

SUMMARY

The interview with Robert Koler, M.D. begins with his description of his family's move from Wyoming to Eugene, Oregon in 1941. Dr. Koler attended the University of Oregon in pre-med studies, entering the accelerated medical program at the University of Oregon Medical School in 1944 and graduating in 1947. Dr. Koler explains that, because of the war, medical students attended classes year-round and received their medical education free as part of their military service. He describes the medical school curriculum, weekly drills in uniform, and buildings on campus in the 1940's. He also talks about favorite professors, in particular Edwin Osgood, with whom he was to have an ongoing research collaboration.

The addition of the Medical School Hospital to the campus is briefly discussed, and then Dr. Koler talks about his internship at UOMS and fellowship with Dr. Osgood in which he performed research in hematology. He paid back his medical education by working for two years at the Walter Reed Medical Research and Graduate Program in Washington, D.C., as well as working in a hospital in Japan during the Korean War. Upon his return to Portland, he became a resident at the UOMS hospital and then joined the faculty, first as a clinical instructor, then as an associate professor. He continued to work with Dr. Osgood on patients with blood diseases. Dr. Koler took a sabbatical during which he received training in genetics at the Galton Laboratory in London.

The interview covers briefly a variety of topics, including Dr. Koler's published research, his relationship with Deans Charles Holman and David Baird, his administrative positions on campus and committee chairmanships. Dr. Koler designed and taught the Medical School's first courses in basic clinical genetics, which eventually led to the creation of a genetics division, and then a full-fledged department. Next, he compares his medical education to the medical students of the 1960's, and comments on women and minorities in medicine. He addresses university consolidation from the standpoint of a faculty member. His appointment to the Medical Research Foundation and its role in obtaining research funds for new faculty and acting as fiscal agent for the Primate Research Center is examined.

The development of the medical school curriculum is addressed, as well as residency training, and career opportunities in research. Dr. Koler then provides an in-depth look at his research into abnormal hemoglobin. He again touches upon his administrative roles, from heading the new genetics division under President Leonard Laster to appointment as university representative on the Academic Council of the Oregon State System of Higher Education. Dr. Koler discusses the relationships between the university, chancellor of the OSSHE, and the state legislature with regard to university funding. He also shares his thoughts on the administrations of Leonard Laster and interim president Dave Witter. The role of private funding and philanthropy and in the creation of research institutes on campus is considered, as well as the contributions of Senator Mark Hatfield in obtaining federal funds.

In concluding the interview, town-gown relationships and changes in information technology are examined. On a final note, Dr. Koler mentions his daughter's (Dr. Mary Wirtz) work in mapping the first gene associated with glaucoma as one of his chief sources of pride in OHSU.

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Interview with Robert Koler, M.D.
Interviewed by Joan S. Ash, Ph.D.
September 18, 1997
Site: Robert Koler's Home
Begin Tape 1, Side 1

ASH: ...was going to be about your birth, and you were born on Valentine's Day, I noticed.

KOLER: Correct, correct.

ASH: Could you tell me at what point you moved from Wyoming to Portland, and was that a direct move?

KOLER: I finished high school in 1941, and came with my family to Oregon. I knew at that point I wanted to go to college in either Spokane or Eugene, and it turned out that we ended up in Eugene. So I entered the University of Oregon in the fall of 1941.

ASH: And at that point did you already know you wanted medicine?

KOLER: Yes, I was in pre-med, and as you may or may not recall, but I do very vividly, December of that year was Pearl Harbor, and I had at that point completed only the fall term, but I wasn't of draft age yet so I was able to continue on with my studies, although many of my classmates were being drafted and going into the service.

[Interruption]

ASH: We're rolling again. Then you knew at a very early time that you wanted medicine.

KOLER: Yes.

ASH: Why?

KOLER: I had some role models as I was growing up who were in medicine, and I was attracted to the challenge.

ASH: Then the role models were...

KOLER: Well, family physicians that I had known as I was growing up. No one in my family was in medicine, but it was an area that appealed to me. I enjoy working with people, and the intellectual challenge as well, I think, was what appealed to me.

ASH: And you took science courses and enjoyed them in college as well?

KOLER: Very excellent faculty at that point in time that I remember very well. Probably among those undergraduate courses, the one that appealed to me the most was genetics, which turns out to be what I ultimately ended up spending much of my time doing.

ASH: Then you were at the U of O and wanted medical school, but I understand that you were in the three-year medical school program?

KOLER: Well, we were in an accelerated program. Our course work went year 'round, and by the time I had completed three years I had enough hours to graduate, the equivalent for a baccalaureate degree. By then I had both reached draft age, but fortunately had my admission to the medical school and was pretty much targeted therefore to go directly from Eugene to Portland.

ASH: So you did college in three years, and then you did medical school in three years as well?

KOLER: Well, actually not. Our class was in uniform by that time when we entered, and that would be January of 1944, with the war still going on, and again a year 'round curriculum.

But the war ended in 1945, and we then had a six-month break to get us back on the standard September cycle for the usual nine months curriculum, so that the total elapsed time was between '44 and '47.

ASH: And what was it like to be in that medical school during the war?

KOLER: Well, we were a fairly close-knit class. There were four women, but virtually all of the men were in the service, were in uniform, were effectively getting a free education.

