, but he was, politically he was not real strong. He’s more of a follower than a leader. And Gene Harrison, he’s a good guy as well, if he’d been younger I think he could have been very much of a strong influence, but he was on his retirement leg, he was on his way out. Gene just didn’t want to make waves. Les Krenning was more charismatic, more smooth, very smart, very good, excellent politician, excellent physician, excellent teacher, and Roger Good was the same way. And so then when we had the faculty hired, we had broken into the hospitals, and we had our core curriculum started, we had our family practice center going, then I left the school, went back into full-time private practice. And Roger assumed the chairmanship of the Department of Family Practice, and did an excellent job up until his death.

THOMPSON: What, what was it about your training that put you, from my knowledge of the history of the development of MDs, what put you in a position to have this foresight to realize the need for trained family practice docs?

CAPEHEART: It’s common sense. It wasn’t anything in my background, it’s common sense. Oklahoma is a rural state.

THOMPSON: But now, that wasn’t the opinion of—

CAPEHEART: Who cares what the opinion was. Too many people looked upon the school as a, as a easy was to make a buck. The state would pay them a salary. The—my career was not focused on the school. My career was focused on being a private surgeon in Tulsa. The—but Oklahoma’s a rural state. And too many people thought of the residency, or let me re-phrase that, too many people thought of general practice and family physicians as they need to be in that office and when they have a problem in internal medicine, they send it to you; if they have a problem in pediatrics, they send it to her; if they have a problem in surgery, they send it to me;

and keep the hell out of my way. That was their attitude. I mean family physician at that time, family practice at that time was extremely, extremely thought of in a very negative sense by some of the, by most of the leaders of the Tulsa Medical Society and of the administrators of the hospitals.

THOMPSON: Your involvement before Dr. Thurman approached you? Had you been involved with—

CAPEHEART: No.

THOMPSON: —getting the medical college here?

CAPEHEART: No.

THOMPSON: So, your involvement started when Dr. Thurman approached you.

CAPEHEART: He approached me out of—and I don't even know why he approached me.

THOMPSON: That was my next question: did you know why he selected you?

CAPEHEART: No. I have no idea. I don't know who he'd spoken with or anything such as that, but all I know is one day he came in and he offered me an opportunity to work with the school with those goals. And I spoke with Ralph Richter because he had been an academic, and I asked him what he thought and he thought, he says, "This is a great opportunity for you." And he said, "Make sure that you retain the power of appointment in your department so you can maintain control of the way the department goes." And so I did. And with regard to the finances, I wasn't making any money off the school; I was making money as a surgeon. And the, so I'm sure that that did not create any problem with Thurman since I didn't care what the budget was, we can do with nothing or we can do with a lot.

THOMPSON: I would guess that he probably enjoyed you. I mean, one of the other things that's been said about him was that he hired people to do a job and then typically got out of the way and let them do their job and only got involved when he needed to get involved. Otherwise he was very content to let those individuals do their job.

CAPEHEART: Yep, I will agree with you on that. He—.

THOMPSON: Now when you, when you went back to private practice, did you keep an involvement in the college?

CAPEHEART: Yes.

THOMPSON: Or just from a—

CAPEHEART: No, I continued to function as an attending at the Marina.

THOMPSON: So, you actually were going to the Marina and actually seeing patients with the residents?

CAPEHEART: Well, let's say it this way, let's say it this way, I was an attending at the Marina. My senior residents knew more medicine than I did.

THOMPSON: I doubt that, sir.

CAPEHEART: The—you know, there was a period of time there that we had trouble getting attendings at the Marina. I mean, family practice, and I presume it is today, is a very well thought of discipline and department here at the University, and in the community. Back then, it was not, it was not. It was, it was less than being negative.

THOMPSON: Would that observation go, since I know you were involved, would that observation also have been true of Oklahoma City?

CAPEHEART: That I don't know.

THOMPSON: That you don't know. Okay.

CAPEHEART: I don't know about Oklahoma City. I know what I've seen here.

THOMPSON: Well, and obviously the proof is in, a little bit in the results because many of the students that were here during your period of time are now well-respected physicians in the Tulsa area.

