Upholding the Hippocratic Oath: A story of medicine in Tacoma and its fight against AIDS

Interview Transcript

Joshua Wright: Alrighty, so we'll try and get it started here. I'll just scoot close if you don't mind.

Dr. Peter Marsh: Sure.

JW: Um...So again thank you again for taking the time to sit down with me. This is just me speaking, it's not necessarily an obligatory opening to my interview.

PM: Yeah, no it's fine!

JW: So thank you again, I appreciate it. Um, so yeah, so I'll warm up with some general easy questions and then we'll get into more kind of, uh, your history with Tacoma and, uh, your experience with medicine.

PM: Sure.

JW: So, first things first, where were you born?

PM: I was born in Chicago.

JW: Chicago, alrighty. And, um, were your parents originally from the area?

PM: Uh, my mother was originally from Chicago, my father was originally from Pittsburgh.

JW: Pittsburgh, ah, very cool. Just going so I don't lose track of things. Um, do you have any siblings?

PM: Uh, I have one living and one who passed away.

JW: I'm sorry to hear that. Brothers, sisters?

PM: Two brothers.

JW: Two brothers. Wow. Were you guys like pretty close together in years or spread out?

PM: Uh, the one that's living is a professor at a university in Sydney, Australia, and my younger brother was 8 years younger.

JW: I see, I see. I'm jealous, I'm an only child. That's why I have all the toys and all that but I don't have fun, chaotic memories.

PM: Well, yeah. You really need two people to make fun of your parents and do it properly.

JW: [Laughs] That's why I plan on having more than one kid, that's for sure. That's for sure. Um, so where did you complete your undergraduate degree?

PM: Uh, I did my undergraduate at Indiana University Bloomington.

JW: OK, what did you study there?

PM: I was a zoology major. And this is how old I am; I am so old that when I went to Indiana University, Bobby Knight had black hair. The basketball coach, you know Bobby Knight? And Mark Spitz was my fraternity brother. The famous swimmer?

JW: I haven't heard of the swimmer.

PM: He won six gold medals in the Olympics, I think it was the Mexico City Olympics. The most swimming medals anyone's ever won.

JW: That's incredible. It would be so cool to be so close to somebody who did stuff like that.

PM: Well, yes and no. It turns out Mark had no detectable personality. So other than being a great swimmer, there wasn't much there. But, he was a great swimmer.

JW: [Laughs] That's very cool. So now kind of what got you interested in medicine. Was there maybe a community member or an elder who influenced you or inspired you in some way?

PM: True story, as a 10-11-12-year-old, I used to watch a series called Dr. Kildare. It was a black and white set of movies—a whole series of movies—starring Richard Chamberlain and everything he touched turned to gold. I mean his patients all got better, the women he met were all beautiful, and everybody was happy when he was done, and I said, "That is just the coolest job I ever saw. So, I'm going to grow up and be a doctor." The town I lived in in Indiana was so small we didn't have a doctor, in the town. Now, I didn't know a doctor, I didn't know anything about it other than saying, "I want that guy's job," and I never waivered from that. The more I got to know about it, the more I liked it but that was—believe it or not—the starting point: was a little kid looking at a television show and saying "Wow, I want that job."

JW: I love that question. Whenever I meet doctors, I love asking that question. Um, so you completed your undergraduate degree outside of Washington State so, if I may ask, did the idea of opening your own practice attract you to Tacoma?

PM: No. When I finished my infectious disease fellowship in Boston and started looking for a job, there was a fellow here named Allen Tice who was the first infectious disease person in Pierce County—ever—who was working here and he had trained at the same place I trained. We didn't know each other, but we knew the same people. So, when he heard that I was looking for a job—sort of through the grapevine—he called me up and said, "I'd like you to come and interview," and I said, "It's too far from Boston," and he said, "Well, I'll buy you a free plane ticket." I said, "For a free plane ticket I'll come interview." And my cousins at the time owned Ski Acres, Snoqualmie, Alpental, all of the ski areas up there. So I had family nearby, so I thought, "All right, you know, family nearby, he's gonna buy me a ticket, I'll come take a look." And I found a guy who was absolutely buried in work, I mean buried. Uh, he gave me the worst offer of all the places that I looked at, but I sure could look down the road and say, "This is a beautiful area of the country that has great potential, so I'm going to come anyway. And if it doesn't work out, I can pack up the car and drive back."

