

SUMMARY

In this interview, Dr. J.S. “Dutch” Reinschmidt talks about his career in medicine and the early experiences that led to his abiding interest in medical education, both graduate and continuing.

He begins by relating the story of how he acquired the nickname “Dutch” and the confusion it causes within his own family. He then moves on to discuss his interest in medicine, and how World War II interrupted his schooling. Upon being discharged from the Army, Reinschmidt was determined to finish his degree in the shortest time possible; after seven years at Vanderbilt University, he graduated with his M.D. Shortly thereafter, he entered into private practice in the small town of Tekoa, Washington, and he notes that this experience highlighted for him the needs of rural physicians for continuing medical education.

In 1970, Reinschmidt joined the University of Oregon Medical School as Director of the Regional Medical Program. He discusses the history of the program and the course changes he initiated. As federal funding for that program waned, the Oregon Medical Association stepped forward with funds to create a Division of Continuing Medical Education at the University, and Reinschmidt became the first Director. He talks at length about the growth and development of that Division and its course offerings.

The second major project to attract Reinschmidt’s attention at the School of Medicine was curriculum reform. Initiated in the late 1980s and early 1990s, the reform sought to address not what medical students would need to know tomorrow, but what they would need to know ten years down the road. Reinschmidt talks about the enormous amount of effort that was required to redesign the curriculum from the ground up.

The development of the Area Health Education Centers was closely allied with the developments in the graduate curriculum, and here again Reinschmidt was the leading force. He talks about his efforts to integrate student experience with the needs of preceptors across the state, and notes with satisfaction that the program often had more preceptor volunteers than it had students to place.

One of the many awards he received for his outstanding contributions to continuing medical education is on daily display in the BICC Building on the Marquam Hill Campus. The “Medicine Man” sculpture, which graces the lobby of the Main Library, captivates many staff and patrons. Reinschmidt describes the awards banquet at which he received that prize.

In closing, Reinschmidt offers his own advice to young medical students embarking on careers in health care, noting that “if you’re thinking about going into medicine because of the income, think again.”

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Interview with J.S. Reinschmidt, M.D.
Interviewed by Joan Ash and Linda Weimer
September 3, 1997
Site: Dean's Office, Mackenzie Hall
Begin Tape 1, Side 1

ASH: It's such a crazy week. Here we are in Mackenzie Hall in the conference room of the Dean's Office suite. It's September 3rd, 1997, and I'm interviewing Dr. J.S. Reinschmidt. I think the first question I want to ask you is where did you get the nickname Dutch?

REINSCHMIDT: [Laughs] Well, it goes back a very long time, and it's a very strange story. Briefly, when I was a freshman in college the head of the chemistry department, who had been there for years and years and years, always called each person's name the first day of the course, and he had them stand and he repeated the name. As far as I know, he remembered everybody's name. If you saw him in the hall three weeks later, he would know who you were.

But when he came to Reinschmidt, he kind of wiggled his mustache a bit and said, "That's the first Dutchman we've had around here in years." And for some reason or other, that picked up with some people, and just gradually that's what people called me. I didn't pay any attention. I also had an older brother that was called Dutch, but that should have been ancient history. I don't think anybody there would remember it, and he certainly didn't know anything about it.

But really it came from that comment. Interestingly enough, over these years, that's a little confusing with this now very elderly brother, who everybody in my hometown calls Dutch, and nobody calls me that here. But that's how it arose.

ASH: Nobody calls you Dutch anymore?

REINSCHMIDT: Oh, yes. Everybody around here. Everybody except right in my hometown, where I grew up in high school and all because they never heard of that. So there's some things in this life that just occur, and you can't do anything about them and you don't worry about them.

ASH: Where was your hometown?

REINSCHMIDT: Pensacola, Florida.

ASH: Oh, you were born in Florida. And you were raised there?

REINSCHMIDT: I was born and raised there. Recently, as a matter of fact, about—well, within the past year, I visited the remodeled home where I was born, actually.

ASH: In the home?

REINSCHMIDT: Oh, in the home. And lived until the time that my mother passed away, and I went off to war and to college and so forth and so on. But some people had bought the home and had refurbished it into a bed and breakfast. It was absolutely spectacular; I couldn't believe it—because, you know, the home was an old, old home. It was built in—oh, I don't know, 1905 or '06 or something, had survived whatever hurricanes had come through with not any severe damage or anything. But they did a marvelous job, and that's the first time I'd been in it in many, many, many years. It was interesting to revisit that place.

ASH: Could I ask you when you were born?

REINSCHMIDT: You can [laughter]. October the 24th, 1925.

ASH: Thank you. And then you were raised in Florida, and you at some point decided to go to medical school?

REINSCHMIDT: Well, it's interesting. For some reason or other, from the time of early childhood—and I don't know exactly when, but possibly in my early teens—I became interested in medicine. I didn't know very much about it except that there were some friends of the family who were physicians, and a couple of them that visited our area during the summer that I went out fishing with, and actually took them fishing because I knew where to go. I was only about ten or twelve years old, but still. And you know, I became interested; they talked to me a little bit about it.

And so that's how I became interested, and that interest never waned. My only problem was I didn't see how I could ever do it, because of the fact that we were very financially impecunious. My father had died when I was a young teenager, and I just didn't see how I would ever do it. But interestingly enough, there was never anything else that seriously sort of entered it.

ASH: But you did go to college. Was medicine your interest even when you entered college?

REINSCHMIDT: Oh, indeed. It was, in fact, *the* interest by then. But you see, there was a combination of circumstances that allowed that to take place and by, if you will, putting those together—I probably never could have done it had it not been for the GI Bill with the service I had in World War II. That really opened the door.

In addition, not for the undergraduate years but for the medical school—at that time, if you can believe it, Florida didn't have any medical schools. So they had some

arrangements with several schools in the Southeast that they would assist in the cost for residents from Florida who were acceptable and so forth. As far as I know, I was the only one from Florida in the place where I went to school. That, with some very kind and trusting people who loaned me money to complete the saga through medical school, I was able to do it. But you know, despite the fact that I certainly didn't like the war and the Army and particularly the time I lost, as I saw it, out of my life, that did make it possible, I think. Without that, I don't think it would have been possible.

ASH: So the progression was—did you go to college before or after you served in the military?

REINSCHMIDT: I went in the military just within weeks after I turned eighteen. That was what happened in those days, you know; in World War II, virtually everybody was involved. So I was in there.

ASH: What role did you play and was it medically oriented at all?

REINSCHMIDT: No, not in the least. Actually, I was in a special program, the Army Specialized Training Program. And I would have gone in the Navy from Pensacola, but because of my eyes and flat feet and so forth, I couldn't pass their physical. So I went into the Army and trod over a good part of Europe on those flat feet.

But nonetheless, I went into that program. And that program, after you completed your basic training, if you had passed all the tests—and I had already passed the test to get into it—you would go to college; in this case, preparation for medical school and on through. And many people did, in both the Army and Navy programs. Some good friends of mine that I went to high school with did.

But due to the fortunes of war, as the group I was with—and this was a group from virtually all over the country, in the same program in our basic training, and you did the basic training in the infantry school. So for some occurrences in the war, they suddenly needed additional troops, and so they took the organized units and then just swooped us—not only ours, but many others—up to fill in those, and there we were stuck for the rest of the war, you know. No way that you were going to get out of that and go back into this program.

So that's just what happened.

ASH: So your education was delayed for five years?

REINSCHMIDT: By several years. You know, by the time, then, that I was going to college, I felt I didn't have any time. I simply had to accomplish it in the shortest possible amount of time because of a big, big slice had gone out of my life.

