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ORAL HISTORY

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Date 4 Oct 79

R M Kessel, M.D.
(Signature - Interviewee)

MU School of Medicine, Family Practice
Address

Huntington, West Virginia 25701

Date 10/4/79

Judy Walters
(Signature - Witness)

MARSHALL UNIVERSITY

ORAL HISTORY OF APPALACHIA

HUNTINGTON, WEST VIRGINIA 25701

The Marshall University Oral History of Appalachia Program is an attempt to collect and preserve on tape the rich, yet rapidly disappearing oral and visual tradition of Appalachia by creating a central archive at the James E. Morrow Library on the Marshall campus. Valued as a source of original material for the scholarly community, the program also seeks to establish closer ties between the varied parts of the Appalachian region-West Virginia, Virginia, Ohio, and Kentucky.

In the Spring of 1972, members of the Cabell-Wayne Historical Society joined with Dr. O. Norman Simpkins, Chairman, Department of Sociology and Anthropology, and Dr. Michael J. Galgano of the Department of History in establishing the program. The Historical Society and other community organizations provided the first financial support and equipment. In April 1974, the Oral History program received a three year development grant from the Marshall University Foundation allowing for expansion and refinement. In 1976, the program became affiliated with New York Times Microfilm Corporation of America. To date, approximately 4,200 pages of transcribed tapes have been published as part of the New York Times Oral History Program. These materials represent one of the largest single collections of Appalachian oral materials in existence. Royalties earned from the sale of the transcripts are earmarked for the continuation of the program.

The first interviews were conducted by Marshall University History and Sociology students. Although students are currently involved in the program, many interviews are conducted by the Oral History staff. Graduate students are strongly encouraged to participate in the program by taking special topic courses in oral history under the supervision of Dr. Robert Maddox, program director since September 1978.

The program seeks to establish contacts with as broad a variety of regional persons as possible. Farmers, physicians, miners, teachers, both men and women all comprise a significant portion of the collection. Two major types of interviews have been compiled: the whole life and the specific work experience. In the whole life category, the interviewer attempts to guide subtly the interviewee through as much of his or her life as can be remembered. The second type isolates a specific work or life experience peculiar to the Appalachian region and examines it in detail. Although both types of interviews are currently being conducted, emphasis is now placed on the specific work experience. Recent projects are concerned primarily with health care, coal mining, and the growth of labor organizations.

Parts II and III of the Oral History of Appalachia collection were compiled by Dr. Robert F. Maddox, Director, and processed by Ms. Brenda Perego.

Dr. Robert F. Maddox, Director
Ms. Brenda Perego, Processor

K.L.: This interview is being conducted with Dr. Ray Kessel, Chairman and Professor of Family Practoce at the Medical School of Marshall University. The date of the interview is July 27, 1979. My name is Kim Lady and I am conducting this interview for the Oral History of Appalachia Project of Marshall University. Okay, if you, like to tell me when and where you were born, a little bit of your family background, early education.

R.K.: I was born in uh, Charleston, West Virginia in uh, August the 29th, 1925. And uh, my father was a physician practicing in Charleston and both, uh, my parents were natives of Jackson County. I had two sisters and uh, went to, had my early education in Kanawha county and graduated from Stonewall Jackson High School. Had uh, my, and I went to college for a year at West Virginia University and then went to the service for three years and then went back to, the uh, University of Morgantown. Completed my degree and at that time we had a upsurge of people trying for medical school. I had to wait a year, I got a Masters Degree in, in zoology before I went to medical school. And uh, I went to medical school at Jefferson Medical College in Philidelphia, graduated in 1955. The uh, the Jefferson Medical College is known as Thomas Jefferson University, like all schools they become sorta sophisticated as the years go along. I had some post-graduate hospital training at Thomas Jefferson University and I came back to West Virginia in 1956 and uh, began to practice in Logan, West Virginia and practiced there until uh, 19-, well, full-time until 1976 and then part-time for a year and then came down here full-time as Chairman of the Department of Family Practice at Marshall University.

K.L.: What brought you to Logan?

R.K.: Uh, I preferred not to have a large town to practice in. I like the small town atmosphere, the identification with uh, with people, uh, (inaudible) the security of a small town from the standpoint of uh, your children had a lot more independence, you knew the people. Uh, it was uh, easier to get around and uh, less confusion. Uh, usually uh, the smaller the town the better quality of the individual. You don't get the melting pot of uh, the cast-offs. You get fundamental, humanistic type of approach to people.

K.L.: When you were, on your training, uh, did you specilize in anything or was it just general practice, family practice?

R.K.: Well, the old term was general practice and uh, this became a little more sophisticated as the time progressed to family practice uh, uh, like everything, to get a new image it uh, changes the name but we also change the quality of training. And uh, we belong to a, an organization called West Virginia Academy of Family Physicians and this is a, had a parent organization in the country, American Academy of General Practice at one time, then later on it was Family Practice. But they were, required that you had uh, in a period of three years, 150 hours of ongoing education. And this means hour for hour,

where they were sponsored by a medical school or an area uh, of uh, continuing education such as the State Medical meeting or a meeting of the West Virginia Academy of Family Physicians which had a good tutorial pattern of education. And as a result of that why (inaudible) had a tendency to keep up and if you didn't keep up you were dropped from the membership. So they uh, went ahead and devised a, an evaluation system that came about in 1970, of board certification for family physicians who had been in practice x number of years, say six years. Or who had completed two cycles of the educational requirement. This entitles you to take the exam. So um, if you uh, took the exam and were able to pass it you became board certified family practice. Uh, the examination was a two day cognitive exam that lasted three hours in the morning, three in the afternoon (K.L. Um.) two days in a row. That's kind of a ph-, cultural shock for an individual that hadn't taken an exam for about 13 or 14 years, to take it. And then after that uh, the family physicians were pioneers in the uh, with the idea of establishing an educational, continuing education requirement and of the hours like I mentioned, 150 hours in three years. But along with that, they had to uh, uh, be re-certified. And you had a sit-down exam every six to seven years after you were certified as a family physician, board certified, to be re-certified. So, we have to be cycled through and we have the competition with the um, or the doctors who are in practice have the competition with the young fellows who are in residnecy programs, or the young people. Because (K.L. Uhm, um.) about 20% of our members who are now becoming, are gals that are coming, going into our programs. That uh, will be able to uh, take these exams, re-certifing exams and pass them and we're in that competition with the younger age group so that, they are a little closer to the education hub (K.L. Right.) and uh, it gets a little more competition. And this is a pre-determined grade that you have to make before the exam is given. It's not a port-exam breakdown and things are scaled, but it's predetermined. If you don't pass the exam the first time you have an opportunity the second time, if you don't the second time, once you're certified, then you have to go back and take the original exam again. They give you that opportunity.

