

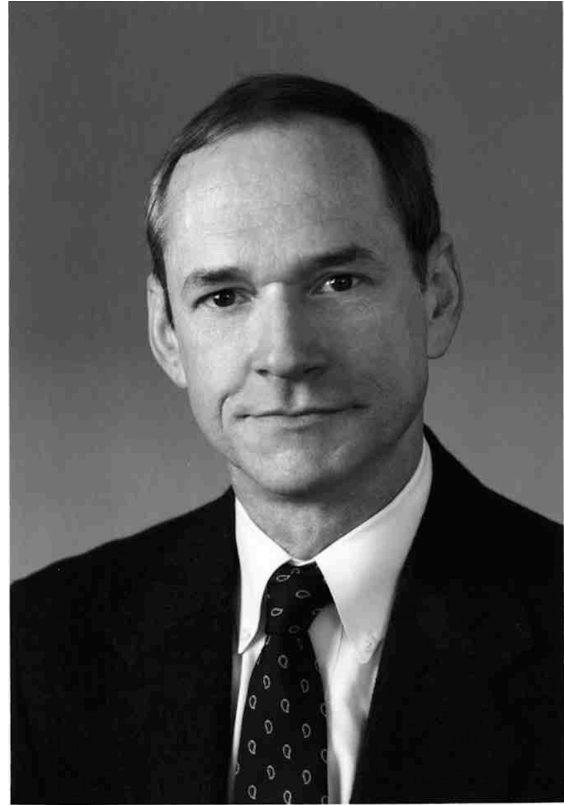
The Gold of Sacramento Valley: Experienced Physicians and their Nuggets of Advice

By Shay Nair Sharma

About the author: Shay Nair Sharma studies Human Biology at Stanford University (graduated from Franklin High School, Elk Grove, CA). He has a fascination in medical history and a passion for sharing the contributions, experiences, and stories of physicians by passing on lessons learned after a lifetime career of service.

Welcome to this educational, informative, and entertaining article series highlighting nuggets of advice from my conversations with retired Sacramento Valley physicians. This is also an opportunity to highlight and thank the healthcare heroes, of different specialties, for their service and contributions to the people of Sacramento Valley.

Dr. William Vetter is our featured physician. Upon graduating from Columbia Medical School, he completed his specialty training in cardiology at the University of California, San Francisco. He practiced Cardiology for 52 years – 2 in the United States Public Health Service (while conducting Space Cardiology Research for NASA) and 50 in Sacramento.



Tell us about growing up.

My brother and I grew up in New York City. We were raised in a very suburban-like setting in Queens, and it was an excellent place to grow up. We had unlimited access to everything in the city – depending on what the subway fare was, which was either a nickel or a dime! With 714 miles of track, we had a great deal of freedom from having to depend on someone else to give us a ride.

Both my parents were teachers – my father a professor of psychology at New York University and my mother a high school teacher of English. My brother became a professor of anthropology and worked in New York but lived in Northern Vermont.

I attended public schools and then went to Amherst College. I returned for medical school at Columbia, completed it in the summer of '64, and then moved west for my graduate training. I

pursued post-graduate training in Internal Medicine and Cardiology at the University of California San Francisco. Following that, I spent two years with the United States Public Health Service as an alternative to military service. All of us MDs had to fulfill this requirement as the Vietnam War was still in full swing, and not enough doctors were volunteering.



Dr. Vetter off on the morning commute in the 1950 Studebaker (2010)

How did you get interested in medicine?

I was probably influenced to enjoy medicine because I was very interested in how things worked, why they worked, or why they didn't work, and medicine sure served that interest. Additionally, I was struck by a brand new disease that was discovered in my neighborhood. In 1946 and 1947, the local general practitioner was faced with a series of patients with an acute illness accompanied by a rash. He felt that this resembled other rickettsial illnesses and correctly identified it as a previously unknown rickettsial disease known as Rickettsialpox. This was written up by a medical writer named [Berton Roueche](#) in the New Yorker and in a book that he wrote as well. It was discovered that the mites on the mice that lived in a neighborhood apartment development were transmitting the rickettsial disease to humans. It made a big impression on me as it was a brand new disease – right here, three blocks from home. At that point I decided doctoring is what I

wanted to do. I didn't change my mind and that was what I was aiming to do from then on.