So I was determined to complete my premedical in three years. I was accepted at Vanderbilt University and went there, and that required a tremendous commitment because

in order to do that, literally, I went to school every day, virtually all day long, including Saturdays, because we had labs and everything else. But I did get it done in that time.

The unfortunate part about that is there were some things I really would have loved to have had the opportunity to have taken in college that I didn't. But I did have some wonderful things I took, too, that I think have been important to me in my entire life and career.

For instance, I had the good fortune to be able to get into a course, because there was a waiting list, a yearlong course in Shakespeare by a wonderful, wonderful professor. And you know, I had had very little exposure to anything like that. But people had told me, you know, it's just a tremendous course. And it was. And I have never lost my interest in Shakespeare, and indeed, I had co-majors in chemistry and English literature.

I think that has been important in my medical career. I think it's given me a perspective from very early that I might well not have had, had I not had those broadening sorts of things, you know. But still, I would have liked to have taken a number of other things. I only bring this up because I think that has had an effect on my career and my life.

ASH: Then after the three years, which sound like a very good three years at Vanderbilt, you went to medical school, also at Vanderbilt? And that was a four-year program?

REINSCHMIDT: Yes. Yes, I went through that. So I spent, you know, seven years at Vanderbilt, which were wonderful years. Hard, but wonderful.

Interestingly enough, related to the Shakespeare, one of the people who was interviewing me for medical school was, again, a wonderful person who was head of the Department of Anatomy. And he was asking me about other than scientific courses that I had taken and enjoyed. And you know, first and foremost in my mind was this Shakespeare course. It was a yearlong course, that's a long course. And he was fascinated with that because he was also interested in it, and he had this skull that was sitting on his shelf that they used whenever they had *Hamlet* in the university theatre [laughter]. Yorick, you know. So we got off talking about Yorick, Shakespeare. But it has been this linkage. So yes, I did spend that four years at Vanderbilt in medical school, and the three years in undergraduate.

ASH: Then you went for your internship where?

REINSCHMIDT: At the University of Colorado Medical Center in Denver.

ASH: How did you select Denver after being in Florida and Tennessee?

REINSCHMIDT: Well, again, a combination of circumstances that today are meaningless, but then were meaningful.

I still was not firmly decided how I wanted to go into a career in medicine. That is, whether I wanted to go into some specialty orientation or some generalist orientation. And that was at a transition time in medicine when virtually everybody went from a rotating general internship to the early years of the specialty-oriented internships, and I decided that I should take a rotating internship, and it would help me look at what I wanted to do and how. And in doing that, it was important to look at the various institutions that offered those and what the avenues were when you completed that internship. So it came down to actually a fairly few institutions.

From what I could gather—and in those days we didn't travel to the institution. I couldn't have traveled anyhow because I didn't have the funds. But people didn't, like they do now. So you relied on what you got from the institution, from people who had gone through the experience, and so forth and so on.

And at Vanderbilt we had a program where groups of five or six students were assigned to a senior faculty member as an advisor for your internship, and they tried to persuade me not to go to a rotating internship, but I finally decided I was going to do that. And I was fortunate enough to get into the program in Denver, and so that's how that happened.

ASH: What year was that?

REINSCHMIDT: That was 1953 when I graduated from medical school.

Also, really, I say fortunate enough because there were a couple of other schools that were also right at the interest level for me that were very good. But when I was in the service—I had never been out of probably within a couple of hundred miles of my home until I went into the service. And you know, I was in the West and then traveled over to the Northeast and so forth and so on; and I really became fascinated by the West, the mountains, particularly. You know, I had never seen anything like that. So that was sort of an extra for me.

ASH: Then after your internship, what did you do?

REINSCHMIDT: Well, then I decided that I would pursue at least some surgical training—and even as now, maybe even more so then, the surgical programs were very competitive. You didn't have all the many separate ones that we have now. They were pretty much general surgery. And I was accepted into that program.

ASH: And this was at Colorado as well?

REINSCHMIDT: Yes. Yes. Well, again, I looked at several others and actually had an opportunity to go back to Vanderbilt, and finally decided I would stay where I was.

ASH: Then when you finished your surgical residency you went into practice?

REINSCHMIDT: No, I didn't complete the surgical residency at that point. At the end of two years, I decided that it was just necessary for me to repay some of the debts I had, that this was going on for a long time, and if I stayed until I completed a residency and got established somewhere, that those people who were kind enough to loan me money—at no interest, incidentally—would be due a repayment.

So an opportunity arose with somebody that was at the University of Colorado Medical Center who was going into practice in an area up in Eastern Washington, and said, "Well, why don't you come on up and start there?" Well, I looked into it and found that I could enter into a practice without any investment, which was very important, because all I had were the clothes I had on my back. And so that really came as again another circumstance that was dictated, to a great extent, by the economics. But like a lot of other things, I found that this was a fantastic experience.

ASH: Where was that? With whom were you practicing? What were you doing?

REINSCHMIDT: I was doing general practice in a very small community called Tekoa, Washington. It's on the Idaho border about forty miles southeast of Spokane. Very small community. And it was a distance from a hospital.

ASH: Where was the nearest hospital? Spokane?

REINSCHMIDT: There was one in Spokane. There was another one in a town called Colfax, but that was a much smaller hospital, and it was about the same distance, so I elected to relate to the hospital in Spokane. Again, there were several reasons for that. One, the roads were generally better than going down the other way. And remember, this is hard winter area. And two, I felt it probably would be better for me, educationally, to be exposed to the people in that community. And I am glad I did that.

ASH: When you say educationally, you mean medically?

REINSCHMIDT: Medically.

ASH: So there were other practitioners?

REINSCHMIDT: Well, by being part of the staff of a hospital there and involved in their staff activities and educational activities and knowing the people, I had the opportunity to learn things and to—if you will, to keep my intellectual stimulation going.

ASH: How long did you practice in that community?

REINSCHMIDT: I practiced there a little over three years, and then I went back and completed my surgical residency.

ASH: At Colorado?

REINSCHMIDT: Yes.

ASH: Aha. [Laughing] So this was like a sabbatical you took from your residency?

REINSCHMIDT: Well, yes, but it was close call, though, I must tell you. By that time I had developed a lot of love for that little community, but there was really very little future for it economically. The two railroads that had divisions headquartered there had pulled out—and even Safeway had pulled out, and when Safeway pulls out, you know things are bad.

And there was nothing for the younger people, so as soon as they got out of high school or finished college they left because there was nothing there. I mean, it was basically agricultural. A very rich agricultural area, but even at that time, very large farms and ranches. As I analyzed it, it looked like to me that the future for me in that community was going to be pretty bleak as a few years went on.

But there was another big concern, too, and an increasing concern, that you'd get stuck and you become farther and farther behind in your own knowledge, expansion and growth. So that had a marked effect on me, and in many of the things that have happened here—because, you know, I tried to discipline myself, for instance, one evening a week, to the extent that you could without being interrupted, just reading journals and textbooks. About cases I had, something that came up that was very interesting or whatever. I looked at things quickly in between time, but I felt if I didn't do that, that it's so easy, five years later, to have slipped way behind.

ASH: The University of Washington Medical School was being developed just about this time?

REINSCHMIDT: Yes.

ASH: And did they have any activities that reached that far?

REINSCHMIDT: It was in fact developed. There was a person in my intern group that was in the first graduating class from the University of Washington. So they had been around about four or five years. But they didn't have any of the kind of things that you have now.

I found that I was really very busy, and I learned a lot about the economics of practice. I couldn't see how I could be working all day long every day and still have to go to the bank to borrow money to live on; and I found out that people don't necessarily pay their bills. And too, you've got to charge them what it cost you. And I didn't know anything about that, you know. I had to learn. Many times I didn't even recover the light and heat cost from patient care. But we got that straightened out.