CAPEHEART: Absolutely. I mean, you know, I had a, I forgot what his name was; he went up to Vinita to go into practice. We were talking at breakfast one day, he was an intern, and they did not really, there was no family practice residency, it was on paper, but there was nothing to it—they had no attendings, they had no game plan, they had nothing. And his comment was, "Why should I spend a period of time, two to three years, in residency here where I don't really have any attendings of note? I'm just having an extended internship, rotating from hospital to hospital, when I can go up to Vinita," and I'll make this number up, I have no idea what he said, "and I can make a \$150,000, and here I make \$20,000 a year. There I can go to Vinita and make

\$150,000 a year and be taught by two,” there were two gentlemen he joined, “two very good GPs up there, family physicians.” And I use those terms interchangeably because prior to the school it was GP, after the school it was family physician. “So, why should I stay here?” And that’s a good question. When you can get more training, better experience, more money, and you’re building toward a life, so that’s what they were facing here. And I don’t remember what I told him, but he stayed.

THOMPSON: And got his training here?

CAPEHEART: Yes.

THOMPSON: As I said, there are very many, there are a large number of well-respected physicians that came out of the family medicine program, no question about that. When you listen—

CAPEHEART: They were good fellas.

THOMPSON: Any other, either local physicians or people inside the college that come to mind in those days that you would talk about? Or have opinions or have memories of?

CAPEHEART: Oh, the—Jim Guernsey was chairman of the Department of Surgery, he was a good ham. The—Frank Clingan seemed to be more interested in politics than anything else. The—of the hospitals. The—C.T. [Thompson] back in those days seemed to be the, basically the leader of the surgical community, and both in a technical and in a political sense. The—I don’t remember who all they were, they had problems over in OB for a while, keeping somebody there.

THOMPSON: ‘Til they brought Dr. Nettles in, and then he stayed forever, so. Dr. Plunket?

CAPEHEART: Oh, Plunket was excellent. He was a good ham. He was a good teacher. Very well respected.

THOMPSON: And we discussed before we got started Dr. Duffy.

CAPEHEART: Duffy was—

THOMPSON: In internal medicine.

CAPEHEART: When I first knew Duffy he was more on the faculty, and he seemed to be very focused on teaching, he was focused on students. I did not feel that he was, I’m sure he was

because he stayed in medicine, but he did not project the attitude that he was more interested in the politics of medicine than teaching, he seemed to be interested in the teaching; whereas Frank, he was more interested in the politics, and it was his way or the highway attitude.

THOMPSON: Did you have involvement in the Tulsa Medical Education Foundation as it was established, or was that kind of outside and was more—

CAPEHEART: No, I was not part of that. I never went to any of their meetings or anything such as that.

THOMPSON: Alright. The—do you remember Dr. Lewis, the dean?

CAPEHEART: Oh, yes.

THOMPSON: Your comments about him?

CAPEHEART: Old school internist. Not too enthusiastic about seeing much change. That's the only thing I can remember on that.

THOMPSON: Okay. Sounds good.

CAPEHEART: I mean he did his job, but he did not see new horizons to do over.

THOMPSON: Comments about how you've seen medicine change during your career, if you want to address that?

CAPEHEART: Well, I practiced one year prior to Medicare. And at that time—let me rephrase it—when I was an intern prior to Medicare, here in Tulsa, there was only one physician that would not take care of anybody—Otis Lee, an ophthalmologist. You had to have money to see him. If you couldn't pay, he wouldn't see you. Every other physician in town would take care of anybody that had a need whether they had money or not. There was no people that was doing without. When Medicare came in, things changed for the negative.

