SUMMARY

In this interview, UOMS alumnus and longtime faculty member Dr. George Porter discusses the history of the institution and his own role in its development. He begins with a short summary of his curriculum vitae and a discussion of the path that led him to embark on a career in medicine.

When he arrived on the UOMS campus as a first-year medical student, the Medical School Hospital was in the early stages of construction. Dr. Porter talks about the integration of both the new university hospital and the Multnomah County Hospital into the teaching mission of the medical school. He then segues into a discussion of the issues surrounding the siting of the VA Hospital here on the Hill, and of his work with a national commission charged with investigating the role of research in veterans' hospitals generally.

Taking a step back, Dr. Porter returns to a consideration of his student years at UOMS, where he earned a master's degree in pharmacology and an M.D. before undertaking an internship, internal medicine residency, and cardiology fellowship all within the Department of Medicine at the university. He describes Dr. Howard Lewis' technique of faculty development, in which he identified promising UOMS graduates and sent them off for additional training in various specialties. Dr. Porter was the recipient of such attention, and as a result, went off to complete a fellowship in nephrology at the Cardiovascular Research Institute in San Francisco.

Upon his return to UOMS, Dr. Porter realized that he was leaving the mainstream of American medical research, but he devoted himself to developing an excellent Division of Nephrology here in Oregon. He talks about the faculty he recruited, the programs he worked to establish, and the Division's training programs. He notes that he was particularly keen to attract women to the faculty, and he talks about the qualities that women can bring to medical education.

One of his many assignments over the years was as a member of the university's Centennial Committee, which was established to celebrate the anniversary in 1987. Dr. Porter talks about the work of the committee, and also goes in to some detail concerning the question of the original siting of the school on Marquam Hill—an event popularly known as "Mackenzie's Folly."

Dr. Porter spends the final third of the interview exploring topics related to the consolidation of the schools into a true university in 1974. One of the consequences of the consolidation was to bring the hospital and the clinicians into closer cooperation; he talks about the work of the University Medical Group in addressing both the relationship of the faculty to the hospital and the new federal requirements posed by Medicare legislation. He then turns his attention to the changes in administration wrought by the consolidation, discussing in particular the changing role of the Dean of the School of Medicine. He compares the administrative styles of Presidents Laster and Kohler and their efforts to define the role of president vis-à-vis the academic mission of the university.

In closing, he looks back on a full career and expresses his pride in the contributions that the school has made to healthcare and medical research.

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ASH: It's August 7th, 1998, and Joan Ash and Linda Weimer are both interviewing Dr. George Porter on videotape.

As I mentioned, the first thing we'd like to ask you is where you were born and raised, and can you tell us a little bit about your early childhood?

PORTER: Okay. I am a fourth generation Oregonian. My family came here both by covered wagon and around the Horn. I was born in Medford, Oregon, where I went to grade school, and then transferred to Salem in 1941, where I finished high school.

I went to Oregon State University, at that time Oregon State College, getting a B.S. in science. I enrolled in the University of Oregon Medical School in 1953 and completed my M.D. in 1957, also getting a master's degree in pharmacology.

As a medical student, I worked in the Department of Pharmacology and also was the toxicologist for the County of Multnomah.

Following my graduation, I was one of eighteen interns who started a rotating internship at the Multnomah County Hospital. Following that, I spent two years as a resident in internal medicine under Dr. Howard P. Lewis, and following that I spent two years as a cardiology fellow under Dr. Herbert Griswold of the Division of the Cardiology at the University of Oregon Medical School.

At the conclusion of that, it was the belief of Dr. Lewis that we needed somebody on the faculty who had an interest in kidney disease, and so with the assistance of Dr. Daniel Labby I was able to obtain a fellowship with Dr. Isidore Edelman at the Cardiovascular Research Institute in San Francisco at the University of California at San Francisco.

Following two years of research training, I returned to the faculty in 1964 and joined the Division of Cardiology, where Dr. Griswold started a renal section. In 1971, we established the Division of Nephrology as a separate entity, which continues until today.

In 1977, I was appointed Chairman of the Department of Medicine, a position in which I served till 1994. Presently I am a Professor of Medicine, on retirement but working about half time, in the Division of Nephrology, Hypertension and Clinical Pharmacology.

ASH: Thank you. That was a summary of about a fifty-page C.V. that I received [laughter].

Now I'm going to take you back again because you were raised during the Depression, and I wondered if that had any influence on what you did later in life, on your decision about college?

PORTER: It may have. Our family was not well-to-do, but it was not destitute. Throughout the period of the Depression, my father worked for my grandfather, and we had a lumberyard in Medford, Oregon.

My decision to follow a career in medicine came about in a somewhat serendipitous manner. When I enrolled in college, my principal aim was to follow in both my father and my grandfather's footsteps and become a lumberman. However, after the first term I found that I was not terribly interested in forest products [laughs]—a disappointment, especially to my grandfather, but not to be lost.

I then decided to spend some time in business, which was a very bad decision [laughter] because I hated business school. So between my freshman and sophomore year, I decided that my major interest was in science. At that time one of the most obvious careers in science was medicine, and so I actually enrolled, re-enrolled in pre-med as a sophomore at Oregon State and then completed my training before coming here to the University of Oregon Medical School.

A very strong influence in that decision was my roommate, Dr. Samuel Gill, who is currently a hand surgeon here in the city of Portland, and who preceded me at Oregon by approximately one year.

ASH: In what way was he an influence?

PORTER: Well, he was in the same house I was in. He was my big brother; we were all assigned big brothers. At the time when I was trying to make up my mind what to do, since forestry didn't seem to be the ideal answer, he was very willing to listen to me, to make suggestions. Sam had been in the service, and so he was a bit older and probably had a little more worldly experience than many sophomores that I had anything to do with. So it was a combination of an unhappiness with my prior choice plus the sheer enjoyment that I found with science that really led me into my lifelong career.

ASH: And tell me about your entrance into the University of Oregon Medical School. What was the application process like, and did you have an interview?

PORTER: Yes. Everybody had interviews. The process was probably every bit as nerve-wracking as it is today.

The difference was that it was extremely uncommon for women to apply to medical school. In my medical school class, we had three women out of seventy-eight students that

started, one of whom had come from a convent, and it was an eye-opening experience to her to suddenly be put into a class with seventy-five males, many of whom were, you could say, somewhat free in their ability to find enjoyment in almost anything that we did, especially in gross anatomy [laughter].

But the process was that we had an interview. As I recall the interview team actually came to Corvallis to interview us, and my recollection is that Dr. Pappy West led the interview group. He was a very austere figure, a large man, and remarkably well known. He and Dr. Todd were at that time co-chairs of the Department of Biochemistry. So it was a very intimidating experience.

The only advantage that I had, I think, is that I had spent four years in undergraduate, which was a bit unusual at that time. Most of the applicants to medical school had only spent three years, so I was actually graduating with a degree when I actually entered medical school.

ASH: Thank you. Now, when you graduated from medical school, it was only a year after the University Hospital was opened, so you were here during the transition between the strictly County Hospital and the University Hospital. Can you describe for us what influence that might have had on your medical school career?