JW: That's quite a journey.

PM: It is a journey.

JW: Do you miss Boston?

PM: No. It's a wonderful place to train but it's not a great place to live. The cost of living is very high and the pay is very low. There is a Harvard doc under every rock so many people take jobs in Boston that they wouldn't consider anyplace else just to stay in Boston. And while I liked it, I didn't like it that much.

JW: And so when you came here you were specializing in infectious disease?

PM: Correct.

JW: Um, so now we're kind of jumping to a bigger view of time here. So, out of all the years you've spent in Tacoma, are there any moments you can recall where, say, a physician figure shined the most? And that can be limited to, say, you're specialty or even just all of them.

PM: Yeah, I don't know about a particular—I mean. When I came to this city, there was sort of a frame shift and—if I can put it that way—prior to my being here, this was a town that was primarily doctored by primary care physicians with very little specialty help. And starting with my partner—my first partner—who started two years before I did and continuing for the next five to eight years there

was sort of a tidal wave of medical specialists who came. Many of them had been here coming through Fort Lewis when they were in the military. And when they got out of the military decided that this was a beautiful place to live and came back. So, the level of competency and excellence in the specialty community took a giant leap forward with this whole group of people coming in basically in all of the medical specialties. And we had fabulous people in really just about every medical specialty you can imagine, and it was far better than we deserved to have for a city this size. And I think Madigan's the reason. I don't think we would of had that without Madigan but it was a fun thing to come in to because we were all kind of new to this area, we're all starting out our practices, we all met each other in the hospitals and worked together. And it was just very hard work but really a lot of fun.

JW: Very cool. Especially like you were saying, in an area that never had it before, to start something like that. That'd be really cool. I think it would be a moment that I'd be proud of. You definitely took a huge part of Tacoma history, when it started.

PM: Oh, big time.

JW: That'd be very very rewarding. As you can tell, I kind of alternate between black and red text and my red are kind of my backup questions. So, I kind of pick and choose as we go along here.

PM: Sure.

JW: So, let's see, do you have any memberships in Tacoma that are not related to medicine?

PM: Well, I am a member of the Tacoma Country Club—golf club, and I also live there. Um, for years I was a member of the Pantages Board—the theater board—so I used to things with that. I was at one point a soccer coach for my girls' soccer team. If you go a little bit further, I'm a season ticket holder for the Seahawks, I'm a season ticket holder for the 5th Avenue in Seattle, and those sorts of things. I am a commissioner for the Medical Quality Assurance Commission for the state. Um, I'm the president of an investment club. Let's see what all I do; I think that covers most of it.

JW: That's awesome. You're really diversified there. You just enjoy getting your hands wet in everything?

PM: Yes. I'm what you would refer to as a neophile.

JW: Neophile?

PM: Right? Neophobes are people who really don't like anything that's new so I'm the opposite.

JW: Yeah, I'm kind of along the same lines and my parents are worried about that because I like jumping into a lot of things but.

PM: No, it's great!

JW: Um, alright, we'll skip that for now. Now, when I was kind of preparing for this interview and also working for, like, a larger healthcare entity in Tacoma, I was reading up on some Puget Sound Business Journal articles. I don't know, is there—I guess you could say—kind of behind the scenes competition between some of the bigger healthcare businesses in the Puget Sound?

PM: There has been a competition between St. Joe's and Tacoma General since both hospitals were built that will go on long after we're all gone. And that's normal, natural—and frankly—I think good for the city. You always—I think—end up with better quality in any product or service if you have competition, so that's a good thing. Sometimes it ends up in costing money that probably shouldn't be spent. You know? It makes sense for one hospital, not both, to have a dialysis unit. It makes sense for one hospital, not both, to have a burn unit. And if they were able to play nicely in the sandbox, they could sit down and sort of divvy up services and one do one and one do the other, and it would be a lot more economical, efficient way of doing things but they're too competitive for that. For example, trauma in the city—there is a trauma service—and it moves back and forth between the two hospitals.

JW: Right. Every week is it?

PM: Right. And the reason it's that way is because neither hospital wanted it because it doesn't bring in any income; but, neither hospital wanted the other to have it. So that was the compromise that they arrived at, so that neither one of them could claim to be the trauma center.

