

**Oral Memoirs**  
**of**  
**Brent Laughlin, MD**

An Interview  
Conducted by  
Clinton M. Thompson  
May 6, 2016

Development of the Tulsa Medical College:  
An Oral History Project

Schusterman Library  
University of Oklahoma – Tulsa  
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## **Interview History**

The recording(s) and transcript(s) of the interview(s) were processed at the Schusterman Library, University of Oklahoma, Tulsa, Oklahoma.

Interviewer: Clinton M. Thompson

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## **Collection/Project Detail**

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

Brent Laughlin was a family medicine resident who graduated in 1983.

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

Alyssa Peterson was a Medical Librarian at the Schusterman Library.

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Brent Laughlin, MD  
Oral History Memoir  
Interview Number 1

Interviewed by Clinton M. Thompson  
May 7, 2016  
Tulsa, Oklahoma

Development of the Tulsa Medical College: An Oral History Project

THOMPSON: All right, today is May 7, 2016. Would you like to introduce yourself?

LAUGHLIN: Brent Laughlin.

THOMPSON: Let's talk about your education. What was your education process?

LAUGHLIN: Okay. I grew up in Fort Smith and lived there my whole life. Graduated from high school in 1972 from Southside High School. Then went to the University of Arkansas in Fayetteville. I had a chemistry undergraduate major. Graduated in 1976. Then I went to the University of Arkansas for Medical Sciences' medical school in Little Rock. I graduated in May of 1980. And then came to Tulsa?

THOMPSON: And you did your residency in Tulsa?

LAUGHLIN: Right, right. So, I was accepted at what was called then the University of Oklahoma Tulsa Medical College, and so I did my internship and residency here beginning July 1st of 1980 and I finished June 30th of 1983.

THOMPSON: Okay. Do you want to go on ahead before we talk about your years as a resident, do you want to talk about your career?

LAUGHLIN: Since then you mean?

THOMPSON: Since then.

LAUGHLIN: Sure, okay. Well, so I'm one of the last people that I know of to just open an office. So, there weren't really any good opportunities for me to join a group, and groups were not actively recruiting at the time. I'm trying to remember the name before it was Warren Clinic it was PruCare. PruCare had some offices, but it didn't seem very appealing to me, and they

weren't contacting me. St. Francis had shown some initial interest in supporting me in an office, but they faded away. I worked with an oncology group at St. John that was run by Lance Miller, who was a long time practicing doctor here in Tulsa, and they convinced me to work at St. John. So, St. John was supportive. I was not a hired physician, but they gave me some incentives to work at St. John. So, I just opened the door of my office on July 25, 1983, and for four years I was just by myself in an office just waiting for patients to come in. And that's a slow process. That's a very slow process. Little did I know at the time, but a very reliable metric is you see one patient per day for every hundred patients you have. So, if you have two thousand patients that's about twenty patients a day, which is a good load. And that's kind of a standard practice. Well, it takes a while to get to two thousand patients when you just turned the lights on and you're waiting for what, I don't know, friends from church, other doctors, whatnot, urgent care—which there were almost none of those then—emergency room. So, it took a couple years and then after that I've been busy every day since then, but the first couple years were interesting.

From there I went, moved offices and shared space with two different physicians for a total of three years. Then I was in a four doctor, small family medicine corporation practice on Yale for three years. But since 1993 I've been part of what was Wheeling Medical Group; then [it was] for a long time OMNI Medical Group, and now St. John Clinic, and all three of those organizations were affiliated and eventually owned by St. John. A long time family physician well known to everybody, and former president of the state academy, Charles McCarty, was my first partner for ten years within this new group at St. John. Unfortunately he passed away. I've been partners with—in an office with Paul Higbee, who's a family medicine physician who trained at ORU [Oral Roberts University] in the In His Image program. And then for the last five or six years we've shared space with several other doctors. And now as part of the new thing we have four doctors and three PAs [physician assistants] in our office now. So we've had that physician assistant component for four or five years now, I think.

Like a lot of people, especially back in the day, we did it all, right? So nursing homes, hospital rounds, office, whatever, you know, night call. I used to be on night call every night for a week or whatever. Dr. McCarty and I were every other weekend, but every night during the week we took our own call, and then if one of us went on vacation we'd be on call for almost three weeks without a break. Now we have hospitalists to take that load on. And the nursing home business has changed, so really you need to have an in-home nursing home physician, so I don't do that anymore. So it's just pretty much office. I have 3,300 patients, not just 2,000. And that's a lot of work. That is a lot of work to take care of that many patients. That's not the biggest panel in our group, but it's one of the larger ones. So it's a five day a week job now, and then we take weekend and night call, but it's just telephone. I mean, I've been on call and I've been in Austin, been in Fort Smith because it really doesn't matter. You're only responsible to take phone calls now. I've been at St. John the entire time. Thought about leaving a couple of times, but it's been a fantastic partnership for me with the hospital. I tell this a lot in different settings, but about

fifteen years ago I was at a cocktail party and a friend of mine said, “Why are you a family doctor?” And I said, whatever, I can’t remember. And they said, “Why are you at St. John?” And I didn’t even think about it, but I never had thought about it before, but inside of me was this answer already which was, it’s a Catholic institution and their mission is to take care of the poor, at the end of the day we’re not just about making money. And that turns out, that’s sort of my mission statement for what I’m doing now at work. Do you want me to go into, like, other stuff now? Is that good?

THOMPSON: That’s good.

LAUGHLIN: Okay. Yeah, you go ahead.

THOMPSON: Let’s go back to when you were a resident. What drew you to the residency program here at the Tulsa Medical College at that time?

LAUGHLIN: Okay. So, when I was in med school—the fourth year—like a lot of residents, we’d do a lot of kind of travelling around looking at different residency programs. I spent six weeks in Fort Worth working in the emergency room at John Peter Smith as a fourth year medical student, but that’s their equivalent of Parkland, but in Fort Worth, and it’s a very busy, well known family medicine program there. We visited; well, we went to Alabama, program in Birmingham, to Charleston, to one in Albuquerque, to one in Fort Smith—which I’m from Fort Smith—and then Tulsa. Tulsa had a good reputation. They hadn’t had anybody from Arkansas over here that I know of yet, at least that I can remember. But I have to say, my wife’s two brothers were already living here in Tulsa, and it’s only a two-hour drive from, you know. So, but then, like a lot of residents I think, I made out this three-page checklist about things about the residency. Check, check, check, which things I thought were good and important and whatnot. And really this residency program came out number one anyway. I don’t think that was just making it look good because we wanted to move to Tulsa; I mean, I really think it was a good decision. Looking back I think it was a good decision; what I’ve heard about the other programs I looked at, I don’t think they were as good as this program.

Unfortunately, as you know, I was here for a year as an intern. Roger Good had taken a real shine to me and was really trying to kind of get me involved in stuff. He had me go to a national resident meeting in Kansas City as an intern. And then he died toward the end of my first year. So, things weren’t as good as they could have been while I was here because of the leadership transitions that took place. But he did get me engaged in the idea of being active beyond just being a doctor. You know, I mean, I also have been a past president of the Oklahoma Academy about twenty years ago. So, he got me involved in thinking about those kinds of things, and then community involvement, and certainly supporting the residency program in other ways, which I’ve tried to do. Because of all that turmoil, he died, we had an interim, Dr. Walls took over

when I was a senior, or a third year resident I mean. And there were just a lot of things about the way things were being run that were a little disheveled still until they got everything reorganized.