But anyhow, the other thing that I found was that with a heavy patient load, there were many things that I had to do that someone who was trained as what I termed at that time

a ‘physician extender’ should be able to do under my supervision—simple lacerations, a number of follow-up kinds of things, but with close supervision—and I would be able to devote the time more productively with patients that were either real diagnostic problems or really needed your attention otherwise.

I mentioned this to people at the University of Washington, that it would be wonderful if such could be developed—which eventually they did. I don’t think because I happened to be somebody who brought it to their attention; I think because many other people came up with it—with people who had come out of the service, and I had seen them, the medical corpsmen; and if their skills could be expanded, they could be these physician extenders.

So again, this was one of the things that contributed to some of the things that I got involved in later.

ASH: Then you finished your surgical residency in Colorado, and then what?

REINSCHMIDT: Then I briefly was in Pullman, Washington, and Eugene before I came up here. By that time—the many things I had learned in that little community about people have stood me well over the years, as I thought about this whole process of, how do we keep physicians, particularly, but all health care personnel, up to date with what’s going on? How do we stimulate them to advance their knowledge and skills? What kinds of things could you put together to extend their skills?

It was very different then. We just didn’t have nearly enough physicians, particularly in places like that. But to extend what they could do by some sort of physician extender situation would make a real difference. When I was approached about the Regional Medical Programs up here, at first I wasn’t sure that I wanted to do that, but as I thought about it more and more and we talked about it more and more, I decided, “Well, I think it’s worth a go. These things have interested me and I’ve learned a lot about them, so maybe I ought to try.” So that’s how I came to the Medical School.

ASH: You were in Eugene at the time? Practicing as a surgeon?

REINSCHMIDT: Well, really just practicing medicine.

ASH: So you were a private practitioner in Eugene and there was this need—

REINSCHMIDT: And I also directed the health service at the University at Eugene.

ASH: All right. It sounds like you were already fairly well known if the Medical School approached you about this.

REINSCHMIDT: Well, I don’t know that for sure, you know. I should have asked people that over the years, but I had—I was very fortunate to become chair of the Educational Committee at Sacred Heart Hospital. And Sacred Heart is an excellent

institution and had an excellent education program, and they got to know who I was from that. I think they must have visited a number of people and I just happened to be one on the list. I think that's how it came about.

ASH: Then the RMP program was federally funded and the goal was...?

REINSCHMIDT: Well, the Regional Medical Programs came about, really, because of some conversations Dr. DeBakey and the president and others had, to disseminate the latest knowledge about heart, cancer, stroke and other diseases to the practitioner, not just in the research activities. He was thinking more of the NIH and NIH-funded activities. So that's how it came about.

So the feeling was they should have one of these virtually in every state, or if not in the state, in an area where there was a medical school. So this institution applied for one of those and received it. Dr. Grover was the original director of that, and then I think there were—when he became Associate Dean, he left RMP, and there were a couple of people that were interim, but they were looking for somebody on a longer-term basis. So that's how I came into the picture.

ASH: So Dr. Grover was your predecessor in the RMP program?

REINSCHMIDT: Correct. And there were a couple of people who were there for very short periods of time, sort of interim.

ASH: I'm trying to get a vision of what continuing medical education in the state was like at that point. You had an association with Sacred Heart as far as education there goes, so there was an effort at the hospital level to keep physicians up to date. Am I correct?

REINSCHMIDT: That's correct. At least at that hospital; now, that wasn't necessarily true in all of them. After World War II there were many physicians that returned from the war who felt the need to be updated, and there were various efforts made in Oregon, as elsewhere, to help them with that.

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

REINSCHMIDT: The when the Regional Medical Programs began, the Oregon Medical Association, in conjunction with the Medical School and others, wanted to have something that could get out a little bit more to the states. So they organized the circuit rider courses that went really even into Montana periodically during the year, for half-day or one-day courses. You have to understand, at that time everybody drove that, and there wasn't any air transportation, of course. So, that was pretty much the state of things.

ASH: The circuit rider courses were sponsored by the OMA.

REINSCHMIDT: And the School of Medicine.

ASH: And the School of Medicine. And this was prior to our RMP.

REINSCHMIDT: Yes, it was established prior to my coming.

Now, when I came up here, after a few months—because one of the things I did was to travel extensively in this area and find out what was going on: what people wanted, and what was there. I felt that we at the Medical School were not really answering the needs of the state sufficiently, and that we really needed to broaden ourselves and, as the University developed, to recognize that we had a fundamental responsibility to the entire state, being the only institution in the state—not only the School of Medicine, but Nursing and Dentistry and so forth. And that we should perhaps even aggressively pursue that. But certainly we should expand what we were doing.

So, that became one of my goals, to expand that. So we began to reorganize the circuit courses in a different way, because I felt keenly that it's one thing for us here to decide that, "Well, this is important, and everybody ought to know this," but it's also very important for us to have some understanding of what people in these particularly smaller communities, but some of the larger communities then in the state, felt that they needed. What did they see as the need?

So, one of the things we began then was a process of needs assessment: what is it that we need to do, not only from our point of view, but from their point of view. So, the word—which I've never really liked—"outreach" continually cropped up, and I would remind people that "inreach" was also important, that we needed to bring their views into what they needed and what we were doing and how it would be most effective. So we sort of redesigned the circuit course program along those lines.

Now, during that time, you must understand that Bend was a small community. This was before they had the beautiful St. Charles Hospital that they have, now an old hospital downtown. And indeed, you could say that about Coos Bay, Corvallis, on and on and on. So the circuit courses went there regularly. As time went on, those communities changed, and the makeup of the health professionals in those communities changed, particularly physicians. It became obvious that you had to continually evolve the circuit courses, because what they may need in Ontario may be very different than what they were needing in a developing community such as Bend, Salem, Medford, and some of those.

So, we began to have a very complex educational program, trying to answer those various needs. Furthermore, the federal funding began to diminish, and it was left up to us to support this; so we began to charge tuition. The Oregon Medical Association had been very interested in developing a broad educational program in the state, through the Medical School, and they had been involved a great deal in the circuit courses. So, they through some discussions with the Medical School, had a grant to support a division of continuing medical education, and this seems like a very small amount of money now: it was \$25,000 a year, but \$25,000 then was really very, very helpful.

ASH: When was that?

REINSCHMIDT: That was about 1975, because the Division was established in 1976. They pledged this grant to go on for five years, and I was asked to head up the Division, so that's how I became head of the Division of Continuing Education. Now, you have to know that I had been involved in a number of other things in the School besides that, but that was my formal responsibility.

As that grant began to run out, we had an advisory committee of people from around the state who felt that the OMA should continue it. There was a mixed feeling then that they wanted to continue that, but they did continue it for several more years. So that was very, very important to having programs, because we knew we had to expand beyond the circuit courses; they were good, served a purpose, but were insufficient.

I was very interested in looking at this; how do we do this? Well, to make a long story short, we decided that we needed to have a variety of educational offerings for people, circuit courses being one, and increasingly for very small communities—communities like Baker, Burns, Klamath Falls and so forth—and increasingly less for places like Eugene, Salem, Bend, Medford, and so forth, as they developed their own community. And we did other things with them. But we needed to develop, really, a profile of what you might do educationally, and so we developed programs that were designed—like visiting professors: they were particularly useful for places like Eugene and Medford and so forth. They would be very interested in something in a particular field, say rheumatology, and we would put things together and suggest, well, “Why don't you do this?” and have this person come down as a visiting professor, maybe for a half day, sometimes a day—which served their needs very well.