JW: I was curious about that because I've had some experience in the emergency department and I was like "Wait a second," they are shopping back and forth but I thought—kind of—you know, especially since they've been building buildings everywhere, constantly following each other into new areas that, um, you know? I don't know. It was just an interesting bridge which I didn't anticipate.

PM: Well they just decided that they could cooperate on something that doesn't make any money.

JW: And as of late, they did some partnership to change Allenmore hospital into a mental health facility or something like that?

PM: I don't know anything about that.

JW: I heard some talk by the CEO of MultiCare.

PM: Well there certainly is the need for a mental health unit in this city. Uh, they have one up here at St. Joe's it's not very large; it wouldn't surprise me if there was room for another one. The other problem is that we are now in an age of contracts and some of these contracts are exclusive contracts so if you're a Premera or you're a Regence or—whatever—and you have an exclusive contract with one hospital system over the other the expectation is that you will be able to provide all of the services that need to be provided and that would have to include mental health. So I could think of a couple reasons why that could happen.

JW: I was curious to ask a physician, so you were saying that when all the specialists came to town it was all at one time. If there was already this kind of pre-existing competition between MultiCare and the Franciscans, what kind of atmosphere did that create for all of these new specialists that were coming to town?

PM: It was fabulous, because we were all part of the hospital staff of both hospitals so both hospitals had to woo us and try to get us to put more business into their institution and we could sort of play one-off against the other. And if you got mad at one you could always go and move your feet. So it was a perfect situation for the docs, as long as you're on the medical staff of both places and everybody was.

JW: Do you think that's changed now?

PM: Completely. Completely. Probably ten years ago, uh, as part of a phenomenon that happened nationwide, the hospitals hired their own inpatient teams—so called hospitalists—who essentially provide all of the inpatient primary care in the hospitals and as a consequence, all of the—and then hired primary care doctors to man their clinics—so all of a sudden everybody was an employee, right? Uh, and the guys who ran the clinics never walked in a hospital door so the people that provided the primary care in the community all of a sudden were unknown to the specialists because you never saw them. So people—even now—I have patients ask me "Who is a good primary care doctor in the city," and the answer is "I have no idea," because I don't—I know who are good hospitalists because those are the people that I see while I work in the hospitals, but the people out in the clinics, you never see them. I assume there are some good people there, I just don't know them.

JW: Right.

PM: So the hospitals have sort of pretty cleverly divided the city in half and you're either a Franciscan patient or a MultiCare patient. And because the

systems don't talk to each other very well, you're probably better off choosing one or the other rather than trying to move back and forth. Where in the old days you could move back and forth easily, it didn't matter.

JW: That's very interesting. That was something I came across in my readings and kind of the initial thoughts I've gathered from my experience. I don't know; if you look back—you know—a few hundred years when the hospitals were first starting here and the way that physicians were talked about and everything, I got this idea that physicians were kind of highly respected individuals in society. Being a doctor was a societal figure, someone to look up to, and it's been very interesting with the whole business model of healthcare. I don't know I just feel that that—I don't know how you would phrase it—the position that physicians once held has been absorbed.

PM: I don't actually think that's true. From what I've read from surveys as far as what professions are respected and which ones aren't and—you know—personal injury lawyers, used car salesmen and insurance salesmen are sort of on the bottom and judges and doctors are pretty much at the top and everybody else is in between. So, I don't think, I don't think there has been much slippage and the fact that you're somebody's employee doesn't make you less responsible, uh, and doesn't mean that you're going to do any less good a job of taking care of people so—I would hope that's true, at least—I don't see it. I don't think that that's an issue; hopefully it won't ever will be. Now, maybe you have some survey information that I'm not aware of.

JW: No! I'm just putting it out on the table.

PM: Now, if you listen to doctors; doctors are like everybody else, they always complain about their jobs, right? They're working too hard and they're also like employees everywhere. So, if you're employed by somebody, there's always something about your employer that you're unhappy about. I don't care who your employer is—unless you're the employer, right—so you will hear some pissing and moaning from the docs about it not being like the old days. Uh, but I think it's their perspective—not so much the patient's perspective. At least that's been my impression. Now, I'm independent; I'm not employed by anyone, so it makes it easier for me—you know I discovered a long time ago I was much happier as a chief, than I was as an Indian.

JW: [Laughs] Um, let's see. Since we're kind of on the topic still. Do you think that medicine is slowly transitioning to, say, a privatized business over patient care?