I came out once or twice a month and spent a half-day in the clinic as an attending. I used to go through five hundred charts while I was there in the afternoon because they were so far behind reviewing all the residents' records. And I'm not being critical of them; I just think it was a situation that everyone was doing their best to manage, so I don't mean it like that. So, I think I was there regularly, I contributed. I knew Bonnie and several of the other people in the clinic quite well. Plus I enjoy the resident interactions, so it was altogether a good experience for me. And that went on until they moved the program over to Hillcrest. And then it turns out they didn't want us anymore because we couldn't sign any charts on Medicaid patients, and they could get paid; they couldn't do that. They said, well, we just don't need you. I was sad about that, but we couldn't even do it just for the heck of it because we just can't supervise those patients, so they just asked us to not come anymore and do that.

THOMPSON: So the University had moved their family practice to Hillcrest?

LAUGHLIN: Right. When I was in the program, there used to be, at one point or another that I know of, there were three clinics. There was a clinic on Sheridan, North Sheridan, which I know where that building still is, but I've never been in there. My clinic was the first year we were out at the Marina, I think, or at least most of the residents, so I was always at the Marina Clinic for my clinic time. And the campus on Sheridan and 31st Street was opened while I was there, but I never went up to that other clinic. And—. Let's see, I lost my train of thought. What were we talking about before?

THOMPSON: I was just asking you about—you're doing it—your training. What you're your experiences and where were you during your residency?

LAUGHLIN: Right. So, yeah, so we moved to Tulsa in 1980. I'll never forget those were the years when they were redoing I-44. Okay? And the Marina Clinic was way out there on 21st Street and Mingo. And I would be at St. Francis or at Hillcrest or at St. John. I had a car that did not have an air conditioner. That was the summer that it was 100 degrees and didn't rain for forty-six days in a row, and we'd be stuck in traffic trying to go work at the hospital, you know, stay all night, make rounds, try to get in the car and run out to get to the clinic by 1:00, drenched with sweat. I'll never forget it. No rain, heat, no air conditioner, traffic backed up on that road, always late getting to the clinic. It was awful. But the clinic was, I thought, a good experience. I remember we had some various controversies. The faculty was a very interesting group, and I don't know who all has talked to you about them. First there was Dr. Good originally, but he was not at that clinic much. Arnie Greenberg was there and Howie Roemer. And they were sort of hippies, and Arnie more so than Howie, but Howie had a twinkle in his eye and always kind of

had a different way of looking at things, you know. Silvie Alfonso would be there. And I don't know how everybody else felt about Silvie, I love Silvie. But he had this really great way of asking you questions where there was no way you could possibly know the answer, it was impossible to know. We'd be seeing a patient that had congestive heart failure, and he'd say something like, "Tell me, did his great-great-grandfather have congestive heart failure?" Some question like that, that you'd go, what? It's impossible to know the answer. And he did that over and over and over again. He was, I don't know this for a fact, but this was the rumor, he was famous for trading calls into the future, so that it seemed as if he never actually had to take call. Like he'd have a call and he'd say, I'll take your call next month, and they'd say okay. And when that call came up he'd trade that call with somebody else for the next month. And it just sort of kept apparently leap frogging into the future and I don't know if he ever took call. Anyway, that's what people said about him. The clinic was really a good place. I enjoyed it; I thought it was good. We probably at times weren't as busy as we needed to be, and at that time the environment at the Marina Clinic was sort of lower middle class, white. We had almost no ethnic patients at all. Now that area of town is almost all Hispanic. And at least I think before they moved away from there they had gotten a whole lot busier because of that, just a lot more demand for clinic type services. But I never saw clinic patients except out there on Mingo. Now we had lots of conferences and meetings and various things over at the Sheridan Campus once they got that open.

THOMPSON: Your experience with the three hospitals?

LAUGHLIN: Well, more than that. So, in my internship I worked at Hillcrest for a month on internal medicine. And my very first call night was Fourth of July. And I remember this is like something out of the book *House of God*. Are you familiar with *House of God*? Okay. So you may recall that New Year's Eve he had a pleasant experience with a patient and then like when the clock struck twelve all hell broke loose for the rest of the year, right? So we saw a patient, we didn't have anything to do. We went up on the roof, it was kind of sunset. You could sit on the roof up underneath where the helicopter landed back then. And we watched the sunset, and then we saw the first few fireworks go off towards downtown because you could kind of see it from up there on top of Hillcrest. And then the helicopter landed with some patient for us and I was up all night and Steve Galley(??), who's an internist here in town now, and I lavaging, which means taking iced saline, or salt water, down a nasal tube into a patient who had intestinal bleeding for about four hours in the ICU, maybe six, just sitting there and just, and then checking a blood count every hour to see if they needed another transfusion, and it just went on and on and on. Anyway. So, internship I thought was hard. Hillcrest was interesting because the call rooms were underneath the helipad, so every time the helicopter landed, if you happened to be up there trying to rest it would wake you because it made an infernal noise. *Star Wars* came out in 1978. This was 1980. Most of the patients who came in on the helicopter were very, very sick, and so the resident nickname for the helicopter at Hillcrest was the Death Star because if you sat up on the



roof and looked, it would come in this huge bright light from the helicopter lights landing and make this noise and then land and then you knew you were going to be down with that patient in the emergency room in about fifteen or twenty minutes once they finished with them.

Then I was at EOPC, which used to be called that, Eastern Oklahoma Perinatal Center, which is at St. Francis with the newborns. That was a very intensive, very stressful experience. The people I worked with I really liked, but that was very hard. So, that was my first exposure to St. Francis. Then I was at Hillcrest again for pediatrics with one of my true mentors in my medical life, Steve Adelson, who's a long time pediatrician. That was fantastic. I don't think anybody could have had a better experience at Mayo Clinic or anywhere. Those were two months that were just stellar, so good.

Then I did obstetrics and gynecology at the Claremore Indian Hospital, and that was an unbelievable experience. That place, you know, the people lining up at 7:30 in the morning and waiting all day for an appointment because they didn't make any appointments, you just showed up and got in line. Our responsibilities were obstetrics and gynecology clinic, deliveries, and at night the emergency room. So, we never got a minute's break. And if a family drove up from Okemah to have a sick kid checked—and they did sometimes—well, they had their family with them because they couldn't leave them at home, well as long as we're here you might as well check them too, doc. And so we'd see eight people almost every time. There'd be one; there'd be all the other ones, too. It was unbelievable. And then you'd get a call to go do a delivery and they're all waiting. During the day we didn't have to cover the emergency room; they had somebody hired. So, that was never a break. I did a lot of deliveries. The faculty was good up there. There wasn't family medicine faculty; it was hired faculty for the Indian Hospital, but that was crazy. I mean I have to just say that was craziness up there.

And then I turned around and the next two months I went and did surgery down at Muskogee at the VA. And that was crazy because, you know, there's not a lot of supervision down there, even less than up in Claremore, and we had to, it's true also for Claremore, we had like an OU car we would all get in and go, to Claremore it's kind of, we'd show up about 7:15 someplace and drive up there and we'd all drive back unless you were on call, then you had to stay, and that's a sad feeling when the other people are driving off and you have to stay. That was a sad, lonely feeling when that happened. And down at Muskogee it was worse because on a surgery program we'd have to stay all weekend. So when we got there on Friday morning, we were on call until Monday night when we got to go back home again. We had to get up and meet at the Exchange Center at Garnett and the Broken Arrow Expressway at 4:15 in the morning to ride down there because we had an insane senior resident who just insisted on that. So, we'd get down there at five something. Made a stop for doughnuts every morning in Coweta at some doughnut place. And then we'd be there all day and we wouldn't leave to come home until about 7:30. So, we'd get back to the Exchange Center at 8:30, get home at 9:00, eat dinner, fall asleep, and get up at

3:30. That was very hard. The thing was we had about four hours every afternoon where we didn't have anything to do, and he could have easily not made us get there that early or stay that late, but I don't know what he was doing, but we just wasted time all day and then, anyway, I've hardly ever been as exhausted as that.