PORTER: Well, the transition was more than just going from a county hospital to university hospital. When I entered medical school, while the basic science departments had pretty much recruited full-time people, the clinical departments were just beginning to make that transition. Dr. Lewis had returned from the service and was heading up the Department of Medicine. Dr. Daniel Labby, who was, if you will, the assistant chairman at that time, had returned from Cornell, where he'd done a hepatology fellowship. And it was a matter of a few full-time people, but my training in the clinics and most of my training on the ward were actually clinicians who had full-time practices downtown. So the clinical faculty for the various departments was strongly dependent upon clinics like the Portland Clinic. The Department of Surgery was very dependent upon St. Vincent Hospital.

The transition that started to develop was that Dean Baird had taken a position that the University Hospital was important, that it was important not just for the city of Portland, but it was important for the entire state of Oregon. And therefore that drew the boundary lines. There were contentious issues on the part of the community, which felt that they had provided adequate training within the community hospitals and we did not need a university hospital. The university faculty felt very strongly that we did need a university hospital, that we did need to be able to provide unique services for community-wide events. Doernbecher by that time had become relatively outmoded, and we needed another place to place patients.

So the end result was that they drew a line in the sand, and it was somewhat difficult, especially for students such as myself who did externships because many of us provided externs in St. Vincent or Good Samaritan. I happened to be an extern in St. Vincent Hospital, and I also answered the switchboard at the Portland Clinic for the last two years in medical school. So I was very much aware and knew that doctors from the Portland Clinic were very

critical players as far as the faculty here at the University. And I received both sides of the argument, and obviously each of them had their points.

But I believe that in the final end, and as we look at subsequent history, Dean Baird was right: the University Hospital was an important resource for the entire state of Oregon, and had he not supported it as vigorously as he did, we may have been a much different sort of university, one which was much more dependent upon community hospitals for their training sites. And I believe that that would have really jeopardized some of the outstanding programs that we were able to develop, especially the renal transplant program, and now all organ transplant programs, and some of the high technology we've done in oncology. I'm sure that the eye center [Casey Eye Institute] would never have been built if we hadn't had the support of the University Hospital.

So in looking at the subsequent development and the availability of a unique resource for this state, the University Hospital probably stands out as a critical turning point in the relationships which over the years I think eventually improved; although, as you're probably aware, when we went into the managed care phase of treatment, once again many of the issues which had faced us previously when the University Hospital was opened were reinvented. Here, however, it was more financial than it was academic. During the arguments about the University Hospital, it became more of an academic argument.

ASH: Well, just because we're talking about this, I had meant to ask you about the siting of the V.A. Hospital, the new V.A. Hospital, and I think maybe we'll go out of chronological order for a second because that was another crisis and maybe a turning point, of which you were very aware. Can you tell us your role in that?

PORTER: There was obviously a great deal of jockeying for position, primarily with Senator Hatfield, over the siting of the Veterans Hospital. Because at that time he was head of the Appropriations Committee for the Senate, his vote was critical in this entire operation.

The argument that was posed is an argument that has been recurring from the time that the University decided to move to Marquam Hill, and that is inaccessibility; and this was once again raised when we talked about the location of the Veterans Hospital. It was pointed out, among other things, that there were times when this was inaccessible in the wintertime. It was also pointed out that we were going to have to tear down a large amount of the hospital in order to replace it up here, but the reason that we got the replacement hospital was because the hospital was not earthquake-sound, so it was going to have to be torn down anyway.

The other favored site was next to Emanuel Hospital. And there were some very critical players in it, including one of the Hoffmans of Hoffman Construction, who served on the board of trustees for Emanuel and was extremely interested in getting it located there. Now, at that time there was quite a bit of land around the Emanuel site, and they were very interested and keen in providing a financial base to improve that area, because by locating the hospital over there next to Emanuel, it would obviously improve the property values. It should, quote, unquote, "be more centrally located," which was one of the arguments.

The counter-argument that was made from the University's side was that it would represent a marked separation between the University and the Veterans Hospital and that the national trend at that time was to put veterans' hospitals in closer proximity to universities because they felt there were several advantages as far as recruiting staff, as far as recruiting house officers, the entire gamut of how the V.A. runs. Plus the fact that the veterans hospitals system runs in a manner that is quite similar to a university system, and not as similar to a community-based system.

Then it got to be very personal, and people went back and lobbied the Senator, and I spent some time talking with him and with Mr. Frank, who was a personal friend, about whether or not we could resolve this in a satisfactory manner. Eventually, because there was a need to show community support, and because Senator Magnuson from Washington was a powerful member of the Appropriations Committee and had been a very close friend of Senator Hatfield, actually had been his mentor when he entered the Senate, a compromise was finally reached. The compromise was that we would site the V.A. Hospital at the present site on Marquam Hill, but in return for that the veterans' domiciliary, which was located in Vancouver, would be expanded to 120-bed unit, which would have a rehabilitation unit, it would also have a nursing care unit and a lot of day care activities, and that it would all fall under the administrative umbrella of the Portland V.A. Medical Center.

When that compromise, which seemed to take an endless period of time, finally was achieved, we initiated the development of the hospital, and it was quite satisfactory. But it always represented—the valley, if you will, between the University Hospital and the V.A. Hospital always represented a physical barrier to complete integration, and when we were fortunate enough to get the approval of the bridge, it made it fundamentally a single unit, with a single purpose. And I believe that, again, history will show that the right decisions were made and that the University Administration held out for what was the right fundamental siting of the hospital because it has flourished as a component and as an integral part of the University system.

ASH: I saw on your C.V. that you were on a committee, a National Academy of Science committee, to survey research facilities for V.A. hospitals.

PORTER: Right.

ASH: And that was right about that same time?

PORTER: The V.A. was under pressure to adjust its budget and to validate its research expenditures. Obviously the V.A. works independently from the National Institutes of Health, and Congress appropriately stated, "Why should you be doing research when we have a national organization that's committed to it?"

So one of the things that was asked of an independent body was to go around and review the research that was being done in selected V.A. hospitals and then to come back and tell Congress how that compared with what was being done under the auspices of the

National Institutes of Health—at that time they were the primary player; today we have more pharmaceutical houses and whatnot involved in it, but they were the primary one—and whether or not there was something unique that the V.A. research did that was not being done by the NIH. So that was our charge.

What we found was that the V.A. had developed a cadre of investigators who were comparable to NIH-sponsored investigators. So we felt that the quality of their research was comparable to the NIH.

The other thing we found is that there were unique aspects of their research that were driven primarily because of the certain unique aspects of being in the armed forces, and the most classic disease we know now is Gulf War Syndrome, but there were other things that were happening, especially in Vietnam, which were unique to service-related injuries. And so there was that component that the V.A. was putting emphasis on that was not being emphasized by the NIH.

But it was a time when the government was reexamining these seemingly, not contradictory, but parallel activities, that they wanted to make sure were truly complementary. Our review of the research that was being done suggested that it was very complementary and it should continue to be supported.

ASH: The reason I asked you about that was I wondered if that had any influence at all on our V.A., the siting of our V.A., the fact that you had been immersed in the study?

PORTER: Well, again, one of the strong issues that we used in our lobbying efforts to get the V.A. sited close to the University was further integration at all levels. And we did point out that there were several activities, research activities, which were being jointly conducted. We also pointed out that it allowed us—the strength of recruiting was not based on a single unit, either the University or the V.A., but they were complementary units as far as our recruiting went.