PM: Well, it can't be privatized sort of by definition because so much of it is government paid for. So, I think it's turning more into a government business, rather than a privatized business. Um, with the cost of health care at a different rate than the cost of inflation—and by that I mean a lot higher—um, you're going

to have to look for cost efficiencies in order to make it possible to keep delivering care. So, in that sense we need some business goals—I think part of the problem was there weren't enough business skills in medicine and everyone is trying to do everything all the time, even when it didn't make any sense to do it. Um, so hopefully little by little things were improving in that regard.

JW: Do you think that there is a certain line that shouldn't be crossed?

PM: Well, you're always looking out for the patient's benefit but who was it—I think it was Ronald Reagan that said "Doing the right thing isn't difficult, knowing what the right thing is is difficult." So we will always have to make choices. One of the set of choices I've seen in recent history was the list of things that Oregon made for their DSHS equivalent—whatever they call it in Oregon—uh, and they made a list of diagnoses of things that they would cover down to a certain level and there was a line. And everything below that they wouldn't cover. And I looked at the stuff below that—genital warts, you know—things that were maybe unpleasant but certainly weren't life threatening or, uh, necessarily compared to heart surgery really needed to be done. I said "You know, it's not such a terrible thing to have a list." And say these are the things that have to be. This state—in my opinion—is a little strange because at one point we had an insurance commissioner who managed to get through the legislature bill that required coverage of all alternative therapies, whether you wanted to buy that coverage or not, and it still exists on the books. So, every insurance company in this state is required to cover all forms of all alternative therapies. That's a little—that's not really cost effective.

JW: Yeah, I was just kind of—I mean it's—as much as I'm a history student and just someone who is interested in medicine, I just love hearing a physician's insights.

PM: It just doesn't make any sense.

JW: I just—you know—I've found it interesting, I have learned that now, I'm just trying to find and figure out where those lines should be drawn because of course a sustainable business vs. patient care and I'm learning that physician compensations are being directly tied to blood pressures of patients for hypertension.

PM: I don't think that's a terrible thing; that there's quality measurements. Quality's a very difficult thing to measure. You sort of know when you see it but to measure it in some way that you're going to link somebody's pay to. You have to make sure that you're doing it correctly, uh, and it's a very slow incremental process—sort of painting a picture—as far as what quality looks like, and of course it's going to be different for every specialty. Uh, but personally I don't think that it's such a terrible thing. Physicians have had their pay cut significantly from what it was ten years ago. I think in every specialty everybody is making 25-

30% less—at least, if not more—and you just have to sort of suck it up and get used to that. That's just, that's just the reality of the world; however, if you still love what you do, so what?

JW: Yeah, that's kind of the way. Every job has its pros and cons. You just got to accept that if you want to go into it.

PM: Yep.

JW: Um, let's see. How about a change of pace here. I thought this was interesting. I was diving through the Northwest Room in the Tacoma Library, looking at old news clippings from like 1970's and articles about excluding students for not being up to date on their vaccinations. And there's been this recent—kind of—phenomenon about parents not having their kids vaccinated and I thought it maybe was a question to ask someone being an infectious disease specialist or just a physician in general. So how do you manage a patient when a family wishes to not vaccinate their child?

PM: Well, understand that it's primarily a pediatric or primary care question you're asking. So, as an infectious disease specialist of adults that's not a question that very often comes to me. Um, I do talk to people about getting flu shots every year, and there are a few numbskulls that don't just don't want to do it because they believe in vaccinations, but not very many. And once they've have had influenza once, they never argue the second time. Um, and for most other vaccines I don't get too much disagreement from the adults. But as far as kids, I don't think they should be allowed to go to school if they're not vaccinated. It's not just about protecting them, it's about protecting other kids.

JW: Exactly. Um, let's see. So, do you—let's see here. What was it like when AIDS hit Tacoma?