Let's see, after that I was out at St. Francis again for family medicine rotation. And you know, I can't even remember what I finished with, oh, no that would have been something else. So, I worked at all the hospitals my first year except for St. John, the one that I ended up staying with, which is just, but we worked it at all the hospitals, right? So if we were on pediatric call we were answering the call for all the pediatric calls through the clinic for the whole; at Hillcrest we were answering the phone for the whole residency program. Not hospital calls from the other hospitals, but anybody calling in, besides being on call for the hospital. It was good experience to work in all these different settings, I think. You know, people could argue that we weren't being supervised by family practice attendings, which was true, that a lot of the stuff at Muskogee, and some of the stuff in Claremore was not very well supervised, but you know, I think the patients got good care. I made a practice when I was an intern especially, and a resident, if I had a minute and nothing was going on, I would just go to sleep because you never knew, if we got, we came on call in the afternoon at 5:00 and there wasn't anything going on, I would just go in a call room and go to sleep, I wouldn't sit and watch TV or go eat or play cards. I guess I was anti-social, but it comes in handy sometimes if at 11:00 then you're up the rest of the night if you got four hours of sleep already. And I did that a lot. And I wasn't hiding from work, my beeper was on; but sometimes there just wasn't stuff to do. I remember one night I was on call and one of the family residency babies came into Hillcrest, but the family practice program was at St. John and St. Francis, so that meant at Hillcrest it was just an un-assigned patient. Two-month-old—I mean two-week-old newborn. I had gotten my sleep already, so now it's 11:30 or 12 at night, they call me down to the baby—just terribly sick, floppy baby. Nowadays this baby would absolutely be in ICU and the whole smear. This is then, that was now and all that. So, I evaluated the baby, did a spinal tap, went up to the lab because there was nobody there at night in the lab to look at stuff, did my own microscopic work to look at the spinal fluid, identified e. coli meningitis in a two-week old, initiated antibiotics, watched the kid all night plus whatever else I was doing. Two year later that baby's family practice resident that had delivered the baby had already moved onto their practice, you know, they finished the residency program, and they assigned the baby to me. I performed this Denver Developmental Assessment, which is a test to see if you're at the appropriate developmental level for your age, and the kid was perfect. And I mean, I have to say, it's self-serving I guess, but because, you know, I took charge of that kid and did all those things that needed to be done and got everything started in time, the kid was okay. But you look it up, the outcomes on a two-week old newborn with that kind of meningitis are abysmal, and it was just a get it together and get going kind of thing. So, that was one of the high points of my internship I think. Let me see. That's all about my internship that I can think of offhand.

THOMPSON: Your residency?

LAUGHLIN: Well, so residency continued. The next two years after internship we did rotations at different, more specialty type things rather than the primary in hospital type of studies. We always had OB, two months each year, that's a core part of family residency. Then, so that's inpatient, so you're always at the hospital on duty to do deliveries. The other OB that I did was at Hillcrest, and that was how that was set up, so I did two months of OB in each of my second and third years at Hillcrest. The, some of the high points, well, I worked with the oncology group, and got to know them at St. John: Charlie Nash, Lance Miller, and Richard Shildt. It was an excellent experience, and they were the ones who kind of got me tilted towards St. John when things didn't work out with St. Francis. I really enjoyed that. Let me think. I did my cardiology elective out at St. Francis with Cardiology of Tulsa. Some of those guys are still practicing. This was quite a while back now; this was 1982. Henry Hawkins was one of their non-invasive cardiologists back then and we were really good friends. So he actually took me with him down to Dallas to the American Heart Association Annual Meeting, which was cool. I really enjoyed that a lot. That was a really good experience; saw all kinds of stuff. Obviously they're very busy, even busier nowadays than they used to be. They used to do more thinking, so that was good, the thinking part of it. The rotations in all the different hospitals were very valuable. I went back up to Claremore and did pediatric clinic, which was really crazy. I mean talk about busy. There was never an end to the patients. You get to the end of the day, and then I guess they just made them come back tomorrow or something because we had to leave. We had to get in that car; they had a time when everybody had to leave, which was good I guess that we didn't drive ourselves up there or they would have kept us all night I think.

All right, so all the different rotations we did we got to sort of pick what we wanted to do for the most part, plus these requirements. The other thing is we had to do was we had to family medicine hospital service both the second and third years. And in both of those situations I was the senior resident on the team. I remember when I was doing my one at St. John, one day we got up to twenty-three patients and that was the most I ever heard of anybody having, and as an intern, had an intern and me, and we had twenty-three people to take care of, and that's a lot. It's easier now because, easier and harder. You know, the documentation requirements with your computer are very time consuming, but on the other hand you can sit in one place and monitor all your patients now, just look on the computer, check all their charts, look at their vital signs. Not so back then. If you had anything come up with a patient, you had to go up and see them. Hillcrest had computerized lab results; St. John and St. Francis didn't have them yet, so you had to wait for paper reports to come up from the lab that they'd written the results on; they didn't print out of a computer. So, if you had twenty-three people you were all over the hospital tracking them down. A nurse would call. You'd have to go up there; you couldn't look on a computer to look at an x-ray. You had to go down to x-ray, of course, that's one of the changes.

One of my interesting experiences, we did this community resources month or something like that, and they set up; it was kind of a hodge-podge of things, but you'd like ride around and make home health visits for a day with a nurse, and then go see what happened at the health department and this thing and that thing or whatever. I'll never forget one day I rode around with the food inspector and it was really interesting anyway to see, darned if we didn't go and we went to the little restaurant that was on the other end of the building where the Marina Clinic was. I think I met the guy downtown, but there was some little place down there. I don't remember what it was, and he was looking around, and he said, "What's that?" You know those old ice machines that used to be everywhere, hotels and everything. They stood up on little legs and then the front was angled in a little and had the top that the ice would come down, you'd flip the lid up, okay. So, they had one of those in there, and they stood up on little legs about that high, and he said, "What's that down there?" And [I] said I don't know or something; the guy didn't want him to look, so he pulls it back, and they were storing their salad in there because they didn't have room in the refrigerator, underneath the machine, which did not have any bottom on it, so it was open up into the machine, and like grease or drippings or anything that might come out of the machine were just falling into the uncovered salad that was in one of those gray plastic containers they would use to bus tables with. And he busted them. I'll tell you what, I couldn't believe it. And then you think what else is going on in these restaurants where I'm spending my money. So even that was a really good experience that just opens your eyes to the sources of health problems, right? And around that same time I remember hearing that one of our really nice restaurants in town, one of their employees had active TB, and that came out in the newspapers. So this kind of stuff you think doesn't matter anymore, but it obviously does.

A couple things about timing. So, HIV didn't become public until 1982. People didn't realize there was a thing yet, and I never saw an HIV patient in my residency, but I know that beginning right around the time that we finished in '83, within a year from then, for the next five to ten years if consumed a lot of the residency programs because there were so many patients all the sudden that had that. So, that was a big difference for us that they didn't have. We had, back in medical school, I think the reason there were so many family practice residents then because it was kind of the heyday [of] family medicine when I was entering it; it was just kind of this hippie sort of let's make the world a better place attitude and people weren't quite so focused on money and all that kind of thing like they are now. I've told this to many people, but I went to college lock, stock, and barrel at the University of Arkansas, without scholarships, \$10,000 for the first four years I went to college. So, that's room, board, tuition, everything except beer money, and that even included gas, maybe my clothes were extra. Medical school was only \$30,000 for four years. My tuition was \$850 when I was a freshman for the whole year, \$1650 when I was a fourth year student. So, you didn't have to have these huge burdens of finance that forced people to go into high paying residencies so they'd feel like they can pay back the money sooner. There was less of an incentive to do a specialty back in those days. Let me re-phrase that, to do different specialty, because I do consider family medicine a specialty, too.