K.L.: I di-, wasn't aware family practice was that uh, I'm not sure how you'd say it. That there was that much of a standard with it. I was (Dr. Kessel interrupts)

R.K.: Well, they established a standard, of re-certification. They were the only specility that did. They were (inaudible), they came in, when they came to the specialty boards and they were accepted as the 20th specialty. And it is a different concept uh, um, the uh, we've got to be well grounded in basic fundamental knowledge. Uh, the primary subject is naturally internal medicine which I would say comprises 40%. Then you'll have to do obstetrics and gynocology which is probably another 20%. Then you've got pediatrics which comprises a, another probably 15 to 20% depending on the type of practice. Then you'll have your support things and your surgery. But surgery's

usually minor surgery, we, we had to, but we have to be diagnostic in ability in order to know where to refer and how to refer. And most people uh, will accept uh, the suggestions and advice of their family physician because, he really knows more, he or she knows more about them than anybody else.

K.L.: Is family practice uh, mostly predominant in the rural areas, such as in Logan county, or in the cities?

R.K.: Well, certain cities uh, the cities have become specialized since World War II. And this is why they're, in fact they've become over specialized. Uh, you have a doctor they, uh, that if you've got a stomach problem, you got a gastro-, gastronologist. If you've got a rectal problem you've got a proctologist. If you got diabetes you have a diabatologist. And we get sometimes too sophisticated because so many of these things can be handled by well-trained generalists. And this is basically what a family physician is. A lot of the talk now that exists about primary care medicine. Well, family practice is primary care. There's some fields such as internal medicine, general internal medicine that is primary care. General pediatrics is primary care. Now in certain areas where these things are lacking uh, obstetrics and gynocology is a primary care specialist and also psychiatry. And you see the family physician practices all of these. So, we are the primary care specialists. Uh, you asked a question uh, if it is in the city, there's not as much in Huntington per se in ph-, in general or family physicians as th-, as there is in smaller towns. And there's uh, the reason is I mentioned for that is the post-World War II boom of um, boom of specialized training in certain fields. And uh, now there's a resurgance that probably one quarter ot twenty, you know, 25% of all medical graduates are going into family practice and the governement wants 50% total go into family practice and to primary care specialists, specialties such as general internal medicine, general pediatrics. So, (K.L. interrupts)

K.L.: Why is this? Because (R.K. interrupts)

R.K.: The lack of it. People like to have their own uh, their family physicians uh, whether it'd be a uh, pediatrician that's it, a family physician, or general internist who's the family physician or the family doctor. Everybody be able, likes to relate to, well Dr. Jones is my doctor and I know him. He's got (K.L. Right.) two kids and uh, he goes to Catholoc church or the Methodist church. Or uh, his son's on the swim team and his wife is in the Garden Club.

K.L: There's more trust there if they know their family.

R.K.: Identification. Identification. The humanistic approach, the wholistic approach and they can kinda sit down and talk to him. And he knows what to do for me or to me, you know. These, these are things that uh, they're very important, they, the psycological effect of care for a patient as well as the pathology that

actually exists. Uh, you really don't seperate the two. The uh, psycopathology they call it sometimes and that's probably a good term. Uh, the old doctors referred to the, the somma and the psyche. Uh, somma being the body and the psyche being the mind. You don't seperate the two. (K.L. No.) And, if you were uh, if you don't feel good emotionally you might shed a few tears and feel bad physically. And, if you feel bad physically, emotionally you may get down. (K.L. Uhm,um.) But when you feel well both ways it's superb.

K.L.: Very true. Uhm, why did you, when did you first become interested in becoming a doctor?

R.K.: I, always wanted to be a doctor. Uh, I idealized uh, my father's activities as far as phi-, being a physician. Both of his brothers by the way were physicians too so, I've been very much involved in medicine, medical care all my life and uh, it's just been a thing I just really didn't consider doing anything else.

K.L.: Did you always want to work in a small community?

R.K.: Always liked a small town. Yes, it's uh, it's just fun. And uh, I, in fact when my wife and I were married we talked about places to live and, and I kinda pushed this idea with her which was quite acceptable to her. And uh, so this is why we ended up probably in a small town. The reason I ended up in Logan basically is my sister lived there. She was very instrumental in introducing me to different physicians who offered, wanted me to come in with them and practice and, and uh once we moved there we enjoyed the people. They were just down-to-earth, fundamental folks. We raised four choldren in the town and uh, I have really no regrets. Uh, worked hard and I was very, very much involved in getting a, a new hospital up there. Was on the Board, uh, as well the the Chief-of-Staff at different times and, we just had a lot of fun in the process of uh, rearing a family and practicing medicine.

K.L.: Was there a shortage of doctors in Logan county at that time? (R.K. Yes.) When you first began practicing?

R.K.: When I first went there, there was practically 30 doctors in the county medical society.

K.L.: What year was this?

