Dr. Kenneth W. Covey
Narrator

Dr. Milo Bologna
Interviewer

February 15, 1986
Heritage Education Commission Oral History Project

MB: ...Dr. Kenneth Covey. And hmmm...

[Brief recording interruption]

MB: We've discussed a little bit about the type of things to be brought out in this interview. So we'll get right into it.

[Brief recording interruption]

MB: Today's date is February 15, 1986. Hmmm, Dr. Covey, could you tell us please a little bit about your background and your date of birth, place of birth and this type of thing?

KC: Yes, Milo. I was born in Bagley, Minnesota on August 4, 1919. Just shortly after World War II...World War I. Excuse me. [Chuckles] I've only lived through how many wars: World War II, and Vietnam, and Korea. But anyway, my father was a dentist in Bagley. And he was also...his father was one of the pioneer merchants in Bagley, in fact, helped to start the first general store in Bagley, Minnesota back in about 1904. And I graduated from high school in Bagley, Minnesota, although my folks did move to some other towns during my growing up time.

Went to Hamline University in 1937 after finishing high school; spent three years there. At about that time Adolf Hitler was raising a rumpus over in Europe. I intended to spend four years in pre-medical education but decided that I'd better get into medical school before Uncle Sam drafted me to go fight Adolf Hitler. And as it was, I got into medical school three months before Pearl Harbor. And during my medical school stay at the University of Minnesota I was second lieutenant in the Medical Administrative Corps. I spent the whole of World War II in medical school and in interning. I interned at St. Barnabas Hospital in Minneapolis for a year and then went into family practice in Mahnomen, Minnesota.

I discovered later that I was the only physician graduate of that class of the University of Minnesota in that year who went out into family practice; the remainder of my colleagues were going into residencies or were still in the armed services. In any case, I was the only physician in Mahnomen, which is a county of about seven thousand people. And I also was a contract

physician for the Indian Service, and their medical care was spotty to say the least. In fact, there were times when I was the only physician on the entire White Earth Indian Reservation, so I had responsibilities for around fourteen thousand people, in that area, which in retrospect seemed a little overwhelming. [Chuckles] And I can recall making seven or eight house calls every day. And I stayed at Mahnomen for around eleven years. Delivered by my last count, I think, around eighteen hundred babies. I figure it was about a fourth of the population of Mahnomen County, anyway. [Chuckles] And I think I can still find my way into a lot of the homes that I called on in Mahnomen. And even now in 1986 I'm still seeing patients that I took care of or delivered back in the 1940s and 1950s. I think...

MB: If I may interrupt, Ken, what you are describing sounds like more than just a general practice then. One gets an idea that there must have been a sense of *mission* in this kind of work. How would you respond to that?

KC: Well, I think the mission...It was a mission. I think medicine came first with me. And thanks to my wife who raised five of our children without too much complaining, I was able to do it, Milo. [Chuckles]

MB: [Chuckles]

KC: You know, you have to have a wife who will go along with those horrible hours. At one time I kept track of the number of days that I got called out of bed, and I came out to about one night out of every three I was out of bed when I was in that general practice. And I finally got discouraged about keeping records and didn't do it. But it was in really a very fun time. And I think maybe the physicians nowadays would look upon that sort of practice as my being a little bit crazy doing it. But I really got to be a part of the lives of many people in this small town. And I know you've had that experience being in practice yourself, Milo.

MB: Mmmm-hmmm.

KC: That people come to rely on you and you're their friend. And it may be that the current clinical...clinic-type practice is not really as satisfactory for that reason in that people do not have the same doctor when they go back to the clinic for care.

MB: With the degree of super-specialization that we're seeing, Ken, when you look back on this, how do feel that it was possible for you to do everything in medicine? Obstetrics, general medicine, probably a little surgery, certainly minor surgery, lacerations...how do you feel when you look back? How'd you do it?

KC: Well, you'd be amazed, Milo, at the things that a small town doctor can get by with. You...I've seen doctors in small towns, maybe they're forty, or fifty, or sixty miles from the closest medical facility. And they probably do more than they really should at times. But then there are times when you are forced into doing it. I did several caesarean sections on people who had premature rupture of the uterus or premature separation of the placenta; that they were emergencies, they were in shock, and something that would be unheard of now for a family

practitioner to do. But I did appendectomies and hernia repairs, besides all the other minor things that came along. And referred as many patients as I could to Fargo, which was the nearest big medical center in those days.