PM: Horrible. Horrible. And it wasn't any different here than it was anyplace else. Well, that's not true. HIV and the Pacific Northwest, it was primarily a disease of gay men. HIV and the east coast, it was primarily a disease of IV drug abusers. So we had two different subpopulations depending on which coast you were on. But, from an infectious disease doctor's standpoint it was like going from an infectious disease specialist to an oncologist because I knew all my patients would die. The success rate would be 0, and I could do things to help them with some of the complicating illnesses that came along with HIV but I couldn't do anything about the underlying problem. And so I ended up seeing these young men—year after year after year—waste away and finally die. Uh, and it was horrible. I had a couple of hemophiliac brothers—they were twins—and hemophiliacs have to get blood drawn in order to keep from bleeding to death and they had the misfortune of working for a company where they were transferred to San Francisco. Of all the cities in the nation you wouldn't want to be transferred to during that period of time would be San Francisco. And so they were both

infected with HIV from blood product before anybody even knew about HIV and I got to watch them both die. It was just awful. And then, the 90's come around and all of a sudden these drugs appear that actually work. And I remember my very first patient who I started on this therapy—he was a grade school teacher—very, very nice fella. So—I mean—that's a huge, huge deal. And because it was primarily a disease of gay men in this part of the world, who most of them were very compliant with their medications and very interested in getting better, we had great success with them. So, it went from being a horrible disease to a wonderfully treatable disease. And I don't know of any HIV patients that are sick, not a single one.

JW: That must be incredible.

PM: It's great, yeah.

JW: Was it just a complete feeling of being powerless?

PM: Oh yeah. Like I said, it was like being an oncologist where you had nothing to offer. There's a reason I didn't go into oncology.

JW: Yeah, I think there's a reason most people don't go into oncology. That must have been really neat to experience.

PM: Yeah, it was wonderful; it was great.

JW: Did you, um, one of the other newspaper clippings I came across was the community task force for AIDS. Did you ever hear about it?

PM: Well, ultimately there was the AIDS foundation that sort of evolved out of that but yeah. I think there was a—it was probably run by the health department. But I don't know how effective it was at actually accomplishing anything. I mean people were able to sit down and share ideas and experiences and research and that sort of stuff. But, in the final analysis I don't know how much it did that was actually helpful.

JW: I see.

PM: There just wasn't much to do that was helpful before effective drug therapy became available.

JW: So because there are drugs now but also more education in everyday citizens, do you see a huge decline in cases you see?

PM: The number of new cases that we see has declined precipitately but unfortunately it's not zero. So there's still people that are badly behaved out there, that know better. Uh, and you see more of that with the IV drug abusers—quite

honestly—than you do with the gay population because those folks are not very responsible to begin with so why would you expect them to start acting responsibly now.

JW: Right, right.

PM: And a much more difficult group to take care of.

JW: Yeah, and that was one thing I was hoping you would lead into. I was going to ask you about, um, just with IV drug abusers.

PM: We—as in our practice—refer most of them to the community clinics. First of all they have more services available for people that have problems with IV drugs, uh, and we're already so busy that we're going to spend our time and resources with people that want to get better and who are compliant with their treatment.

JW: I see, I see. That definitely makes sense. Um, let's see here. So again, jumping to a bigger scope. So, someone who is obviously interested in the welfare of their community, what does having a successful practice mean to you?

PM: To me—I mean that's an interesting question because it's probably a different answer for every doc. Uh, for most people I suppose it must mean that whatever hours your clinic is open it's full and you have lots of patients to see. Uh, that you have a staff that you enjoy working with. Um, and at the end of the day you feel like you've done something worthwhile. So, if you can—you know—do all of those things, then I think it would be—for most people—considered successful. For me personally, I discovered that I needed some things out of just day to day clinical medicine in order to make life a little more interesting. So, I was president of the Pierce County Medical Society and moved up the chairs there; and then I was president of the Washington State Medical Society and moved up the chairs there. And so that added a little different dimension, uh, to what I did in addition to clinical care and it just made life more interesting and I sat on the board of Physician's Insurance—that writes most mal-insurance for docs in the state—for nine years. And now I'm a commissioner for the state so I always like having something on the outside—kind of—interesting going on in addition to my clinical work.

JW: Right, right. Is it possible that you can, um, describe some of the things that you did while you were at the Washington State Medical Board.

PM: Um, at the county level it's probably 80% community service and 20% political—where you go down to Olympia and try to push bills through that should go through and stop bills that shouldn't. When you go to the state level, then it flips—and it's probably 80% political and 20% community service and there we spend a lot of time in Olympia educating the legislatures about why

something is a good idea or a bad idea, uh, and seeing if we can influence their vote.

JW: Sounds like that would be frustrating at times and very rewarding at others.