R.K.: 1956. And, when I transferred from Logan county to Cabell county as far as medical membership there was probably, oh, twenty-five doctors in Logan, but most of them were foreign medical graduates. And, the foreign medical graduate uh, don't, not all of them fully uh, recognize and understand the intricasies of the Appalachian individualist, the uh, the sociological make-up, the psychological uh, involvement and uh, in turn it was a learning situation for each of them. And, we were, even with the number of foreign medical graduates we were short of physicians. So

uh, we haven't really had that many people from that area to get an education in medicine. So we figure that uh, long before Marshall was even established that we needed to have a medical school dedicated to primary care, family practice and have to take them from the area's that are in need, educate them, train them, then send them back or encourage them to return. And they have to have uh, the experience of a role model physician. (K.L. Uhm, um.) A community that uh, wants them and a community that they want and need. So, it uh, I've coined the term sev-, several years ago that it's a romance between the community and the budding physicians and what goes on. And they both have to have a courtship and, and a, a, a period of uh, of involvement so that both know what, the good, strong points the weak points and the fact that uh, they can be happy together.

K.L.: Do you, when you work in a small community, do you get much closer to the people?

R.K.: Oh, I think so. Used to be that uh, that no matter where I went, uh, which store I went into, uh, whether it was a grocery, a drug store, or a shop or restuarant uh, I knew most of who were there. And a goodly portion of them were patients of mine. A lot of times they talked shop which uh, might irritate some, but I really wasn't bothered about it too much. So, you do get very much involved, yes. Uh, you uh, get to know people extremely well. You get stuck for a lot of uh, responsibilities such as inspecting the jail on Sunday and uh, being involved with the team physicians for the local high school and trying to get somebody else lined up to take care of the junior high schools and, and uh, people involving you in church and activities, but this is something that uh, I think is a citizen's responsibility and they should get involved. Be a, a uh complete involvement. Uhm, um.

K.L.: When you first went to Logan um, you mentioned that you helped get a new hospital established. What type of facilities were there when you first went into the area?

R.K.: There were uh, two hospitals in the city. Both of them were propriatary, meaning private for profit. And they served an excellent purpose because there was no hospital uh, to give that service prior to that time.

K.L.: Were they the only hospitals in Logan county or (Dr. Kessel interrupts.)

R.K.: There were uh, two others. One uh, at Holden, a propriatary hospital which was quite old. And uh, the Appalachian Regional hospital formerly, at Mann, which was the former miners hospital. That was only 12 miles away, but as uh, as the buffalo travels the ro-, the roads on Rt. 10 go, it takes a half hour to 45 minutes to go to Mann, sometimes even longer now. But uh, both the hospitals physically were 50 plus years of age. So, as a result of that we had to uh, we were interested in getting the,

the transfer from a private hospital to community uh, not for profit hospital. And uh, it ended up we ran a bond issue and they borrowed some money and so forth and they were able to build a hundred and ten bed uh, modern hospital that was a good general care hospital. They had uh, mini-, largest number of people in one room would be two. And they had uh, bathroom facilities for each one and, and uh, it was really a, a very well put together building and uh, it uh, wnet to about 5 million dollars involvement. And we made a lot of trips and I had to go to a, to Philidelphia before the H.E.W. people and show our plans and reasons and rhymes for it. And it was kinda a fun thing because uh, it's like getting uh, all the to-, toys you need to do a job or the tools you need to do a job. Once you have them you can do a better job.

K.L.: Give you a sense of accomplishment to get something like that constructed.

R.K.: Very much so. For, for the community. Not from the standpoint of (K.L. Right.) person, but more for the community.

K.L.: Did you ever have trouble getting people um, in the remote areas into hospitals facilities?

R.K.: Definately. That uh, there's no good system we have at the present time for mobilizing uh, people, transport them from a, a very remote area into this even a smaller towns in Appalachia. And then from there to a more regional area for medical care such as Charleston or Huntington or Beckley. And uh, they're developing these things but it's not as good as it should be and it's a very expensive thing. Not even, forgetting the fact of gasoline prices going up even prior to that it was a very expensive thing to transport. And uh, in principle it's nice to have all these technical people standing by waiting to help you, but uh, th-, that's a high cost item and if they're not used that much uh, it can run the taxpayers a great deal or if it's private pay it becomes an expensive item.

K.L.: But is it a very necessary item in these, in West Virginia?

R.K.: It is a necessary item, but we don't have worked out the correct way of handling it. Uh, I think that we, it's abused. A lot of people will call and say uhm, take me to the hospital, that probably could go in by automobile or four-wheel drive or something like that. And uh, every time that you get a hospital to uh, uh, ambulance or emergency med technicians, that's an expensive, probably a hundred dollars an hour or more.

K.L.: Did you ever have uh, how did you bill your patients? Were you every paid in kind, did you ever have trouble with that type of thing?

R.K.: Oh, kind. Do you mean script or what?

K.L.: Well, instead of just cash or credit, um, some sorta like paid

in trade of some sort. I've heard of some uh (Dr. Kessel interrupts.)

R.K.: Oh, yeah, yeah. This, it used to exist uh, particularly in an agricultural area where somebody would, would come in and uh, they wouldn't maybe have a, actually money, hard money was not as uy, free. (K.L. Uhm, um.) But they did have chickens and eggs and uh, calves uh, uh, lambs, pigs. All those things would be uh, but I didn't happen to be, have that involvement. But I did have people that would be very nice, uh, bring me a load of firewood uh, would uh, (inaudible) the vegatables or, I had a fellow who every year he, when he would butcher would always some meat uh, down in the fall of the year.

K.L.: Not as payment, but just (R.K. Well, it's payment, just is ap-) out of gratitude. (R.K. Appreciation.) Right.

R.K.: And uh, I've uh, never did uh, feel that anybody should ever be sued over a bill or anything. Uh, mainly from the standpoint, that uh, in fact uh, I thought it was very important that people uh, know their responsibilities as far as uh, financially that they're responsible for paying their bills. But uh, I think that uh, if they're having a hard time, if they would come in and talk about it you can always work that out. Uh, when I left Logan I probably had 8 or 10 thousand dollars on the, the books. Maybe more. Than uh, which is still there today. (K.L. Huh.) So um, we made a fairly decent living and I was able to pay my bills at the end of the year. (K.L. So you weren't going to worry about it.) I didn't worry about it uh, still don't from that standpoint. And we, took care of a lot of people who couldn't afford it. And the uh. But I think one is responsible for bills they contract or they come in and ask you to assume their res-, their care than making you a verbal contract with that and you are too. You, you owe them, to them to give them the best service possible.