My college preparation was excellent in terms of giving me a background in the sciences. Whether one college or university would've been better than another for that, I certainly don't have any idea – the one I attended worked out just fine. My younger son also went to Amherst College and decided on Physics as his field – his maternal grandfather had been a physicist. None of the grandchildren have expressed a particular interest in the biological sciences; two of the boys are in Computer Science and we'll see what the others decide to pursue.

What influenced your choice of specialty? How did you decide on your speciality?

When I was in medical school and in post-graduate training, what appealed to me most about cardiology was that one had many many more means of measuring and determining, with some accuracy, what was wrong.

In medicine, in general, in terms of finding out what is wrong with somebody, we take a history and ask questions to try to get a good feeling from the patient of what has changed and what is going on. We examine pertinent parts of the body to identify clues and use tests to confirm the problem. Now, in hematology, it depended a lot on looking at microscopic slides of blood or tissue samples, or the results of blood tests. I always had trouble with looking at microscopic slides because I have red-green color blindness, and it's very difficult to see some of these things that people keep pointing out about what's under the microscope. So, I had to rule that out. In gastroenterology, you're always wearing gloves and had to change them all the time, and that was not quite to my liking, although my training was fine. Kidney disease was interesting because

we were just here in Sacramento getting started in chronic dialysis, and I was trained in that during my internship in residency. Pulmonary disease was not appealing.

But cardiology, I thought, was a pretty good specialty. With some precision, you could determine exactly what was wrong. In cardiology, you had the ability to make very accurate measurements of hemodynamics – that is, pressure within the various chambers of the heart and in the blood vessels of the lungs – by cardiac catheterization, which was very appealing. Additionally, the ability to do angiographic evaluations, selective injections of contrast material into various chambers of the heart and big blood vessels, again, gave you a lot of very good precise data. Cardiac catheterization was an established clinical technique when I went into training, although my professors at medical school – Dr. Cournand and Dr. Richards – had been the Nobel Prize winners for their clinical use of cardiac catheterization in 1956. They were still my teachers – from 1960 to 1964 – and I was very much comfortable with that type of work. Just about that time when I was finishing my cardiology fellowship, ultrasound became in use and expanded the types of so-called non-invasive ways that you could assess the heart. That made it something you could do that does not involve poking holes in blood vessels and sticking long tubes into the heart. The accuracy of these noninvasive methods actually grew very quickly and was very rewarding for me in terms of being able to diagnose. Those were the things that kept me really engaged in the idea of cardiology. There was always much more you could do once you knew exactly what the problem was. And again, the availability of really good treatment for high blood pressure, the availability of statin drugs for treating hyperlipidemia, the availability of medications for treating heart failure really grew while I was

practicing, and it really felt as though I was doing some good for most of the people.

Now, I wasn't ever tempted to be a cardiac surgeon. People ask, "Well, when you were a cardiologist did you do surgery?" and I say no – the purpose of a cardiologist, the way I distinguished it, is to draw the dotted line for the surgeon to cut on. Now, surgeons sometimes disagree with this description of their practice, but we Cardiologists thought that was the right way to describe it. I was a so-called Invasive Cardiologist – I did angiography and implantation of permanent pacemakers. I was not trained in interventional cardiology which involves the ability to unobstruct or treat occluded vessels with dilators and stents. But that was okay – I enjoyed what I was doing very well.

Cardiology is one of the fields in which you can never tell the patient, "Okay, you're cured. I don't need to see you again." Cardiac disease isn't curable, per se; it's treatable. So, I enjoyed long-term connections with many patients.

What cardiology research did you conduct with NASA?

I was commissioned in the USPHS during the Vietnam War. We were working on a research project for NASA. Those were the glory days for NASA because about three weeks after I joined up, was when we landed on the moon for the first time. This was an exciting period of time to work with NASA. Our project was studying the cardiovascular effects of weightlessness because they were designing the space shuttle vehicle. Originally, it was to be a piloted vehicle. The astronauts would take the thing off and land it. Well, it turns out that if you have been weightless for a period of a week or more, you don't tolerate reentering gravity very well, and so the way the space shuttle vehicle was envisioned, they were going to be sitting in a

pilot seat and piloting the thing down. Well, that wouldn't work. They'd all black out if they did that. So the design was revised, and the astronauts forever became ballusked rather than pilots. They never piloted those things at all. There wasn't anything for them to do but go along for the ride.