Some of the outstanding things that happened back then; I recall that poliomyelitis was really a scourge at that time. Every summer parents were frantic about their kids getting polio. We had no idea how it was transmitted. Had no way of treating it, you know, once it occurred, other than sort of sit it out and hope that there would be no residual paralysis. As I recall, the polio years were in the early 1950s, maybe late 1940s and early 1950s, we had quite a few polio cases. And I recall Dr. Pray [sp?] and Dr. Lancaster [sp?] in Fargo and Dr. Fortin n Fargo cared for a lot of the patients that I referred over that way. And the other thing was the equine encephalitis. That came along about 1952 or 1953, 1954 and we had some fatalities from that. And that was another scare that we had. But I think a family doctor can handle a great majority of the problems that come along. Unfortunately, nature cures anything if you wait long enough, you know, and so you sort of help people over the rough spots until they do get better on their own.

Anyway, I recall my malpractice insurance being...it was thirty-five dollars the first year I was in practice, and now forty years later it's eighteen thousand five hundred dollars. That's a major change as far as economics of medicine is concerned. I used to charge one or two dollars for an office call. Of course, my fees have gone up, too, Milo, so now maybe I'm charging ten, twenty dollars for an office call now. So the price...my fees have risen proportionately. But even then, delivering a baby with the prenatal and postnatal care was thirty-five dollars, if I did no prenatal care it was twenty-five dollars, and if I didn't get there in time for the delivery (whether it was a home delivery or a hospital delivery) I usually got about fifteen dollars for the care of the patient.

MB: Just to be sure that we're correctly placed in history, what years were those?

KC: That would be from 1945 to 1956 in Mahnomen. And I probably would still be there...The Sisters of St. Benedict from Crookston operated a hospital and little home there. And it was only twelve beds or so, and the nuns really were great. They worked sixteen hours a day, seven days a week. I'm forever indebted to them, you know, Milo, for what they have done. But anyway, the Department of Health came along about 1954 and suggested that the place was not safe from a fire standpoint and that they would have to close it. So we had a bond election. And I really worked hard on it, and I know the nuns worked hard on it. And I think there was some religious feeling about building a hospital for the Sisters. And the bond issue was turned down by a vote of six to one.

So I could just see myself practicing...without a hospital. And I had done that for a year when I first came to Mahnomen, delivering babies at home, doing house calls. So I made up my mind to go somewhere else. And I thought, well, as long as I'm going somewhere else, maybe I should change into a specialty. And orthopedic surgery always intrigued me quite a bit. So I applied to the Mayo Clinic. I thought I might as well go the whole hog, you know. [Chuckles] And I'll be darned if they didn't accept me!

MB: [Chuckles]

KC: [Chuckling] I didn't...you know, I was surprised, because here's an old family practitioner, been out of medical school for almost ten years, and they accepted me into a rather...what I thought at the time was a prestigious residency program. Well, hmmm, a lot of tears, you know, in leaving Mahnomen. We had our five children there, and I'd been a part of the lives of so many people, so it really made it tough. But hmmm...we made the break. The hospital closed. And then they tried to get a doctor into Mahnomen and they couldn't because there was no hospital. So the county for a year and a half or two was without a physician. So they then had a bond election for a hospital [chuckles] and passed it overwhelmingly when they discovered they needed a hospital to get a doctor there. So I feel in a way that ultimately I did get the hospital for Mahnomen, but in sort of a roundabout fashion.

MB: What sort of inkling did you have toward orthopedics when you were in family practice?

KC: Oh, I think in orthopedics you're dealing with things. You're dealing with your hands, I suppose, and surgery, and then manipulating fractures. You're dealing with deformities that you can see. And as you know in pathology, you don't have to deal very much with psychosomatic illnesses, which have always been sort of a hard thing for me to deal with, you know, the emotion...the way the emotions affect us. And that's important, you know, in disease, but it's also a rather difficult part of medical practice. So orthopedics was something...you can see a short leg or you can see an angulatory [sp?] deformity in an arm or you can see the curvature of the spine with no problem. And hmmm...hopefully try to do something about it. So I went to the Mayo Clinic and spent three years there at the grand salary of a hundred and fifty dollars a month, which they paid residents back in those days. And with five kids and a wife...But we had enough saved to make it through alright and had a good time.