K.L.: Um. When you first went into Logan did you have a lot of medical help such as nurses or, or other physicians?

R.K.: We did uh, we had a nuclues of good physicians in the city, per se. And it was unusual that we had so many specialities represented. We had two people who were in ENT or (inaudible) nose and throat. (K.L. Okay.) And one board certified man in opthomology which is eyes. One in pediatrics. And we had several people who did uh, uh had, had some training but had, didn't have board certification in ortho pedics and general surgery. So we didn't, we were um, um, than we had different people in family practice who didn't have their boards at that time because they didn't have said boards. But um, there were several in town in that order. But there were several d-, doctors in all these smaller towns and than, these coal camps had 'em. (K.L. What...) And the companies uh, helped support them, the coal companies, plus the miners themselves. So this is where the numbers really shrunk. Uh, and the doctors mostly are based uh, as I mentioned the foreign medical graduate, in the hospital. Some are outside the hospital, that become liscensed. But uh, uh, we're now just

beginning to get the influx of American graduates going back. In fact, last, this year uh, a native of Logan finished the family practice training program in Charleston has gone back to practice in Logan and is very happy. I've tried to send uh, some of my former patients, we still practice here. I still see people two days a week. And the goodly portion of our patients are from Logan. Because I felt that I owed them the priority if they wished to come they could.

K.L.: Uhm, um. And I'm sure they would wish to after having been with you for so long.

R.K.: And a lot of fun.

K.L.: Um, what was the most, some of the common ailments that you had to treat? Was there any one that more so than others?

R.K.: Well, fortunately uh, uh, most of the people were on two forms of uh, finances. Which is kinda the background. Working, making a pretty good living or people on some form of subsistence. Either social security, miners pension, or uh, medicaid from the state uh, so forth. Uh, some were on disability. Uh, since mi-, mining was the primary occupation, we sa-, saw a lot of occupational diseases.

K.L.: Such as black lung?

R.K.: Such as black lun-, lung, (inaudible), chronic bronchitis,uh, uh respiratory infections such as uh, uh, pneumonia and uh, the ones that complicate that. And you would see then the de-, degenerative illnesses such as uh, heart disease, hyper-tension, etc. But uh, as I said we did complete family practice and I did a lot of deliveries, a lot of OB and I delivered about 2500 uh, youngsters up until the time we came down.

K.L.: Did you ever deliver at home or was it always in the hospital?

R.K.: Oh I, only once was at home uh, because well, be-, I felt that it should be at the hospital. Every delivery is normal after it's completed. You never know what the situation can be prior to the delivery of the infant. And this is uh, where we kind of draw that line. Uh, so, the one delivery I did at home was for another physician. It was during a, a uh mine disaster at Holden 22 several years ago when twelve men were trapped underground (K.L. Um, um.) and subsequently they were found dead from methane gas poisoning. And I went to the home to deliver while this doctor was on duty at the mine. In case that uh, they needed a physician or medical help so that's the only home delivery that I did. (K.L. Yeah.) All the rest of 'em were in the hospital. Had a lot of fun though. We had uh, delivered two sets of triplets during that time. (K.L. Oh my goodness.) And the first was just one year after I'd been in practice.

K.L.: Oh, I bet that was exciting.

R.K.: Oh, they were real exciting. I said the mother lost about 27 pounds that day and I think I lost ten. Was on a hot summer August day too. This was before all the days of sophis-, sophisticated air conditioning.

K.L.: Right. Ah, I'm,glad I live now I think. Uh, were there any midwives practicing in the area?

R.K.: They had a few on the job training midwives that had not (K.L. Nurses?) any formal training. No. These were just women. And uh, I lived in the era at this time when they tried to take all of the women who uh, were pregnant and needed uh, help, to the hospital for delivery. And as a result of taking them to the hospital for delivery the uh, the st-, state of West Virginia and then the federal government would pay a fixed amount for hospital care, but the doctor donated his service and we did that. And then they gradually worked that into the Medicaid program or the E.P.A., the E.P.W., And uy, it was fun and I think the (inaudible) to getting the girls in off the street. And this was probably a good thing because a lot of 'em were delivered at home and they ran into complications and uh, you can have complication anywhere, but it's nice to be able to have the equipment around that you need to handle those complications. (K.L. Right.) So uh, we, we don't have many of those going on at the present time. I, I personally was born at home. I, I think that uh, that has uh, a lot of advantages when everything goes well.

K.L.: But you can never be sure.

R.K.: But you can never be quite sure. But now they're getting 'em in, delivering 'em, and sending 'em home within 24, 48 hours which is probably a pretty good thing.

K.L.: Now I've heard a few clinics that, that a woman can just go in and have the child and be able to go home. Sort of reverting back a little bit.

R.K.: Well, I think we need to get uh, the fundamentals. You know we get too, too sophisticated and find out that uh, tender loving care is a very important item in dealing with human beings. And uh, everybody likes to have somebody to say thank you and good morning, to be very pleasant and how are you and really be genuinely concerned.

K.L.: I had read where a lot of women, uh, most of my reading has been on womens medical history, uh resented the foreign doctors. That they were often forced to go to is they were on welfare ot something, because they couldn't communicate with them and they felt they didn't care. Did you ever run into that? Where people would refuse to go to certain physicians or (Dr. Kessel interrupts.)