We were using volunteer federal prisoners as subjects. That was – and still is – a minimum security federal prison in Lompoc, California. These are not particularly dangerous people, it was felt, so we asked them if they wanted to come to San Francisco for a couple of months, and it was not tough to convince them that they'd like a change of scenery. So we put them to bed for long periods of time – two weeks, four weeks, six weeks. They couldn't get up. They could use a pillow at night and they could elevate one pillow's worth to eat; otherwise, they had to use bedpans and they had to stay in bed. And we studied them from a cardiovascular standpoint with noninvasive methods that were, again, becoming available, as well as nuclear medicine studies to look at fluid volumes in the body. We were lucky enough to get involved with Al Angar at UC Berkeley who had devised the positron camera, which allowed us to take pictures of the heart contracting as the radioisotope was injected into the vein. So we did that and established the effect of bed rest on cardiac function. The heart basically got very lazy during a period of bed rest. That, and the dehydration that occurred from bed rest, made pretty much all of them faint when we subjected them to an upright tilt after bed rest. And that was a good two years' worth of research. Very enjoyable. Ours was the second paper, I think, written on the radioisotope method of assessing health. It was a good paper. We used another method to assess left ventricular systolic function with the method of apex cardiography, a method that isn't used much anymore but that's what we did for our bed rest patients as well.

And we did the clinical work for the hospital patients as well. Then I came to practice in Sacramento.



Dr. Vetter in his brand new USPHS uniform (July 1969)

Tell us about your years practicing.

I enjoyed practicing medicine a great deal. I was talking to a friend last week who said that he had retired after 30 years of practice as a cosmetic and plastic surgeon. I stayed in practice for 50 years, and he asked me why? Well, I said I enjoyed it, I really enjoyed what I was doing. I enjoyed the patients. I enjoyed the work. And certainly, it was an excellent time to be a cardiologist because the range of things that we were able to do for people dramatically increased during the period between 1971 and 2021, when I retired.

I practiced in a multispecialty internal medicine group initially. It was at that time possible for a pulmonary medicine physician to cover for the gastroenterologist who covered for the

neurologist who covered for the cardiologist! And that, of course, has gone by the wayside as all medical practices have specialized, or sub-specialized. After 11 years, I formed a cardiology specialty-only practice and have practiced in the cardiology setting only since that time.

One of the things that I didn't want to do particularly was deal with surgery. However, when I came to town here in '71, the heart surgery program at Sutter was well-established and Dr. Smelloff and Dr. Miller had just hired a third cardiac surgeon named Dr. Kelly, a man with whom I had trained at UCSF, so they were going to be increasing the amount of time they were spending in the operating room. One of the things that we had done in our training program was running the heart lung machine for the surgeons and that was the standard way it was done at that time.

There was always a cardiologist in the operating room, principally because the anesthesiologist had not had special cardiac surgical training. For the first number of years I was in practice, I was in the operating room a great deal more than I thought I would be because we were expected to be helping in the treatment of the patients during and after the surgical procedures. So, I had a lot more exposure to surgery than I thought, as a medical student, I would. Again, a very rewarding thing about cardiology here in Sacramento is that we've always had available excellent cardiac surgery for the patients.

I can remember the patients whom we would do valve surgery or recommend valve surgery for, and in the early '70s, it really wasn't common practice to operate on patients with chronic renal failure, patients on dialysis, due to the absence of kidney function. However, in the group that we were practicing with at the time – there were nephrologists as well as cardiologists – we said,

well, we can do this because we are as well integrated and used to working with one another as any place. So, at a point when there were perhaps two or three case reports that had been made of doing valve replacement surgery on dialysis patients, we decided we could do it as well as anybody and went ahead to do it very successfully. It was really very rewarding to be at the cutting edge of what was capable in cardiac surgery. Likewise, when we went ahead and developed our own cardiac transplant program, we had excellent – and still do have excellent – results. All in all, it's been a good place to practice cardiology, and a good time to do it.

Is there a medical patient or story that had a major effect on you / that you remember?

Well, you remember a lot of patients for many reasons. There's the fellow that was my patient beginning the first month I was in practice and I saw for the next 49 years. We don't cure people, as I say; what we do is give them the appropriate treatment to palliate whatever's wrong with them. I enjoyed very much describing to the patient on dialysis, whom we were able to successfully replace the aortic valve, that we made his situation much more comfortable for him.