The faculty at that juncture were very dedicated people because many of the physicians both at the University and in the Portland metropolitan area had gone off to war as well, and they were down to a very small number of dedicated people who were doing most of the teaching.

ASH: So you were in medical school in uniform? Do I understand you correctly?

KOLER: Mm-hmm.

ASH: And your entire class was? What branch of the service were you affiliated with?

KOLER: I was in the Army, in a program that they called the Army Special Training Program. There were also classmates who were in the Navy in something that they called the V-12 Program. Those are the only two armed services that were represented.

ASH: What was the curriculum like?

KOLER: It was pretty much lecture and laboratory, not like current self-learning and problem-solving that's evolved over time. There was a lot of rote memory work, which wasn't a lot of fun, but it was necessary because that was the standard of those days in achieving your progression through the course work.

The clinical years were not too different than they are now, but the pre-clinical years were virtually all large lectures and laboratories such as anatomy and biochemistry, where we would work with either cadavers in the first case or with biochemical problems in the second.

ASH: How was the acceleration accomplished?

KOLER: Just by going twelve months a year.

ASH: So you would take the same number of courses during the semester?

KOLER: The duration of the course was the same as it would have been had we been back on the standard curriculum. It was only that there was no interim for vacations or summer holiday during those years.

ASH: And I have this picture in my mind of OHSU as it was then with everyone in uniform, which is very striking. But is that

A. That is virtually correct. In fact, one of the expectations of the sergeant who was responsible for our ASTP [Army Special Training Program] was that we would march in uniform Saturday afternoons, and we did that on the macadam blacktop behind what is now the old library.

In fact, there are pictures of some of those units in the School of Medicine centennial history, if you want to look at them.

ASH: Also during that time, what was the physical structure of the campus like?

KOLER: Well, it was much smaller. The buildings that existed at that point in time were the old library, Mackenzie Hall—Baird Hall had not been built yet. Doernbecher Hospital was separated from Mackenzie Hall by the width of the current Baird Hall, but that was in lawn at that time, and Doernbecher was then adjacent to the existing outpatient

building, and then at the north end was Multnomah County Hospital as it was then. The only other buildings on campus were the physical plant and the TB [Tuberculosis] Hospital.

ASH: During your clinical years, then, did you work at the Multnomah County Hospital exclusively, or did you rotate?

KOLER: No, our training was virtually all on the hill. The outpatient clinic was one setting, and then the three hospitals, really, TB, Doernbecher, and Multnomah County, were the three clinical inpatient services.

ASH: Tell me about any very special professors you may have had.

KOLER: Well, there were a number of them.

One that stands out in my mind was the then-chair of surgery, whose name was Tom Joyce, and he was a very strict disciplinarian, if you will, and expected us to come well-prepared and be able to answer whatever question he threw at us in a kind of a Socratic fashion. The class were all sufficiently uneasy about missing his classes that they were fully attended, as opposed to some of the others where occasionally one would feel able to at least skip a lecture.

Another role model that I've felt had the major effect on my training then and in subsequent years was Edwin Osgood, who was really the only one of the faculty at that point in time who was doing active research, and he was well ahead of his time with some of his ideas about how to approach problems like cell culture and antibiotic development and ultimately the use of radioactive tracers to study metabolic problems.

ASH: So you actually came in under his influence when you were in medical school?

KOLER: As a student, yes.

ASH: You took a course from him?

KOLER: As we all did.

ASH: Was there any opportunity to do research during medical school?

KOLER: Not during the medical school sequence. There was essentially full commitment to the standard curriculum with no free time.

ASH: I have a note here that the Medical School Hospital opened when you were a resident, and I wondered if you'd comment on that.

KOLER: Well, until that point in time, the patient population that we were responsible for were essentially all indigent, and the revenue stream from that depended solely on either county or state budgets.

And it became apparent that—the legislature, in fact, recognized that—for the institution to have a broader role in training and develop some of the specialties that were then in the ascendant, they passed legislation that was to authorize the construction of the existing Medical School Hospital. This was not without controversy because it immediately put faculty in the position of competing with people downtown for patients, whereas heretofore most of the clinical teaching was done by volunteer faculty who had their own practices downtown. There was a period of several years of transition before that became an accepted kind of interaction where there was then collegial interactions and patient referrals both ways.

ASH: Then you at the end of medical school obviously decided to stay, both for an internship and a residency?

KOLER: Well, I stayed for an internship, but that would be 1947, and at that juncture all of the returning veterans were also applying for post-graduate training and the competition was keen. And because we had an obligation to repay our service, I took that option at that juncture and spent two years at the Research in Graduate school in Washington D.C. Actually, I spent longer, but the Korean War came along at that point

in time, and I was a general internist in a hospital in Japan during the Korean War.

ASH: So you were both in Washington D.C. and then...

KOLER: Following that I was in Japan. Our hospital went over as a unit shortly after the Korean War broke out.

ASH: But you were doing research in Washington D.C.?

KOLER: In Washington I was doing research and teaching, correct, at the graduate school.

ASH: What graduate school was that?

KOLER: The Walter Reed Medical Research and Graduate Program.

ASH: What kind of research were you doing there?