PM: Well, it's always interesting. And—you know—like anything else, sometimes you're successful sometimes you're not. Um, and then for Physicians Insurance that write the med mal-insurance; you can't practice without med mal-insurance. So we all have to have it. Uh, and I was in charge of their investment committee so I would—you know—managing $300 million of other people's money, I found pretty interesting. Um, but the casework as far as medical malpractice suits—how you defend them all—the ins and outs of running a med mal-insurance company was very very interesting.

JW: Let's see here.

PM: You're running out of boxes.

JW: [Laughs] No. I mean there was no set agenda. I had no idea where it would go. Uh, I was talking to Dr. Sullivan about this. You know—because our interview had gotten so far back and—you know—I was like "Maybe I can just start on just some community history research and stuff." And he said "Go ahead, but you never know where your interview is going to go."

PM: Someone's probably talked to you about this but as far as community history, Tacoma is an interesting place in the sense that the first HMO in the United States aas here. And it was started by the railroads because they were concerned that their employees, um, were not getting as the quality of medical care that they wanted and that the cost of it wasn't what they wanted. So they essentially created an HMO and it became an organization called the Western Clinic, and it was the first HMO in the nation, right here in Tacoma.

JW: The longer I'm here—because I have only done my undergrad here—but I've lived in this state my whole life. Every time, I'm always amazed at how many famous things originated here: Mars candy [inaudible]. I'm never sure why so many big things came from this little area over here, it's really cool. And you're part of that history.

PM: We're all part of it!

JW: [Laughs] Um, so jump to today.

PM: Sure.

JW: Where do you think physicians are needed the most—I mean—part of the large conversation in Washington.

PM: Well, by definition, you need more docs per higher density population. Uh, they certainly need more primary care people—I suppose—in rural areas. They don't need any more specialists in rural areas because there wouldn't be enough work to keep them busy. Um, any time you have a place that is a quality place to live, a beautiful place to live, you're going to attract more docs. So docs tend to want to go and—Seattle is the most attractive city in this state to most docs—so it's going to draw the most people to it. Um, Tacoma isn't as attractive—but is still very attractive, so it'll draw a lot of people here too. So, it's difficult to distribute doctors based on need as opposed to distributing them where it's a nice place to live. One program that does work well is people who have public health scholarships—or scholarships of one sort or another—that can work off a percentage of that scholarship every year if they go to a designated shortage area. So that is a way to distribute them. Um, but how do you do that long term and what's the best way to do it? I have no idea. I certainly didn't come here because I thought there was a shortage here, although there was. Uh, for what I do, two of us managed to do what six of us do now. So, clearly there was a need for what we do; uh, but I would guess we need more primary care. You know? I also think that PA's and nurse practitioners will do a higher percentage—every year—of primary care than they have in the past. Because for the routine day-to-day sort of things, I think they are very qualified and competent to do it.

JW: Yeah, I've come across that and I've heard about it from people all of time. It's one of the things medical schools ask you about. Um, and I've witnessed that quite a bit before. Yeah, I don't know; that's one of those things I think is interesting and I think communication with rural parts of Washington State—I think that it needs a lot more interaction?

PM: Not everybody wants to live in a rural area though, you know? If you are a child of the city or even the suburbs, uh, going to east cupcake is not your cup of tea.

JW: Mhmm, yeah. There's a definite trend like with students who go to WSU; [laughs] they come home on the weekends, you know?

PM: Right.

JW: I think that's a big problem that needs to be solved but it's hard because that's the first thing that comes to my mind as well. Just places that are attractive to live. That's where all the physicians are going to be, naturally.

PM: Yep. One thing they are doing on the East Coast that to me is sort of interesting. One of the big pharmacies—more on the Eastern, not so much here—is CVS; and CVS is setting up clinics staffed by nurse practitioners that are sort of walk-in clinics where people can go in—it's not for long-term care—but it's for acute problems. Uh, and particularly if you're a young family with young kids,

there's lots of acute problems and it's a way to get people in and seen quickly, relatively inexpensively and taken care of. So, there's always room for innovation.

JW: So, this will be a fun one. Where do you see medicine in the next 50 years?

PM: Um, where do I see it headed in what category?

JW: Um, I would like to open that up to you. Um, I think with just perhaps the role that physicians will have in communities, uh, or—I don't know—because I just felt that in some respects the role physicians play are changing and adjusting to the whole HMO organization.