There were times when we would meet an individual who had a certain skill, a certain background, a certain ability to do a particular kind of research procedure, and we didn't have to worry about whether we sited them at the University or the V.A. because we knew that they would be a common resource available to us.

ASH: I see. Thank you. Now I'd like to back up again [laughs]. We talked about your medical school a little bit, but I'd like to explore more the people you knew in medical school and who your mentors were on the faculty.

PORTER: [Laughing] Well, it was fairly easy to know the faculty because they were relatively small. All of the classes were basically taught by the professors: Dr. West, Dr. Todd, Dr. Van Bruggen taught us biochemistry. It wasn't given to somebody else. They were there, and they were active.

Probably one of my strongest mentors was Dr. Norman David, who was Chairman of Pharmacology, because I had gone to work for Dr. David between my freshman and sophomore year, working in the laboratory, and over the succeeding two years was able to obtain enough information so that I could complete a thesis. My thesis happened to be on toxicology, and as I have mentioned earlier, I was the toxicologist for the County Coroner of Multnomah.

Other people that had a strong influence were Jack Van Bruggen, who was Chairman of Physiology. Jack became Chairman after Bill Youmans left to I think go to Wisconsin, as I recall. Other people that—again, it was people like Bill Stotler was very instrumental in the first year, but these were all individuals who spent virtually all of their time teaching.

Now, the thing that was missing that obviously developed with time was the research base. In most of the departments, the undergraduate departments, as I say, the primary purpose for the faculty was to teach, and then they did research when they had time to do it. The programs for graduate students were of very limited development. What graduate education there was was basically individuals such as myself who would arrange with a department a sufficient length of time so that we could get a master's degree. The one that was most frequent was in Pathology, and there were two or three students who started with me who eventually took a five-year program, and the five-year program included approximately a year's time spent in pathology, but they graduated with master's degrees in pathology plus an M.D.

I was fortunate that with my summer projects I could get everything done. Now, at that time medical schools ran nine months out of the year, so the summertime was basically the time that you worked to make enough money so you could go back to school in the fall. In my medical school class, at least a third were veterans from the Second World War and the end of the Second World War. Many of them were on the G.I. Bill. We had a high percentage of students that were married in our class. And as a result, while there was levity, it was probably not to the same degree that you would find with a group of students who came directly out of college without that additional experience.

And then when I got into the clinics, I must say that Dr. Lewis was a profound influence; but Dr. Lewis was a profound influence, I think, on everybody. He was a very imposing individual, being very tall and slender. He was highly knowledgeable, extremely articulate and set very high standards as far as his expectations. We used to have professor rounds twice a week, in which one of the teams—and usually a team would be made of two interns and a resident—would have to make a presentation of a single case over an hour-and-a-half period in the basement of the Multnomah County Hospital; and we did it every Monday and Thursday without fail. And Dr. Lewis would grill us. The amount of time that one spent preparing for these was unbelievable, and yet we never quite got it right. He always could find something that we had failed to recognize, a physical sign that we hadn't elicited. He would give us three different names for the sign. He would tell us its derivation. It was an amazing, amazing situation.

[End Tape 1, Side 1/Begin Tape 1, Side 2]

PORTER: He was very unique to the community, in that there were very few physicians in the community that had the experience as a diagnostician that Dr. Lewis had. So we would see—virtually every unique case in the state of Oregon would eventually come to Dr. Lewis' attention. He was a remarkable person.

Then there were individuals who were my peers: Paul Burgner was one. Paul was a chief resident my first year as a medical resident, and Paul was constantly probing and keeping you—trying to get you to be a better diagnostician. He had this great technique of betting a six-pack of beer that I didn't know what was going on with this patient. Now, obviously he was the arbitrator, so he always won [laughs], but it was a very interesting time.

When I was a medical resident, there were nine of us to run the entire medicine service. There were three a year that were selected. The year that I was selected as a medicine resident, my other two residents were Bob Gray and Mike Baird, so we were the three residents. We had four-month rotations. Our off-time schedule was either Wednesday night and Friday night, if you had all your work done, and you came back in Saturday morning, or if you were very fortunate, every other week you'd get Thursday night off, and then Saturday from noon until Monday, a rare entity.

Because of the small number, there was a great deal of camaraderie. We actually lived in the hospital, had our rooms, everything there. It was a much more intense involvement than the house staff of today. I suspect that we defined what is now known as sleep deprivation [laughter]. There was a great deal of that going on.

ASH: You lived in University Hospital, or was it the Multnomah County Hospital?

PORTER: No, we lived in the Multnomah County Hospital. But there were beds in the University Hospital, and I had a sleeping room in the University Hospital. By that time I was married and had a family, and so my time spent was primarily in a sleeping room. But as an intern, our times were so tight that, as I described it, you lived at the Multnomah County Hospital, up on the fourth floor.

ASH: I wanted to ask you about Dr. Bristow and Dr. Kassebaum, also, because they must have been around at that time?

PORTER: Yes, yes. They had the unique experience that neither one of them were good enough to be residents for Dr. Lewis, interestingly [laughter]. But they were good enough to be fellows, and they were good enough to be faculty members. They both obviously preceded me. They were both residents in medicine at the V.A. Hospital. I came, as I remember, it was about—when Kass and Dave were third-year residents at the V.A., I was a first-year medicine resident.

Then Dave left, both Dave and Kass left to do their fellowship. That was a time when Dr. Lewis had made a variety of decisions about how he was going to expand the faculty. In 1947, the University of Washington opened a medical school. Now, prior to that time we had

been the only medical school in the Northwest. They established complete faculties. They went out and recruited—Dr. Williams was Chairman up there of Medicine—and they actively recruited nationwide. So they had an established faculty from the outset.

Here, we had individuals who had returned. Dr. Lewis had been a member of the Portland Clinic prior to going to war and also on the faculty. When he returned, he actually returned, and six months after having joined the Portland Clinic was offered the full-time position as Chairman of the Department of Medicine, and then joined the faculty.

But most of the individuals who were clinical faculty members at that time were individuals who had been recruited out of the community; and they were not traditional academic careers. And so Dr. Lewis, recognizing this, decided that rather than go out and try to recruit a brand new faculty from scratch, what he would do is identify individuals within the program and send them off for training with the expectations that a certain percentage of them would return to the faculty and we would be able to establish our needs in a manner that used individuals who he personally felt comfortable bringing onto the faculty. And I think that you have to remember that it was a very personal sort of department that Dr. Lewis ran at that time.

So both Kass and Dave were identified as such individuals. Dave and I were fellows for a brief period of time in cardiology together, and then Dave went to the CVRI, the place that I eventually went to, and also the place that Miles Edwards went to for our training. But those were both at the behest of Dr. Lewis, the expectation being that we would return and participate as faculty members and start to establish a research base for the department.

Kass went to Salt Lake under Hans Hecht and came back knowing a great deal about electrophysiology and also established a laboratory. But that period of time in the ’60s and early ’70s, where we had a rather substantial expansion of our faculty, especially in Medicine, came about by such a technique. And it was not limited to individuals who had graduated from Oregon. Several members of the house staff training program, people such as Bud [Bardana?], were identified as individuals that Dr. Lewis was very interested in trying to return to the community. So that they were encouraged to go off, get excellent training, and then come back, join the faculty, start a research program, become educators, and thus build the department.