THOMPSON: Hm, that's an interesting observation. So, you think that changed the—

CAPEHEART: Well, no. I don't know what changed it, but prior to Medicare if you had a problem, and you went to either St. John's or Hillcrest or, you would be seen, you would be cared for. They would—they had essentially no house staff, they had a few house staff people there, but you would be cared for whether it was, whatever field. So, there was no big dearth of medical providers here that would take care of indigents. As I said, there was only one physician

that you could not call—let me rephrase that—one physician, if you called him, he would not take care of someone unless they had money or insurance, and that was an ophthalmologist, a Chinese gentleman by the name of Otis Lee, who was a very fine ophthalmologist, but that was just his attitude. But everybody else took care of them. And when Medicare came in, then you started seeing things change for the negative. The, of course, a smaller medical society, there are more collegiate among themselves. I remember going over, I forgot what the name of the hospitals were, there used to be several private hospitals here, over on Peoria there was a big red stone two or three-story building that's still there, it's a house or apartment house now, that was a hospital, privately owned. There was one downtown that was privately owned. There was just, it was a much smaller town, much smaller community. The care you got back then was good. Physicians today seem to be, they're—. I think we in medicine have lost the art of medicine, the calling of medicine. Physicians, what I see today, they're more interested in having time off or something like that. The, people work for three reasons, physicians in my opinion work for three reasons. They work for power, they work for money, and they work for time off. Well, you can't get any power because physicians have given power away to the administrators, and they're not going to give it back. And you can't work more and make more money because it's controlled by other persons. So, it's time off. Dan Plunket, I've seen him go into a baby's room and spend forty-five minutes evaluating the baby and talking to the parents. Today, I doubt if the physician here would spend four minutes talking to them, they would send a PA in with a checklist. And this is occurring all over the country, because in my current consulting business, I speak with physicians all over the country, and they have the same problem, or they are observing the same problem in their locales, in that physicians have stopped being a physician, they have begun being a technician. More—less than a technician. They, they take a checklist and think that that's an evaluation.

THOMPSON: Do you attribute your ability to do those kinds of things to what you learned in medical school? Or did you develop those over a time?

CAPEHEART: No. Okay. My Alzheimer's is kicking in here.

THOMPSON: You're fine.

CAPEHEART: I was fortunate enough when I was in medical school, we had a gentleman, William, William, he's from Iowa. He came down as visiting professor of internal medicine for a couple of years. And I'll think of his name in a moment, but he was a very big internal medicine doc with the VA, in fact, one of the VA hospitals, I believe in Washington is named after him. The library at the medical school in Iowa—Middleton, William Middleton is his name—the library there is named after him. And he was an old school internist that recognized that you make diagnosis—that every disease has a pattern. And it varies somewhat, but every disease has a natural history and a pattern. And you may have heard the concept if you listen to a patient

they'll tell you what's wrong with them, or that the history is the most important thing—that's absolutely true. The, if you understand the patterns of disease, and you just listen, you can see that pattern, and he was a true bedside teacher. And the only physician I know in town today that is any way close to him is when Dick Marshall was in practice. Dick Marshall was a true, true bedside physician, and as such he earned the reputation of being the best diagnostician in the area. And—I don't know if that answered your question, I don't even know what your question was.

THOMPSON: No, I, well, I placed you in a box, which was probably inappropriate.

CAPEHEART: That's all right. I'm used to being in boxes.

THOMPSON: That was my observation of comments that you had made that you had been schooled very well, and that you yourself were a good diagnostician.

CAPEHEART: Well, I don't know that. I feel that in my field I am competent. In my field I'm competent. The, I stopped surgery in '88 when I amputated a thumb, but I've stayed busy in a consulting practice even 'til today. That's why I couldn't talk with you next week because I have to go to El Paso for some clients.

THOMPSON: So, you are still consulting then?

CAPEHEART: Not in medicine.

THOMPSON: Not in medicine.

CAPEHEART: No. Back in the early seventies, the defense attorney, the defense bar came to me and wanted to know would I be willing to teach them medicine, pathophysiology on a quick PRN basis, and I agreed to. And in doing so, I became—oh, you asked if I was a pathologist, I'm not a pathologist, but back in the academic days I did teach in pathophysiology, which would be in the area of pathology. But anyway, I saw that physicians who practice excellent care shoot themselves in the foot during their testimony because of several reasons, and I thought I saw a small solution to those things, and so I went to PLICO and asked, "Could I work with a few problematic cases?" And they said, "Yes" and "What are you going to do?" I said, "I'm going to teach physicians how to listen." And the, so, that's what I started doing, teaching physicians how to listen and how to think. And as a result of that, I've gone to a jury verdict with over 1,100 doctors in 46 states, and we've lost 11 cases. The, and I'm still doing it. I'm doing most of it by phone now.