KOLER: I was doing some metabolic work, trying to understand iron metabolism. Most of this was predicated on ideas that I had been exposed to when I was working with Dr. Osgood during my—I guess I skipped over the fact that I had a year of internship, a year of fellowship with Osgood during which I had some opportunity to do some basic research under his tutelage, and it was that kind of work I continued then when I went to Walter Reed.

ASH: And that was what brought you into research? The influence again of Dr. Osgood?

KOLER: Again, yes. I can attribute virtually all of my ideas and stimulus to get into areas that have continued to interest me ever since to those early days with him.

ASH: What kind of a person was he?

KOLER: He was a character.

ASH: Can you tell me about him?

KOLER: Well, he was brilliant. He had a mind that could capture everything and remember it. He could scan a page and knew what he had just seen with hardly any effort, apparently.

But he also was very original in his thinking, and he was among the first to successfully culture human cells in a laboratory setting. He was using experimental approaches to treating infections in an era before penicillin had been developed, and successfully was using some heavy metals, nearsphenamine for one, to treat bacterial infections.

But probably his major contribution was to think through what might be the appropriate way to measure cell cycles and the control of cell division, which has continued to be really the basic question of most human biology because that starts with development at the fetal level and continues with abnormal division in cancer, so he was right at the fulcrum of what were really very important questions, and these have continued to be very important.

ASH: Did he work one on one with you and with other fellows?

KOLER: Yes. He also practiced clinical medicine. His specialty was diseases of the blood and the blood-related organs and ergo hematology, so that was kind of my initial specialty was in hematology.

ASH: Now, at that time were there still many volunteer faculty?

KOLER: Yes. Volunteer faculty continued to participate, and they continue today, for that matter. But over that period of maybe a dozen years after the University -- or the then Medical School Hospital was built, a number of specialties were developed and staffed with full-time faculty, and I could tick off dermatology, neurology, as examples. So the full-time faculty that was probably only four or five at the time that we were in medical school, shortly after the opening of the Medical School Hospital grew almost exponentially.

ASH: So it was really the opening of the hospital that triggered that?

KOLER: As I think back on it, I'm sure that was the principal basis for it.

ASH: Was Dean [David] Baird the dean of the Medical School at that time?

KOLER: He was indeed, for twenty-odd years.

ASH: Did you have an opportunity to know him?

KOLER: Yes. Yes, I considered him both a mentor and a friend. I didn't know him very much as a student, but after I got into my residency training and then eventually as a faculty member, he was always a wise counsel if I needed information or help, and I think he was also influential in helping me think that an academic career was something worth pursuing because he did make efforts to encourage people that were interested in doing research.

ASH: What brought you to Walter Reed? How did you happen to select...

KOLER: Joe Trainer, who is now deceased, was in the class ahead of me, and when he graduated—their class finished in a standard sequence—he had the good fortune as part of his service tour to be assigned to the research and graduate school at Walter Reed, and when he was discharged he was aware that there was an opportunity there for people like me who wanted to repay their service time and urged me to look into it and gave me a recommendation such that it fell into place at a very convenient time.

ASH: Then at the end of your residency, what happened?

KOLER: I came onto Osgood's team as a clinical instructor first, with a salary of about 3,000, I think, a year. But over the next few years that improved considerably, as did my academic title. I think by the second year I was already promoted to assistant professor, and it's that

kind of fairly prompt promotion that I thank both Osgood and Dean Baird for, because otherwise I probably would have been, as most of my class, planning to move out into doing private practice.

ASH: As a clinical instructor, then, did you divide your time between research and patient care?

KOLER: That's correct.

ASH: About what portions?

KOLER: It was probably thirty percent benchwork and lab, and then both teaching and clinical care for the rest, and it was really backing up Dr. Osgood in the patient population that he was then following, that I was allowed to move into.

ASH: And at this point, these were patients who were paying for care?

KOLER: That's correct. They were mostly patients with blood diseases: anemia, leukemia, polycythemia. It was clearly a specialized subset of patients that he was asked to see because he had special skills and special knowledge.

ASH: So that was the population that you saw?

KOLER: That's correct.

ASH: Tell me a little bit about the research you were doing in those early faculty years.

KOLER: The other thing I should cite as part of the setting for my research is the fact that the Atomic Energy Commission was then making radioactive isotopes available for both research and for treatment, and Dr. Osgood was a leader in that area, as well, and was doing some of the basic biology of P-32, radioactive phosphorus, and some other isotopes. I helped with some of that work, and I also was fortunate

enough to have several patients of my own who presented unique problems that eventually, as I worked my way through them, led me to understand I needed to learn more about genetics, because they were diseases with family patterns of inheritance that needed to be worked out.

ASH: So genetics, then, became a related interest?

KOLER: It had been almost always in the back of my mind. It had not been part of the formal curriculum in the School of Medicine then, as was true pretty much around the country, and I had therefore a need to learn more about basic genetics, and that was my first sabbatical year; in 1960 I took an opportunity to go to the Galton Laboratory, which was then the Mecca for human genetics, so that I could get better basic training.

ASH: By the time you had that sabbatical, then, you were at what rank?

KOLER: I was then an associate professor.

I should say that the family that provoked my interest in genetics is one that I collaborated with Dick Jones on. Ultimately, he was the one while he was doing his Ph.D at Cal Tech who worked out the basic molecular structure for the abnormality that this family presented with. It was an abnormal hemoglobin, and over the years that followed we collaborated on a number of such families. He was the first to do the chemical work, and I was the first to do the clinical workup on.