And I’m biased, but I think that we were reasonably successful in doing that.

ASH: Why cardiology for you, and then how was it that nephrology followed?

PORTER: [Laughing] Well, we didn’t have any nephrologists here. The only nephrologist was actually one of my—had been a resident with me at Multnomah County, and that was Gordon Haynie. Gordon at that time had gone to train with Bill—oh, I’m going to forget his name right now—but he was at Tufts University in Boston, and then returned to the V.A. Hospital, where he set up a renal unit and eventually set up a dialysis unit.

There was at the time that I took my fellowship a very limited number of clinical fellowships that were available here. Cardiology was one. There was nothing in G.I. There was experimental medicine under Dr. Osgood. I don't even think there was a pulmonary fellowship at that time. There were a very limited number of fellowships.

My interest was in the kidney, but my interest was also in heart, in blood vessels and high blood pressure. So I took the fellowship with Dr. Griswold. I was able at that time to continue to pursue my interest in the renal failure that was associated with cardiac bypass. That was at the time that Dr. Starr had just joined the faculty. We were very keen to do some valve replacements, but one of the problems that was developing is that in patients who were on the heart-lung machine for any period of time, there was a high frequency of acute renal failure in that population.

So during my two years as a fellow, one of my major research interests was in trying to sort out the issues with regard to this renal failure and then see if we could do something about it. And fortunately we were able to identify hemolysis, and probably not necessarily the hemolysis itself but as a surrogate for the condition that was leading to the acute renal failure; and we further were able to stabilize the amount of hemolysis by using mannitol in our pump solution and were able to substantially reduce the frequency of this.

So it was very rewarding because I actually started out with a clinical problem, took it to the laboratory, brought it back into the clinical practice and found that it actually worked.

It was obvious to both myself, Dr. Griswold and Dr. Lewis that we were going to need somebody in the area of kidney. I had two opportunities at the time when I finally made my decision. One was to go with Dr. Scribner in Seattle, who at that time had just started to develop the chronic hemodialysis program, and the other was to go to San Francisco with Dr. Edelman. Dr. Labby was very strongly influencing me to go with Dr. Edelman, feeling that I would get a very sound scientific basis for understanding the entire field of nephrology, which I actually did. And also it would be an opportunity for me to get into what he considered to be an intellectually stimulating environment, which it truly was. Dr. Julius Comroe, who was head of the Cardiovascular Research Institute at that time, was an amazing individual who had brought together some of the brightest minds in medicine and just allowed them to do their thing. It was marvelous, a wonderful experience.

So that's how I ended up going down there. The understanding that Dr. Lewis and Dr. Griswold and I had is if we were all successful that I would return, I would stay with Cardiology, but I would develop the area of kidney and hypertension as a component under Cardiology, which is exactly what I did.

ASH: So what was it like when you came back from your San Francisco fellowship, and with Dr. Starr on board, things were getting pretty active around here?

PORTER: Well, clinically, it was exciting, very exciting because it gave me an opportunity to get back into the areas that I was interested in.

Research-wise, it was a letdown. I had come from a lab that had had two papers in the *Proceedings of the National Academy of Science*; we'd been on the plenary program at the spring meeting, clinical meeting for the American Society of Clinical Investigation. We had just defined the preliminary mechanism by which aldosterone activated the nuclear messenger and led to a protein. And it was obvious that I was not going to remain in that mainstream coming back to Oregon. I must say that as my time to return approached, there were qualms on both sides. I very much wanted to return, as did my wife and children, to Portland because we greatly adore this area. On the other hand, I knew that we were, in the laboratory, at a point where we were really going to make a major breakthrough, and I wasn't going to be part of it. So eventually after counsel from my mentor, Dr. Edelman, we decided that in the long run I'd be far better off going back, establishing a laboratory and starting to develop a career independent of him. And I believe that, again, was the right decision.

It took quite a bit longer than I anticipated to get the laboratory started. We had space but didn't have anything in it. So it was a matter of accumulating all of the equipment and finding technicians, and just this process of going from nothing to something that even though everybody told me would take a long time [laughs], it seemed to take a terribly long time.

But once we got the laboratory up and running, it was very, very satisfying. We selected a couple of projects that Izzy wasn't interested in, and we worked on them for a couple years, and we were successful. So we were able to do it, but it was—it sort of is like moving from, if you will, Times Square to the middle of the Midwest and suddenly realizing that things are a lot different, a lot different.

ASH: Now, somewhere in here also we got the big cardiology grant. Did you benefit from that?

PORTER: Yeah. Obviously the Division benefited. Dr. Griswold was extremely aware and helpful for me, even though I represented a peripheral interest of the Division, because at that time the emphasis was so much on hemodynamics: we were pushing very hard on valves, valve replacement, the follow-up, that entire area was taking a lot of time. Then we were expanding the fellowship quite rapidly.

Now, one of the things that I brought back to the Division was expertise in hypertension and expertise in renal disease, and that was a benefit to the Division. And you know, it brought in some extremely bright people as fellows who did work on some of my projects. So yeah, I benefited. Maybe not as much as the catheter-pushers, but I benefited.

ASH: [Laughs] Tell me about the fellows. You came back here as a junior faculty member, but you were starting something new?

PORTER: Right.

ASH: And who were the people you brought to work with you?

PORTER: Well, the first person that I really went out and actively recruited was Bill Bennett. Bill had been a house officer and then had returned as a chief resident. And we had discussed it and talked about the possibility that once he completed his training, there might be an opportunity for him to return here.

We had made by that time a couple of very fundamental decisions about what we thought the Division of Nephrology might be at the University. The program for care of end-stage renal disease in the state of Oregon began with a Governor's Commission, which I served on, which looked into the issue of how could we provide care for patients who had renal failure—because we now had a technique for taking care of it; we had dialysis.

We were fortunate because Dick Drake, who had gone to spend time with Dr. Scribner, had with Charlie Willock developed a home dialysis unit, and they were being built right here in the city of Portland. So with that in mind, we then set up—or the Governor set up this commission. We went out and we took testimony. We decided that between public fund raising and some financing from the State, that we should try to establish what eventually became the Kidney Association of Oregon, and we would provide home dialysis support for patients in the state.

Once the Commission was dissolved, then the OMA undertook the responsibility of the medical selection committee. And again Dr. Drake, myself, Emily Fergus, Gordon Haynie—and we were the only four nephrologists in the state—all served on the committee. And we were able to develop a program in which we would entertain candidates for dialysis. Obviously we had far more candidates than we had machines. Our only limitation was when Dick and Charlie would finish a machine, then we'd be ready to put somebody on dialysis.

That program I strongly supported. It was a program that basically ran out of Good Samaritan Hospital. And my conclusion was that dialysis should be done by the people that do it the best. We gave our total support to the program down at Good Samaritan, and we reserved the transplant program for the University.

When Bill arrived, that was one of his primary responsibilities, to continue to grow the transplant program here at the University, which he did extremely successfully. And we were the nephrologists for probably close to maybe five or six years. And then shortly before I became Chairman of the department, we started to do some additional recruiting. At that time we recruited both Dr. David McCarron and Dr. Marsha Wolfson. Marsha was at the V.A., and David was at the University.