THOMPSON: I had no idea that you had done that.

CAPEHEART: Nobody does. I've never advertised, I've never promoted, I've never marketed. I speak only under privilege, and no one, unless you've been a client of mine, no one knows that I do anything like that.

THOMPSON: How interesting.

CAPEHEART: But if you learn to listen and you understand the rules and you think clearly and you don't be brainwashed by hospitals and by lawyers and by insurance companies, that you think as a physician, you will do well.

THOMPSON: And that's—you've been doing that since you retired or before, actually before you retired.

CAPEHEART: Started that back in the early seventies. I've been doing it about forty-five, forty-six years.

THOMPSON: You were doing that then while you were here.

CAPEHEART: Oh, yes.

THOMPSON: Did you start out just doing it in Tulsa with physicians, or—?

CAPEHEART: Well, what happened is I just did it with some physicians here, and a few around the state because I, PLICO's the one that paid for the thing, and I had one or two in Oklahoma City, here, and then I had a physician that I prepared here and he got a good result, I don't remember what his name was, but I remember Joe Best was his defense attorney. But anyway, he got good results. And then he moved to West Palm Beach, Florida. And in West Palm, he got sued. And so when he got sued there, he asked his attorney could I prepare him, and his attorney knew nothing about me, and so he hired me, and he sat in with us while I did all my preparation and when he got through he was impressed by it, and the physician won the case there as well. And then that attorney's named Gene Ciotoli. And he is, or was at that time, he may still be, I don't know, but at that time, he was AIG's golden boy among defense attorneys. And AIG at the home office in New York, the person who was head of all of their medical malpractice claims was a lady by the name of Lisa, I'll think of her last name in a moment, but anyway, she had asked Gene to come up and put on a seminar for medical malpractice claims reps of AIG. And he agreed to. Well, about a week before he was supposed to go up there, his wife was diagnosed with cancer of the breast, and he decided he did not want to have anything to do with it. So, he asked would I be willing to go up in his place. And I said yes. So, he called Lisa up at the home office of AIG and got me substituted for him. So, I ended up speaking to about 500 claims reps for AIG from all over the country. And right after that I started getting calls from attorneys in Hawaii and Atlanta and Florida and New York and all over. And so, by word of mouth from

attorney to carrier, carrier to attorney, I've prepared over 3,000 doctors for deposition and or trial. I've prepared one serial murder case.

DaVita, the dialysis people. Here three or four years ago, they had a nurse down in Lufkin, Texas that was knocking people off. And she murdered probably thirteen patients in the dialysis unit. And they finally caught her, and they tried her, I think they tried her on five cases out of thirteen. And DaVita was concerned that the defense would try to, and they did, try to throw the blame on DaVita and say they did not have their equipment clean enough and all this sort of stuff. It was a procedural thing instead of, because what this nurse was doing was putting bleach in the dialysis fluid. But anyway, so DaVita hired me and I prepared either thirteen, fourteen, or fifteen, thirteen to fifteen of their senior people, medical directors, director of nursing, board of directors and all this sort of stuff, so if they were called during the criminal case—because there's no discovery in criminal, it all comes out at trial. So, I've had one serial murder. But—

THOMPSON: Interesting.

CAPEHEART: —most of my clients have been, 99.99 have been physicians and nurses.

THOMPSON: Interesting, interesting. Another question, because you were so prominent in the Tulsa area, are there any other doctors, you mentioned a couple, you talked about Dr. Marshall, you talked a little bit about Dr. Lewis, are there any other physicians in the community that stand out?

CAPEHEART: Yes, the...used to be head of the county health department. I apologize for forgetting names.

THOMPSON: We'll find it.

CAPEHEART: The, he was, I think he's still alive, but he was the county health department, head of the county health department for eons, and he was active in the family practice department. The, have you spoken with Les Walls?