The oldest fellow we ever replaced an aortic valve on was another gentleman who was 95 when he really got very sick from aortic stenosis. This was just prior to the transvenous aortic valve replacement or the transaortic valve replacement (TAVR) technique became available. I remember he was extremely limited by heart failure before cardiac surgery and really made a very good recovery. He lived here in Sacramento during the 2nd World War, and his neighbors in the South end of town were all Japanese farmers. When the Japanese relocation orders came through, when they were sent to

internment camps, he volunteered to care for a half dozen of their farms (they were small fruit and vegetable farms – strawberries especially) and keep the place for them while they were detained. They didn't have to sell the place; they trusted him to look after it, and he did. He was a real hero among the Japanese American community here in Sacramento. When he came by several years after surgery, he said his family wanted to make a big fuss about a birthday. He said and a lot of his neighbors wanted to do that too. The Sacramento Bee had an article about him, on his 100th Birthday, about the Japanese American community wanting to remember him for the help he and his family had been. He was one of the really successful aortic valve replacement patients, even though he was 95 when he had it done.

Other patients you remember... well, as a doctor, one of your chief sources of patient referral is, of course, your patients themselves. And I remember a woman who came to see me as a new patient. She had brought her older brother (who was developmentally delayed) to see me for many years. She said, "You were so nice to him, I thought I'd like to see you as well. You were nice to him, and I thought you'd probably be nice to me." I said, "Well, of course," and for the next 30 years, she came to see me for her blood pressure, cholesterol, and other problems. It's always a real source of satisfaction that you are able to help people and continue to follow along with their progress.

I was disappointed in the most recent years, with the emphasis on patient care to be done remotely, face to face on a TV screen instead of face to face in the office. We were encouraged to minimize people's visiting to the office, and I am very skeptical of the ability to diagnose heart patients without seeing, touching, and listening to them, and so that was a disappointing situation. My favorite occurrence there was

when a fellow I had been treating for some years had bypass surgery – he had had a permanent pacemaker put in – and he came to me for a follow-up because his oncologist wanted me to okay him for an MRI. Now, some of the older pacemakers were not considered to be MRI compatible, not felt to be safe in use in a high-intensity magnetic field. The reason they wanted an MRI was because one eye was sticking out. His right eye was protruding rather disproportionately. I asked, "What's going on with your eye?" He answered, "Well, the oncologist thinks I have a tumor behind my eye and that's why he wants the MRI." And I said, "Well, that's not the most common cause of an eye sticking out. Do you see double when you look over to the right side?" He said yes. "Have you been to the eye doctor? Did the eye doctor take a look at you?" "Well yes, we had a video visit and he said my eye was red and it must be allergic conjunctivitis." I told him, "No, this is not allergic conjunctivitis – your eye is sticking out, it doesn't do that. Did you go to another doctor?" "Yes, my primary care doctor. She saw me on a video visit as well." "Well, what did she think was wrong?" "She didn't know. That's why she sent me to the oncologist to see if it was a tumor." I told him, "I think the most common cause of an eye sticking out is still Graves Disease, hyperthyroidism. Go down to the lab, I've ordered the thyroid test and we'll see if that's the case." The next day he came back and I said, "Yes, the problem is the thyroid gland. You have Grave's disease, thyroid eye disease, and you can have a CT scan to look at the area behind your eye, but that will just confirm that diagnosis." I was sorry the doctors were not able to take advantage of seeing the patients in person. And, at that point, I didn't want to continue to go along with this much longer so I decided on the 50th anniversary of starting practice, I would retire.



Dr. Vetter and his wife Kathy on a hike in southeast Alaska (2002)

Looking back, what would you have done differently?

I don't know! So much depends on what circumstances present themselves to you at what point in your life. I don't think that I'm sorry I picked being a physician. I am certainly not sorry I picked cardiology. I don't regret coming to Sacramento, although at Columbia, as far as they were concerned, medicine ended at the Hudson River and the Hudson River was about a block and a half west of the campus. The dean of the medical school, when he handed out our residency matches, he said, "Well Congratulations, you got your first choice – UC San Francisco, although I can't imagine why you would want to go there." Hey, it was the mid-'60s. It was clear that it was going to be happening in San Francisco more than it was in New York at that point, so I certainly didn't regret coming to the west coast.

Why did you choose to move from New York to San Francisco for residency?

My family had originated from the Pacific Coast. My parents grew up in the Puget Sound area, Washington. My father moved east to study psychology, having gotten bachelor's and master's degrees in forestry at the University of Washington. He then decided that he wanted to make a change and came east and taught psychology at NYU for 35 years. I was coming to the west coast because I really liked the San Francisco Bay area, having visited there at the age of 9, and I thought this was potentially a good place to live. When I came to look over internships, gosh, San Francisco looked awfully appealing to us. My wife and I said, "This is the spot." We are very glad that we did. New York was getting definitely rougher at that time in terms of just the way of living. It was hard to envision trying to raise kids and practice medicine, whereas it was not difficult to do that here on the west coast. In New York, we were on the third floor of a walk-up building on the Upper West Side. We were ready to leave New York apartment living.