PM: Well, what's happening internationally is that countries are developing two track systems. And there's a private track and a public track. And the public track is available to everybody, it's paid for with government dollars and there's a certain basic level of care that everybody can get and is paid for by the government out of our tax dollars by the government. And that's true all over Europe, for example. Uh, and then beyond that if you want to go to specialty hospitals—private hospitals—for a different level of care then you pay for insurance to provide that—and sometimes you pay a lot of money for that insurance to provide it and it wouldn't surprise me if we move closer and closer to that sort of a system here.

JW: Maybe we will tackle some of these red questions here. Um, so being that you're closer to retirement and looking back at your career—in your eyes—what are some of the highlights?

PM: The things that I enjoyed the most were the interaction with my staff and with my patients, you know? And in my particular specialty we get to cure people. And that's relatively unusual in the internal medicine specialties, you know? If you're a cardiologist or a diabetes specialist or a kidney specialist or whatever, you do lots of very wonderful things for your patients but you rarely cure them. Where as in what I do—if I do my job correctly—90% or better, uh, of the patients I see I actually get to cure. Uh, and that's really fun.

JW: Is that what attracted you to infectious disease?

PM: Yes, yeah. I like the intellectual challenge because—to a large degree—we are kind of medical detectives; people send us patients, they just can't figure out what's wrong with them. They have a fever but they don't know why. Uh, so they don't know what it is or what to do about it, and we have to kind of unravel the mystery. So, I like that part of it but I also like the part that when we discover what it is, in most instances we can cure their problem. You can't get much more fun than that. Surgeons cure people all the time, right? You have a problem,

surgeon cuts it out, problem's gone. Medical doctors don't get to do that very often, but we do.

JW: Could you see yourself doing anything else?

PM: No. I'm perfectly situated for what I do.

JW: That's awesome. Uh, one interesting thing—because whenever I come across some kind of survey that they took from physicians nationwide, I keep a copy. I thought it was interesting—so the majority of physicians included in this particular survey—they do it every two years, they include about 15,000 physicians and, um, more than half of them said that they would not recommend to—as an occupation to someone—I don't know if it was necessarily their kids or anyone in general but more than half of them would do it again. They would become a doctor.

PM: That's an odd dichotomy isn't it?

JW: Yeah, I didn't get it. I just stared at that for a good two minutes and then I sat there for about ten minutes and I still get why that was.

PM: Well, I wouldn't change it. Like I said, I'm perfectly situated for what I do. I can't imagine a profession that would suit me any better. It's unimaginable. As far as recommending it someone else, the number of years and the amount of time and effort and stress involved in getting to the point that you can do what I do or what other docs do is a lot. I mean you essentially give away your twenties. Other people are out living life and experiencing things as young adults. You're nose to the grindstone, working hard. And that's a big sacrifice so people need to understand what the sacrifice they're making in order to get there. But if they're so fascinated by what they're doing, at the time it doesn't seem like a sacrifice.

JW: Yeah, I'm done with my questions but I'd like to keep this going because I like to get your insights on things.

PM: When my children were little and they drove past this building they said, "Gee, that's where Daddy lives." That's kind of pathetic. So I hope that changes and I think it has. I think younger physicians coming out now are willing to take a pay cut in order for a better lifestyle and more family time and I think that's healthy; that's a good thing. Probably a lot fewer marriages will break up if they are able to continue in that way.

JW: Yeah—you know—kind of going back to what you were saying, I'll agree with you. You have to really make sure this is what you want.

PM: You gotta love it, you know? I mean it's a decent income but you can make a decent income doing lots of things. So, that's not a reason to do this; it's too hard.

JW: I throw people curve balls because I'm officially a history major but I'll be applying to medical school with that degree. Um, part of me starting the whole journey to consider medicine was—of course—being I'm half Filipino and half American. My father's American and my mother's from the Philippines. All East Asian families just want their kids to become a doctor. So, I said "You know, you guys gave up everything to come here to give me the opportunity to do more, so the least I could do was take a few classes. In high school I struggled in chemistry and all this and that; but when I came here I found professors who loved chemistry and made it interesting—you know. I like all the sciences but I heard medical schools encouraged students to get a degree in something they like.

PM: As long as you get good grades in the sciences, they actually like it if you're an English major, a history major, some other kind of major besides biochemistry.