I tried to join the Air Force or something, but they wouldn't take me because the Vietnam War ended in 1975 and that was when I was looking for how I was going to pay for medical school, and they didn't need doctors because they had too many extra ones from Vietnam. And that was the only year that that was true, otherwise I would have signed up for the Air Force or the Navy. I've checked. Beginning the next year they started taking doctors again, which would have completely changed everything; I wouldn't have been here. I would have been in a military residency somewhere after med school. My life would have turned out completely differently. I was, Jerry Gray and I were the senior residents when we were third years. So, we attended all faculty meetings. Once a week we had a family medicine faculty department meeting. So, we had a lot to say about call schedules, which is one of the most important things to a resident, when are they going to be on call, who's going to have to work Christmas, stuff like that. That was a really good experience. We split the year in six-month blocks, but we both went to all of the faculty meetings for the year. That was a really good year because Les was there then and he really was so energetic and so focused and organized, so it brought a lot of clarity back into things and I think the experience then for the next few years was so much better with Les Walls there. And everybody did the best they could, but interims are just interims. They're never as focused and organized and purposeful as when you have a new head. He's another guy by the way you might want to talk to, Jerry Gray, if you can track him down. Let me see, you want me to now talk about working? Or what do you want to talk about now? You tell me.

THOMPSON: Well. Let me ask you, let's stay with the college for just a little bit.

LAUGHLIN: Okay.

THOMPSON: You've already mentioned some faculty. Are there any other faculty or doctors that you worked with during your residency that you want to mention?

LAUGHLIN: Absolutely. So, two other people come to mind in the family medicine department for sure, and I mention Dr. Adelson, this pediatrician. We're still really good friends. We've maintained a friendship this entire time. Bernard Robinowitz is a dermatologist, still is a dermatologist here in town. I rotated with him and we've remained really good friends, and he's been a resource and an excellent guy and he was very supportive. David Schwartz, an ophthalmologist was very active early in the program and I think gave Dr. Good some support. He's still practicing. He's been my eye doctor for thirty-five years and I've been referring people to him all along. He's been, he was a real strong friend to family medicine early on and gave, I think, almost all the residents rotated through his office with him, so that was really good. In the program, I can't forget one of my other mentors—thank you for asking me that question—Gene Harrison; I mean he's just a great guy. [He is an] interesting guy. I guess he was sort of the backbone of the program in that his practice became the patients that the residents worked on and worked with, depending on how you want to look at it, at first. And he had I guess a very

understanding group of patients because they didn't see him all the time, but they maintain this relationship with him within this department, and I think really he had two or three thousand patients probably himself back then and that was really how things got started for the program before they were able to start recruiting community patients. He was there most of the time. He was, you mentioned Dr. Plunket as kind of an unexcitable guy, okay, that there's not much you could say or tell that Dr. Plunket that would set off. That certainly was true of Dr. Harrison. He was slow paced. We couldn't tell him anything that would, didn't matter what, we could have said so-and-so's head fell off, and he'd just say, well let's go, let's go take a look at that and see what we can do, you know, and just kind of walk off in there. And he's still like that now. We just had this luncheon a few months ago that kind of helped kick this project off I think and he hadn't changed a bit. He was just rock solid, always had practical advice; that was what was so great about him. He'd been in practice long enough he really knew the stuff that worked in the real world. He wasn't this academic sort of guy. And, now he had his interesting side. So he believed in, I forget what you call it, but it was reflexology maybe where the foot had a heart place and a lung place and whatnot, and he had all this equipment we would have us use on people to work with their feet to help their other medical problems. And I'm still not sure about that, but you know, I mean, I try to have an open mind. He taught me how to do all kinds of skin surgeries and things. Vasectomies, or something, he taught at the clinic. So we did those, I did those in practice for years, and delivered babies for the first few years until that no longer seemed like a good thing. So he could really teach practical things, surgical procedures. Then Dr. Plunket actually over at headquarters, he was sort of one of the more senior, central people. He was always a good guy; he gave a lot of great lectures and like you said, he was a good friend. These people all were or became good friends in not too long a time. Dr. Duffy, we actually had a few disagreements here and there, from time to time when I was in training, but we're good friends now. And the, I'm trying to think who else. Those are the main people.

The other place I worked that impacted me a lot was the perinatal center at St. Francis, the neonatal unit. It was just so stressful. That was just like on a TV show in the sense of this intensity that they always get on a TV show because they cram a year's worth of ER experiences into an hour it seems like. It was like that all the time out there. Dr. Giacoia, who was the head of it, and I think it was Angela Carthanos(??), one of his secondary people, she, they were great. That place was intense. A medical crucible sort of thing.

It's funny that, I'm trying to remember, I guess I did emergency room when I was a resident, but I don't remember exactly. But I ended up doing that part-time for my whole career almost. I've worked at St. John as an ER doctor for ten years part-time at night and on the weekends. And for the last ten or fifteen years I've done various extra projects at the hospital that involve care of transferred or admitted patients and whatnot at nights and weekends, primarily revolving around the emergency room, yet I never really did that, and I never officially moonlighted when I was a resident. I didn't do that. I didn't really have to, but it just didn't seem, yet then the rest of my,

most people do that when they're a resident and then they quit after they go into practice. Mine was the opposite, I never did it as a resident, I've done it, I'm still doing it, and I'm actually on a kind of a call today. If a certain of my partners' patients end up needing to get admitted, they'll call me and I'll have to go over there and see them, although so far I haven't gotten called, so fingers crossed.

I think, we didn't have that many faculty members in the program. Now the one I haven't mentioned is Les Krenning. And Les was interesting. He was a very analytical guy. And so, kind of a cool, reserved personality. And he had a way of really helping you to kind of think about the process of analyzing a patient and doing differential diagnosis, which is kind of the core of seeing a patient encounter is somebody says they have a sore throat, but you have to think about what all the implications of that might be, and do all that over in this part of your brain, while this part of your brain is checking to see if they've had their pneumonia vaccine and this hand is examining their gall bladder, whatever it is you're doing. So, he was able to help us multi-task like that. He also had, in 1980, a transgender practice, which was almost unheard of, and I don't know if you even knew this or not. So, he had a number of patients who were transitioning from male to female, and we would have the experience of seeing those patients in the emergency room at St. Francis where all of his patients would go if they had a problem. And I saw maybe ten different times one of those transgender patients, and we had no experience or training in that, it's just something that happened because he had that practice. We saw lots of nursing home patients at St. Francis because Dr. Harrison had some arrangement, and I can't remember the guy's name, but a nursing home doctor, and so all his nursing home patients that needed to be admitted got put on the St. Francis family medicine service. And that was a busy thing. And we'd be seeing those patients, plus any that the ER had in a rotation of unassigned patients between us and internal medicine service. So that could be very, very busy out there. But between Dr. Harrison patients, and mostly they favored St. Francis for most of the patients that came out of the clinic, but between his patients and Dr. Krenning's interesting patients, and then Dr. Roemer and Greenberg weren't so busy, but they were in the clinic a lot, and they really had a lot of impact on us in the sense of how to take care of an outpatient versus inpatient. Especially nowadays, most people have hospitalists, what we do is outpatient medicine. Same for internists even though they train in the hospital almost exclusively. So that experience working with them was really good. I do not know what happened to Dr. Greenberg. I know Dr. Roemer either still is, or for years and years, was an ER doctor at St. Francis. So I used to see him out there back in the day. What else you want to ask me?