ASH: I noticed on your CV that you had published many, many papers in collaboration, and that's the way it usually worked was that there was that...

KOLER: It was interdisciplinary in a way that not many people did in those days, because it really bridged somebody who was skilled at basic chemistry with the clinical arena where the material came from.

ASH: Well, what did it feel like to be more or less on the cutting edge...

KOLER: It was fun.

ASH: ...doing this kind of research with people you clearly enjoy working with?

KOLER: Sure. That was what made life worthwhile. But it also allowed us to compete for federal grant funding and to accept responsibilities like yours to sit on study sections and to go to meetings and to publish papers.

ASH: So let's think about your typical day. At this point in your life, when you're an associate professor, you were doing a lot of research, a lot of publishing, a lot of professional activities, presentations, teaching. Did you have time for anything else?

KOLER: Sure. Children who are now grown, going fishing, and spending some time at least with them as they were growing up. It wasn't all work.

ASH: Well, it sounds like a lot of work.

KOLER: Oh, well, it was do-able.

ASH: So the next thing I wanted to ask you about was you also knew Dean [Charles] Holman, and I wanted to take the opportunity to ask you about him as a man.

KOLER: He succeeded Dr. Baird when Dr. Baird stepped down. In fact, Dr. Baird didn't live very long after he stepped down, but Dr. Holman took over.

He had been in charge of the hospital prior to that, but his training was in—this is Dr. Holman now—his training was in internal medicine, and he was able to bridge that gap very nicely, and that was an important ability because we were in the process then of developing hospital inpatient services in the University Hospital—I'm sorry, it was still the Medical School Hospital at that point.

Because of my interest in research, he had asked me to chair the research committee, which I did, and at about that same time the VA

[Veterans Administration] Hospital had reached a point where they had a significant group of faculty members who were also VA employees and doing research.

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

KOLER: ...and, in fact, I did so and that was the point in time when the direction of the research program fell to—I'm blocking on his name; give me a moment, it'll come; I'll pick it up in a minute—because I was then in the position of being responsible for reviewing research protocols that might be funded from funds that would put me in a conflict of interest because of making the recommendation at the VA, he asked me to instead chair the Radiation Safety Committee. So that I did, then, for a number of years, rather than chairing the Research Committee, although I continued to interact with colleagues and actively do research. John Kendall is the person who took over the research.

ASH: If you were to characterize Dr. Baird as being well known for something during his administration, and then Dr. Holman as being well known for something during his administration, what would you tell me?

KOLER: Well, Dr. Baird I guess I would characterize—they were both very competent clinicians, both trained in internal medicine, but Dr. Baird was very savvy politically. He was able to interact effectively with the legislature, even though nominally he was managing a school within the University of Oregon, although there was no real responsibility or reporting relationship that he needed to carry on back through the president of the University of Oregon.

But nonetheless, he managed to interact in ways that were very effective in assuring that we had funding for new programs as they came along, and over the course of his deanship there were a number of improvements, the hospital being the major one. By the point in time, there was effective therapy for tuberculosis, and the TB Hospital was being transformed into a more general kind of facility, and I believe that the transfer of the Multnomah Hospital, Multnomah County Hospital,

occurred also during Dr. Baird's tenure. If it was later, it certainly was something he was influential in working through.

ASH: And what about Dr. Holman?

KOLER: A different person. Very thorough, well organized. He had great people skills. He interacted very well with people. I think he was a scholar. In fact, if you haven't seen it, I have only recently had a chance to read a history of the Medical School that he wrote [*University of Oregon Medical School: A History of the Years 1904-1905*], but unfortunately he's focused only on a five-year period from 1904 to 1909, but reading that you can appreciate that he was very thorough and very accurate in things that he wrote or prepared.

ASH: It was an interesting period of history.

KOLER: Right.

ASH: Then you started moving a little more into administration, and you became a division head.

KOLER: Yes. What happened when I got back from my sabbatical at the Galton in London was I recognized that what I'd learned there was very important to teach to medical students, and it just did not exist in the curriculum at that point in time. So with help again from Dr. Jones and a few other colleagues, we worked up some new courses that would cover basic clinical genetics of a kind that medical students really needed to know if they were to keep up with things that were already beginning to move very rapidly in that field. And initially this was kind of an elective course, but eventually it became integrated into the curriculum and was a required course for first-year students. And in the same vein, we were also accepting trainees who had completed their medicine training as fellows. Both of these—well, the latter certainly funded by an NIH [National Institutes of Health] training grant. And although it took twenty years to accomplish, what that ultimately led to was a division, and then finally a full-fledged department within the School of Medicine.

Ransom Arthur, who was the, what, third dean succeeding Dr. Baird, was the one who was finally persuaded that it had achieved a stature or an importance enough to designate it as a department.

ASH: You were then teaching medical students a new course. How would you characterize the medical student class of that day versus your medical student class?

KOLER: Well, there were more of them because, for reasons that in retrospect probably were not correct, there was a significant increase in the number of both medical schools and class size during the late '50s and early '60s. So we had larger classes. There were other curricular changes over that time, though, that were in the direction of what we now think is optimum, namely more small group teaching, more problem-solving and self-learning.