If there is one thing you could tell your 20 year old self, what would it be?

Certainly smile more! Try to think the best of people rather than continually being on guard. What I found in dealing with patients, particularly, was to share with them. The more you are able to share with them, the better they will share with you. It's important to break down the things that hamper communication between doctor and patient. And if that means opening up a little more of yourself to the patient, that's all worth doing. I probably didn't do that until later on in my practice.

Now, one thing that I found that patients kind of got a kick out of was when I would talk about the hobby I've had of keeping older automobiles running! When I was dealing with senior

citizens and diseases of the elderly, I think some of them appreciated the fact that my 1941 Chrysler and the 1950 Studebaker continued to function well. I continued to value that as something to do, just fitting in with my general scheme of wanting to make things work and figure out what was wrong with them if it didn't. They liked the idea that I continued to maintain older vehicles. And my younger son has taken that as well. He's a physicist and he retired long before I did!

What would you say are the major values or principles that you live by?

I think that a lot of the goals which drive people are not necessarily the things that motivate me. I was reading last week about sort of that question – what are the potential goals, what are the things that you're striving to do or achieve? The ones that have been envisioned since the Greeks began writing about it are the accumulation of wealth, the accumulation of influence, the accumulation of status, or religious enlightenment. Those are things that are not particularly what I've done. I think, for me, the part that's most rewarding is the understanding of the relatedness of cause and effect – of what makes an individual, a given situation, or even the political word, tick. What is happening and how does one explain this? You can learn any given field that you start out to understand or learn, you can do. There's people that can teach you this. In my case, I became very interested in the problems of medical professional liability and worked at that at the Medical Society level and then joined the board of our mutual insurance company, Norcal Mutual, when a position became available. I said now here's something new and different. I'm going to be on the board of directors of a business corporation with assets of a third of a billion dollars. I'm going to be in charge of the appraisal of executive function in an insurance company and in a corporate manner. Fortunately they send

those of us who were new on the board to school to learn about insurance and how to be a member of a board of directors and yes you can take a course on how to be a board of directors member. I felt that I always wanted to understand what made a particular situation or particular organization work well and what didn't. Why did people behave the way they did? Part of it is being able to make connections between what you have learned in one situation into each new one that you encounter. It's easier to understand and remember things if you can relate it to your previous experiences and what you've previously learned to be the case. People talk about educational underachievement or groups of people that have had less educational experience or advantage. That is a real handicap, it's really important that learning begin very early, you've got to be able to learn because the stuff that you pick up when you're very young really does stick with you. But it's also important to never stop learning.

Ha, I'm looking out the window from my study into the atrium now. There's a bunch of squirrels that keep coming up and down the tree there, and I take to putting out some shelled peanuts in a bowl once a day for them. They think this is a pretty magical bowl. Now, I don't think they figured out the diurnal period here, but they know that this bowl is really important because on three occasions, they've tried to pick it up and take it home with them! They would really like that. But that's magical thinking. They're not doing cause and effect. They don't associate me with that bowl and the food. They think the bowl produces the food and they want that bowl, they want to take that with them. Well, people are a lot that way. There's magical thinking on many levels. What people accept as a reason for behavior, whether it be ideological, spiritual, whatever it is, there's a lot of magical thinking that goes on in situations like that and we really do better when we abandon magical thinking.

I don't know if that answered what you were thinking about, but the more objective you can be, the better!



Dr. Vetter passing the gavel for SSVMS President to Dr. Joanne Berkowitz (1996)

Who were your mentors that had the most influence on you?

Well, it was parents, of course, to a great degree! I think people all wonder about what their parents would think of what they've done, would they be surprised or not. My father had grown up in a socialist upbringing, and he would've been amused that I ended up a participant in capitalism. He would've enjoyed the fact that it was a mutual insurance company because he always made every effort to be insured by mutual insurance companies that are owned by their policyholders. That was a good thing, as far as he was concerned.