Again, we did not have a lot of finances. As you probably know, most of the financial support for faculty members by that time was being derived by clinical fees and whatnot. So in order for us to recruit somebody, we had to be able to show that we were financially sound enough that we could provide the additional faculty salary that was going to be necessary.

I think that Dr. McCarron was probably my last recruit before I left to become Chairman.

ASH: And I wonder at that point what it was like being a woman recruited to the V.A. Hospital?

PORTER: Well, Bill and I had from the very beginning felt that we needed to find female faculty members because several things were obvious. The number of house officers was starting to change, from being all male to being a mixture of male and female. We also felt that women bring a different attitude and a different type of experience to house officers, and they also have a different approach as far as education. And we thought that the blend would be extremely beneficial to us. So Marsha was an individual that we were very keen to recruit.

Subsequent to that, Susan Bagby was recruited by Dr. Bennett, Julie Tank. We have a large number—Cathy Shuler—I think that probably our Division has had more women faculty members per capita than any other division of the department. But that was a conscious decision that we made feeling it was extremely important, if we were going to be adequate in our training activities and we were going to also fulfill the faculty. Women do have a definite different influence when it comes to decision-making, policies; and we felt that was a very important input that we needed to have.

ASH: You mentioned that you thought that their teaching methods were different. Could I ask you your perception of how that is?

PORTER: They're much more perceptive, I think, of how a student is responding to the information that's being given. They have a better sense of when students aren't getting it, and I think they allow the student more opportunity to interrupt them and ask them questions. I think they're less intimidating, just by the style; not because they're women, but the style that they use to approach people with.

They also have a different perspective than we do on certain issues, and it becomes very important to hear it. And we also thought that there had to be some role models. We thought that this was extremely important. We had a rather substantial number of women house officers, and we were very interested in recruiting some of them to the nephrology program. We felt that they would be excellent recruiters for it.

ASH: Thank you. You were on the Centennial Committee?

PORTER: Yes.

ASH: [Laughing] Tell us about that. We've seen the product, the book, and we really don't know very much about how that was done.

PORTER: I've always been extremely interested in history, not only my family's history, which is long and, I'm finding, more involved because I just got some information from one of my cousins in California that traces us now back to Ireland; but also when I was a senior at Oregon Sate, I took a course called the History of Science, and it was taught by Dr. Gilfillan, who was at that time Dean of the School of Science. It was absolutely

fascinating to me to find out more about the individuals who had created much of our knowledge base.

So from the time that I first came to the University here, I have collected and tried to keep track of the number of things that we've done. And when it came time to do a centennial celebration—and as you probably know, there are two different dates that have been selected: one date is the date of the Willamette University's first inception, which I think was 1869, and then the more recent one, which was the time when the medical school divided, part of it went back to Salem and remained Willamette, and the part of it being up here was the University of Oregon, and that's when we have our current date for our medical school.

But when the Dean offered me the opportunity to head the Centennial Committee, I jumped at it because I really wanted to—we had a history that had been written up through, I believe it was the late '50s or early '60s, and had been done by one of our librarians. And I wanted to expand that, because much of the rich history of this institution has occurred since the Second World War, a period of time when I was intimately associated with the University, and I wanted to make sure that as much of that information as possible got in. Plus I didn't want to denigrate the early activities, and so I went back and with the help of the Oregon Historical Society was able to piece together much of the political intrigue that surrounds the siting of the University at this place, how the land was granted. There are numerous stories about, you know, this being a railroad depot, being given over by Union Pacific, some of the things that Dr. Mackenzie did as the Medical Director for the railroad.

ASH: What do you think the truth is?

PORTER: You know, I think the truth is probably that it was part of a parcel. I don't believe that they ever were dumb enough to buy this sight unseen. I think it was part of a parcel. I think there was a parcel that ran from the area and this came on to it.

There's also the issue about what the Jackson family actually provided, which seems to have gotten lost in this entire discussion. But I think that there's still information to be gained about it.

There is no question that there was, at the time of the re-siting and the establishment of the County Hospital up here and the University, that there was a lot of back-room politics in Salem before that got accomplished.

ASH: The tape is going to click off in just a second, so why don't we get ready for that; and then, I still want to explore this further.

[End Tape 1, Side 2/Begin Tape 2, Side 1]

ASH: It's August 7th, 1998, and this is Joan Ash and Linda Weimer interviewing Dr. George Porter. This is tape two, and we're continuing the story of the siting of the University

of Oregon Medical School, and what I would like to get on tape is your impression of Dr. Mackenzie as a man.

PORTER: [Laughs] Dr. Mackenzie today would be called an entrepreneur. One of the things that I think characterized Dr. Mackenzie was that there was no problem that could not be solved by knowing the proper people. And as I had pointed out, he had very close connections within the political community of the city of Portland and also within the State Legislature.

He was, as I recounted, the Medical Director for the railroad, which basically donated the property for the University siting. Now, it's well to point out that it was property that was donated to higher education, but it was not specified as to what its purpose was; and it was Mackenzie's desire and lobbying that actually got the medical school as the recipient for this piece of property.

What the component of the Jackson family was is yet to be defined, and why the railroad company decided to donate the property remains to be clearly identified. Conceivably they could have had either a financial or a political motivation for turning the property over.

ASH: Thank you. And you were just suggesting that if we were to do more research about this probably the best place to go is *The Oregonian* at the time?

PORTER: Yeah. I think the newspaper accounts are probably the most unbiased of any of the recordings. Dr. Mackenzie's recounting of how things happened tend to always allow him to be extremely provident in any of the final negotiations and decisions [laughter].

ASH: Well, we were talking about your interest in the history and the Centennial Committee. Could I ask you about the production of the 1887 to 1987 book?

PORTER: Booklet. Obviously when the Centennial Committee first met, we had visions of doing what you're doing now. We really had hoped to develop a video presentation that would depict the hundred years. We also had some very grandiose plans about how this would be presented in a yearlong tribute to the University.

And then financial reality set in, and so as we examined our budget and tried to determine what we could do that would be of benefit to those that came after us, plus to encourage those who had contributed to it, we felt that a historical booklet would be within our financial capabilities and probably would be as good a record as we could provide.

So it started as a much larger project, but I think that the product that we finally were able to achieve was, given financial constraints we had, quite satisfactory. And we did have two or three events associated with it, which I think did identify the contribution that the University has made.

One of my particular—oh, how should I say this? The pride that I take with the University, among other things, is what it's been able to achieve as a resource for not only the state but also the region. I think it's been a remarkable progression and has provided continuing intellectual stimulation. It has provided that kind of leadership which has been critical at times, I believe, when sometimes financial issues or other things get in our way. It has been able to view itself as a state resource rather than a local resource, and I think it has held to that, especially under people like Dave Baird, Charlie Holman. It was very strongly felt by our leadership that we were a state resource and that we had to always remember that whenever we made decisions up here.

ASH: Who put together that book? Who did the research; who did the writing?

PORTER: Oh, boy. It was an effort of the committee. Most of the research was done by Heather.

ASH: Heather Rosenwinkel?

PORTER: Yeah, Heather Rosenwinkel, with the assistance of the Oregon Historical Society, which was extremely valuable as a resource for us.