The students have never been other than superb in my view. The admissions committee, I think, has successfully managed to enroll only people who were very dedicated and very bright, and so teaching was fun.

ASH: Now, how many students were there in your class?

KOLER: My class had 73. The maximum that I allude to where there was this effort to increase the number of physicians I think reached 115, and then was ratcheted back down, both because of fiscal concerns and also the recognition at the national level that there really was not that great a need for trained physicians.

ASH: And in your medical school class, you mentioned there were two women?

KOLER: Four.

ASH: Four women, and can you estimate how many minorities?

KOLER: There were no minorities in my class. The only black student who was a peer of mine was Dr. Walt [Walter] Reynolds, whom

I knew both as an undergraduate in Eugene, where he was also going to school, and then later on when he came to medical school. He was the sole black student of that era, at least in the School of Medicine.

ASH: I'm trying to get a feel for, because I haven't found any statistics on women and minorities over the years, but—well, actually there was one article very early on, and there were, oh, between four and six women in most of the classes starting in 1887, and that was a big percent because the classes only had fifty or so in them, and then was there a dropping off of women in medical school?

KOLER: No, no, no, the converse, if anything. The current classes are about 50-50, and that has been true, I think, for the last three or four years.

ASH: See, I had thought that you would tell me there were many more women in your class because it was during the war.

KOLER: No.

ASH: And that's not the case.

KOLER: No, it was a career that women did not opt for. The culture, I think, was different at that point in time, and nowadays I think women see it as an opportunity that there's no handicap, no problem they have in accomplishing, whereas in those days, for whatever reason, they didn't see it as a career.

ASH: Did you find them in the research areas?

KOLER: None of the four that were in my class went into research. But they weren't precluded. There were examples of research labs around the country that certainly included women.

ASH: Well, let's think now about your days as a faculty member and the mix of men and women faculty.

KOLER: Again, the majority and in fact, the preponderance have been men until relatively recent years, and again I think it's just that the catchup is only now beginning to occur. Most of the women would have finished the training only in the last few decades, as opposed to the predominantly male graduates that would have been my peers.

ASH: Let's move on now to when we became a university because at that point, you were a full professor, and therefore you must have played a role.

KOLER: Well, not an active role. The then chancellor, Roy Lieuallen, and the State Board of Higher Education were persuaded, and I was not privy to what presentations were made or what logic involved in their decision, but the outcome was that they saw the importance of having a university that would include all three professions, namely medicine, nursing and dentistry.

And I suppose it was partly fortuitous that the what had been the North Pacific College of Oregon was looking for another teaching site at about that time. In fact, their then new dental school was built on our campus, I think either at about the time or shortly after we became a university. And nursing as a profession, with degree-granting capability, had also become much more accepted. So I think those were the trends that persuaded the State Board that what had been the medical school with a nursing department and a separate dental school should merge into a single university, and we're still working at it, the merger, that is.

ASH: So who was dean then? Was it still Dean Holman?

KOLER: Yes, and he was succeeded then by the first president, who was Bill [Lewis W.] Bluemle, and that wasn't a happy transition for Dr. Holman, but he was very gentlemanly about it and turned the reins over.

ASH: But he remained dean?

KOLER: He remained dean for a period of time, not very long, though.

ASH: Because he was probably accustomed to being the top-level administrator on campus, is that true?

KOLER: That's correct, that's correct, and that role was preempted as soon as it became a university.

ASH: And yet, there was a dean of medicine, of nursing and a dean of dentistry?

KOLER: No, actually, I don't think there was a full dean of nursing until after the merger, or after the creation of the university. I think it was mainly—there was always a hospital nursing unit, but the academic side with students and degree-granting, I think, was something that grew fairly shortly and quickly after it became a university.

ASH: And, but the School of Dentistry probably had a dean?

KOLER: Had a dean. In fact, they had continuing deans. The current one is probably sixth or seventh in a sequence because they have a long tradition of being an academic unit with a dean.

ASH: The organization chart then, when Dr. Bluemle came as university president, was probably two deans reporting to him, soon followed by a third dean reporting to him, and then a group of ancillary units like the library that had been reporting to the dean of medicine?

KOLER: Now, it became a campus-wide entity. Another important player was the hospital director, and there was a period of transition, particularly after they became a university, where that was not as collegial as it could have been. That is, who was responsible for patient care and teaching in the hospital was somewhat divided, depending on whether the hospital director thought it was his function to manage all of that, or the dean thought it was his function to manage all of that. And Dr. [Donald] Kassebaum, who you will be interviewing, was playing a

very active role at that point in time, and you will be able to hear his perspective of how that worked.

ASH: So that he reported to the president?

KOLER: Yes.

ASH: Just like the deans did.

KOLER: Yes, and that still is true.

ASH: And prior to that, he ☐

KOLER: He had reported to the dean.

ASH: To the dean, I see. So then he became an equal to the dean.

KOLER: Right.

ASH: I see. And the dean also had the nursing component reporting to him. So actually, the dean was in a position that had to undergo the most change.

KOLER: That's right. It was probably the most of a kind of a downgrade, if you will, for Dr. Holman in terms of what his role and responsibilities were after we became a university, as compared with what we were before.