R.K.: Most of the time they uh, the unfortunate thing they had nobody else to go to. There were, and uh, this is true everybody likes to be understood and have some idea what the story is and what's going on. So uh, fortunately we are beginning to cycle through a few people that are West Virginians uh, or who understand West Virginians, that are able to go back and take care of them. And, but quite a few if we hadn't had the people who are the foreign medical graduates, there we wouldn't have had any help or, the ones that were there would have been so inundated with people and problems that we would have had a hard time practicing.

K.L.: Is there, there's no way you can force a West Virginian to practice in West Virginia, all you can do is encourage it at this point.

R.K.: There's no way you can force them anymore than we're forcing you to (K.L. Go to Marshall?) go to Marshall or to, to go to a little town and live. They call that indentured servitude. (K.L. Right.) And uh, as I say, you have to get the interaction with the patient uh, and with the community and so on. What we try to do is to establish uh, in fact we have a mandatory uh, senior clerkship in family practice where the students will have a four, four to six weeks clerkship with a qualified family practitioner and go to the community and just live and uh, work with the doctor on a, in his office, in the hospital, go to the li-, the uh, uh, uh meetings with him at the clubs, civic clubs, church activities, football games, basketball games, let him be identified and maybe get some, some liason and some interest established. But also let them know what kind of medicine is being practiced, how you can do a good job of practicing medicine and the fellow that's livin' out in the small town isn't all that far behind and isn't that much of a uh, improper practitioner of the art and science of medicine. And fortunately the, the reac-, the relationship with the doctors in southern West Virginia we know the ones that are qualified teachers and are willing to teach. Gotta have both things. And as a result they go out and do learn a lot and live a lot of uh, of worthwhile activities and we sometimes can get things started. We're sending the residents out now. They have a mandatory four week rural rotation. In fact uh, one of the residents was up in Ripley for four weeks and thoroughly enjoyed it. And the doctors enjoyed him as well as the community. In fact, the community would like to have him back. I believe he would've gone back if his wife would've been interested, which is the other thing. You gotta have everybody. But she only saw the periphery , she didn't go there and live with him. And this is what's nice if they can do that. They can meet different people and see what's going on. You know uh, I think my wife made a statement that raising kids and, and uh, keeping house and, and cookin' and washin' dishes and everything, you can do that practically anyplace. It's just where you goin' be doin' it. (K.L. That's true.) And people are pretty much the same except the, in the smaller towns in West Virginia, they're extremely friendly. Almost seems like the smaller the town the more friendly they are.

K.L.: Do they trust in the doctos once they get to know them? Trust their opinions?

R.K.: Oh, I think so. I, the uh, I've sent patients to for coronary by-pass surgery, the Cleveland Clinic or uh, to Dr. DeBahé in uh, Texas for uh, some possible transplant work. And uh, they accept it as uh, on your word of recommendation. Or if they, going to refer to somebody in Charleston or Huntington, where ver it happened to be, (K.L. Uhm, um.) they accept you as a, as a counselor for it and that's the way it should be. Because, naturally we're better qualified than others, capabilities of somebody that is non-professional.

K.L.: Were there any particular problems you ran into that would be particular to Appalachia? Um, either personality or medical, with your patients?

R.K.: Well, there's still a lot of home remedies tried. Than uh, this is, sometimes they wait uh, there's still a little bit of superstition. Uh, but there are a lot of satisfying things like if a girl gets pregnant and uh, the people in Appalachia have a tendency to take the baby and keep it rather than give it up for adoption. And uh, oh there'll be a certain amount of uh, finger pointing in the minds eye standpoint. But, mo-, basically they accept that as part of the family and go right ahead. Uh, they're given a lot of support

uh, for uh, in illness uh, for instance, crisis situations the family's very much interested in what's going on. There's a greater tendency to take care of the old folks instead of saying oh, it's the states responsibility to care for them. Uh, there's a little, a great deal of honesty among the prevential people. Uh, it's uh, which is a good thing uh, they may fuss and snort and, with people uh, fuss with, in a sense of uh, uh confrontation, but it's really a, a symbolic type thing rather than a feuding type of activity. And uh, if you uh, need some support uh, from the community you can usually get an agency to do it or, if uh, you need uh, direction for, like I had to, send a patient to Morgantown one time because of a severe illness and uh, uh I wasn't able to get the governors airplane at the time, or his chopper. But one of the fellows in the uh, National Guard Reserve was a pilot, heard about it and he called me and told me he had it coming. Which is, it is kinda nice. It's a small town effect again that uh, people are concerned and uh, they uh, well, they just kinda like the identification of knowing people that are taking care of them, doing things for them.

K.L.: They're a closer knit group than the (Dr. Kessel interrupts.)

R.K.: I think so, very much so. Uh, the uh, as I said that you uh, you lost a little privacy, but you gained more identification. If you wanted time off, you really had to get out of town. If you liked uh, to play, in a sense where you go out to play golf, you usually had to end up coming out, coming home and working so I ended up playing golf seldom. I've always left my number listed in the telephone directory, the home phone, because of that really didn't bother me, you got calls. But you can train your patients to whether they've got real serious problems than somebody else, uh, they can call you then you don't have to send them to somebody else to do that work. If it's not too severe, they can wait till the next day usually.

K.L.: About how, how large of a population were you held accountable for or, however you'd want to say it, how many did you have as patients? Could you have had?

R.K.: Oh, I would imagine uh, the, I'd say between 6 and 7 thousand people. (K.L. Um. That's a lot of people.) By the time you figure out a total, or folder, file cabinet after file cabinet after file cabinet of records. And uh, as I say, when you deliver 2500 in that period of time. Sometimes I've had the privilege of delivering a, a baby to a patient that I had delivered themselves. This is kinda fun. (K.L. That would be.) Kind of exciting.

K.L.: Were a lot of your patients women and children?

R.K.: Yes, uh. Actually the, see the women comprised most of the patients, because they're con-, with the health care of the female in her reproductive years which is pregnancy, managing the children's health and uh, this, this brings them all into contact with you so that interfacing. And they usually drag their husbands in with them at times. Very seldom does the husband drag the wife in.