THOMPSON: Other physicians in Tulsa that may have influenced you during your career?

LAUGHLIN: Well, let's see. So, I had all these different mentors at St. John once I started working there. They've all retired now, pretty much. Dr. Farmer in the emergency room at St. John. You don't know a part of life until you're working a night shift at the hospital and Dr.

Farmer says, “Brent, I need to see you in my office.” And he would do that to all of us from time to time. And I missed a fracture in an x-ray, you know you never forget this kind of stuff, you don’t remember the good things, you remember the bad things. I missed a fracture on a carny who had gotten hurt out at the fairgrounds while they were here in town with the fair. And back in those days we looked at the films at night, but they weren’t viewed by the radiologist until the next morning. And the next night or the night after that he calls me in, and by this time this guy’s up in Springdale or somewhere, anyway. Dr. Farmer I worked with him a lot, and he had a lot of impact on me. Jose Medina, who’s a cardiologist, recently retired. And all these people I’m going to mention, they all interacted with residents, too, you know. So, they at various times had residents in their practices, and this is their private practices, so they’re taking time out of work to teach residents, and anyone who does that will tell you [that] you can’t work as fast, you know, it slows you down. You’re either going to be late or you can’t see as many people, and so it’s a real commitment for them to do it. So, Dr. Medina, who was in my building when I first opened my office, and sent me a lot a patients, but just lots of good ebb and flow of information and education for me in residency. John Phillips, general surgeon. John Forest and Harold Calhoun who were urologists. Harold’s brother, something Calhoun out in Beaver, Oklahoma, was like a huge, huge family doctor, paradigm of family medicine in Oklahoma for years and years. I never met his brother, but I’ve read about him in the OSMA [Oklahoma State Medical Association] stuff. Harold told me a story, he said, you know I was out visiting my brother for Christmas one year, and we get a call and he says come on Harold, let’s, we have to run out here and check on somebody, and they get in the car and head out, and delivered twins in somebody’s trailer. Okay? I mean right there in the trailer on Christmas morning.

THOMPSON: Another story about him to add to your collection.

LAUGHLIN: Ed Calhoun is the guy’s name.

THOMPSON: The nurses in the hospital at Beaver swore that he went to the ranch before he came into the hospital to look at his patients.

LAUGHLIN: In the morning—

THOMPSON: In the morning.

LAUGHLIN: —at four AM or something, yeah. Right. That guy’s truly a legend. Let me think. Well I mentioned Dr. Robinowitz, the oncology guys, the obstetrics group that kind of backed me up on complicated patients when I was doing obstetrics, Don Stout, which was the main one in that group, and Rick Dixson, Terry Zanivitz(??), who’s still practicing, just so helpful. The, Kenneth Ihrig, i-h-r-i-g, was a practicing family doctor. I’m not sure what his training was, but he had a family doctor practice. And I was doing my own thing and wondering how I was ever



going to get busy enough, and he walks into my office about a year after I started and said I heard about you. I'm moving to Florida, I'm going to give you all of my patients. And you know, some of them were interesting patients, but he sure enough did. He brought me all his charts, just left them with me. I ended up, I still am seeing some of those patients; I can think of one absolutely for sure. And I can't remember, I just remember her as part of that deal, but I'm sure there are others. That was a real shot in the arm when I needed it back then. And I didn't know him, solicit him, nothing, he just walked in, and did he want me to pay him or anything, no, just gave me the stuff and then off he went. And back then people would sell their practices, so that was very unusual for this kind of thing to happen. I'm just thinking of the different specialties. James Griffin is an orthopedic guy in Tulsa Bone and Joint, now he brought a doctor, I'm trying to think of his name, I can't remember, he bought another practice of a guy who had been at St. John for twenty or thirty years. I worked with him a bit when I was in residency. He was in the building next to me, he must have seen a thousand patients for me over the years, a lot of good feedback, and he's actually operated on me four times, too. So he's kept me going. I'm just thinking back to the early years when I was getting started and really needed more advice. I didn't have partners. If I had specialty questions, these guys were all really available. Who else, let me think? Cardiology. And then really I could always call Dr. Roemer or Dr. Walls after I was in practice if I had a question about something, and they were also very helpful. So, those would be the main ones. Family medicine wise I was in my own office; I had various other people that worked with me. This little corporation, we've had a very strong family medicine community in Tulsa, and so we see each other. Practice wise everyone was pretty independent back in the day, and of course now there's just a few groups for the most part that we're all a part of, so I don't think of it the same way anymore. Thanks to the computer and not being in the hospital as much, unfortunately a lot of the specialists now I couldn't even tell you what they look like. I've never seen them. Back then we, you know, we saw each other, exchanged Christmas gifts or whatever, staff meetings, and none of that stuff happens anymore. St. John doesn't have general staff meetings; it did away with those years ago. I guess the other hospitals, too. It's all online or whatever. That collegiality doesn't exist in a way it did before. Now you just have everybody's cell phone number, right? That's my colleagues now, the ones that I have their cell phone number, the ones that I consider they like me enough to let me call them directly. The rest of them don't give me their number. So, that's the change. Okay, what else do you want to ask?

THOMPSON: Well, you're in an area I was going to ask you. What do you, what are the key things that you think have changed since you started practicing.

LAUGHLIN: Well, obviously we had paper charts, dictation, everything on paper, paper lab reports and things. The practices have changed because again, for the most part we're in larger groups. It's getting to the point now, finally, it's not all about volume. I think that's the biggest change in our practice. So, we get, we still get paid primarily on work units, relative value units,

but we're already getting paid a little bit, and this is getting ready to radically change in the next two or three years, based on quality measures. Is everyone getting a mammogram? Are they getting the shots they need? How's their diabetes control? Are they taking the right medicines they're supposed to be on? There's a whole checklist of things like that. And that is what the computers allow. So, computerization, of course, is the hugest change.

We had our first electronic medical record in the office beginning in January of 2001. And three or four years before that the emergency room had one, two different ones. So, I used two different ones in the emergency room; we're now on our second one in the office, so I've participated in four different electronic medical record systems. The systems now are allowing for I guess what people call data mining. I kind of hate all these terms, but anyway, we're able to input things in the computer in a sensible way: test results, visits, medicines, and things. So, if you were in Kansas City and you had permission, say you worked for Medicare or BlueCross or some quality group, you could pull up and look at my data from there. And we can do that too though, which is what helps us, so we can assess ourselves. Right now we're in the middle of a mammogram program to try to make sure we're getting mammograms on everybody. It's pretty easy with the computer to do that. It's really easy for patients that do it in our system, but those that go to St. Francis or Hillcrest we kind of have to fish through those reports, but as a group we're at about 80 percent. And when you consider that some people will say I don't want one, forget it, then that's still part of the 100 percent, so those people come off the top, then people we can't find their reports, people who forget to go and whatnot, so 80 percent is pretty good. Well, we couldn't have given you any number like that five years ago; we couldn't track it. So we know how each individual doctor is doing, office is doing, the overall practices, Tulsa versus Bartlesville because Bartlesville is part of our system now, compare with national norms, you name it. So, we can really benchmark ourselves against any other slice of the pie you want and see how we're doing on any number of these quality measures. So, you know how it is, every doctor thinks they're doing a great job, and they do I think, but when you look it turns out, well we're not all doing the same great job, that's for sure. While there's plenty of room for variation, some of these things need to be taken care of. You should be getting mammograms, you should be getting pneumonia vaccines and flu shots and other things, no matter what you personally think that you're doing okay, you look and see and only half your patients are getting a flu shot, that's not good enough. And part of it is sales. You know, medicine is a sales job, right? It's all about sales. You size up your customer, you figure out what they need, and you have to sell them on it, whether it's a Buick or a big TV or a mammogram or it's time for your colonoscopy. Now there's a sale job for you. Who wants one of those? So people at least want a car when they go in a car dealership. People come in the office; they don't want a colonoscopy. So, that's part of our job. And it's a little more of a part now because we know these things we need to do; it's not just being friends and just waiting for them to get sick and come in the office. So, that's one of the biggest changes is just computerization. Larger panel sizes are different. We're all seeing more patients than we used to see. Not working in the hospital and the office is a huge thing. Not

getting that 10:30 in the morning phone call, Ms. Smith is here with heart failure and needs to be admitted. Talk about messing with your day. And the ability to now organize and plan your life because I can know that I am going to be through in the office by 5:30 and then go to dinner or go to a play or something and not be constantly just fighting this stressful battle to be somewhere.