But we also felt that there were broader needs. One of the things: the Oregon Academy of Family Physicians had requested the Medical School put together a program for family doctors. The first one that was put on—actually when I came up here with the Regional Medical Programs; and it was very small, and a very small number of people. So when I became Division Head, I decided that we needed to expand that and to approach it in a different manner. It was, I think, a day-and-a-half course or something that eventually we developed into a weeklong, intensive program.

And that's gone on now for, gosh, I guess twenty-five years, and it regularly has two hundred to 250 people attend for the week, not only from the state, but usually—on average, it'll be from eighteen to twenty states; mostly from Oregon, but in that course, Dr. Girard has told me, they still get them from New York, Minnesota, Florida, who come, some of them very regularly, to that course.

But it is a course that takes a tremendous amount of effort, a tremendous amount of organization. I made a decision then, and I didn't know how it would go, but I decided that it was the way I was going to try; that we would design and produce that course in the Division of Continuing Medical Education and it would not be a departmental course: not the

Department of Family Medicine, OB/GYN, Pediatrics, or whatever. And my reasoning for that was, that we had all of these needs assessments and we had a better feel of where things were and who the people and players were out there; and I felt that we could put it together in a more meaningful manner to satisfy those needs.

That meant a tremendous effort, because we had each year, and still do, usually some sixty faculty that participate. It's designed in such a way that we have sections, but since family medicine is a broad field, each individual doesn't have the same need. So we felt we should design this course so that we had certain things that our faculty and the literature and everything would support, that these are things that are really developing and are very important and everybody should know about; and then to develop a good part of this course that had alternative pathways. So, that if Dr. Smith felt that what he really needed more than anything else was increased obstetrical skills, that he could do that; but some people who didn't do obstetrics didn't feel that they needed any additional update. They would be off with Dermatology, Cardiology, whatever else came up.

So, it was a *very* complex program to build. As a matter of fact, I still consult on it; we've been working on the one for next February—it's always in February. It takes practically a year to build it because of all of these—you know, every afternoon, there are four simultaneous sessions going on; all the mornings are usually devoted to these special areas: infectious disease, cardiology, et cetera, et cetera, et cetera; women's health. And when something new comes along, we block out some time and put that in there.

So, that is what really started the broader course formats, so that then we developed a number of these courses that would go anywhere from about a half day to two-and-a-half or three days. For instance, some go on every year, now, still: obstetrics and gynecology, cardiology, and a number of others that are every year, just regularly; and then a number that are ad hoc, if you will, go on as needed when new things develop or there's new information that needs to be promulgated. So there's this whole panorama of educational endeavor; and that was our intent. I projected, as we started this, that we were starting from nothing but the circuit courses, virtually, to these several different areas of educational endeavor.

One of them was to have the opportunity for people to come up here and spend a few days or a week just learning things that they could be completely refreshed on. And it's interesting, you know, that we would have people from a town like Enterprise, and they would have four physicians there, and one of them would be up here for a week or two *every* summer, taking a refresher in one thing or another. So we wanted to promote that, that they could get away from what they were doing and come in. And those things still are opportunities that are available.

So it was this breadth that I felt we needed. I also projected that because of this, we would have a very steep curve of increase in participation in these educational activities for a period of maybe three years; and by that time we would have had many of them in place, and then that would level off. Now, that was very important because that meant that was the point at which you had to see, how do you support all this? When you reach that leveling off period. And in fact that turned out to be very close to the truth.

Anyway, that's how all that began.

ASH: It sounds like, in many ways, you were a matchmaker: when a physician from Enterprise wanted to come here for two weeks in the summer, you'd match that person up with the proper person or department on the Hill here. So that in many ways you were getting people together. I know, with all of your courses around the state, you always have them in very nice places: Ashland, Bend. Can you tell me a little bit about what it takes to get people to come to the courses?

REINSCHMIDT: Well, now, you understand that the largest attendance we have are at courses we have in Portland. Family medicine is here every year—downtown, because it's too big, we don't have parking, we don't have any place to do it. We take virtually all the space of the Marriott or the Hilton Hotel, *every* room that they have, besides their big meeting rooms, because of the complexity of this. So we still have a significant number of programs in Portland, and the biggest ones are all in Portland.

But we had requests—Ashland, for instance, started because people down in Medford said, you know, “Can't you come down here with a course that's more than a circuit course?” And I said, “Well, sure; let's work on it.” So, anyway we did, and the weekend after Labor Day, we put on a course at the country club down there for a day and a half. And I was astounded at how many people attended; I think there were something like ninety people. That became a tradition, incidentally.

Now, we did it there for a couple of years. The country club had some severe limitations: one, our attendance was growing; two, one of the things you learn in doing educational things is that it's not only the content that you present, but the whole environment in which you present it that is important. One of the things there was that their ceilings were low. Well, you project slides, and people are trying to look over people's heads—that's very distracting. So we began to develop protocols for what was required in order to put on an effective course. When they built the Ashland Hills Inn, we had the information and we said, “OK, that's where we should be;” and we moved down there and have been down there ever since.

But that's how it came to be there. And it's always been the Friday and Saturday after Labor Day. And it always has a great attendance. We have asked people, “Would you rather have this at a different time?” “No, this is a great time.” We get people there from California regularly, a lot from Seattle and Eastern Washington. It's become—I told the people down there, once we did this a couple of times, that “We will put on this program every year, I think it's important to do it around the same time, so people can depend upon it, they can make their plans from one year to the next; and too, we will vary the topic, but I assure you it will always be a first-class educational event.”

Again, the Ashland program we have kept within the Division all these years, and it still is, because I felt when we started it, we put the people down there and built something, that we had the requisite environmental feel, if you will, of what they need and how to do it.

Literally, over the years, there has been a waiting line of people up here, of departments wanting to be part of that, because it was a very nice thing to do.

And Ashland is actually a great place to have an educational thing, and let me tell you why: it's because there's very little distraction during the day—and we put them through a long day—but in the evenings, they can go to the plays, they can do other things. On Saturday afternoon, they're free and they can wander around, I don't care whether they play golf or whatever. We have tried from the first to organize that so that the luncheon on the first day is a luncheon to which families are invited. Now, you have to pay for it, but we always, from the very first time, had a speaker from the Shakespeare Festival come; it may be costumes, it may be one of the people who had a lead in one of the plays, or how they did things. And over the years, some of them have been marvelous. We have had to expand it into two dining rooms; there's not enough room because everybody brings their families. The thing is, you don't take away from the educational thing, but you make it enjoyable and—you know, people develop enthusiasm.

So, it is a very unusual place, and I think an excellent place to have an educational event because of that. So it's gone on. Indeed, we have another program that we now put on regularly in Ashland—it's not as big, but this one is one of, what I call, the group of perennials. The Division has the responsibility for it; we talk to various departments or groups within the School, and sometimes we have a waiting list for a couple of years. But I always tried, early, to make that selection on what were things that were terribly important, that weren't very off-and-on.

One of the things, incidentally, from my point of view, was neurology. The reason for that is that people often don't get as much neurology as probably would be desirable in their medical school and residency programs. I remember when Dr. Zimmerman first came here and I asked him—actually, he came to me and said, “We'd like to put on a program, so we can get known.” And I said, “Well, that sounds like a great idea; I think it's a very important thing.” He sent me an outline, and I don't know whether you want to keep this or not [shows document], but I looked at it, and I was dismayed. It was a wonderful program for neurologists. So I went down to talk to him, and here this person was brand-new; I didn't know him. I told him that, “This is a marvelous program for neurologists; was that your intent?” “No, no, no.” He wanted to have it for generalists. And I said, “Well, I think we ought to talk about it then.”