K.L.: No. I suppose that's true almost everywhere though.

R.K.: Yeah. Women are much more concerned about uh, uh, health care matters than the male. The male tries to think that he knows a good bit about it and he

doesn't have to pay that much attention.

K.L.: Did you make house calls or was it all done in your office?

R.K.: I made house calls to people that really needed them. And most of the time these were people that weren't able to get to the hospital. The older folks that uh, the ones that maybe were semi-invalid or folks that weren't psychologically adapted to groups, group areas. So I would see them at home. I probably averaged fove or six calls a week. Which is a fair number.

K.L.: Right. You said there were some home remedies. Do you know of any specific illnesses or...

R.K.: Oh, there's a spring type tonic they used to give with uh, a little sulpher, molasses. And then they would uh, try the asphydity bag for fever, around the neck. And then the copper wire for the arthritis. And...(K.L. interrupts.)

K.L.: They still try that?

R.K.: Oh, yeah. Well these, you see 'em now. Times, you'll see people with maybe fancy little bracelets of cooper that are going to do that. And then uh, used to be that they would uh, uh put a metal uh, a dime, they would string around for good luck for a baby with a hole in it. And uh, then uh, used to be that a woman felt she, as long as she breast fed she couldn't get pregnant.

K.L.: I'd heard that.

R.K.: Which is not, which is not true. And uh, them there's just many activities uh, such as that. In fact uh, oh that's where the remedy's of religion come into being with this too. There's still some snake handling going on in Logan county.

K.L.: Oh, really? I didn't know it was that close?

R.K.: Yeah. One of the teachers here in the Department of Sociology wrote a masters thesis on (K.L. interrupts. Dr. Simpkins?) No, one of the others, uh. I can't think of his name right now but, but uh, it was up in, around Switzer area. It's uh, so it's uh, kind of a interesting affair when you go back and listen to all of them. They uh, there's a lot of, see the, the hub of the social activities in Appalachia is the church.

K.L.: And that's true in Logan county also? (R.K. Yes.) Snake handling is not the predominant church is it? Just...

R.K.: Oh, no. This is a, this is on the periphery. Way out there. But this is, they still happen.

K.L.: Did you ever have difficulty convincing the patient that the remedies weren't going to work and if they were ill?

R.K.: Well, most of the time they were ready for help when they would come

into you. They'd, they (K.L. And you'd find out about it.) would come to that realization and you wouldn't have too hard a job. But I try to be, try to explain and communicate what the problem was, what the best way was to manage it, and what they could expect and when they should come back.

K.L.: You never made them feel like their remedies were absurd?

R.K.: I think that's uh, ridiculous to approach it in that fashion, because it, after all, all you're doing is creating confrontation rather than cooperation.

K.L.: You mentioned there was a mining cave-in while you were there. Did you ever have dealings with any other mining disasters that might have occured?

R.K.: We were uh, I wasn't involved directly into it other than the fact that we took care of the product of the, the mine or even maybe part of the people involved over the period of grief from trauma. And uh, yeah, we saw a fair amount in that sense. There's not as many, there's not as much mine fatalities and accidents as there were. (K.L. Yeah.) But uh, there was a good bit whenever I first went up. Wat'ent unusual to have two or three a week. Because it's, was uh, serviced a large area of Logan county, Mingo county, Wyoming county.

K.L.: Did you ever have trouble with the mining companies in regards to a, a, I imagine at this time the mining companies would pay the medical expenses?

R.K.: Oh well, that came out through uh, the medical expenses far as uh, injuries you're talking about? (K.L. Yes.) This came out through Workmans Compensation. And, they paid, the mining companies paid into Workmans Compensation that was in direct effect. And then they had the United Mine Workers, the miner's union, that paid for uh, oh, goodly portion of the problems of the miners.

K.L.: Those hospitals, set up by the United Mine Workers, were they relatively good hospitals for their time?

R.K.: The, in concept they were real good, but they were idealistically set up instead of realistically. And they stacked 'em with uh, uh, sometimes uh, specialists in certain fields that maybe weren't uh, wasn't a great need. They had a lot of uh, structural people from the administrative standpoint and maybe from, not so much from the uh, medical or functional standpoint. So, it's, they, they did serve a good purpose, they were good buildings. Sometimes they weren't, they were sp-, placed politically rather than, than for strategic service sometimes. And this is, in anything that's done, politics have a lot to do with it. Whether it's going to be a university or, or a library (K.L. Medical School?) medical school, or, or um, the uh, what is it, the tax bill now that's coming back from, from windfall tax, windfall profit tax from gas, the energy companies. So uh, it's uh...

K.L.: It's a shame it has to be political when it comes to medicine. I

suppose it's like that in everything.

R.K.: It's, it's very, very much humanistic type of affair. Uh, it's, it, the concept of medicine, I feel that people should have some responsibility when it comes to paying their, for their, called the cost of medicine. Uh, whether it's going to be out of, out of pocket directly or, whether it's going to be out of pocket and plus insurance, whether it's going to be Medicaid or whatever it happens to be. If they have a certain responsibility, people tend to appreciate it and do a better job with it. And, and I think this, this uh, something for nothing attitude is not very good. I'm, I'm not convinced that, that the governments concept of national health insurance is the best thing for us. Uh, I think we need to develop uh, person responsibility. And uh, I think we'd all do a little bit better. You know, we pay so much in hidden taxes now and then they turn around and say that the, the government itself is efficient. Well, it's really not a very efficient thing. Uh, what is it, they say that for every uh, dollar benefit that the average citizen, this was several years ago, that every citizen gets they have to pay at least ten dollars in taxes. And it may be, may be that type of thing. And, I believe that, I'd like to have more uh, what would you call it, free enterprise or, or consumer involvement, con-, real consumer, not the consumer advocate telling (K.L. Right.) everybody they ought to do it. But consumer involvement and direction where, where everybody works as a team to take care of themselves. I, I think that when we get more physicians trained, that we're going to have a little better concept. I don't think the cost is going to be quite as bad. I think that people would rather go to a physicians office than go to the hospital for crisis type, oriented medical care. Bu they like continuity, ongoing medical care, and this is what we feel that family medicine can give you. You talk about the midwives a little bit ago. We use a lot of para-medical people. Not only the nurses, but we use the nursing assistants, the lab technicians, the uh, the physical uh, the, the physician usually, doesn't have a physical therapist in there, but we do, can refer to 'em, the X-ray technicians, so there's a lot of members of the medical team.