THOMPSON: No, we're still trying to track him down. I'm hoping that he and his wife will be returning to Tulsa now that it's starting to cool off. They leave and go to Oregon. She has some kind of a—

CAPEHEART: She has inflammatory bowel disease.

THOMPSON: Is that? Okay. No one had ever said, but. And so they go north when it gets warm.

CAPEHEART: Well, I don't know if that's why, but they, because he was up there and was president at the College of Pacific, outside of Portland, I believe, in Forest Grove or something like that.

THOMPSON: And so they go back there. And then he, like you, is still very involved and just recently did a stint as the interim head of an optometry college on the east coast that was having some problems, and he went there to stabilize that situation. But as I understand it in the last email I had with him, they are now back in Oregon, intending to come back to Oklahoma when it cools off.

CAPEHEART: The, if you can speak with, I can see pictures of their na—I can see pictures of them, but I can't think of their name.

THOMPSON: You're like me. You do the physical description; forget the name that goes with it. You can describe where they were at and we can probably figure their names out later if you want to.

CAPEHEART: While you're looking at the, if you're looking at the history of Tulsa, something I would like to know, if you ever run across it: why did they change the north side clinic from Moton to Morton? See, that was Moton for a long time. M-o-t-o-n.

PETERSON: I think it's when they became a federally subsidized health clinic they changed their name. So they were like a home grown kind of thing and—

CAPEHEART: But that was named, as I understand it, it was named after an old colored doctor who spent his whole life taking care of people in North Tulsa. Very well respected. His name was Moton. And then they changed it to Morton, and I've often wondered why.

PETERSON: Okay.

THOMPSON: We'll find out. I believe Stewart's got some contacts that we can get that information.

CAPEHEART: The, I can't think of anybody off the top of my head right now.

THOMPSON: I'll ask you because you were at St. John's for years and I'm having trouble, the sister that was the administrator over at St. John's for years. What was her name? What are you looking for?

CAPEHEART: My phone. My wife will know the name.

THOMPSON: I was just getting ready to say, you know, I like to tell people that there's nothing new in the new world, but cell phones definitely have an advantage. Now, did she work in healthcare, your wife?

CAPEHEART: She's an OB nurse.

THOMPSON: Oh, okay.

(phone rings)

CAPEHEART: You have spoken to C.T. Thompson?

THOMPSON: No, he's one that's on our list to do.

CAPEHEART: Diane?

DIANE: Yes?

CAPEHEART: Think back in history. St. John's. What was the name of the sister that was administrator of St. John's?

DIANE: Oh, gosh. Oh, Sister—. Let me look up something here, let me Google something.

CAPEHEART: Okay.

DIANE: Okay.

CAPEHEART: Bye-bye.

THOMPSON: I've got a Sister in Oklahoma City in my mind, at Mercy, that I can't—

CAPEHEART: Sister Mary George?

THOMPSON: Yes.

CAPEHEART: She was there in surgery.

THOMPSON: Yeah.

CAPEHEART: There was a sister here, and I forgot what her name was in surgery, she was an old, old lady. She loved her booze; she loved classical music. And every Christmas all the surgeons would bring her in a fifth of booze. So, she'd have probably two or three cases of whiskey. And they'd bring her in classical records. And she would spend her free time—now this I should not say because I'm saying for the first time and I've never really thought it, but instead of going to the chapel to pray in the middle of the day, she would go to the OR, she'd be up there by herself, everything would be closed, locked up, except for her office, and she would be playing Mozart and having a toddy.

THOMPSON: Oh, lord. Well, I have said on occasions that the loss of those individuals may have hurt healthcare as much as anything. Their interest was totally—

CAPEHEART: I totally agree. The, there was an old pathologist at, he's dead now, so it wouldn't do any good, at Hillcrest, Lobeir(??), have you had anything on him?

THOMPSON: No, we have not.

CAPEHEART: Lobeir was a classical, classical pathologist, of the old German school of pathology. If he did an autopsy, he didn't do what they do today, look in the cavity and brain, he would split the arms and legs and take the bones out, he would do a very, very thorough, he was a, suffice it to say, he was an old school German pathologist that came here to get away from Hitler.