Anyway, he was absolutely marvelous. We sat down there for probably two hours and redesigned the whole program. I remember one of the things I wanted him to have in the groups—because I am a great believer that you have to have audience interaction—they had to have opportunities to ask questions, they had to have groups that are small enough that you can have discussion back and forth, in addition to just lectures.

So, that's been the hallmark of whatever we've put together, that that occurs. Not with every department, but everything that the Division puts together for sure; and everything that the departments put together, we really strongly urge them to do this. Because that's the way people learn best, and it's the way you generate their interest.

But anyway, I suggested that we have a couple of sessions in these groups of the abbreviated neurological examination. So, he agreed to do one, and I said, "I bet that won't be enough." Because when we put it on with the family practice and review of other things, it's very popular. But he was reluctant to put on more than one. Well, I want you to know that we expanded that to three sections [laughter] before that program was over.

But I think that's a reflection of a need that probably you don't think about if you're a specialist in that field, because you know so much about it. That program had a huge attendance; we could hardly squeeze them in. It was very, very successful, and we've had several in neurology since. So, we vary them. We don't do the same thing every year; we do things like infectious disease—probably every third year we put that on, because enough has changed that a whole course on that is worthwhile.

Now, the other big one is probably Salishan. But again, the people on the coast wanted something over there, and, at that time, there were very few places you could put anything on over there. There still aren't very many. So we went to Salishan. Salishan is also an excellent place to have an educational program—not like Ashland in some ways, but because it is a place that has got the right distribution of space; they pay very close attention; they want it to work; they are very helpful; it's well organized so you can depend on it. Expensive, but you can depend on it. And that's important for an educational course, in my mind—I just don't want any part of a course that's just put on in whatever hotel happens to be available, you just put it on and people can't see, they can't hear and this and that.

So, we continue to have one or two courses over there every year, because one, it puts something over there on the coast, and two, it's an excellent facility for an educational program. But there's another reason for having these things spread out in places like this—and we do go to Bend and so forth—is that physicians' time is limited. It's our feeling that we want what we do educationally to be solid; we don't want them to be lollygagging with other things. But we also think it may be useful for them to have the opportunity to do something with their families at the same time. But we never have these weeklong ski things, where you spend an hour and a half and then the rest of the time you're out skiing. I mean, we do have one ski one from time to time over there, but you know, they come in there at six a.m.—I guess it's 6:30—for about two and a half hours; they have the rest of the day skiing and they come back at four and they work until eight o'clock. So we say, "Okay, you can do this, but you're expected to take part in the educational program."

Now, I'm not as enamored of that kind of program as I am the others, but as far as I'm concerned, I don't think it's appropriate to have a thing where you have an hour or something, people watching videotapes and then going off. That's a gimmick that I am not very much in favor of, not in favor of at all.

So, it's this breadth.

ASH: Did you have any problem getting instructors over the years, for the courses?

REINSCHMIDT: Sometimes. It became increasingly difficult to get people for the circuit courses, but for very good reasons really: one, the demands on our faculty—see, the federal grant provided some subsidy to departments to provide these personnel to go out. That was no longer so. And increasingly, they had to provide the clinical care, and do their research and other things. The time commitment became such a huge thing—you know, early in the circuit courses, they used to be gone for a couple of days at a time. And it became increasingly difficult to do that.

The cost became such that it was very difficult to meet, and when we had the Eugene meetings, and the Medfords and the Salems and those in there, we could do that by taking some of the tuition from that—because they would get a very good attendance and we'd have extra money—to pay for the ones out in the small communities, Eastern Oregon and Southwest Oregon. As they developed their own medical communities and educational programs, it was not possible to do that. So, we had to come up with another alternatives for how do we reach those people.

So we did; we developed—at that time, we didn't have all the video and everything, but what we did was develop telephonic conferences. We would get somebody that was going to give the talk, make slides, and we would make copies of them, put them in a carousel so they were right in order, send them out, and at a given time, regularly, that program would go on, and everybody would be changing the slide at the same time, and we would have a question and answer period.

Now, that's not a perfect way to do it, but it's a way to reach an Enterprise or a Burns that you couldn't reach otherwise. You do learn that people have to need it to do it, because they'd rather have somebody visit. That has grown into now the teleconferencing as things advanced; and indeed, there are some computer conferences going on. But those are techniques that can be used to make things grow.

So, finances became very important in all of this, so it was important to make this pay. So, in all of our programs, there is tuition; and, like with the family practice review, we always projected a budget for what it was going to cost us, and said ok, this is what we have to charge in order to make that—because the hotels were very costly for us.

So, anyway, these things have progressed from one technique to another. Faculty were sometimes difficult—we went through a phase where it was more difficult to get faculty than I think it actually is now. People were very busy and some of them just didn't see the need, and I was continually—

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

ASH: This is tape two, side one, and it's September 3rd, and I'm still talking to Dr. Reinschmidt.

REINSCHMIDT: Well, anyway, I would point out to the faculty that there are advantages in them being out there and being known, although it was a time commitment and it sometimes was on top of a lot of other things. Sometimes it was a problem, usually not a really major problem.

At one point there were some people in the School that said, “Well, we don’t know whether we have time for some of these things.” So I said, “Well, as long as physicians out in the state want and need this education, we’re going to find a way to provide it. If you can’t do it, we’ll get other people to do it.” Well, they decided they’d do it. But I think that has not generally been a great problem. I think occasionally it has been.

Now, actually I felt that faculty should get some small recognition for what they did. So very early in this process with the circuit courses and others, I said, “Okay, we’ll pay you a small honorarium. You understand we can’t pay you what your time is worth, but it’s a recognition and whether you want to use it for slides or whatever, you can do whatever you want. But it’s yours.” Most of it they just put in the departmental fund for slides and everything else. And so that’s pretty well continued over time.

ASH: What about promotion and tenure considerations? When faculty members are particularly active in taking part in teaching CME activities, do they get credit for that?

REINSCHMIDT: Yes, and I have over the years often been asked to write letters about their participation, because some of them participate a great deal.

ASH: Is it part of a community service effort or part of the educational effort?

REINSCHMIDT: Well, both, really.

ASH: One of the other questions I wanted to ask you was about sort of a town-gown feeling. Was there ever a feeling out in the community that the University was trying to dredge up business by reaching out to the community?

REINSCHMIDT: Well, I think there’s always been some of that, there were always some people that felt that, but that was never—maybe more recently than earlier—a predominant feeling. I mean, people were appreciative of having it. I would warn people before they went out, for instance, in the early days of the circuit courses, “Be very careful about talking about esoteric tests that there’s no way people out there have any access to. So that if you mention it, be sure and mention what they have and what they can do, or ask them, ‘What do you have?’ But if you just go there and talk about it, they’re lost in that.” It’s important, that people understand that—not so much nowadays as it was in the early days—those things were not available. So when you start saying, “Well, you ought to do this, you ought to do that,” and it’s not available to them, does that mean every time they’ve got to send them to Portland? No, it’s not going to work that way. So ask them what it is they have and then explain to them how they can proceed.

ASH: You mentioned Dr. Grover as your predecessor in the RMP program, and you had also mentioned him when you were talking to Dr. Benson. I wondered if you could just tell me a little bit more about his role in the RMP and continuing medical education.

REINSCHMIDT: He was the one that really began with the circuit courses and the Regional Medical Program, so he was the first Director of that program and began all of that.

ASH: Did you continue to work with him when he was—was he Associate Dean?

REINSCHMIDT: Oh, yes.