K.L.: Uhm, um. Yeah, I've discovered that in doing some research on it.

R.K.: It's kind of a fun thing too. But we all have to find out we're all participants and we're all members of the teams.

K.L.: You have to work together.

R.K.: That's right. You've got to have somebody to coordinate it and not anyone individual is any more important than the other one. He may have more responsibility, but we all have to work as a, a coordinated unit to function well.

K.L.: Is there still a need for some type of certified midwife in West Virginia, would you think? Or is there, are there enough doctors to take care of...

R.K.: There's not enough doctors at the present time. I think that the certified midwife uh, I don't know what you mean entirely by the certified midwife.

K.L.: I thought I said nurse-midwife.

R.K.: Nurse-midwife probably could be a team member. But the, but the thing is what, what are we going to do when we get enough physicians. Sufficient number of physicians trained then these people'd be relegated back to a different level. (K.L. I can see that. Yeah.) So, uh, I think that uh, maybe it's a two-edged sword. There are some qualified people, but sometimes uh, I may be critisized for this but sometimes, nurse-midwifes consider themselves obstetricians. (K.L. Uhm. um.) And if they know their limitations, it is supurb. (K.L. Right, but it's...) If they've been trained, to what level they've been trained too. It's kinda like uh, emergency medical technicians or physicians assistants, there's such a thing as having a three months course or a four year course.

K.L.: Uh, um. Just because you've graduated, that does not mean you're ready to do it.

R.K.: This is what they say about physician and hospital privleges. Just because you have board certification doesn't mean you're qualified to do something. You need to be checked into, supervised, make sure that you can document, it's documented that you can do it. That someonesactually seen you perform this. Besides what you have written on the paper. I think this is good.

K.L.: Yeah. I want to talk a little bit about the Buffalo Creek accident, incident, however they want to term it.

R.K.: Disaster. (K.L. Disaster.) Natural disaster I guess is a...

K.L.: Um. Now you were uh, working at the hospital at the time, as a family practitioner?

R.K.: Uhm, um. I had a private office and Logan is, practice in Logan at that time.

KL.: Were you ever, was your family in any danger from this?

R.K.: Never. We watched the uh, muck go by which was blackish material in the river. It was a Saturday morning you know, never forget it cause I happened to be home early in the, and it was raining like it had been here recently, just hard, hard, hard, but it didn't have the ability to, to absorb it and when the dam broke, there was just people weren't able to get out of the way.

K.L.: They had no warning before?

R.K.: Well, maybe a warning from the standpoint they were watching the dams. But I mean, a lot of people say now people within low lying areas be careful of flash flooding and , and uh problems (K.L. And they still are there.) and the people, still remain. So, they're not going to run too much from it. And there was uh, a lot of people on Saturday morning were still sleeping in a little bit or, a little lazy on getting started, maybe they didn't have their radio on, maybe the communications weren't established that good. Cause we had the radio on because remember we had some company then. My daughter-in-law and my grandson was there and he naturally got up early so we were up at 6:00 that morning and, and did have the radio on and still didn't get it until after it had happened. And uh, knew what

the story was and what the disaster. And it came down just as, as a torrent down that hollow, Buffalo Creek hollow.

K.L.: Were most of the people killed, killed pretty much instantly, or I mean it was over with in like say an hour or so?

R.K.: Yes. Basically. Uh, there were very few injuries. It's uh, either were, (K.L. I was wondering about that.) very few injuries. In fact uh, several people came in, they flew a choper full of people in from, from Huntington that were trained surgeons and anesthesiologists, othopedic people that, to help out, but there just weren't that many people. They were either kinda shocky from the emotional assult or, or not knowing who was dead and who wasn't dead or they were uh, dead. That's about the whole incident. You know the bodies kept floating down the river and then they got quite a few and uh, there were some complications like people whould have heart attacks as a result of stress and the strain from it. And there was a lot of emotional involvement. People lost a lot of members of their family. But it was a uh, a real community crisis uh, uh, probably preventable. But most crisis uh, are preventable. (K.L. Right) Most disasters are preventable. Automobile accidents are preventable.

K.L.: Then most of the problems after the flood were emotional.

R.K.: Mostly emotional. Tryin' tp get their house back together, a place to, job uh, um, trying to pick up the loose ends.

K.L.: Were large number of families wiped out or...

R.K.: Yes. Yes. There's one woman that I knew that lost 13, had 13 members of her family lost. Either children, brothers and sisters and, or grand-children.

K.L.: Were there quite a few children killed?

R.K.: Yes. Uh, um. I uh, forget the exact breakdown, but we were visited the morgue that they had at the, at the South Main grade school. And uh, the bodies came in and I know this one was the scout master that had been up there for a number of years and uh, then this much of the stuff was very thick and coated the bodies and they had to clean all that off to try to identify the body.

K.L.: Must have been a traumatic time for people in the community.

R.K.: It was. But the nice thing about it, I give credit to the crisis oriented people that brought in the state policemen and the national guard. State police wouldn't let you in, they sent the, the detachments in, enough sur-plus people in that unless in there, you couldn't get in. It wasn't for sight-seer's. (K.L. Yes.) And I though that was great and uh, they used these chopers to go up and pick up victims and bring 'em back in, watched 'em unload and handle that. They were really set up for disaster.

K.L.: They've had enough of them in West Virginia. Um.