ASH: And you as a faculty member, did you feel any of this? You were active probably in the faculty senate and that kind of thing?

KOLER: Yes, and the medical board, which was another group in which some of those contests needed to be worked through. I sat on that body, in fact, was president at the same time that Dr. Kassebaum was head of the hospital, and Bob Stone was dean of the School of Medicine, and they interacted in a collegial way, but they often were tussling about issues and problems.

ASH: When you say the board, do you mean the Medical Research Foundation?

KOLER: No, no. I mean the hospital clinical staff who have what is called a medical board that has its bylaws and that is charged with assuring the quality of care and accreditation of practitioners meets standards.

ASH: But I did make a note that you also played a role in the MRF.

KOLER: That's correct. As I told you earlier, I was chair of the Research Committee in the School of Medicine when Dr. Baird, in fact, was still dean. I moved out of that role and took over the chair of the Radiation Safety Committee, but I continued to have an interest in supporting pilot project funding for research, young faculty research, and in that role I was appointed to the Medical Research Foundation Committee that reviewed and made recommendations on those kinds of proposals. And I've continued to be a member of the MRF Board until it merged with the University Foundation, and am still functioning as a kind of an honorary emeritus board member.

ASH: Now, at least one person mentioned to me that the history of the MRF itself is very interesting. Could you give me a brief summary?

KOLER: Yeah, it pre-dated the University Foundation. It, in fact, is something that Edwin E. Osgood, among others, was able to, I think, get up and running. It was a collection of local philanthropists, I guess is the best word, mostly business people who saw that it would be useful to provide funding for medical research, particularly start-up grants that were kind of the necessary entry point for any new faculty person who was just getting started and didn't have a track record yet such that they could compete for federal research grants.

Part of the dynamic also that led to that was that Don Pickering had persuaded the NIH to fund what was one of the first primate research centers, and he was very aggressive in getting it up and running—this would be in the very early '60s—and a number of the faculty who had been in the School of Medicine were planning to move to the new facility that would be built in the current sort of then rural area where the Primate Center is located.

He and Dr. Baird, however, had a falling out about administrative kinds of management, and was relieved of his responsibility, and because then the fiscal agent for that unit did not really belong to the state system, it was decided that it would be better if the Medical Research Foundation, which had then become a fairly well-established board, would become the fiscal agent, and so they were quasi-separate from the school, certainly from the standpoint of administration and budgetary matters.

So they had a 50-year history then, the MRF now, of doing several things, being the fiscal agent for the Primate Research Center, funding start-up grants for new young investigators, and then more recently creating an endowment for an M.D./Ph.D. program which has been in place now almost fifteen years.

Those all three were primarily initiatives that the MRF began, and they were folded into ongoing activities when the two foundations merged, as were the members of the two boards.

ASH: So that the Primate Center budgetary process has changed and is no longer part of that?

KOLER: No, they still have their own separate budget. It's not part of the University budget, but the oversight for it is from the University, or from the Foundation, yes.

ASH: So it's still ...

KOLER: With the merged Foundation, yes.

ASH: I see. Well, thank you. Then, let's see, after your role in MRF, I wanted to ask you, you've alluded to curricular changes a couple of times, but I thought if we could look at the whole range from when you were a medical student until today, and you could describe to me the changes you had seen in the curriculum.

KOLER: Well, there have been really three. It was not just gradual evolution. There were significant school-wide upgrades or updates, if

you will. The first one would have been the one shortly after we started the elective course in genetics in which it was formally integrated into the required course work for the first year. At about that same time, there were a lot of other new curricular offerings that had been developed that focused on basic science, which was in a fairly rapid development or growth period.

So from that point in time until—what would it be, I think the cycle is about eighteen years, something like that—there was then another major effort to change not just the content, but the format, and this occurred at about the time I had moved out of my chair role and was starting to help in the central administration. But the focus was really on more self-learning. The library clearly became a much more important setting as we became electronically able to allow students to have access to their own PC or Mac, and small-group learning and individual problem-solving has been pretty much the mode that now characterizes the curriculum.

One of the victims of that was what I thought was a very nicely oriented and organized course in medical genetics which got split up and distributed among a number of other different disciplines. But that's the nature of curricular change. I still do teach when asked in some of the small-group sessions that involve genetic topics, but it's in a different arena than the course that we organized in the early '60s.

ASH: Would you describe ours as a problem-based learning curriculum throughout the four years, or how would you describe it to me?

KOLER: I think it probably could be described as problem-based. There is certainly a minimum kind of structure and content that students must have. They need to know the anatomy and the basic biochemistry and the basic physiology. But most of medicine after that is really integrating and understanding how to assess signs and symptoms, make diagnoses, or reason through approaches to intervention, therapy, whatever, and those are best learned, I think, not as rote memory kinds of recall, but as understanding the basic

underlying processes and being able to reason through what is a logical, possible set of causes, and if you have then a reasonable diagnosis, what's the best current therapy?

ASH: Moving away from the medical student years into the residency years, is there any change that you see from the residency you took to the curricula today?