ASH: When you were directing the RMP yourself. I also wanted to ask you, you were out in the state a great deal but you were also always part of the Dean's Office?

REINSCHMIDT: Well, not formally, but a lot of activity was going on with the Dean's Office from very early in the time I was here. Dr. Holman at that time—I had some opportunities elsewhere on the East Coast, and he had said, "Well, I hope you will stay here because I really think that you offer something that we need." So I was always involved in things in the Dean's Office, but not with a formal title there or a formal position at that time in the Dean's Office.

ASH: But you eventually did?

REINSCHMIDT: Yes. Yes.

ASH: At what point was that?

REINSCHMIDT: Oh, gosh, that was in the early '80s when I was made Associate Dean. When Dr. Grover stepped out of that position, then I was asked if I would be. Although I don't know how it came about, I have always felt that he probably had suggested that I might be a person for that. But they had a search. So I became Associate Dean.

And you have to remember at that time that there was the Dean, the Associate Dean, and the Associate Dean for Student Affairs. That was it. And we were in a little place over there in the Basic Science Building, and we did everything; you know, it didn't make any difference what came down the pike, it had to be handled. So a very broad set of responsibilities, including academic affairs, a number of things related to the curriculum, the continuing education; I had responsibility for just a whole group of things.

ASH: So you have these other roles as well as your CME role. And then the AHECs began, and you particularly made mention when you were talking to Dr. Benson also of Dave Witter and his role in AHEC and Dr. Kohler and his role in the AHEC.

REINSCHMIDT: I think, though, before that in the evolution of all this was the whole curriculum thing. I served as an ex officio member of—I have no idea how many

committees, but it was admissions committee, promotion and tenure, on and on and on, and the student faculty committee.

And it was increasingly obvious to a number of people that the curriculum really had some problems, and a curriculum revision task force was formed to look at that, and came up with some recommendations which went nowhere. But it was still clear that something had to be done.

For one thing, the curriculum was so absolutely packed that there was no room to change anything. To change something, something else had to give, and what was to be left? Several people recommended to the deans that we needed to change it.

Curriculum revision in the School of Medicine, if you're going to do an extensive revision, is a huge project. Not only is it a huge project, but it causes a lot of people intense anxiety.

But one day I did go into the Dean and said, "You know, we've just got to do something. There is no amount of patching or band-aids or anything else that will solve this problem." And he was very concerned because he realized it would take a great deal of time, effort, and money to accomplish this.

ASH: Who was the Dean then?

REINSCHMIDT: At that time, it was John Kendall.

And I said, "Well, we've got to find some way." And he said, "I'll tell you what. If you can develop the resources, okay, I'll back it."

So we set out to do that, and we sent letters of inquiry with generally what we thought we wanted to do to a number of foundations and so forth, I think there were ten or twelve, and got back various letters: "This is not currently a priority for what we're doing," et cetera. But one—and the way I came upon this, I had asked our own Foundation to give me a list. Well, what they gave me, I didn't think was terribly useful, so I asked them to give me the books, and I spent one weekend going through them, and I identified every foundation I thought that we could reasonably approach, either from the area of the country geographically they would fund things in, or the type of things they funded, et cetera, et cetera. And I came up with a group, and we sent to this group.

But there was one in there that nobody had ever heard of, but I picked it out because they'd never funded anything like this, but on the other hand, they didn't restrict it and they didn't restrict it geographically. They didn't have huge amounts of money like Commonwealth and so forth, but it got a reply from them, the single one out of the group, that said, "We think this is very interesting. We would like to pursue it with you. Would you send us an application, no more than five pages?"

So we developed this application of no more than five pages, and they approved it.

ASH: Who was that?

REINSCHMIDT: That was the Charles E. Culpeper Foundation. And that really was the seminal support that allowed all of this to occur. And I still remember, the first check was just addressed to me and sent to me in the mail, you know, and I thought I wouldn't send my electric bill like that [laughter]. I was astounded.

ASH: It was made out to you?

REINSCHMIDT: No, it was made out to the School but sent to me, and I thought, heavens.

But they were wonderful people to work with, and it really made it possible. But I made it clear that what we intended to do would probably take ten years, and their rules were three years and X amount of money. And they said, "We urge you to approach other foundations also."

Well, the Dean said, "Great." He was a hundred percent behind it then and remained so forever after. But it allowed us to get Vicki Fields, who had had considerable experience in this area, and an assistant for her, and for us to go about this in some logical way—that is, we had to know precisely what was in our curriculum, not just in general and what was written in the catalogue.

Vicki actually trained students to identify key words and they went in to various lectures—because in that way we found out that there were both gaps and a lot of replication. Too, it allowed us to determine what other schools were doing. We drew a small group together for this, and we made visits to a number of places that were doing things in the country, to find out what they were doing and the advantages and disadvantages.

And then we had some people come here through this grant support, because we had to know not only what we were doing but what the possible might be, and my watchword to everybody was, "Don't limit yourself to what we're doing now. Expand the horizons of what we ought to be doing and how we can get there." That was very, very helpful. I'm a great believer that you have to be very familiar with the culture of your own institution. What will work at an institution like McMaster, as an example, which started out with a new thing going on, didn't have any tradition or anything to have to deal with—or Harvard or somewhere else, won't necessarily work in Kansas or Oregon or Washington.

So we had to look at our own culture and say, "Of these things what may be useful, what is probably not going to be very useful, what's reasonable for us to pursue?" And so we developed a set of nineteen principles upon which curriculum revision would be based, and went to the Dean and department chairs—and we had regular retreats with the department chairs on the principles and progressive steps. So, through that developed the genesis, if you will, of the curriculum revision with a large number of task forces that worked on them. We gave them very short timelines, no more than three months, to come up with

what this ought to be. We started with very broad concepts and progressively narrowed them.

One of the big principles is that you must have a built-in mechanism for continuing evolution of the curriculum. It should never be static, because that's been one of the problems: that by next year, we may say there's a better way, so let's be looking at it.

But that predated the AHEC and was a huge, major effort, and took a tremendous amount of energy of many people. I think in the aggregate we had something like 225 faculty involved in the process before it was done. Some people thought it was the worst idea that had ever come forward. You know, "What's the matter with our graduates?" And I was constantly trying to persuade them that we have to look at what our graduates need ten, fifteen, twenty years from now, not what they needed yesterday or tomorrow. And we have to really design our curriculum to be flexible, to be able to incorporate new things readily, which we can't do now.

And one of the major tenets at the time was to reduce lecture time by fifty percent or more and replace that by self-directed learning and group learning activities, et cetera, so that there was direct involvement of the students in their educational processes. Because I interviewed about ten fourth-year students as we were at the beginning of this—and actually I started the interviews for another reason, and I switched after the first two because I was very interested in how often I heard phrases like, "I often wondered what this first two years had to do with why I came to medical school."

And I thought that was damning, and I said, "We've got to change that. They must see early what the basic sciences have to do with the practice of medicine and clinical science." So, you know, that's why we designed the curriculum like that, so they see patients in their first two weeks—very superficially, but they have exposure to clinical situations so that they see the connection between what they're learning in the basic sciences and what's happening to this person's heart and cardiovascular system, as an example.

Anatomy, for instance, includes the imaging techniques. A significant segment of anatomy is taught by the non-anatomists, by surgeons, by radiologists, and others, because now we can see the heart dynamically with these problems—we still have to dissect, but you need to know see the dynamic functioning.

So, you know, it's a way of linking the student to all of these things, for them to appreciate the importance of the basic sciences, and see how they fit. So as we moved through that, then AHEC came along, to answer your earlier question.