R.K.: So, I must give 'em credit for that. We didn't have all the vechicles we needed for a flood type affair, but even, we didn't come out uh, parti-cularly with , with the community support. As I said with the National

Guard and such.

K.L.: And you said about 125 were killed?

R.K.: I think so, about 121 I believe, in that range. And, uh.

K.L.: What was that 1974, was that (Dr. Kessel interrupts.)

R.K.: No, I believe that was earlier than that. I believe that was '70, '72, '72, '73. It was in the spring when they didn't have the vegatation out (K.L. to absorb) you know (inaudible). But it was a uh, very interesting affair. As I said, the uh, medical community responded like everybody else. But they were ready to take care of people and, and uh. Even after this happened, they couldn't get a line through the area. And, uh. This is why we decided we better go up to the disaster. We did get a call through on the radio to them to find out if they needed medical help in any sense because we wanted to mobolize and do it where we were to break down into an echelon of less severely injured people here cause you didn't know what it was. All we did, we heard about it, but you'd only hear generalities cause you one persons report.

K.L.: You had no idea what you were going to face.

R.K.: That's right. So it was uh, we said that, that's what we said they were either dead or in a state of dazed shock.

K.L.: Okay, let's see. A couple of other things. Were there any professional organizations in West Virginia at that time that you could belong to or room for advancement in West Virginia? Was there very much training available in West Virginia at that time?

R.K.: There was practically no training as far as residency programs. That were what I would consider first rate. There were some that weren't uh, maybe that were second class type. In fact, you had some in Charleston, some in Wheeling. But this was about all of 'em that weren't a real, not a real top-knotch program. Until a medical school was established in Morgantown then Morgan-, that was in the '60's and then we had the formal medical training program at the University hospital. And it gradually, through the impetus of the family practice, again, started nationwide in the late '60's and then uh, we developed a program in Charleston, or they developed a program in Charleston for post-graduate training and in Wheeling. And since that time we have post-graduate training here in Huntington with the medical school and then there's a little bit in Wheeling. (K.L. Wheeling? Really?) At Wheeling, it's a residency program talkin' about post-graduate training like that. We have ongoing seminars which the state medical association has one in August and when in uh, January where they have a three day educational program and then they have organized national programs where they're as close as an airplane almost. If you want to pick up concentrated knowledge in a particular subject you could go for a week.

K.L.: But in the '50's there was very little well qualified training in West Virginia?

R.K.: That's right. Very, there was some training programs, but not too, not too strong. And it really has taken off and we have uh, oh I would imagine

close to 200 residency, 200 people in post-graduate training in West Virginia right now.

K.L.: What do you see as some of the most basic medical problems of Appalachian West Virginia? Um, do they need family practioners or do we need more research into coal related diseases?

R.K.: Well, I think you need to establish priorities, first things first. In other words, if the house is on fire, you're going to put out the fire before you start building a new house. (K.L. Okay.) So, I would say that you need more primary care family physicians to get out and handle the acute care problems. Then develop some insight into the uh, the preventive medicine or the occupational medical type problem. So, I would think we need both, but we have to get to the needs of the people first and that first is primary care, family practice. Get that handled and then you can work on the research end.

K.L.: Are the problems in the rural areas of West Virginia basically the same as they were say in the 50's or has there been a great deal of improvement?

R.K.: No, I think it's been in that the problems have changed. I think that alcoholism is probably worse, I think the drug uh, problem is probably worse in the smaller towns then it is in the city cause things are kinda slow about coming in. I think that uh, there's more, maybe not more but uh, mental illness is more of a problem now than it used to be. And uh, well, I think society has changed a great deal. I think there's uh, moral deterioration has changed it. And, and uh, standards are not quite as good as they once were. So I, I believe that uh, disease patterns, they've changed too. There's less peptic ulcer disease, uh, but there's probably uh, more trauma as due to the faster driving, more vechicles, and uh, closer communication, television to live it up and uh, maybe (Ms. Lady interrupts)

K.L.: More society related disease than (inaudible).

R.K.: Oh, yes. Veneral disease for instance is uh, much more serious now than it's been for years. Uh, the life styles as a result of the birth control pills change people.

K.L.: So it's not the diseases that you were treating in the 50's as being more predominant would not now be, supposedly?

R.K.: I think there's been an emphasis change. Uh, you still have you diabetes, but I think di-, we're going to pick up more diabetes because we're going to see more people and as a result of seeing more people, you're going to make the diagnosis more. (K.L. Right.) There's going to be, there's better treatment when I came out in 1950, we didn't have much to treat hyper-tension. But right now you have a lot of drugs that you can use that can control hyper-tension. We have a problem with obesity. Obesity is quite a severe problem in this country and it's very severe in Appalachia. Malnutrition is a severe problem. (K.L. How could that be?) Worm infestation is a severe problem.

K.L.: I was under the impression, under the impression that in Appalachia, because

of being a rural community, there was not, never a great deal of problem with nutrition. But there is?

R.K.: Nutrition has been a severe problem. Malnutrition. Poor, ill-balanced nutrition. Too much carbohydrate...

K.L.: Is that the result of the poverty level of some of the citizens?

R.K.: Well, poverty level ot an ignorance level. Uh, a sense of not knowing the right things to eat. Like drinking a Coca-cola, eatin' moonpie for breakfast. You know, a moonpie is one of those little bakery deals that they come up. (K.L. Uh, huh.) Or an R.C. or a Pepsi, either one. It doesn't make any difference what it is but uh, uh, there's a, an educational level. Education will help a great deal. You've got to get the gals in who's gonna, who are going to be raising the children and if they know the right things to provide for their family than they'll be able to do it a little better.

K.L.: Uh, the way you're talking, it seems that there wouldn't be in Appalachia much more of a difference than in other areas of the country when it comes to health problems.

R.K.: Well, it's, it's a little bit different, but you've got as many core problems in the inner cities as you do in Appalachia. (K.L. Yeah.) And that's malnutrition, social diseases, emotional and mental diseases, uh, cultural problems....

END OF TAPE