In education, I remember vividly all of the teachers that I've had, and I was extremely fortunate. I had really good teachers – they were not foolish people. In college, I was really tickled that my younger son, coming 30 years later to the same college, had three of the same professors that I did because they were really good ones! And in cardiology training, I can think of several cardiologists who trained me that really did shape what I did as a practicing cardiologist. John Hutchinson was the cardiologist who taught us management of the intraoperative cardiac patient, cardiac surgery, and the care of the patient following surgery. My friend Bob Solovan taught me a great deal about

dealing with the questions of research, how one did that, and how to work with your colleagues in a collective project like that. My first senior partner was William Fong, whom I practiced with for 11 years. He taught me a great deal about how to get along with the other medical colleagues – referring physicians, consultants. He taught me a great deal about how to interact with the medical society and pointed out to me how important that was. He pushed me in the direction of activity with the medical society, and I did serve as president for a year, so he was very influential. And he taught me if there's a committee meeting or a board meeting, never call for a vote unless you've already counted your votes and know the answer already! Count your votes beforehand. That is really important in trying to make committee work go.

What do you like most about medicine? What do you like least?

I've enjoyed the interaction with patients, which I've talked about. Over the years, however, I've learned that there are a lot of doctors who don't like people very much. They don't seem to be enjoying themselves much! I remember vividly one professor of dermatology who would never touch a patient. Now, that may be because he felt that they were not terribly clean, but still, his idea of examination was to take a wooden tongue blade, break it in half longitudinally, and poke at the patient with the end of the stick. This was very symbolic to me. It was not quite a ten-foot pole, but you know what I mean, it was pretty symbolic. I guess he didn't like that patient very much. The Chairman of the department at the time was another fellow who didn't like patients very much. He would frequently say "Remember, every patient is covered by a thin film of feces." Well, there are better ways to tell people to wash their hands, but you know you could tell, that was his view of humanity. You have to like people. Now, we used to tease the people that went into X-ray as being shadow doctors, never seeing patients, just shadows. It turns out that the better radiologists that I've known have tended to be more likely to go into the interventional fields of radiology, where they actually have contact with the patient instead of just the images of the patient. Then, I

was really surprised to learn, by spending more time in operating rooms, that there were OBGYNs who really didn't like patients, they didn't like women. That was disappointing. When you hear the way they talked about their patients, you could tell they didn't like them very much. I was sad about that. You certainly wouldn't want to go to a doctor who didn't like you. That isn't what you'd want.

Now, on the other hand, a fellow like Dave Dozier, who you interviewed, is a first-rate fellow. He liked patients, he really did. You could tell that.

I feel sorry for people who end up in a situation where they're not happy with what they do. After all, they say life's too short to drink bad wine, well life's too short to be in a job where you really don't like the people that you are dealing with, working with, or the subject.

How has the field of medicine changed over your career?

I think the thing that changed most strikingly during my period of practicing was that, initially, in the '70s, we would practice at many, many hospitals. Now, Sacramento is a mildly unusual town for medicine in that there are no for-profit medical systems operating general hospital care.

That may change soon with the new university hospital being set up here, but for now, we have Kaiser Permanente, Dignity Health, Sutter, the university, all of whom are non-profits. It has set a little bit of a different tone from other medical communities because we were all members of both Sutter staff, the Mercy Hospital Staff, and many of us had clinical appointments at the University for teaching, and that has changed significantly as medical practices have been bought by Hospital Systems. So now you have the vertical integration that tends to leave the practitioners practicing only at one hospital facility. Whether this is good or bad remains to be seen, but it certainly makes it less complicated to make rounds. It was not unusual to round at three different hospitals every day when we first started practicing.

Medical care has gotten extremely more expensive. I'm struck by the amount of advertising for medical care or medical products (drugs, prescriptive medicines, etc.) that's done, seemingly, to create demand. Medical literature has been confined to rarer and rarer and more circumscribed diseases and conditions than in the past. By that, I mean there are many more specialized therapies being devised for conditions that are less and less frequent. It's good that we know more about them, but as far as their general applicability, it's narrowed down some. I was a student of genetics in college and did some medical research in genetics in medical school as well. I've been surprised at how long it's taken for that field, human genetics, to become more clinically oriented. Yes, the genome analysis has made a big difference in that, but I think it's had a little less effect than I thought it would in some areas. But that's an enormous change of course. We encountered, when doing research on 6 chromosome abnormalities, and in particular, males who are apophaticism, males with more than one X chromosome. They were fascinating. You could pick them out clinically and then analyze them. They're not common but we learned what there was to learn about that. We didn't know in college, when I was counting fruit flies, what a gene was. We knew the construct of a gene and we knew what it did, but we didn't know what clinically constituted one. Now, I think we know that pretty clearly. Joan Dudna's discovery of how to make alterations, or corrections of the genome is a wonderful discovery. That was progress. When I was in training, there were some pretty primitive efforts being made at correction of genomic abnormalities, but it was pretty primitive and didn't work. I guess I'm surprised that it's taken so long to become clinically applicable.