The other thing that we're doing with the computer that's different is going to be what is called population health. So, we have a new aspect of our practice, which are what we call at St. John, care managers, but there are all different names for these people and various practice situations, but they're RNs, so they have the ability to do assessments and manage things. They look at and monitor and follow our sickest patients. We've done what's called risk stratification on all our patients in St. John clinic, and I know that Warren Clinic and Utica Park Clinic have done the same thing because we're all participating in a large Medicare equality program. We divide them into six different strata depending on various characteristics of not sick at all to really, really sick. The highest two tiers are looked at very carefully by our care managers. We're doing things like calling these patients just to check on them if we haven't seen them in a month or two, they're not supposed to be back, or we're looking into why haven't you been in for your appointment and calling them. And then very much they're calling all the patients that are coming out of the hospital, are coming out of a skilled nursing facility, and we're tracking them so we know where they are at these places. We get notifications when they get discharged, so people are not falling through the cracks, and those cracks are big and that's why people get readmitted to the hospital so often. They get out of the hospital or the nursing home. They're on the wrong medicine; our list is different than theirs. They take two medicines that are the same or same kind because they didn't know to stop the one we gave them when the hospital gave them a different one. And so the care managers are very much able to keep track of all that stuff, so we have seen substantial reductions across all three of these large medical groups in Tulsa. I know in our group, in readmissions within thirty days and in heart failure admissions and emphysema admissions, things that are up to a point avoidable, you know, eventually people are going to get sick and get in the hospital, but the frequency of admissions is cut way down, and talk about a good way to save money here and put it somewhere else where it's going to do more good. So those are very exciting things. I've been very active in that. Our clinic, I'm not the only one, but in managing that and trying to figure out how to use that data to do a better job. As you can tell, I'm starting to get worked up now because I'm very excited about this stuff. It's a real game changer for what we can do for patients, even when they're just home watching TV. We're actually taking care of them. They're on vacation; we're still taking care of them. We're looking at their data, putting them in these registry groups of patients with diabetes or patients with heart failure and making sure they've had all these things done, and if they haven't we get a hold of them and try to use our sales skills to get them to do things: go to the eye doctor, whatever, things like that. So, that's the biggest change. And going forward over the next five years, we're going, right now most everything that family doctors and doctors in general do is still based on

seeing patients and getting paid just because you saw them today, just they came in, you bill a code, you get paid. We're really changing to a quality payment scheme, certainly for primary care practice, and so five years from now I think we're going to be more than 50 percent is going to be based on quality, and how you measure that is one of the questions we're trying to wrestle with, but there wasn't any of that back in 1983 when I started. I even used a different billing system based on California relative value units, which was, my accountant convinced me to use, which was even then kind of archaic, but so you know, I had a Superbill system, you know what I mean, Superbill? Flat thing on the counter, little brads on the side, you'd lay the Superbill down, it would lay out where it was lined up with their name on today's schedule, put in the charges, it was all manual, add it up at the end of the day, I didn't have a computer in the office at all for the first five years I worked. No computer at all in my office. And then no patient management, you know, electronic health record computer until 2001. So that's a huge difference isn't it?

THOMPSON: Let me ask you one other question because you mentioned it a while ago, the college now has a PA program, you use the PAs in your practice?

LAUGHLIN: Yeah, so—

THOMPSON: And when that started?

LAUGHLIN: Yeah, so, that's an interesting thing. We've had nurse practitioners and PAs in the practices now I think for about ten years. I mentioned that for every hundred patients you have, you're going to need to see one person per day, right? So, if you have 33 or 3400 patients, that's 34 patients a day on average. And that's if you never take an afternoon off or a vacation or have to yourself go to the doctor or to a funeral or anything else. So, as you start taking time off, that number per day even goes up higher. Well, for the average person, especially in the land of quality, you can't do that. It's impossible. In the old days you could sort of herd people through the office if you wanted and just kind of okay here, okay here, okay here, good to see you, but we can't do that now because every visit we see has to be much more detailed, much more information reviewed and covered. So, I had a couple of not so successful forays into PAs, but beginning about four or five years ago we had one join our practice primarily to work with me because I'm the busiest person in our office. And it's been a really good experience. The PA program here in Tulsa has trained all but one of the people that we've had in our office, and we've had altogether I think five, maybe six. But anyway, the other trained up in Springfield. They've all been unbelievably good. I'm so impressed by the PAs, their demeanor and their skill set, knowledge base. I'm trying to figure out how they learn so much in such less time than it took me to learn what I know, because they're sharp. They don't know everything. The nice thing about working with PAs, at least the one's we've worked with, is they don't mind that they don't know everything. They're eager to learn, happy to learn from us. I do know more than they

do, but they learn fast. And, in fact, the newest one just started about six weeks ago. I was reading one of her notes and I saw this word I had never heard of, a medical word, too, and I thought what? And sure enough I looked it up. I couldn't find it in a regular dictionary. I hunted around for it, but it was a real word that mattered and it was right for the patient. So, they're learning and really helpful. Our patients love them; we get great satisfaction scores on them. That's another thing; patient surveys that we do nowadays, we didn't use to do patient surveys, and that's really helpful. And the patients really enjoy working with them. So, the use of physician assistants, we now call them advanced practice providers instead of physician assistant, that includes nurse practitioners, too, APPs in our parlance. They have allowed us to develop something that really seems to be important nationally and is looked to as a model for the future, which is team based care. So we have, of course, medical assistants and doctors, we've had that forever; now we have these extenders, or APPs. And the patients are getting it that we're a team. Most of the patients that come to the office come because they want to see us because they saw us online, somebody referred them, their mother used to come here, any number of reasons like that. It's a bit, again, of a sales job to get them to accept a lot of times the extenders, but once they see them they love them because they've all been sharp, nice, good, everything. So, now we're moving into this world of teams. So that they don't mind if they don't see me every time, some people do, you know. We're working on blending our schedules and making opportunities for all kinds of visits and things. I will certainly applaud the PA program here and say it's been a great thing. And so now we have hired another one; we have one leaving, who got married and is moving out of town, so we'll have three APPs going forward, and four doctors. So, we're almost even split now, and it's a good thing. It's a wonderful thing. We couldn't do it without them.

THOMPSON: Now one of the things I wanted to do, because I don't think the camera was rolling before when you and I were talking—

LAUGHLIN: Right.