THOMPSON: He came to the library a lot to do research.

CAPEHEART: Yes.

THOMPSON: He was—. One of my favorite stories about him was is that I had an attorney in the library one day looking for a bunch of stuff, and they just were driving me nuts asking me for materials because they were overlapping some stuff that he had looked for. And I finally said to the young lady, it was a young lady, I finally said, "Are you representing somebody? Or what are you—what's the information all for?" And she said, "Well, we're checking up on our witness. We want to be sure that he has everything that he has to have." And I said, "And so who would that be?" And she said it's him. And I said, "You don't have to worry about a thing." She says to me, "Have you ever been in his office?" And I said, "Well, ma'am, I wouldn't have a reason to be in his office." It was exactly what she said. She said there was a trail to his desk and a trail to the door and that was it. The rest of the room was covered in material. And she said, "He has us nervous." I said, "Ma'am, you don't have a thing to worry about." I said, "There's not a piece of literature he has not looked at, I can tell you."

CAPEHEART: Physicians—or more than one attorney has learned: ask your questions and shut up. There was a case, Joe Glass was representing the defense, and I'll make this number of things up, but there was, Leo was a defense expert and Joe had fifty questions that he asked him, and Leo gave the absolute truthful answer to every one of them, and Joe thought, "He's on my side." Then he asked the fifty-first question that he did not know what the answer was going to be. And Dr. Lobeir gave him a truthful answer that totally destroyed the case. I mean, and I don't remember what it was, but I'll make this up. The guy's being sued for not making a diagnosis on the right arm, and he asks all these questions—the diagnosis was there, the diagnosis was there, the diagnosis was there. The defense would have won. But then he asked the next question, "Now what arm is it that you examined?" He said, "I examined the left arm."

Medicine is, has changed. The art of medicine is getting better—the science of medicine is getting better. The art of medicine is something we're losing. And when you go into a physician's office and they never touch you, all they do is look at what the person, whether, and I won't be, I'll be politically correct, the boy or girl, male or female of whatever education they had checked before they came in, and then they make their diagnosis based on that, and we'll see you whenever. I'm glad I'm not in medicine anymore.

THOMPSON: Is that your wife?

CAPEHEART: (answers phone) Yes? (murmurings from phone conversation) Therese? Sister Therese?

THOMPSON: Yeah.

CAPEHEART: That's it. Okay, that's it. (more murmurings from phone) Gottschalk. Yes. Yes, that was her. (more phone murmurings) Yes, yeah. That was it. Okay. Thank you.

Sister Therese. Last name Gottschalk.

THOMPSON: I'd forgotten her last name.

CAPEHEART: Diane, she's like an elephant.

THOMPSON: So, how long did she—we'll come back to the medicine—how long did your wife practice in Tulsa?

CAPEHEART: The length of time I did.

THOMPSON: The whole time. She worked in OB/GYN at St. John's?

CAPEHEART: She worked as a surgery nurse with me, and then she worked nights and weekends in OB.

THOMPSON: Very good. Now, back to the art of medicine. You think it's been lost?

CAPEHEART: Oh, I think it's been lost. The, and the problem is our residents don't have mentors to know what it's like.

THOMPSON: Do you think that's just eroded over time?