So then after I got out of Mayo's, I had northern Minnesota in my blood. I went back to Crookston, Minnesota and practiced in the Northwestern Clinic up there. I had known several of the doctors up there and respected them. And I stayed there for seven years and left because of...hmmm...well, some financial considerations and also some practice considerations which are not...all that great. I started out in independent practice in Moorhead, Minnesota. And that was in 1966. I started out as living in Moorhead and being on the staff of St. Ansgar Hospital, which is a hospital run by the Catholic Sisters, and a great hospital. And that's where I met my interviewer of today, Dr. Bologna.

And ah...I've been in sort of solo orthopedic practice since, although I've had several associates with whom I've had an office sharing arrangement, so it hasn't been *impossible* to get away or take vacations. I've had good help from my peers. But we like Moorhead very much. Two of our children went to school in Moorhead, one at Moorhead State University and the other at Concordia. So we really consider this to be our home now and we've been here for the last twenty years. We've watched St. Ansgar Hospital grow. And at the time I came, I think Dr. Bologna and Dr. Carlin [sp?] and myself were the only two specialists that were residents in Moorhead and who practiced at St. Ansgar Hospital. There were other specialists in town, but they were all on the Fargo side of the river. Saw the...and the family practitioners, of course, Dr. Carlson [sp?], Dr. Rice [sp?], Dr. Houghton [sp?], Dr...

MB: Duncan.

KC: ...Duncan.

MB: Saxman [sp?].

KC: Saxman, yes. I'm missing a couple of them, I'm sure.

MB: Johnson.

KC: Olga Johnson. Hmmm...Moorhead had always been somehow or other labeled as a family practitioner town, medically speaking. And the specialists were all on the Fargo side at the Fargo Clinic, and to a lesser extent, the Dakota Clinic. Since that time, well...at the time I came, the orthopedists were Bill Kelly [sp?], Fargo. He was independent. And there was Doug Lindsay [sp?] at the Fargo Clinic and [unclear – sounds like Did Wens] at the Dakota Clinic. And before...before we all came, the only orthopods in North Dakota and northern Minnesota were Dr. Harry Fortin and Dr. Joel Swanson, so at one time two orthopedic surgeons covered all of North Dakota, and the northern half of northern Minnesota...or northern half of Minnesota. And now there are sixteen or seventeen orthopedic surgeons in the Fargo-Moorhead area alone, and we have them in Fergus Falls now. And two in Fergus Falls, and one in Detroit Lakes, one in Crookston, two in...or one in Thief River Falls, about a half a dozen in Grand Forks. So the specialty of orthopedic surgery has really grown. And it's...everybody seems to be busy. I don't know how in the world Dr. Fortin and Dr. Swanson did it on their own.

MB: Of course, there's been a terrific proliferation of orthopedic procedures.

KC: Yeah.

MB: Since the days that you're speaking of.

KC: I recall one story about Dr. Swanson and Dr. Fortin. They all... they didn't trust each other, so they took their vacations at the same time. [Chuckles] So there were times when there was no orthopedic coverage at all in north Minnesota and North Dakota.

MB: [Chuckles]

KC: I didn't really...I never met either one of them, to tell you the truth. I referred patients to them but I never met them. So Dr. Fortin died about 1957 or 1958, somewhere along there. And Dr. Swanson died not too long ago but he was retired for a long time. But I've seen the orthopedic practices grow in this area primarily, I think, because of the increasing specialization of medicine. And physicians are afraid to do things beyond...I mean, they might be perfectly capable of doing procedures, orthopedic procedures, but they get nervous about the liability situation, so they tend to refer orthopedic problems more than they used to. And I'm sure you

can recall Jim Duncan pinning hips here and something that a family practice practitioner would never do anymore. Not that they might not be able to but just...

MB: They are under duress.

KC: Yeah.

MB: The near presence of an orthopod in a community would dictate against their doing anything like that.