ASH: What's the connection between the curriculum and the AHEC programs?

REINSCHMIDT: Well, the AHEC program was something the Carnegie Foundation reported that there should be throughout the country. Many of them were organized—the federal government funded this program about 1970-71, and a number of them became operational in the country in the mid-seventies.

Now, when I was here in Regional Medical Programs, I became interested in AHEC and thought we ought to get involved, but people here for various reasons didn't think we could do it, and so it kind of drifted. I continued to press people, and when we became a university, I also pressed the presidents that we ought to do this, but each felt that we couldn't do it, we had too many other things here we had to do, and so forth.

When Dave Witter was Acting President, and because I had been working with people all over the state in these things, he had a call from the Chair of the Ways and Means Committee and another legislator. They wanted to come up here and see what we could do to help these physicians and communities in these rural areas. Dave called me one morning and said, "They're coming up here this afternoon; can you come over here?" And, you know, "Yes."

Well, to make a long story short, we spent several hours with them, and it was agreed that I should develop, if you will, a white paper on what might be possibilities. So I developed this paper, relatively short, a list of things, some of which we could do and should do, if given the resources; and others that we couldn't do but somebody ought to be doing, and AHEC happened to be one of them. I'd been interested in that a long time, so I made sure it was included in the group with a priority. Anyway, they became very interested.

Concomitantly, one of these people, the Chair of the Ways and Means Committee from Pendleton, had been meeting with some people in Enterprise, and they were concerned because they needed physicians and they were losing them, and he said, "Well, why don't you get together a group and see what they can do?"

Well, from that came what we eventually termed the Joseph Conference. I was involved with that, as well as the Dean, the Dean of the Nursing School; several other people, and legislators and people from that area of the state; a number of physicians from Northeastern Oregon; and the Academy of Family Physicians and the Oregon Medical Association. From that came what they called a blue-ribbon committee, of which there were about half a dozen of us assigned to put something together to go to the Legislature. Really took the list of things that had been developed and developed a revised group of things we ought to do, such things as support for physicians to go to small communities, some of the rural health initiatives, and support to develop an AHEC program.

Well, that went to the Legislature, passed unanimously in both houses, and that's how the funding for the AHEC program came, for the planning and development of it.

Now, during this time, Peter Kohler was named President. When he came here he asked me if I would take on the proposed AHEC project, and I said as long as John Kendall agreed, yes, I would. So anyway, that's how I became responsible for it.

Again, we felt that like the curriculum, an AHEC had to be developed in our own image, that is, what was our culture in this state and what was likely to work and what was likely not to work and how to go about it. We had developed knowledge of other AHECs in

the country and things that they were doing, and Dr. Kohler had had experience with AHECs and was very enthusiastic about it and has remained so, an absolutely staunch supporter. Indeed, I don't think there's anybody in the entire country that's a stronger supporter of the principle of AHEC than he is.

So we needed to put together an application to submit to the federal government. We did so in a period of a few months, an application of some three hundred pages that was submitted. Typically, an application went in and maybe the second or third time it would get approved—because there had been a lot of changes in the federal program with AHECs and how much money was available. But ours was approved with considerable praise the first time.

Somebody asked me actually in the developing of this, “Do you think we can develop a quality application?”

I said, “I'll tell you, I'm not going to spend this time if we can't. We *will* develop a quality application. Whether they'll accept it or not is another matter, but we will do that.”

So we were launched. And our determination was that we initially would have four centers in the state, and we divided the state roughly into quadrants, through many discussions with people regarding where the lines ought to be drawn.

One of the things you have to be careful about in this state is too much transgression of county lines. You get into all kinds of jurisdictional problems. So we said right at the beginning, “We will—unless it's really very, very important—stick to county lines when we divide the state.” In only one place, and that's Malheur County—it's so huge that we saw no other way. Anyway, we decided that we would develop one of these centers per year and move along as rapidly as possible.

Now, the federal government said, “Well, you don't have to go that fast. You can go slower.” And I said, “Well, you need to understand the culture in Oregon. We've been talking about what we're going to do now for a couple of years. People don't want to be waiting ten years for what you're going to do to maybe become reality. We need to develop reality as soon as we can.”

And they must have said this to me a dozen times over the next couple of years, “Well, you don't have to”—because we were strung out just as far as we could be to accomplish this development schedule. We picked the Northeastern area first because it had the greatest problem, and that's where we concentrated our initial efforts.

Now, as we began to get that area developed, we decided that it maybe made sense to have five areas and to take this large metropolitan area, including Marion County and so forth, and have it differentiated, because it is very different. It still has rural problems, but has lots of other lack of service problems. But different, very different.

Our statewide advisory committee accepted that; Dr. Kohler agreed; and I presented it to the people in Washington, D.C., and they agreed; so that's how we arrived with five areas.

Some people felt threatened. I said, "You should feel more threatened, particularly the Northwest area, if that big Portland area is right there all the time."

And we accomplished getting them developed in the time frame that we said. I'll have to tell you, it took an absolute one hundred percent effort from the people involved. I mean, Dick Grant, Jeff Butler and Jill Spencer and a few other people—because as we began to make one area operational, for instance Northeast, and go to the next one, Cascades East, we found out that you just don't drop them. They have to be nurtured and helped through this process, and every one of them was the same way. We learned things as we went along. But each of them took a lot of nurturing in the first couple of years.

So we then eventually did get a couple of other people because we just couldn't do it when we were getting to four and five, there just was no way, with the amount of time it took to carry on the rational and logical development.

So that's how it came about, and again I would say that Peter Kohler has been just tremendous in that whole process. He's been excellent. He's not only been very supportive, but he's very knowledgeable about it.

[Pause.]

ASH: If I could just ask you about the connection between the curriculum and the AHECs. From what you said, it sounded like the AHEC was serving the other parts of the state, but on the other hand we also have students going out into the AHECs, so we're getting something—"we" meaning University.

REINSCHMIDT: In our particular case, and again that goes back to the culture of the institution, I happened to be responsible for all of those areas in the Dean's Office. So I didn't have to get in prolonged battles with this unit and that unit and the other unit. You just looked at it and said, these things logically fit together, you know? Logically, the continuing education thing fits. It fits with the curriculum; it fits with the AHEC. The AHEC fits with the curriculum, and the curriculum with that.

One of the things we wanted to do was to have our students have experiences in real clinical situations where they see the patient as they come into the system and follow them. Not in a hospital, not in a big tertiary care center. That meant we had to go out. And our intent was we were going to go out beyond the confines of the Portland metro area, and that's what we did. And the students had to be there long enough to develop this knowledge and experience into something that was really worthwhile to them and might influence what they were going to do in their medical careers.

So we said, how long is that going to take? We decided it would take a minimum of four, but preferably six, weeks. They had to live out there.

Now, when do we do this? It needed to be in the third year. The third year was absolutely crammed. So we said, “We have to change it,” and we did. We changed the third year around so that we introduced a family practice rotation and this six weeks primary care rotation out in the state. That meant a lot of people were threatened by that and we had to change a lot of things. But my feeling was the fourth year was not nearly as strong as it could be, so let us recover the fourth year, and put some of those things in the fourth year, solid educational things.

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

REINSCHMIDT: The reason that why they need to be in the third year is so the students had these experiences before they were having to make their decisions on postgraduate study, for their internships and residency programs. Now, the thing that I felt was absolutely essential was that these be very valuable educational experiences. There had been lots of experiences with students going out places, and there’s an old saw that, “Yeah, somebody says I’d like to have a student, and you buy a bus ticket and send them.” And I said, “No, we want our faculty to say this is a good educational experience. We don’t want them carping that this is not education—some of them did, when we proposed this: “That won’t be good education.” So, we said how do we do it?