We also had the opportunity to, at that time, still talk with some faculty members who had been here prior to the Second World War, which was extremely beneficial to us. I'm trying to remember if Bertha Hallam was still alive. I believe she was. I think she was. And there's a small group of individuals—Jimmy Speros and that group—who were living down on the beach at Rockaway, or close to Rockaway, who were a great resource for us because they had been in the administration for a long period of time.

Another individual who was very helpful was Joe Adams, who had been a participant and a member of our administration for a number of years, and Gwynn Brice. Gwynn Brice was a big help.

But again, one of the things that characterized, especially University Administration, was long tenure, profound commitment and loyalty to the institution, and an overall desire to see it succeed in the broadest of terms and the willingness to share all that information with us.

ASH: Now, I heard a rumor that you were working on a history of the Medical School. Is that true?

PORTER: Well, yes. Dr. Bloom, one of his—one of my chores in my partial retirement is to work on a history of the school. However, once I found that you were doing this project, I have not done a great deal more on that right now. I'm much more interested in your product, I think. I think it will be—it's a richer way of gaining a historical view than the one that I was planning to do.

ASH: Well, as you know, we are not the product developers, however. We are the information gatherers. We're the data gatherers, and someone else has to do the data analysis.

PORTER: I see.

ASH: And so we're encouraging anyone with an interest to use the information that we're gathering, and we're trying to be proactive in gathering the right information, but we probably need to talk about what we've done so far and your suggestions on what we should do in the future.

That book goes up to 1987, so there is a gap.

PORTER: Well, a substantial gap. Several name changes [laughs], which as you—you probably weren't here, but we used to put a banner up on Mackenzie Hall with every name change. Nobody was going to put the permanent name up here until they decided exactly which one it was going to be, and for a time it was the local joke: "I never could figure out what the name of my university was or whether it became a university or a college or exactly what the sequence—or was it Health Science Center, or what it was."

So that was an intriguing time. It did represent a very rational administrative change on the part of the Chancellor, because at that time he was faced with, as I recall, four presidents—or maybe it would be six presidents of universities, and two deans, one of the Dental School and one of the Medical School. And he was having a great deal of difficulty deciding how to deal with these because although—at that time the Dean of the Medical School had many of the same responsibilities that a president would have, plus the additional responsibility of the University Hospital, which was quite different. And so when the decision was finally made, which I believe was in '74, to change this to a university base, and obviously that incorporated the Dental School and allied health sciences, there was great trepidation about how we were going to end up, especially from the standpoint that there was concern about whether or not we were going to be adequately financed to do such a thing.

But you know, I do believe that it led to—after the consolidation and after we started to develop some of the efficiencies, I do believe it did offer us an opportunity to take a giant step forward, which would have probably been denied to us if we would have continued to be part of the University of Oregon. Our interests are so much different. Our missions are so much different. And we deal in areas that it was very difficult for their trustees to understand—for that matter, it was very difficult for most anybody to understand.

It did also allow us the opportunity to present our case to the Legislature and to the Governor, and it made it much more possible for us to start an educational process about how we were unique from other components of higher education.

ASH: I understand that the faculty of the Medical School actually approached Chancellor Lieuallen fairly early on about becoming a university. You were chief of Nephrology at that time, and apparently there was some discussion about the number of new faculty. I wonder if you remember anything about that?

PORTER: No. The discussions that were at my level of the faculty were more concerns of what would be our relationships with regard to grant activities, with regard to tenure, with regard to our PERS, and the sort of things that I think impacted all faculty members. But that activity—at that time the faculty negotiated with the Dean, and Dave Baird used to make agreements in his office and then he'd take them down to Salem and get them done. There may have been a grassroots movement, but it always went through one place [laughter]. And if Dave approved of it, it would get done.

Charlie Holman was a little different. Charlie was a little more willing to give up, and to allow a little more democratic process. But it was still primarily run from the top down. But it again was a relatively small faculty, and I don't think the faculty was opposed to the idea; I think we were very supportive of it. We felt that we were being stifled because, for example, the only other state hospitals that existed were mental hospitals in this state, and clearly we were an entirely different hospital than the mental hospitals, and yet when the State looked at us, they looked at us as, collectively, like the other mental hospitals of the state. It was very difficult for us to get them to understand we had entirely different needs.

On top of that, we were a teaching hospital, and primarily a teaching hospital. So even their availability of information about community hospitals didn't translate directly to what kind of a hospital we are. So we really wanted to have an opportunity say, "Look, we are an entity, this is what we're about, this is our mission, this is what we hope to achieve, let us explain to you, teach you about what we do, what we are as a value to the state, what we expect, what you should expect." And as I say, I don't think any faculty member was opposed to it. We all viewed this as being an extremely positive step in the right direction.

ASH: Thank you. A lot of things were happening right at this time, so I'm going to focus on 1974, 1975, in there. Dr. Bluemle was hired as President. Were you involved in that decision-making at all?

PORTER: No. I knew Bill because he was a nephrologist, and when he came to visit the campus, I obviously met with him, but I was not part of the search committee.

I had some discussions with Gerry Frank from Senator Hatfield's office about the wisdom of moving forward with this particular—and the Senator was extremely supportive; however, the Senator also had some past experience with the University when he was Governor which made him believe that there were times when we actually did things that were in our best interest but not always in the state's best interest. And so I did spend some time discussing with Gerry and also with the Senator about what I thought were the pros and cons of this particular move.

The issue became much more interesting when Dr. Laster was our president. There it was more a problem of convincing Senator Hatfield that we should allow the President to resign and move elsewhere.

ASH: Still focusing on 1974, but we'll move forward in a few minutes, this was also the time when the hospital almost lost its accreditation, and Dr. Kassebaum became vice president. You were on a steering committee for University Medical Associates. What was the role of University Medical Associates and the steering committee?

PORTER: The University, with the enactment of Medicare, had suddenly started to become paid for clinical activities that we had never been paid for before. But there was no real technique for collecting those in an orderly fashion. The hospital did a good job, but the physicians all had to do separate billings and that sort of thing, and it turned out that each component, be it a division, a department or whatnot, were doing their own billings, and we were trying to get a central billing service. It was becoming evident that this was relatively inefficient and we needed to move forward and do something that was more a faculty-wide collection service. Then we could establish some policies and start to establish some standards of practice and we could start to deal with, at that time—this was long before contracts and whatnot, but that we could have a common legal entity that would allow us to accomplish this, plus the needs of various Internal Revenue requirements and whatnot. And so it was under those auspices that we started to develop this concept.

University faculties are like trying to herd cats. They're very bright; everybody has their own idea about how things should be done, but it's always very difficult to find the common ground. And the other thing is that, for the first time, the faculty started to recognize that they had some real financial potential. Prior to that, you know, we took care of indigent patients, we took care of a few patients at the University Hospital that did pay, but everything that we collected was turned over to the hospital, so we never saw anything. And then there were some changes in the laws and it had to be done differently. We had to have an established group to do this with, and it was, you know, sort of that changing political environment, changing requirement environment, that led us to doing this.

Plus we started to recognize that if we were going to expand as a faculty, financing was going to have to come from relatively creative ways because the State was certainly not going to put more money into faculty salaries. We didn't have a lot of endowed chairs. So the options that we had were either research grants or clinical practice, and clinical practice at that time was one that had really just been totally untapped.