KC: Yeah. Anyway, orthopedic...Do you want to [unclear] for just a moment?

MB: That's alright. No. No, that's okay. You tell me if you want me to stop.

KC: Alright. As far as orthopedics itself is concerned, I've seen the advances, especially in the treatment of arthritic joints. And I think prostheses have really developed since then. When I first started in orthopedic surgery we had no implants to put in joints. Smith-Peterson had a cup, called it a cup arthroplasty. And that worked sometimes. The admonition is that the technique had to be exact, otherwise it didn't work. [Chuckles] Well, nobody seemed to be able to get the right technique, and that was a common complaint, sometimes you got a good result and sometimes you didn't.

But then along about 19-...well, actually, 1964, Dr. [John] Charnley in England started doing what they call total hip replacements. And in this country in about 1970 or 1971 the first total hip replacements were done. And those really revolutionized the treatment of arthritis of the hip. And [it's] still a great procedure and it's being modified slightly at the present time but it's still...the procedure that Dr. Charlie developed is still working well. And of course the joint implants have also been jumped into the knee and practically any joint you could think of somebody has tried to replace. But really, the successful ones are the knee and the hip ones, and possibly the finger and hand prostheses. And the advent of metals and plastics which have been compatible with tissues, that has made it possible to do all these things.

And there are two other advances that are more recent which are occurring in orthopedic surgery. One is arthroscopy. That is the technique of looking into joints with lights on fiber optic instruments. And the techniques of being able to operate then under this visualization through tiny incisions has really revolutionized especially knee surgery. That is being done also in other joints. And the latest development which is in orthopedics which is really taking hold is a microvascular surgery that has the ability to reattach amputated parts or to do muscle and bone or skin grafts using...detaching the parts with their blood supply and then reattaching them to a remote area so that they grow...grow well. That is sort of a young man's procedure, the microvascular surgery, because it requires a steady hand and a lot of patience. And the younger orthopedic surgeons are doing that now. I don't think the older ones are.

But along with our increased expertise, we're exposed to more liability, I think. People expect more from us now. And with poor results they are more inclined to think about suing the doctor.

Whereas in the olden days people accepted the fact that medicine wasn't all that exact and would accept a poor result or even a fatality, you know, as one of those things that happened in medical practice.

MB: Dr. Covey, what do you see on the horizon of the future of orthopedics? What are some of the newer things coming along?

KC: Oh, right now I feel that the present joint replacements are not a long term affair. That is, they are liable to break down in ten, fifteen, twenty years. And we've been saving those procedures as much as we can for people who are elderly, so that they will probably die before the prostheses breaks or loosens. However, I think that in the next few years we are going to see joint transplants much like we're seeing liver, and lung, and heart transplants now. And that the person who has a severe injury with destruction of the joint or a tumor or arthritis can eventually look forward to some type of cadaver transplant, as a piece of joint taken from another person who died, much as they do heart transplants now. And I think the technology is evolving for that. In fact, it's being done now but usually just with malignancies or sort of hopeless joint situations where the only alternative is an amputation. So...

MB: So if it fails, you still have the...nothing worse than the amputation you would have had anyway.

KC: Right. Yeah.

MB: Hmmm, there's a great deal of turmoil. I know I got out of my specialty just in time, Ken, a lot of economic turmoil in medicine. What are your feelings about that?

KC: Well, back in the days when I first started practicing...you know, and my fees at most would be maybe a hundred dollars for taking out an appendix and a dollar or two for an office call. Economics was not all that bad. Back in about 1946 and 1947 during Franklin Roosevelt's time as President, the push came on for socialized medicine. And I recall a Wagner Murray Dingell Bill, which scared the *heck* out of the medical profession. All of a sudden they saw socialized medicine rearing its ugly head and rather rapidly.

And there was quite a campaign by the medical association. And I recall that the symbol seemed to be the painting of the doctor by Luke Fildes [the 1891 painting *The Doctor*] sitting at the bedside of a little girl, you know, and not being able to do very much but at least he was showing concern. So in response to this Wagner Murray Dingell Bill, Blue Shield and Blue Cross were developed. And they originally became...started out as doctor...Blue Cross did, anyway. Or Blue Shield started out as a doctor's organization. And I was one of the original incorporators of Blue Shield in Minnesota, about 1946 or 1947. And the impetus for that was the threat of socialized medicine. And the doctors and the hospitals felt they had to come up with an insurance plan which would be an alternative to a government type of medical service.