KOLER: The sophistication of medicine, the very body of knowledge, if you will, has grown dramatically in that span of time. Then, subspecialization was the only way for disciplines like ophthalmology and dermatology and neurology to stay on top of the then body of knowledge, and unfortunately the pendulum now, with primary care and managed care, is swinging back again such that the need for highly specialized physicians is not as—it's probably just as great as it ever was, but it's not going to be funded in the same way as it has been in the past. So that the house officer today is probably learning a larger body of knowledge and being discouraged from focussing on a specialty, but rather to stay on top of as broad a content or base as possible, and therefore be competent to do primary care. That's true for family practice, it's true for general internal medicine, it's true for general surgery and for obstetrics, and those are probably—and pediatrics, I should add—those are probably the career goals of most people in training now because they recognize that there aren't going to be many opportunities.

To pick one example, the statisticians who studied health care needs would say that one pediatric neurosurgeon is all that the state of Oregon needs. So it makes little sense to have a pediatric neurosurgery program to train more.

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

ASH: This is the second tape with Dr. Koler on September 18th. Excuse me for interrupting.

KOLER: We were talking about research when the tape ran out and career opportunities in research.

There's predicted to be an ongoing need for people who are skilled in academic medicine and research, and indeed the rewards for that in terms of anticipated income are not very competitive with doing private practice, so that there needs to be some encouragement or subsidy that allows students who take that goal or track to have an opportunity to do it so they don't graduate with \$100,000 debt, as is unfortunately true for some of the medical students.

That was the motivation in getting the M.D./Ph.D. program up and running that was agreed to by the MRF board, and that in fact is one of the areas where I've tried to help raise funds; the endowment now to help to support that program now is over two million. It needs to be larger, but that allows Dr. [Brian] Druker, who's now running the program, to have a steady state of about -- I think it's thirty total medical students who are doing the combined degree program.

ASH: Does it provide for fellowships or scholarships, or does it provide for faculty salaries or for equipment?

KOLER: No, no. It's really a scholarship. It covers the tuition and the fee cost for both the M.D. and the Ph.D. part of the training, and the Ph.D. three or four years are no different than any other Ph.D. except at the end of the training the individual can work in both arenas, as I was able to do; without the Ph.D. but by working with Dr. Jones, I was able to bring clinical problems into the lab and think through how to approach them from a molecular viewpoint.

ASH: We've gotten away from your research now by quite a few years because the last time we talked about it was when it was early in your academic career. Can you briefly tell me what you're most proud of in the research area that you accomplished?

KOLER: Well, I think it's the advances that we were able to make and original reports of new and different genetic abnormalities that affect not just hemoglobins but other red cell components: red cells enzymes, red cell membranes, are the areas in which we've made—"we," and it's always been collaboration—have made original

observations that have then had value in holding up this field. We've looked at other populations—subjects with the same problems.

ASH: I noticed that you've had a stream of publications right up to the present, so ...

KOLER: Well, my research now is vicarious. My daughter has her own research lab, and she likes me to come and help her when she does field studies, and in return she puts my name on her papers.

ASH: So is your daughter in the same area?

KOLER: She's doing genetics, too.

ASH: Is she really? And is she here? She's at OHSU?

KOLER: Mm-hmm, in the Casey [Eye Institute].

ASH: I didn't realize that. How nice for you.

Well, this is the problem I've had with everyone I've interviewed is that you don't want to tell me what you're really proud of, but I want to dwell on this a little longer because you have had a lot of publications, and you've done a lot of work, and I even noticed some things that were named Willamette and Portland, and they must have been discoveries that you all, you and your collaborators made.

KOLER: That's correct. And it's an interesting kind of reflection of the times in which we worked. Nowadays, wearing the hat of chairing the IRB [Institutional Review Board], which I've just passed on to Dick Jones, confidentiality is the name of the game, and you wouldn't dare divulge in a publication the name or a description of a subject without their permission.

In those days, however, the hemoglobin findings were coming at such a pace that the initial sort of standard was to give them a letter of the alphabet, and after they ran out of alphabetical letters, convention turned to naming them for the city or geographic area in which the subject lived. So Dr. Jones and I contributed a number of geographic

names which relate to—each one to a specific new abnormal hemoglobin.

That wasn't just stamp collecting, though, because most of those also taught us something about normal hemoglobin and hemoglobin function. For example, you mentioned hemoglobin Yakima. It was the first—or second, depending on which reference you cite—report of an abnormal hemoglobin that had an increased oxygen affinity. And the reason we tumbled onto it was that the family that was affected had too many red cells, and they initially were thought to have a condition that's called polycythemia rubra vera, but that is a sporadic condition that affects only people in late adult life, usually, and in this family it turned out that the initial family member who Dr. Osgood had seen and thought had polycythemia then turned out to have two daughters who had identical blood findings. That led us to ask why would this happen and to look at the hemoglobin and ultimately to locate a single amino acid substitution. That's a long tale but it's the kind of fun one derives.

ASH: There was one named Willamette also and one named Portland, so these were families located in...

KOLER: In those areas, yes.

Portland is interesting. It's not quite the same as the others in that it's not a single amino acid substitution; it's a kind of very early embryonic hemoglobin that persists in subjects particularly from Southeast Asia who have a kind of thalassemia, which is a defect in production of one of the globin chains, and this was kind of the hallmark that led to recognition of the neonates who were born with one of those kinds of fairly severe defect in ability to produce one of the adult types of globin chains.

ASH: So these were firsts?