You want to look over the newest data that I saw today, on mortality data and life expectancy in the US by state. There's a good table based on the causes of death and death rates in 2020. Life expectancies are sortable by state and when you draw a map of the US and the states, and you look at life expectancy at birth, or at age 65, what you see is a red state-blue state dichotomy. That is, the Pacific coast and the northeast, as

opposed to the center from Ohio to Texas, on a diagonal, is really strikingly different. Hawaii is the state with the greatest life expectancy at birth and at the age of 65, California is number 2, Mississippi is last. So you're seeing that medicine has made a big difference in life expectancy except in the red states. That's a remarkable finding. We gotta learn to do something about that! That has to change. The treatment that's available – and it's not exotic nor high price – that isn't what makes the difference. What makes the difference is the availability of ongoing and long-term care and the ability to persuade people that taking your prescription med as directed, getting immunized, and not smoking is a good thing. We've learned the enormous benefit of all of those things, but it's taken a long time. The first article that was really prevalent on cigarette smoking and lung cancer came out in 1939. It was widely recognized that bronchogenic carcinoma was due to cigarettes. It took a long time to convince the rest of the people to do that. So we've made enormous progress, but the things that are holding us back now are the much more simple and easy-to-understand concepts.

Where do you see the future of medicine?

I see we're really being held back now by a sort of distrust and apathy about medical care. People are very skeptical of experts. The problem is both the willingness to accept someone as an expert who clearly has no ability in that area and the willingness to reject the experts. We have at the medical society, as you know, the Iron Lung out in the hall for show. In 1955, I remember when the Polio vaccine came out, there was no such thing as a parent who said, "My kid isn't going to have that shot. I want him to have natural immunity." There was no parent ever, anywhere, who said, "I want my kid to catch polio and become naturally immune to it." That's crazy; everyone wanted a shot. Now there are parents saying, "I don't want my kid to have a shot to prevent HPV. I don't want my kid to have a shot to prevent respiratory infections, MUMPS, Measles. I don't want my kid to have a polio shot, that's unnatural." We have to figure out a way to overcome this. I'm not sure how to do that. Because unless you convince people that medicine, immunizations,

and good practices make a difference, you're going to have such a dichotomy that will forever look like that red state, blue state map.

What do you enjoy doing outside of medicine?

I like traveling. We've not been traveling in the last couple of years, but we hope to resume that. I've been to all 50 states. I've been to Western Europe and Asia. I've really enjoyed diverse places. When traveling, it's always important to try the local favorites. Don't go to Lhasa without eating a Yak burger. Don't go to Ulaanbaatar and turn down the opportunity to have their national alcoholic beverage – fermented mare's milk – it is an acquired taste, believe me. When you go to Africa and they offer to serve you antelope, don't turn it down.

I like to fix things; I'm a great fixer of stuff. Whatever breaks, I'm on it. I was putting together the lawn chairs and just had the cupboards replaced, and now I'm reassembling the whole thing. You know, taking care of the pool. When one of my friends retired, he had new business cards printed that read "James Hammil, MD, retired, Pool and Sprinkler repair." I thought that was really good. Yeah, that does take up a fair bit of your time if you put your mind to it.

I've enjoyed being a grandparent very much. Grandchildren are very engaging people. Fortunately, I enjoy talking to people.



Dr. Vetter posing with a friendly Macaque in Gibraltar

How have you dealt with stressful times during your life?

I don't know. Talking about them. Yeah, I think it's very helpful to talk. Don't hesitate to get professional help if needed. One of my colleagues has emphasized that several times. If things are getting very stressful, remember that a combination of stressful events can lead to physical illness. That's real. Find someone to talk to.

I participated in the physician's health study. I believe its results say it's good to have a glass of wine every evening. Avoid anything else. It really is a great benefit never to have taken up other substances. The problem with medicine is that we are much like everyone else in the population – 1 in 7 to 1 in 10 has a substance abuse problem, and that does not mean tobacco or carbohydrates. That's something we need to get over, very quickly. And fortunately, in medicine, docs are pretty good at getting over it – because they have monitoring. There are programs that can help you through a situation like that. I've had partners in that condition – in that situation, and it works. You can rehabilitate some of them.