When I first started in practice advertising was sort of a no-no. When I started in Mahnomen, I called up the medical society and I said, "Would it be alright to put a little card in the paper

saying that I have started practice in Mahnomen?" [Chuckles] And they said yes, it would be. So that...that was about it, except we did have a little professional card, all the small town papers would have a little professional card listing the doctor's name and his hours, and that...that was about it. But along with the insurance, Blue Cross and Blue Shield and that...and then the subsequent proliferation of medical insurance companies, things have changed.

And of course I think economically Medicare was the big impetus for change in this country. I think it was all made possible by the computer, which was very...an easy way to keep track of payments and manage this whole system. And when I...oh, if I think of one technical thing that's happened, I think it's the computer that has really made it possible for all these changes to occur. And anyway, Medicare established...it was originally designed to provide most of the medical patients, care for patients over sixty-five. But the program I think had a built in incentive to increase fees, so the doctor's fee profile was dependent on what he charged two years before. So everybody was raising their fees so they would not be left in the cold two years later when the profiles were raised. And Medicare has now come to the point where it does not pay even half of the average medical bill for an elderly patient. So as a result, government is now trying various other alternatives....

[Recording interruption]

KC: At the Dakota Clinic there was sort of an aggressive orthopedic surgeon, an excellent one. Hmmm...got publicity in the newspapers. And this...some of the other orthopedic surgeons felt that this was sort of an advertising thing, and I know there was some concern about it. But that's...that was nothing compared to what's going on now with the government and private insurance. Insurers are doing more of the financing of medical care. The clinics, especially, have gotten into competition for patients. So the Fargo Clinic and Dakota Clinic particularly, in order to survive, have tried to insure that their base of referrals is kept fairly intact. So they have assumed all the little doctor's offices and clinics in eastern North Dakota and western Minnesota. It has made it harder for an independent physician who has relied upon referrals from independent doctors to survive. And there's quite a concern now in the independent medical community in the Fargo-Moorhead area about their ability to maintain their patient base. But anyway, we now see, rather than that little box that I had in the paper when I announced my practice, we're now seeing full page ads in the *Fargo Forum* and...

MB: Billboards.

KC: Billboards are uptown and everybody's out to get their share of the thing. And I think some of the camaraderie that doctors had in the old days is now missing. We seem to be more concerned about the economics of medicine. I think we were concerned about economics in those days, too, but we seemed to have more respect for each other as practitioners than we do now. And there was a time when it was very difficult to get other physicians to testify in malpractice trials. And I see that even that is sort of breaking down. Physicians are more willing to openly criticize other physicians. Now then one might argue that they should have been criticized in the first place. But I'm just noting that that's a change that's occurred.

MB: So is it the tendency.

KC: And things...whether that's good or bad, I don't know. We seem to be in a more litigious society right now. And that's not only doctors, but every other profession is affected by it.

MB: I gather, Ken, that you don't subscribe to the idea of socialized medicine. Is that correct that you do not? And why not, if you don't?

KC: Well, I started medical practice in the days when in my county the Poor Fund was seven hundred dollars per year in the whole county. So I took care of a lot of people who didn't have money for nothing. And I managed to have a good living. My fees were not very high. Even according to the standards of those days they were not high. And I think that the doctors could do well probably doing more charity work than they do now, and avoid some of the pressure for government financed care. Now that may be sort of unrealistic when we're dealing with technical equipment such as CAT scanners that are in the hundreds of thousands of dollars, and talking about magnetic resonance imaging with machinery that costs two or three million dollars. Obviously, you can't do charity work with that kind of capital outlay involved. And certainly the hospital expenses have gone up. And I think nurses are underpaid, or were underpaid. Goodness, when you could stay in the hospital for five or six dollars a day...and the nurses were being grossly underpaid, they were actually donating their services. That price wasn't right either. But it might be harder to give charity work now than it used to be, probably because of the expenses involved. In any case, I...we sort of...through the increases in our ability and our technical abilities and skills have priced ourselves out of the market for a lot of people. And that's...it might be good for medicine, but it increases our susceptibility to being taken over by the government, I think.