ASH: So the steering committee—did it do actual work?

PORTER: [Laughs] Oh, yes. Yes, yes. What we tried to define was, you know, what would we like this entity to look like; and then, what would it take to get people to come to that agreement? And obviously we had an idealized organization, and we had a group of, if you will, independent fiefdoms, and the issue was how were we going to move them closer to the ideal and still allow people to retain their independence and still allow people to retain, quote, unquote, their "academic freedom." All of those issues were extremely important and made it much more difficult to get the nice, you know, well-defined boxed-in program.

So we ended up with a compromise program that has worked quite well over the years. But it took a lot of work, of discussion, of renegotiation, of redefining. That's what the steering committee did.

ASH: About that time still we were recruiting for a new Dean of Medicine, and I wondered if you were involved in that at all, when Dr. Stone was hired?

PORTER: [Pauses] No. No. Bob was responsible for appointing me as Chairman, but other than the fact that I had, I think, sat in on one or two of the interviews, I was not on the search committee for the Dean.

ASH: I wonder if you could tell us a little bit about Dr. Stone as a Dean?

PORTER: Dr. Stone was a very intellectual and astute administrator, who found it very difficult to work with the President. What ended up is that we had had a medical school that was basically run out of the Dean's Office, and that individual was the chief executive officer of this campus. When the President's position was put in, it was not clear how the Dean would interact; even though it was put out in the table of organization, the actual human interactions were much different.

The faculty still viewed the Dean as the chief executive officer, not the President. So when they went out to recruit a dean, and when they had a dean, they had the same expectations for that individual as we had for Dave Baird. And yet the positions were much different.

Over the years, I think the positions have been redefined. The dean's primary responsibility is an educational one. He or she defines the curriculum for the undergraduates; they're very interested in postgraduate medical education; and they are very involved with the education of house staff and that sort of thing. The educational component is very critical to them.

Now, because of that they have an ongoing interest in the clinical activity, but they don't have, for example, the clout of the hospital. Now, previously when it was only a Dean, the hospital was under the Dean. Now the hospital was separated from the Dean and became a separate entity. It started to develop a power struggle that had not existed before. And it took the faculty a time to understand that their Dean was not the final word, that their Dean had to answer to a President. And that was difficult, and I think Bob Stone was recruited and heard from his faculty that he should be like Dean Baird. Those were their expectations. There was no way he could be that. I mean, things have changed substantially, and he had a difficult time, I think, trying to play those two roles, trying to be the old-time Dean for the current faculty and still be the helpmate for the new President, and it just didn't work.

ASH: Well, then Dr. Bluemle left to go back to Philadelphia, and we had Dick Jones as the Acting President, and then we hired Dr. Laster as the President. Were you involved in that recruitment?

PORTER: [Laughs] Yes. Yes, I was. Leonard was a very gifted politician who had spent time, as you know, in the White House in the—was it in the Reagan White House? No, it wasn't. It was in the Nixon White House. He was well connected. He'd been at the National Institutes of Health. He was a charming individual. His wife was extremely charming, and my wife was very fond of her. She was very nice.

Anyway, Leonard came. Now, it was still in transition because we had gone in name from Dean to President, but all the turmoil that existed and surrounded Bob Stone's leaving and whatnot was still in place when Leonard took over. And there were constant challenges to the presidency. We had a terrible imbalance in the fact that if you looked at the strength of the University, it was weighted totally towards the Medical School. Financially, it was the hospital. So the hospital was a major player, but the hospital depended totally on the clinical faculty.

The Medical School was the dominant force as far as research and as far as line personnel in the total number. And then there were all these other ancillary things. There was the School of Nursing that wanted to be recognized. There was the School of Dentistry which was starting to downsize, with a Dean who felt very comfortable with what he was doing and sort of allowed everybody else to go on their own way. He didn't worry a lot about it.

But all of these dynamic features were occurring at a time when we were trying to recognize how do you—what does a president do and what does a dean do and how do we make sure that—and now I'm talking from the faculty standpoint, how do we make sure that we're protected in this whole thing and that things don't interfere with what we want to do, which is teach, do research, that sort of thing, take care of people.

Leonard probably wasn't the best person because he had a great deal of difficulty in compromising. He was very articulate. He had a technique of developing concepts by talking about them. He'd make a presentation, and then he'd change it just a little bit; and he kept doing that, and that's the way he did his development. He did it by little increments [laughs], but he always was talking to somebody about doing it.

[End Tape 2, Side 1/Begin Tape 2, Side 2]

PORTER: And so the result of this is that you get a whole series of different stories about what was going to happen, and you were never quite exactly sure about what direction we were going to go with this or that or the other project. And he was at times very difficult to pin down.

I can remember an issue where we had—Dave Bristow was involved in it—we decided that it was important to start a heart transplant program here on the University campus, and we had gone to Leonard over two or three different times, and he'd always sort of put us off. There was always this or that or the other thing that was standing in the way. So finally one day there were—and I can't remember who all was involved; I think Don Trunkey was involved in it; but we actually confronted him in his office, pinned him down, and made him sign the document saying "We're going to do this."

That was the way oftentimes you had to deal with Leonard. He was at times—I think many of the faculty became very aggravated with this because it seemed as though you could never get a final answer. It never was quite, "Okay, right, wrong or indifferent, this is the direction we're going to march and let's go at it."

That kind of anxiety in not knowing exactly what was going to transpire I think finally led to a lot of the faculty rebellion around Leonard and Leonard's leadership style. It was a style that probably would have been very useful in a well-established organization that had an administrative structure and had a culture that was well defined with regard to how the responsibility ran, how the decisions were made. But we were still in this transition of trying to decide—our Dean's left, we've now got a President, what does he do? He's got to do all these other things. Who speaks for us? Because we think we're the most important—and we were. I mean, if you looked at it financially, if you looked at us by sheer numbers, looked at us any way you wanted to balance it up, we were the most important component of the university system. And yet there was this concern that we were not being given our fair share.

Well, you know, that's what statesmanship is about, going out and proving to people that they are getting their fair share, or, if they're not, why they're not and what we're going to accomplish. That didn't seem to come forward too well with Dr. Laster.

He had many other wonderful traits, though. I mean, he was a visionary. You know, he put up the Vollum. I mean, that was Leonard's great undertaking, and he convinced Howard to contribute huge amounts of money to a public institution, which had never been done before in this state. In this state, while it was very supportive of private schools and whatnot like that, and there is some support for public education, the public has always felt, "Look, that's public education. That's what I pay my taxes for. That's who takes care of that." And Leonard was enough of a visionary to say, "Look, it doesn't have to be that way anymore. We can change that." And he did.

You know, the Vollum has been very successful, extremely successful. It's attracted world-class investigators. It's moved us in a direction and given us a profile internationally that we never would have had without that.

ASH: The other thing Dr. Laster is known for is his relationship with Senator Hatfield, and as we interview people we're discovering a lot of people from way back have had relationships with Senator Hatfield, and just hearing you speak earlier, you had a relationship with Senator Hatfield. So give me your impression of the relationship between Senator Hatfield and Dr. Laster, if you would.

PORTER: Well, Senator Hatfield was very instrumental in getting Leonard appointed, unquestionably. He had a profound respect for Leonard, not only through his connection with the NIH, he had testified in front of his committees before, he also knew him socially.