THOMPSON: —and that was for you to mention again some of the other residents that you told me that we should interview—

LAUGHLIN: Yeah, so—

THOMPSON: —that were in residency when you were there. We weren't on camera then, so I think—

LAUGHLIN: That's okay. We had a great experience. So Joe Choteau and Doug Cox were kind of the cool head guys when I was there, and Paul Cochran I think, and Julie Cochran, they were the third years. And they'd have parties and all kinds of stuff, you know and just little cookouts,

nothing fancy at all. And by the way when I started I signed my contract, my salary was \$13,000 a year. Because there was an oil boom going on at the time, by the time I started they had increased it to \$16,000 a year. So I got a \$3,000 raise before I started, but even back then that's not very much money, I can tell you right now. But Richard Reinking and Robert Gray I think were in the next class. We've, they stayed in Tulsa, and so we've remained friends all along. And although I've never been in practice with Richard, we've been very active in the Oklahoma Academy. He's also a past president. Dr. Gray's been in practice situation for about fifteen or twenty years and also had a leadership role, and we've worked together a lot. Jerry Gray was in my class. We had Ed Wegner and another guy from the Dakotas that came down and joined us. I can't remember the other guy's name; he ended up doing extra OB and whatnot and I think really went out and tried to be the full surgeon, family medicine doctor, kind of the Marcus Welby plus kind of person. I mentioned Marcus Welby in the office the other day and nobody knew what I was talking about because they're too young. Nothing like getting old, right? Jerry Gray was the co-head guy. We had, you know, all these other people a little bit younger. There were some guys from Arkansas that followed me and kind of heard about it through the grapevine, Mike Jansen(??) and Peter Post. They're in Arkadelphia and Morrilton, Arkansas, respectively now and I keep up with them. I'm trying to think who else was in my class. It's unbelievable you can't remember now, you know, because you spent so much time with them at the time, how could you forget? But those are people that come to mind. There are a lot of people in town that were in the residency program. Lynn McClintock who's out in Sand Springs and now up in Claremore, worked a lot in the emergency room for use. Debra Colpitt who was my intern when I was in family medicine; she's been up in Collinsville for years and years. I don't know. I almost wish I'd looked at a list before we came in, but believe you me; the family medicine program has seeded Tulsa and the surrounding area with so many good doctors. And another one, I don't know if he did the program or not, but he's the head of it now, John Tipton over at Hillcrest, and he's been a real staunch supporter of family medicine. Some of the guys from Doctors Hospital, let's not forget them; Dr. McCarty was over there, John Tipton was over there, David Shule(??) was over there; they were all real involved with family medicine. Those were the three that pop into my mind. But as far as that goes, if you go over across the street over here in Founders Hall and look at that picture of the Founders, well I knew all those guys. Now of course I'm not going to remember their names, but Dr. Orr, Dr.—what's the guy's name? See I wish I had the list to look at. Go look at that picture, they all had involvement in the family medicine program at the time. Their commitment to family medicine, building Doctors' Hospital, and I'm sure taking out mortgages to do that, and then turning around and instead of gifting their children with the money that they made when they sold that hospital to whichever hospital company that was, putting it as a foundation, and then all the things that that's accomplished around town here, that room for one thing, but lots and lots of support for family medicine residency and training programs. That's an amazing legacy that in many hands would have simply the money been divided up and their kids would have all taken a trip to Alaska or something instead, and that's okay if that's what they wanted to do, but it's so marvelous what

they did decide to do. Les Walls knows obviously a lot more about that because he was the kind of executive person for years with that group.

So you have to, you guys have to decide about this, when I say you guys I mean the University of Oklahoma, the Physician Manpower Training Commission. Does that still even exist now or not? Okay. So a whole lot of us stayed in Tulsa, which was not the stated mission of the residency program. And it sure is at the one at OSU, I know somewhere it says rural, I don't know what all. But you know, people need doctors. And family doctors are hard to come by these days because of all these financial issues and other things. It doesn't seem very glamorous, et cetera, et cetera, et cetera, you know. But so many of us did stay in the Tulsa area, or moved here from other residency programs, and I think it's been great. I mean I think that family medicine, well you know, this is, when I went to St. John and I opened my door, I was the first family practice doctor that had ever made that hospital my hospital. The only other family medicine doctors there, their main hospital was somewhere else or they didn't do hospital before. They just sent patients there, but they didn't actually round or anything. There were six people in the department; Dr. McCarty was in the department, the guy from PruCare was in it, see I can't remember anybody's name anymore, Frank Phelps, he was in the department. But nobody used St. John as their hospital. They used Doctors' or St. Francis or somewhere. It was an anti-family medicine hospital. It was an internal medicine hospital. They weren't going to let any osteopaths in; they weren't going to let any family doctors work there; we weren't good enough, blah, blah, blah. And to see all that change over the years, the family medicine department now has sixty people at it at St. John. And a lot of them had to do with the In His Image residency, which moved over there a few years ago, but nonetheless, lots of us in St. John clinic, from all over the community, and to see all that grow, and it's mostly because of OU-Tulsa and all it did. It's also because of the kind of the rump of ORU Medical School, which was In His Image Family Medicine Program, which started as part of that. And now the last few years, OSU has really started producing a lot of good quality people. So, family medicine really kind of rules in this, even with all the strikes against it. And that's a wonderful thing. When I went to St. John, Sister Theresa; Tony Reed, her facilities manager; and Colonel Reeber(??), her second in command person, the three of them took my wife and me out to dinner to convince us to come to St. John. Now that's the three top people in the hospital trying to get one little family doctor to come because they realized family medicine was going to save them because all their old internists were going to die off and they weren't going to have any patients anymore. And they were right, and I just kind of lucked out a little bit. But that's the kind of changes in Tulsa in the last thirty-five years. And I'm still friends with Sister. We chat, you know, she's retired now, but I see her because she's still over there at the system. But you know, most the people, half the people probably now that are joining the clinic, they don't know what Sister looks like, they have no idea. They don't [know] what Dave Penn looks like who's the head of the hospital. They don't have any interaction, those guys are way over—they were actually taking me to dinner in that old restaurant over there in the Utica Club over, two or three times, to convince us yeah, you want to

come to St. John, you really do. And so, that was, I look back on that and it's kind of, it's just funny, right?

THOMPSON: It's good.

LAUGHLIN: I know it's good; it's just that there was that lack of family medicine within town, right? St. Francis just gave me the brush off—nah, we don't need you. I could have helped them. They never thought about it. Who knows how many—I think I have about two, my patients have about two colonoscopies per day, maybe three, because I look at every report that comes across my desk, and that's just one thing, and that's a lot of revenue stream. That's a lot of business for the hospital. Not to mention everybody in the hospital, every other thing that's going on and all the different specialists that see patients of mine every day. So for a hospital to just brush off the whole idea of family medicine, well obviously Doctors' Hospital never did, Hillcrest was a little bit more supportive because that's where most of those doctors came from before they founded Doctors' Hospital, but wow have things changed, no doubt about it.

THOMPSON: Is there anything else you want to add?

LAUGHLIN: Let me look at this little cheat sheet.

THOMPSON: Go right ahead.

LAUGHLIN: Is that okay? All right. Is this boring?

THOMPSON: No. You have done an excellent job, sir.

LAUGHLIN: Let's see. We hit on most of this stuff, didn't we?

THOMPSON: I think you did a pretty good job. You did a good job.

LAUGHLIN: Okay, there's one other thing I want to mention.

THOMPSON: Go ahead.

LAUGHLIN: So one of the things that I think is still important, and it's easy to forget in this world of clinics and hospital ownership of practices, I'm an employee of St. John, have been for years, is [that] people forget about the other stuff and the little stuff. And by that I mean, I do think there's been a drifting away from organized medicine, that the OSMA [Oklahoma State Medical Association] and the OAFP, Oklahoma Academy of Family Physicians, is not, people aren't as engaged with those groups, they don't see the value. I think there's still a value; I, a



little bit, drank the Kool-Aid because I'm a past president, I'm not terribly active, but I do attend the meetings and various things. There still needs to be a voice for family medicine and those of us who have been presidents, Kevin Steichen, that's another person I didn't mention before, Kevin Steichen, and Mark Keeter. Kevin's been president, Sidney Moy's been president of the state group, and I've been president just within St. John Clinic, maybe one other of us. We certainly feel the need and see the importance of maintaining a political base for keeping the state government and insurance companies and everyone focused on primary care. And trying to make sure that they orient the system so primary care is a good career, that it's satisfying, that we paid enough, and all that kind of thing. And there's still forces that are trying to make that not happen. For example, look at right now with Medicaid wanting to cut 25 percent of their already low reimbursement rate, which doesn't affect me very much, but it affects profoundly all the family doctors that are out in the rural areas and clinics. That's going to be a huge hit for this OU facility here, the family medicine clinic over by Hillcrest, I mean I'm sure they're just pulling their hair out trying to figure out what to do. If we don't have a united voice to represent primary care and family medicine we're just not going to be happy. Nobody's going to be happy.