JW: As you being a physician, um, I'm just curious so see what—if someone does balance out their education—how are they going to benefit?

PM: It makes you a more complete person—certainly a more interesting person. Uh, the more things that you can take outside of the sciences where you'll never get another opportunity to do it. I mean I took courses in Shakespeare, I took courses in comparative literature, I took course in political science, I took courses in philosophy, I took courses in mythology. And I'm glad I did all of those things because you'll never have another opportunity in life to do it. And it just makes you a more complete person, a more interesting person, I think.

JW: Do you think that—perhaps—a lot of physicians at least in their undergraduate education lack that?

PM: Um, some. I think it varies from person to person. If you look at some other countries and the way they educate their doctors It's a six year program, uh, where medical school and university are sort of combined into a single thing and they have much less time to do all of these other things that I was talking about. I just think it makes them less interesting, less educated people.

JW: I think it'd be really great to study humanities to balance everything out. I think that it's helped me personally build a connection with the idea, like, treating community rather than a clinical mindset and science being a problem and solving a problem and more of a fulfilling hope for your future as a physician.

PM: Well, I don't know about that but it should certainly make you able to express yourself both in written and verbal form. If you do the things that you

need to do in humanities courses, you need to learn how to write. Uh, you won't learn that in a pre-med curriculum. And yet communications is a very important skill and in the humanities is where you learn to do that.

JW: Well thank you very much but I think I am processing things as we go along. Sometimes I felt like I was jumping around but I'm actively processing things as we go along here. Are there any other areas that we haven't covered in our conversation that you would like to—?

PM: I think we've covered most of the highlights really and sort of a brief—at least—history of what's happened in this community over the last 30 years, which is an interesting phenomenon, I think.

JW: But as someone who is ready to retire—

PM: Now you're making me feel really old.

JW: [Laughs] Let me rephrase that. Um—

PM: No, I'm kidding you, sorry; it's OK.

JW: Do you think there are big changes coming?

PM: I think life has changed. And you learn to adapt to change or life isn't going to be very good and some changes will be good and some changes not so good. But like it or not, you need to learn how to adapt because, life is going to change. For people in your age group who are tech savvy, life is a whole other experience. You guys are—with mobile phones—and you do everything through them practically while people my age don't and I can see the difference between my kids who are able to pick up all this stuff very easily and old people like me who don't—so that's certainly a big change.

JW: That's kind of one of the things I was curious about was, uh, the way that you think medicine is going to go because you now have virtual doctors.

PM: Telemedicine, virtual doctors, all of these things will become more a reality for everybody's life and whether that's good or bad I don't know but it's going to happen.

JW: Do you think that's going to answer the whole rural medicine—?

PM: Uh, it might help it from a specialty standpoint; there's certainly some types of specialities—I think that can be done—I mean pathology, radiology, they're obvious examples where you don't need to be present. So less obvious examples like dermatology, where you can interview a patient. And then there are things where there are nuances and ways you can communicate with patients:

their body language, their facial expression, their tone, that's more difficult to do—I think—in that sort of format as opposed to face-to-face interaction. And it's pretty hard to operate on somebody. Although they have talked about operating robotically, I don't think that's ready for primetime yet. There's work to be done, and then I think it will be.

JW: Yeah, sorry I can't miss up on an opportunity. I came across an article that—I think he's an Italian physician who wants to do the world's first head transplant. I think that's kind of weird.

PM: Head transplant.

JW: Yeah [laughs].

PM: Dr. Frankenstein.

JW: Yeah, that's always the number one answer.

PM: Well, Walt Disney's head is frozen somewhere, hoping someone will do it.

JW: [Laughs].

PM: I wouldn't hold my breath for that.

JW: I know, it's pretty wild stuff. Let's see, I'm just trying to see if there's anything I missed—I don't want to take up your time.

PM: I do have to get back to work.

JW: OK, yeah. I think I've exhausted my questions.

PM: I think we've covered a lot of ground. So hopefully you can turn that into something interesting.

JW: Definitely. I'll take some time to process this and I'll be working on it. I understand you have a busy schedule but if I have any follow up questions—

PM: Oh, sure. Just call me. Nice to meet you.

JW: Nice to meet you, sir.

PM: Please say hello to Michael for me.

JW: I will. You have a great day now, take care.