He was convinced that the faculty was, at times, a group of malcontents out here and that what we needed to have was somebody to put some discipline into us and to make sure that we abided by the rules. And there probably were, from his perspective, some reasons—from the Senator's perspective, some reasons why this was the case.

He was very strong that, with Leonard's appointment, he would look favorably on several of the projects that the University had in mind. And there's absolutely no question but that we would not be where we are today without the long-term support of Senator Hatfield, not only financially, but every other conceivable way. I mean, I've heard him at times discussing with other people what profound respect and admiration he has for this University and for what it's been able to do. But he also had certain expectations for it, which he felt needed to be changed at the highest level in order to get those accomplished.

So there was absolutely no question but Leonard was the Senator's picked choice for becoming the President of the University to succeed Bill Bluemle. And I must say his credentials were good. I think that some of the concerns that the Senator had about our environment and the way we—I'm now speaking about the faculty—the way we dealt with things, were issues that weren't so much faculty-based as they were based on the conditions and the circumstances that we were facing at that time. As I say, I did on two or three occasions try to explain that to the Senator. [Laughing] I also got dressed down once for going back and telling him something that he didn't want to hear, so I learned to pick and choose when I talked to him about it.

ASH: Throughout Dr. Laster's presidency, did you notice a change in the relationship between Hatfield and Laster?

PORTER: No. No. I mean, the Senator remained true to him to the very end, and I can recall that when it was very close to Leonard leaving and going to Connecticut, that there was some—I had heard a rumor that the Senator was thinking very seriously of stepping in and trying to prevent that—and I was on my way to Washington, D.C., anyway, and I did stop and talk to him about that and tried to explain to him that I felt that this was going to be the best for everybody, that it was being done in the most amicable manner that could be achieved, and I thought that it needed to proceed because we needed a different kind of leadership, that we had gone through a period of time and we were in a new phase, and that new phase was going to take different kinds of skills and different kinds of leadership. And on the Senator's behalf, he didn't interfere with Len leaving, and I think that that was a critical point for this university.

[Pause.]

ASH: Let me look at some of the other themes that we haven't yet explored here. Curriculum changes and space; I think we talked about organizational culture changes, although we could bring that more up to date, post-Laster. Why don't we do that? I would like to do that. Let's move on from Dr. Laster, then, to the hiring of Dr. Kohler.

PORTER: Yeah. Again, I think that we had a much different kind of requirement at that point. I think the house was pretty much in order, and what it now needed was somebody to give us some clear direction about where we should be going, what were the important things for this university to be accomplishing, and how were we going to be known nationwide.

I think that Peter had all of the right credentials. He had gone from the NIH to Arkansas and from Arkansas down to San Antonio; and one of my very close friends and colleagues who was Chairman of Medicine at San Antonio when Peter was there was very supportive of Peter and his style. And I think that everybody was pleased when he came. I think that he gave us more of the presidential. He had, I think, probably a little more recognized academic credentials—being a dean, being a chair, I think people felt that he'd come up through the ranks and understood the issues that faculty face and understood the requirements of academic physicians. And that was, I think, you know, a credential that he brought with him, credibility that was instantaneous.

I think he was also very good about defining what people did *for* him, and he didn't try to be Dean of the Medical School. And that's a terrible tendency, and I think that having established clearly that he was the President, that he was going to build for the future, that his purpose was to give us direction and leadership—those were very important components for this faculty to undertake.

I think that he did a very good job in eliminating some of the management layers that interfered with communications. Difficult times, you know, with the advent of managed care and the influence it had in the community, which clearly probably made some changes in the direction that this university went versus what he had probably envisioned for it initially.

ASH: Do you think we've become a university?

PORTER: I think we've become as much of a university as professional schools can become. There is something clearly lacking because we don't have the undergraduate component; there's a whole series of arts and sciences which provide a culture to a university that we don't have, and we never will have. We knew that from the outset. We didn't have it even when we part of the University [of Oregon] because they were a hundred miles away from us.

But as a medical center, and I think that's what we need to be viewed as, and a health care center, yes, we've accomplished most of the things that I see in other health centers, and I think we've done an excellent job. But as a university, no, we'll never be a university.

ASH: What did you find most rewarding, as you look back, in your years as a full-time faculty member here?

PORTER: Well, number one is all of the house staff and students that we've trained and continue to. Yesterday I was down at the Board of Medical Examiners sitting on one of

their committees, and one of our consultants came up to me and he says, "Oh, you don't remember me, but I was your student back in 1972."

And then he related to me a story about how they as sophomore students had been given this little electrolyte course from actually one of our pediatricians; he'd been told all this ghastly effects that can happen if you give too much fluid, and they were all frightened to death. And he said, "The nice thing about it was you came in and you gave us a very reassuring fact about that, it's really not rocket science, it's pretty much just keeping track of how much goes in and how much comes out, and if you're very careful and cautious, you won't kill anybody." And they all felt much more comfortable after that discussion [laughter].

And you know, as I travel around the state now I encounter so many people who have been in part of our training program here, and that's probably the most rewarding.

And then personally I have—especially in the area of nephrology, virtually all of the nephrologists that currently are practicing in this state were trained by Bill and I. And then I'm extremely proud of Bill Bennett. He's done phenomenally well; for somebody who's had limited amount of basic investigative training, he's done astoundingly well as an investigator. He is the incoming president of the American Society of Nephrology, which is the largest society of nephrologists in the United States and probably in the world. So those are the sort of rewards that one achieves from this business.

ASH: Is there anything I should have asked you that I have neglected to ask?

PORTER: [Laughs] I don't think so. I think we've covered most of the things that—especially, as I say, the remarkable aspect of my time here has been that I've seen this go from a very traditional sort of community-based medical school—which was not all bad; I mean, that was what most of the medical schools, with a few exceptions of the Harvards and the Yales and the Hopkins, were prior to the Second World War—to a university which has national and international renown, has made major contributions to improving health care for people, and which has still retained its ability to teach people how to take care of sick people. And I think of all the things, that's probably its greatest achievement, is not losing sight of what it was all about.

ASH: I need to give Linda an opportunity to ask a question. She's been working hard on the camera here, and listening in.

WEIMER: Well, I realize that we're short of time and tape, and you've been remarkably thorough in discussing the various influences, whether they were brought in because someone hired them or they just developed through—because the nation was developing, going that way.

But you mentioned one little article that a librarian wrote about the history, and you did not give me the name of that, and I was wondering if that was…

PORTER: Oh, it's in the *Western Journal of Medicine*, and it's referred to in our booklet. The *Western Journal of Medicine* did histories of medical schools of the West, and that's where that article appeared. And then there was another brochure that—it wasn't Bertha Hallam that did it, but it was…

WEIMER: Margaret Hughes?

PORTER: Margaret Hughes did it. And it may have been in '67, when they recounted the history from the beginning of the Willamette time.

I was going to bring my history folder over here, and I can't find it. I'm a little concerned. I don't know what's happened to it. But you know, I have a lot of information about it, and all I could find was my slides.

ASH: Well, we'd like to take a look at those. So let's close, and I would like to thank you, for both of us, for giving us this time.

PORTER: Okay.

[End of Interview]

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