Well, one Sunday afternoon I came up here, and I outlined on the blackboard the objectives that we had for the students, the objectives for the curriculum, the objectives for preceptors that were going to be their teachers. And that was what we were going to require. So, we got our group together, our primary care committee, and we agreed on those things, got them set out. You understand, everybody didn’t agree the first time; it took some weeks to get agreement on some of those things that were proposed.

But critical to that was making certain that we selected preceptors who would really be good teachers, and good mentors and role models for these students. So, we said, ok, we have three departments involved. Most of these, in places across the country, were family medicine. We said, family medicine, general internal medicine, general pediatrics: there will be rotations in all of those. We put together groups and I went to each of those departments and I said, “Would you give me people out in the state that you have great confidence in, and either have as members of your department or would like to have or would be pleased to have”—because one of the conditions was that they had to have a clinical appointment in a department. A line of responsibility, if you will, with what was going on.

So we did that, we got that, and we went through that, and we sent people applications, which they had to fill out if they were interested. So it wasn’t just an announcement sent somewhere. And this application was, if I recall, about four pages long: what experience they had; if they were interested, why; other people in the practice; other support personnel; the clinical facilities they had, their offices—did they have room for a student; the hospital; et cetera.

Those interested sent those in, and we reviewed them. Then we selected the ones that—and we required that at least two people from those departments and, usually, me, would visit those, and then decide what we were going to do. We were very careful to select those practices and select the preceptors—and we turned some down. Some, particularly that were very, very good practitioners, but there was kind of an attitudinal thing in their group in the community that we felt was perhaps not the best place to put students in their third year, particularly early in their third year for this kind of experience. So we didn't put them there.

Interestingly enough, the interest was so great that our greatest problem was turning people off because we couldn't send them students. And that's very different than in most parts of the country; most parts of the country are constantly trying to find preceptors. We have a plethora, have had and still do.

One of the requirements was that they had to participate in programs to enhance their teaching skills. Initially, they came here on Saturdays and we would put on the programs; then, this evolved and as they grew, we started relying on them to put on more and more of it. You know, "I've learned this, and this is how it helps and how it works"—to each other. Wonderful group.

I remember, we said, "Well, would you like to have an educational thing for an hour and a half, just for you?" "Yes, and continuing education." "Well, alright." And the thing that came back with the most votes the first time was geriatrics. So I presented it to them, and I said, "What about you pediatricians?" And, you know, I just loved it. One of them spoke up, and they all agreed—because we had three pediatricians from down in Coos Bay and two from Pendleton and one from Klamath Falls, and I don't know where else—one of them got up and said, "You know, we are a special group. We've come to look at each other and to know each other, and we as pediatricians are big enough to learn something about geriatrics" [laughter]. And I loved that, because here we had done something I felt was very important.

So, we've gone to great efforts to do that. Now, that's how all the linkage came together, because I happened to have responsibility for all of those. I really worked hard to try to make this AHEC program link carefully to what we were teaching our students, and that really is true in the School of Nursing, too, but particularly in the School of Medicine. The curriculum, all of these things link; the continuing education—link together. It seemed to me they were logical; why not put them together so that they were a logical educational program.

ASH: Sort of seamless.

I have to ask you this question I had written down, that is a far cry from what we've just been talking about, but before we close—and actually I want to give Linda a chance to ask some questions too—tell us about the sculpture in the BICC, since I look at it every day as I walk around my building. It is so magnificent. How did that come about?

REINSCHMIDT: Well, it's one of life's surprises. I was invited to the Oregon Primary Care Association annual awards banquet down in Eugene, and I knew from that I was going to get something, but I didn't know what. Anyway, I was given their annual award for the outstanding person contributing to the health in the rural areas of this state; and that was very nice.

Over on the side of the podium, there was this thing sitting there draped in this black thing; all you saw was this black thing. And I thought, "That's a strange way; I wonder what the hotel left that here for" [laughter]. And then when all of this was done, they said, "We would like for you and Dr. Kohler to come up here." Pete and I walked up there. Then this person said something about me, that "You have been our role model now, our mentor" and so forth and so on, and said some very nice things about Dr. Kohler. And then he said, "We want to present you with this." And they unveiled it.

And we were flabbergasted, absolutely flabbergasted, because in the first place—people knew this—I *love* working with wood and I love things made out of wood. I mean, I have a piece, as a matter of fact, in our entryway to our house, that's just one piece of myrtlewood but it has such beautiful figuring in it that I have sanded and polished that thing so; and people comment on it. It's wonderful; they think it's a work of art. I didn't think it was a work of art; I just thought it appealed to me.

Anyway, so they got this artist down there, out of Klamath Falls, who does this and has shows all over the country. He carved this out of juniper roots—

ASH: Ah, that's what it is.

REINSCHMIDT: And they commissioned him to carve something. He carved this thing with the Medicine Man and the spirit of healing.

ASH: Very appropriate, very appropriate.

Well, thank you for allowing us to have that in our building, because it's just beautiful.

REINSCHMIDT: It is, and I didn't know what to do with it when we got it. We talked about it and Dr. Kohler said, "I think this needs to go in the Library or somewhere." The more he and I talked about it, we thought, well, the Library a lot of times doesn't have anything there, and maybe it ought to be, for security reasons, where people are around most of the time. Well, how do you secure something like that? Actually, we went out to the Nike museum—it's gorgeous—but they had these things, plastic cases like this. And we went to the people that did that, and they were the ones that designed the case and put it in.

ASH: Well, most of us just love it.

Now, since we're running out of time, I need to give Linda an opportunity to ask any questions that may have come up in her mind as you and I were talking, gaps that I may have left.

WEIMER: Dr. Reinschmidt, you've had a long and illustrious career, and you've worked a lot in continuing medical education. I think my only question is, what advice do you have for young people going in to the medical field today?

REINSCHMIDT: Well, it's different; it's going to change more. It's probably more threatening to people of my generation and just behind me than to many of them, because you come along in a certain way of doing things, and suddenly that goes through wrenching changes, and that's very difficult to deal with. I think for students now, that's less wrenching; they can see it as a way of life. You also, I think, have to understand that, for most of us, medicine was our lives. They want a more balanced lifestyle, most of them. And that's not unreasonable, really, because you know, I have no count as to how many vacations I have cancelled and given up; and that's not healthy for everybody to do that.

So, I think that you have to look at medicine as evolving, as going through some wrenching changes now, but it's still one of the most fascinating fields there is. You can look at it as like a daily Sherlock Holmes adventure, almost virtually every day you find something that's a challenge to you—not huge challenges, but little challenges: what is this? Why is it behaving like this? I'm certain what this is, but it's aberrant in the way it's behaving. Not many people have that opportunity in life, to do things like that.

And then the other part of it is, to be a part of caring for people. Because medicine, above all, from my perspective, is fundamentally a covenant of trust between a competent, caring physician and patients. You just can't allow anything to interfere with that, I don't care whether it's corporate entities or overwhelming technology, because that's the fundamental part of medicine.

I think that's what makes it great, and that's why I think young people will continue to be interested—I certainly hope they will be, and I think the challenges will continue to be there; the satisfactions will continue to be there. Perhaps this is looking at it from a perspective many people wouldn't, but the fact that maybe the income is a little less I don't think is critical to most of them. Indeed, I have always believed that if you're thinking about going in to medicine because of the income, think again. There are easier ways to make more money [laughter].

WEIMER: Thank you.

ASH: Well, thank you so much Dr. Reinschmidt. This has been a superb interview as far as I'm concerned.

[End of Interview]

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