MB: What advice would you give, Ken, to a young medical school graduate who came to you for advice, pearls of wisdom, a philosophic approach to his existence? What kinds of things would you tell him?

KC: Well, I realize that probably the young doctor, he comes out of school with a debt. I think the average medical school debt now they figure thirty or fifty thousand.

MB: Easily.

KC: And he's faced then with the establishing a practice in view of all the government regulations. Just the tax and accounting things are tremendous to look at for a new doctor. So...which is a little bit different than in my days when I started out. We used to keep our receipts in the refrigerator because we thought that would be the least likely place for some thief to find it! [Chuckling]

MB: [Laughs]

KC: We called it cold cash! [Laughing]

MB: [Laughing]

KC: And some of it got reported to the IRS and some didn't, I must say.

MB: [Laughs]

KC: [Chuckles] But most of it did, Milo. In case...in case you're wondering. But hmmm...and we didn't have the bookkeeping to do with social security, and unemployment, and withholding taxes, and all that sort of thing to start with, so it is hard. It is; it's harder to get started. But I still feel that medicine is a great field. And I think to a young doctor I would say: always like people. And realize that you're dealing with people with their concerns about their health, concerns about how it affects their families, their illness, and how to have an empathy for patients. I think that...I would try to avoid the tendency to get into a nine to five routine. I think that you're...have to be...if you're going to be satisfied with your practice, you have to be involved with your patients; not only with their medical care, but also with their emotions and with their families. You have to be willing to accept the fact that they're going to call you with concerns which may be very elementary to the physician but which are not elementary to the patient or his family.

I think that the satisfaction for me in medicine has been my involvement with people. And sure, it's satisfactory to have a difficult fracture and reduce it and have a good result, that's important, but how you deal with that family during that period of convalescence from the fracture is very important, too. So as far as...you asked me about advice to a young person...I would think that it's very important to get an education, and to do as well in school, in elementary, or high school, or college. Do as well as you possibly can, because if you do well, then the horizons are unlimited. If you stop school too soon or don't do well in school, people are not going to want your services. Particularly...you're going to have to work in occupations which may not be entirely satisfactory because they're more menial. And so I would say to any young person, if you have the ability, be sure to use it to the maximum.

MB: Is there anything, Ken, that you might have done differently from the way you did as you look back?

KC: Oh, I think...I always tell you, I probably would have spent more time with the children. But really, thanks to my wife, Grace, the kids grew up to be fairly decent people, you know. Hmmm. And yet my kids now tell me that the times that we were together were really quality times. That is, the times I would take them on house-calls, and oh, we'd go out to the lake or whatever. Even though it...perhaps it wasn't as much as I would like to have done, they recall those things, and they're really telling me about it now as being quality times. So no, I think if I were to do something different, I probably wouldn't have gone into such an isolated area medically where the demands were so overwhelming that the family really came second most of the time. And hmmm...that's about the way I'd change, I guess.

MB: Well, Ken, as you know, I retired about two and a half years ago. And we've heard about your possible retirement from time to time. You haven't retired. What are your thoughts about retirement?

KC: Well, I think about it all the time. I'm now almost sixty-seven years old. And I think it's dangerous for a doctor to practice too long, primarily because of the inroads of physical disability and also mental disability. And I've told my colleagues that if they ever think that I [chuckles] should not be doing something, that I would hope that they would tell me right away. And I would hope I would be able to accept that. Because I've seen physicians who practiced much too long, who were dangerous to their patients. I hope not to get into that stage. And yet people look at sixty-six and a half and think, well, maybe you shouldn't be working. And in a clinic situation, usually there's a set date for retirement, and you don't *have* to make that decision. But in individual practice then you're...that's a decision you have to make for yourself, as you well know.

But I would plan to go primarily to an office practice. And Gracie and I have always talked about doing some volunteer work for a month or so in some mission field. Currently, I'm working with the Dorothy Day House in Moorhead, which is a home for sort of the transient homeless people, and I'm providing some medical care for them. That's certainly something I can continue to do and intend to continue to do. And there are ways of retiring and still be in medicine. Doing consulting work for insurance companies, and being physician for the high school basketball games, and this sort of thing, you know. Things where you sort of keep your hat and move it but no...no big deal.