CAPEHEART: I think it's because of the socioeconomic changes of medicine has gave rise to this. The, I had a client up in Springfield, Illinois. Family physician. In fact, we won their case last week. But he said, "You know, twenty years ago," I'll make these numbers up because I don't remember what they were, "twenty years ago I would see thirty patients a day, five days a week. I billed," I'm just pulling numbers out of the air now, "over a period of a year, I would bill \$500,000, and I'd get paid \$400,000. After my expenses, I was making about \$180,000 a year. Today I am seeing thirty patients a day, five days a week. I bill \$500,000, but my take home is \$42,000 a year." Because you get paid less and the expenses have gone up. And there's a gentleman here in town that worked for Hillcrest, and he had to see, in their system at that time, he had to see so many patients a day. And if he didn't see that many patients a day, his salary went down. And he was, he said, "I am not practicing good medicine. I am just dispensing medicines. I hear you, you come in and say I've got a pain in my ear, here take this medicine." He left Hillcrest and went up, he works at the Indian clinic up in Vinita now. And I know a couple of younger physicians that are in our church or I know personally, and if they are satisfied with the system, they like the time off, then they don't worry about, and they don't worry about the money, they're happy as can be. And it's not money that drives physicians, that's one of the things that people work for, but, I mean, everybody doesn't want power, everybody doesn't want money, everybody doesn't want time off, but those are three big motivating things. I hear, talking to them, their frustration of not being able to practice medicine the way it should be practiced as opposed to being a checklist. And so that's changes in medicine. I'm glad that I'm not practicing anymore.

THOMPSON: You fit with another group of people that I've respected for many years, and they all say the same thing.

CAPEHEART: Well.

THOMPSON: That's why I said a while ago I suspected that you did an extremely fine job of diagnosing your patients, so.

CAPEHEART: You asked about how, who, what people influenced me in my career, William Middleton did. You know what a CPC [Clinical Pathologic Case Presentation] is?

THOMPSON: Uh-huh.

CAPEHEART: When he was, I saw this occur over there, more than once, but I can specifically recall this case. CPC. The resident comes in, the internal medicine resident comes in, everybody's in the big amphitheater, and he presents the case. And then the pathology resident gets up and presents the pathology of it. And then everybody renders a guess or an opinion as to what the diagnosis is. And no one knew, no one sees the case ahead of time, not even the faculty. And I remember this one time Middleton came in, and he sat at the back of the auditorium and he was back there and he was sleeping. Literally sleeping. He was snoring. And they always ask him for comments at the end of it. And they gave their opinions; they had these opinions from A to Z. No one got the diagnosis. And so finally they asked Dr. Middleton would you care to put your opinion forth. And he got up and he refreshed his memory verbally, let's see, if I understand if this patient was this age, et cetera, et cetera, had these signs and symptoms, et cetera, et cetera. And he says, oh, this is a very obvious case of an endocardial lipoma on a stalk, a polyp on a stalk inside the heart. He said this is a very obvious case of that. And he says, there's been five cases of this reported in the literature, of which I have reported two of them. It was. I mean, he was a clinician. He understood pathology; he understood pathophysiology. And he taught that the only time you get lab work is when your physical and your history do not jive. If your history says A and your physical says A, treat it. Don't worry about lab work. And there was other reasons you get lab work, but that's the big thing.

The, and the other person I learned a lot from was my attending in general surgery, George Farha. Two things: one, there was a lady that we did some surgery on, and we walked in the room and she was the ugliest woman you'd ever seen. And we evaluated her, did whatever we did on rounds, and when he got ready to leave, he said, "Gloria, your hair is very beautiful today. You have really got beautiful hair." And Gloria perked up. And we walked down the hall and he said, because her hair didn't look good at all to me, but anyway, he told her that it looked good. And we were walking down the hall, and the point he wanted to make is it doesn't hurt you to give kindness. The other thing I learned from him is, we had done a cystocele rectocele on a lady, and did it through the vagina. And to keep the labia out of the way, you would take the labia and put a stitch in it and stitch it to the thigh, the inner thigh, and then do the other labia, and so you had these pieces of labia sewed up against the thighs. Well, there it was, day ready for her to go home—this was back when they kept people in the hospital a few days, three or four or five days after surgery, and we're ready to go home. And we walked in and he said, "Mary, I'm going to send you home today." And she says, "When you going to take the stitches out?" Well, there isn't any stitches to come out. And he said, "Stitches? Show me the stitches that you're referring to." She opens up her leg, and there's labia still stuck up to the thighs. And he said,

“What day of surgery is this? What is this?” “Well, the surgery was Monday.” “Monday, Tuesday, Wednesday, Thursday. What time did we do it?” “Thursday, after, Thursday morning.” “They need to stay in there four more hours.” And he says, “Bob, you come back four hours from now and take those stitches out.” She thought that was wonderful. She thought that was exactly what that was. And so I learned to roll with problems, don’t say, by god, there’s a big problem here.