Tell us about your involvement at the Sacramento Museum of Medical History.

After I retired, the med society wanted some more help in the museum. When I first came to town, we had a library there but there was no medical library in town. And in those days you had to look at books, journals, and magazines rather than just reading them on the screen so we had a very extensive medical library – we had a full-time medical librarian even. It was very valuable to have but it outlived its usefulness so we turned it into a museum. Doctors save a lot of stuff and when they close up their offices, they want somewhere to send all this stuff so Bob LaPerriere – a great historian and collector of stuff – dedicated he would do it and I gave him a hand. Bob's a dermatologist. He didn't have a cardiologist's input, so what I've tried to do in the past several months is bring in some more contemporary equipment to contrast with the old stuff. He has one of the best collections of prosthetic heart valves I have ever seen, and I

helped organize it. We have a bunch of the tissue valves that are now more commonly used than they used to be. And we have a good collection of old pacemakers, the electrical power devices that stimulate a heartbeat when it's not occurring fast enough. We have some pacemakers as big as a package of cigarettes! These were buried under the skin and attached to leads that ran under the vein under the collar bone back to the heart to stimulate a heartbeat. Bob's display worked down to normal size and I said, "Bob, you don't have the new ones." [Dr. Vetter is holding up a modern-day pacemaker.] The new one is about an inch long and about a third of an inch in diameter and it sits inside of the heart itself, there are no wires attached to it. You put this in with the end of a catheter and run it into the apex of the right ventricle and that's it, it stays there. The battery lasts ten years. It transmits telemetrically to your smartphone and will relay that to the doctor monitoring that device. So we've got lots of contemporary stuff and we're trying to make the displays more interesting and up to date. It is fun.

BONUS! Story of President Ronald Reagan and the Wine Advisor

I was brought up to believe that the best wine in the world was Château d'Yquem, and I've known that since I was 5. I would have to say that I haven't been disabused of that fact! One of the highlights of my eating career was lunch at Château d'Yquem, where we were served the 1942 d'Yquem. There's a story behind that.

David Berkeley, a Sacramento wine merchant, when Ronald Reagan was governor here, was friends with some of Reagan's associates, and he became the informal wine advisor to the governor. When Reagan went to the White House, Dave obtained the title of "Wine Advisor to the White House." Reagan really liked to give parties and organize a lot of state dinners. Before a state dinner, the menu would be sent out here to Sacramento, and Dave Berkeley would pick out, following Reagan's advice that only domestic wine would be served at state dinners, appropriate domestic wines for each dinner. If they couldn't find them in Washington D.C., the Air Force 1 would come up to Travis and Dave would load on the cases of wine that he picked out and fly it back to Washington. On the occasion of the bicentennial of the Battle of Yorktown, 1781, which was the penultimate battle of the Revolutionary War, in honor of the French assistance in our revolution, President Mitterrand of France was invited to a state dinner. An exception was made to the rule that only domestic wine be served because Thomas Jefferson was a great fan of French wine, in particular Château d'Yquem, a very sweet dessert wine. So, Château d'Yquem was served to the President of France at the bicentennial dinner. Well, David got an autographed menu signed to the owner of Château d'Yquem, Alexandre de Lur Saluces. And in 1983, two years later, David took a bunch of us to France to tour some wineries and armed with the autographed menu, we went to Château d'Yquem with Lur Saluce. That was a worthwhile effort. We went on to further north than Bordeaux, to Château Margaux, which is one of the 5 best wines of Bordeaux, according to the 1855 Classification. We were invited to lunch at Château Margaux by the proprietress, and Dave said that Mr. Reagan's birthday is

coming up, and he was born in 1911. Do you have any of the '11 Margaux in your cellar? The president would really appreciate some Château Margaux of his birth year. She said yes, of course, certainly. We went down into the cellar and went into all the cobwebs and in the piles of bottles from 1911, she picked out three bottles and I'm sure that Reagan enjoyed both of them. Because one of them never made it!

Dr. Vetter Fun Facts

Favorite books/reading

History Books about the 14th Century Black Death, Civil War, Political Era of the 30's, and World War II
Scientific American
American Scholar
New York Times, Sac Bee

Favorite musicals

Musical of The Philadelphia Story
Gilbert and Sullivan operettas

Favorite foods

Choucroute garnie or anything Alsatian
(Favorite wine: Château d'Yquem)

Favorite Quote

Something by Henry Louis Mencken. He was always good at coming up with something ironic to say.

Favorite place/vacation

Mont-Saint-Michel, France