The other thing I want to mention is that I talked a minute ago about how I've worked out at the clinic for years, you know, volunteer. I just love volunteering. I've had a lot of orthopedic problems I guess you could say over the years, back trouble and this, that, and the other, so I just decided not to tackle like going to Africa or South America or somewhere to do mission work, that's all kind of spotty and there's a lot talk about just how good that all is anyway to do because you go for a week and then you leave and what goes on after that. So instead I've tried to work really hard on just Tulsa, and so for years I worked with Kevin Donovan who was one of the pediatric people; he's another mentor of mine, once a month a night clinic up at Neighbor for Neighbor. And he would see peds; I would do the adults. We'd work four hours, three hours, see tons of patients. It was really fun. We had a great, fun evening. It's hard for people to think it would be fun I guess to go work, you worked all day, you work up there all night, you get home tired, but it really was fun. And my family kind of got busy so I stepped away from that, but for the last six years I've been a medical director and working in the clinic at Neighbors Along the Line, which is between downtown Tulsa and Sand Springs on Charles Page Boulevard. I think that, I want to say I'm not bragging, but I think we still have a commitment, should be a commitment, that there's a need for this kind of work that I hope other doctors see that is very valuable on every level: patients need the care, patients even in the era of Obama Care. There are lots of people who can't afford to go to the doctor and these kinds of clinics see everybody for free, for nothing. Give them medicine for free usually, lab tests for free. You know we've had a number of patients that through various programs put on the County Medical Society, St. John, the medical school, that have gotten surgeries and all kinds of things done for free that we've seen at the clinic. The neighborhood likes that kind of thing because they have a place. Some of these neighborhoods are pretty lacking of place, and they're just a bunch of houses and crack houses and who knows what, but they've got a safe house where they can go and get some things

done and commune with each other. It's really so important. And so it's a hard sell. I've been trying to get volunteers to go and work at the clinic for several years now, I have gotten zero except for the PAs in my office, who I said, would you all like to come out and work the clinic, and I hope they didn't feel compelled, but they said sure, and so all three of them have been out there working already a lot. I'm hoping to, I don't know how to do it, but to get more physicians thinking it really is okay to spend two hours a month doing something like this, and it's a hard sell. Somehow the mission trip's sexier, right? You know it is, right? We're going to go to Guatemala; we're going to go somewhere. But this is continuity care, patients in our community, they need help, too. So, I think you get in one of these clinics and you just kind of clock in and clock out and I just don't think there's the same necessary community commitment that there was in the old days. And I'm old enough now to say the old days, and I hate that. But it's true. Things have changed, you know, mostly for the better. And I'll say this and then I'll be finished. I love being a doctor; I haven't changed my mind one bit about being a doctor, I haven't changed my mind about being a family doctor. I've thought about it a few times, I thought about switching to radiology about ten years in, but you know what? I'm so glad I didn't; I love my patients. They're begging me not to retire. They see I'm getting some gray hair now I didn't use to have, and so they ask me about it a lot. I'm not planning to retire anytime soon. It's been a blast, a difficult blast, but nonetheless I'm so glad that I've done it. And I would hardly change a thing. It's been a wonderful thing.

THOMPSON: I have a couple questions I want to ask you.

LAUGHLIN: Sure.

THOMPSON: Number one I want to say that we just recently interviewed Dr. Thurman, who was the provost at the Health Sciences Center when the school was started.

LAUGHLIN: I don't know who that is—you got me.

THOMPSON: We interviewed him and I think you'll find this very interesting. When he left the Health Sciences Center and went to the Oklahoma Medical Research Foundation, he got involved with the Children's Home in Oklahoma City. He's ninety-five and he's still involved with that and raising money and doing things and getting people to work there, same thing that you're talking about.

LAUGHLIN: Well we just had our fundraiser last night, like I said, over here for Neighbors, which is the clinic out there. And it's a basic needs agency just like Neighbor for Neighbor, not as big.

THOMPSON: So that is good. He would be very excited to hear you say all that. I do have a question though; did you know Dr. Dennis at Arkansas?

LAUGHLIN: Dennis?

THOMPSON: Uh-huh.

LAUGHLIN: What did he do?

THOMPSON: He was, should have been about the time you were there, he should have been the dean or the provost at the University of Arkansas Medical Center.

LAUGHLIN: Probably provost, not the dean. Dean Bruce was our medical school dean when I was there. So just like saw him a couple times, didn't know him.

THOMPSON: Well the only reason I was is because he was at the University of Oklahoma Health Sciences Center before he went to Arkansas so that was the reason I asked.

LAUGHLIN: Well yeah, there's a lot of regional kind of crossing around.

THOMPSON: And then I have another personal question because you're about the right age. And I cannot remember her maiden name, but did you know a young man whose last name was Goodson when you were at Fort Smith?

LAUGHLIN: Not Goodman, Goodson?

THOMPSON: Goodson.

LAUGHLIN: No.

THOMPSON: I'm going to have to find out what Jennifer's maiden name was.

LAUGHLIN: Not that I can think, no.

THOMPSON: Because you're about the right age.

LAUGHLIN: Well how old am I?

THOMPSON: Well I have a pretty good idea.

LAUGHLIN: I graduated high school in '72, so I'm sixty-one.

THOMPSON: Okay. She may not be quite as old as you, she—

LAUGHLIN: My wife when to North Side, I went to South Side, so we kind of know everybody in Fort Smith, pretty much.

THOMPSON: Well she's now the director of the public library.

LAUGHLIN: In Fort Smith?

THOMPSON: In Fort Smith.

LAUGHLIN: Man, don't you wish we had a library like—have you been to her library?

THOMPSON: Yes, I've been to Jennifer's library.

LAUGHLIN: We're going to have a pretty good one I think when they open the new one down here. But they've had a beautiful one for fifteen years now. We've had crap. It makes me so mad.

THOMPSON: She actually worked at the Bird Health Sciences Library in Oklahoma City before she went back to Fort Smith, so that's the reason I asked.

LAUGHLIN: Yeah, they've got a great—. Fort Smith's got a lot going on. They've got a med school they're opening over there. Did you know that? Osteopathic med school.

THOMPSON: No, I didn't know that.

LAUGHLIN: Yeah.

THOMPSON: Is it a private one, or?

LAUGHLIN: I don't know. It's going to go out east where that Chaffee Crossing is out in Barling. And then they're doing this same thing in Fayetteville. You know, they're opening a fully formed branch campus in Fayetteville, Springdale, just like this is, but over there. A lot going on.

THOMPSON: You know they had there

LAUGHLIN: AHAX. I trained; I did some AHAX stuff when I was in my fourth year of med school. So, didn't work at the one in Fort Smith actually, but I did in Texarkana.

THOMPSON: Oh, you were in Texarkana. Oh yeah.

LAUGHLIN: So, just for a couple month, but—. Okay I guess we're done?

THOMPSON: We're done and I appreciate it. Thank you very much.

*End of interview.*