MB: Is there...what is there of a non-medical nature in your life that you might be looking forward to?

KC: Well, I've been an amateur radio operator for all my...ever since I was in high school, and that's a hobby that I've always enjoyed, but which can get a little boring, doing nothing but that. But I intend to do more of that. And I tell people if I really retire, I'll be spending a lot of my time in the Moorhead Public Library reading, something I have not...ever since college, I have been reading [unclear] nothing except scientific stuff. And I think one gets terribly one-sided with that, you know. And other...as you know, there are so many opportunities for other education in this community. Three colleges in town all offering continuation type courses for people who want to go back and learn things. I think the opportunities for that type of thing are tremendous. So I would intend to do that. And financially I'd have no problem retiring and being Medicare age. I can draw Social Security at this point.

Community activities, I have been fairly active in the Presbyterian Church, and been the chairman of a committee which has to do with the sponsoring of refugee families. We've adopted five different refugee families in our church and they take a fair amount of time. Currently, we have a Cambodian family of nine, and a Polish family of two, and now a Hungarian family of four, all of whom...even though some of them have been here for some time, seem to require some support from time to time. And so they keep me busy, too, along with the other people in church. I felt that our refugee program is sort of a logical extension of our Christian world concerns. And I hope that I could inspire my own church to share that view with me, so that's why I've sort of pushed the refugee programs. I've been on the session or the

governing board of the church for many years, so much so that I worry about other people being left out, which is a danger in the church, too. So anyway, I have enjoyed doing that.

MB: Ken, in 1981 you received the award for the physician of the year in association with the Maurice Jones [sp?] Memorial Lectureship in Medicine and Religion. And Reverend Art Johnson (for reasons that I still don't know) asked me to write a little blurb that appears on this plaque. The blurb being that you're a man who very quietly does a lot of very nice, sometimes very wonderful things with very little fanfare. And I believe this sincerely. Tell me something about your quiet way of doing so many things for the community and for people, Ken.

KC: Well, I...hmmm...I don't know how it starts. But you know, in medicine you have to go along in sort of a...you have to be a little bit bland at times, Milo. You can go into one room in a hospital and you're the greatest doctor in the world. And you can go into the next room...

MB: [Laughs]

KC: ...and you can be the dumbest and the worst doctor of the world! [Chuckles]

MB: [Laughs]

KC: And in order to deal with that emotionally, you have to be on an even keel. And you can't get too excited about the good things, and you can't get too depressed about the bad things, otherwise you're in a constant turmoil. So...so when something great happens that I have done, you know, some life-saving thing, I think to myself, well, that's great and...but I'm not going to get up and blow my horn about it because the next...

MB: [Chuckles]

KC: ...the next hour, I could be in the darnedest mess you ever saw, you know!

MB: [Laughs]

KC: With a patient that's scaring the *hell* out of me, whether he's going to survive or not or he's going to have a good result or not. So I guess that's part...I try to stay on an even keel emotionally through the ups and downs. But I also feel that...I suppose the Biblical admonition, I suppose, that Christ is the one who made it, that you should not let your left hand know what your right hand is doing. And when you pray you go into a closet and you don't pray in front of everybody as the [unclear] do. And I think there are other Biblical admonitions...that the thing is... the things that you do, you should not expect a reward for. I suppose, basically, it's sort of nice to have something come along and write a nice thing like you did about the Maurice Jones Memorial Lectureship. It's nice to have things said about you. And I...but I wouldn't dare to openly admit it, Milo! [Chuckles]

MB: [Chuckles]

KC: [Chuckling] But thank you, anyway! [Clunky sounds] And when...in fact, if I run off the end of it almost...Okay.

MB: Well, Dr. Kenneth Covey, I think we have a nice tape here. I'm...as usual, I'm very proud to have any association with you, including this, the opportunity to interview you. It appears that we pretty much covered the gamut of subjects that you wanted to cover. So we'll terminate this tape.

KC: Well, thank you very much.

MB: Thank you.

[End of interview]

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September 2015