THOMPSON: Well, that is a good one. And it isn’t what a lot of physicians do nowadays. You’re lucky sometimes if they talk to about what their problems are.

CAPEHEART: Well.

THOMPSON: My children, a story, I had my oldest one with me when she was about eleven. Went to the doctor and I told him what was wrong with me, and he said “Yep that sounds about right, yep, yep.” Then we started on this long, elaborate discussion about searching because he was an extremely fine searcher of the literature. And do we had this long discussion about surgery, about searching. So, we get done. I go outside. I pay the lady. And we’re walking out the door, and I could see that my oldest child had this real puzzled look on her face, and I said, “What’s wrong?” And she said, “Dad,” she said, “how come you paid for that visit?” And I said, “Well, he took care of me, hon. Why wouldn’t I?” She said, “Well, you spent more time talking about how to search than he did treating you.” She said, “So why are you paying him?” And I said, “That’s just the way it’s done, hon. That’s just the way it’s done.” I said, “I’m an unusual patient in the fact that I normally go, I say what’s wrong with me, I get them to do what I want them to do, and then I move on.” I said, “I don’t spend a lot of time there.”

CAPEHEART: Someone that you might enjoy speaking with is Steve Gawey.

THOMPSON: That name hasn’t come up.

CAPEHEART: Well, Steve is, he’s probably in my opinion, currently the best internist in town today. He’s the son-in-law of Dick Marshall.

THOMPSON: Oh, okay.

CAPEHEART: And he is in a concierge type practice. He does not use electronic medical records. He does not, he is not tied in with any programs or anything such as this. You can see him, if I called right now with a problem, he’d see me today. And he spends as much time as necessary with you. And he limits his practice to so many number. And he’s left traditional practice and went into a concierge practice where he’s not behold to any insurance company or plan or anything such as this. Everything is between you and him.

THOMPSON: Interesting.

CAPEHEART: He would be a good person for you to speak with.

THOMPSON: He would be.

CAPEHEART: Steve Gawey. He's over in St. John's. Over there where the physical center is.

THOMPSON: Physical center.

CAPEHEART: It's on the third floor there.

THOMPSON: Well, are there any other comments that you would like to make?

CAPEHEART: No.

THOMPSON: Well, it's been a pleasure.

CAPEHEART: Well, thank you.

THOMPSON: And I appreciate it. You brought a perspective that we've not heard before. So I think that's great to this project. It adds greatly to do it. We appreciate you being willing to come in.

CAPEHEART: The, to me, the people that have really shaped this community is C.T. Thompson, Bob Block, Dan Plunket, and probably the internist—what's his name?

THOMPSON: Dan Duffy.

CAPEHEART: Dan Duffy. I don't know much about Dan. I don't, we've, I know him when I see him, I know him to speak to him, but we are not real social together. Probably him, Lapolla, and Thurman.

THOMPSON: Yes, I think it's interesting that Dr. Thurman had such an impression on this but actually was working out of Oklahoma City. And I think it's interesting. But then when you hear how he got his medical degree, it became a little clearer to me about why this had a warm spot in his heart and why he really wanted it—he went to a two-year medical school, then had to go to another medical school for his clinical years. And so this wasn't so different to him as it was to a lot of people when the school got started up here when I first arrived in 1976, so.

CAPEHEART: You said you've spoken with C.T. Thompson?

THOMPSON: No, we have not. He is one we have yet to interview.

CAPEHEART: He's one, he has an interesting background. He went in the Navy, and I think he was a corpsman in the Navy. And then he, because, and here things get fuzzy, he got into a medical program somewhere and eventually was accepted or transferred to Harvard. And he graduated from medical school at Harvard, but it was not the classical way you go. It's, his degree, his medical degree started going into the Navy from Louisiana, went into the Navy, being a corpsman, and then something happened and he then went to Harvard and he graduated from Harvard.

Well, thank you all very much.

THOMPSON: We appreciate it. Thank you for coming.

End of interview.