KOLER: Firsts, yes. Each geographic name was one of a kind. Well, I shouldn't say that; they've turned up more than once. We were the first to find them.

ASH: Once you call one Portland, is it called Portland forever after?

KOLER: Yes. Even if others have this.

ASH: So that's like being the first to climb a mountain?

KOLER: I guess.

ASH: And pretty exciting to see it in print. Moving closer to the present, I wanted to ask you about your administrative role when Dr.—we talked about Dr. Bluemle—when President [Leonard] Laster was president. Did you have any administrative role?

KOLER: No, I was chair of my own—well, I was head of the division until the time when then-Dean Arthur decided that there was enough substance to make a full department, and that occurred while Dr. Laster was president. The reason he now, Dr. Laster, asked me to help was because he was developing some new graduate offerings that needed to be taken to the State Board of Higher Education for approval, and he wasn't succeeding very well, and asked me then to come and do essentially the job that Lesley Hallick does now -- although it was somewhat lesser in stature under Dr. Laster; Steve Bauer had been doing it, and it had been treated more as an administrative than an academic kind of function. But I was able then to help him present some of the proposals to the State Board that eventually led to Ph.D. degrees, which was his goal.

About that time, then, he stepped down and Dave Witter took over. Dave has, I think, a master's degree but no scientific training, and asked me to stay on therefore as both the principal investigator at the Primate Center, which has always been sort of the role of the president for those presidents that have had the M.D. credential, but also to do the academic affairs. And I did that for a year with Dave, and then when Dr. Peter Kohler came, he asked me if I'd stay on for another year until he got settled in and could recruit a replacement. Which he then did.

ASH: Lesley Hallick?

KOLER: Lesley Hallick, yes.

ASH: What did you do when you were in this role of academic affairs? Were you a dean?

KOLER: No, no. I was responsible for the university, if you will, as opposed to an individual school, for academic affairs. I was the one who attended faculty senate meetings and represented the president at the State Board meetings where the agenda had to do with academic issues. I was on the academic council of the State System of Higher Education while we were under the state system, and that, in fact, then, is the role that Dr. Hallick moved into when I retired.

ASH: When Dr. Laster had you assist him in this role, it sounds like you were very successful in getting the programs through. To what do you attribute that success?

KOLER: I think it was just getting the work done. Nothing unique.

ASH: Getting the work done meaning that you went through the right channels?

KOLER: Yes. Attending the meetings and presenting the scope of the proposal and justifying it.

ASH: Did you write the proposals?

KOLER: Well, I helped. They were usually

Well, to pick an example, one that came through at that point in time that I helped with is the Ethics Center, and Susan Tolle was the one who really wanted to develop that. She took a year and went back to the University of Chicago to get additional training and then came back with the idea that here was a new arena that needed to be visible and part of the education of not just one of the schools but all components, all the health professions on the hill. And she succeeded. She did it in large part by presenting her own credentials, which by then were sufficient to say she could carry it off, a proposal that would allow a unit to be recruited and developed on campus, and curricular offerings that have grown

over the years. And I must give her credit for doing it virtually all on her own. It's largely philanthropic support that's accounted for what she's been able to develop.

ASH: It was your responsibility to take that proposal?

KOLER: I helped her put it in a form where I knew it could be presented, that she could present it. I could present it, but she could then be there to respond to questions.

ASH: And that was to the State Board?

KOLER: State Board of Higher Education at that juncture.

ASH: I'm a little confused about the relationship at various points in our history—well, first there was the president of the University of Oregon that I guess we had to have a relationship to, but at the same time were we also relating directly to the legislature?

KOLER: We weren't supposed to. Dr. Baird could do it sort of surreptitiously and get away with it, but the budget for both the Medical School and then ultimately for the University, while we were part of the system, was supposed to be developed by the chancellor's office and part of the state system budget. Now, that's not totally true because the hospital was kind of off in a unique role, and the legislative budgets related to indigent care and other health care components always, I think, did have a separate hearing at the legislature. But until we became a public corporation, the budget for at least the academic component of the campus was managed through the chancellor's office in Eugene.

ASH: So Dean Baird had to go first supposedly to the president and then to the chancellor?

KOLER: Well, I think he went more to the chancellor, and it was an understanding that they knew that that was the efficient way to manage planning.

ASH: Then when we got a president, Dr. Bluemle, he was reporting to the chancellor?

KOLER: Yes. Yes.

ASH: What was the relationship with the legislature at that time?

KOLER: His budget—for academic issues at least, only the hospital would stand aside—was part of the package that the state system prepared.

ASH: And that didn't change with Dr. Laster?

KOLER: No. It didn't really change until Pete Kohler was able to persuade the legislature that we could manage the institution more efficiently if it were, like the Port of Portland, a public corporation, and I think that's gone very successfully. Clearly it is easier to manage. It turned things around.

ASH: So that he reports to the chancellor—no, the board.

KOLER: He has his own board now, which is different from the State Board of Higher Education. Their sole responsibility is to help him manage this university.

ASH: The relationship, then, with the chancellor of the Oregon state system is?

KOLER: No longer—well, it's collegial but not required.

ASH: It's not formal?

KOLER: No. Dr. Hallick, though, I think very wisely, has continued to run all of the academic plans and proposals through the academic council so that there is meaningful dialogue about curricular and academic programs that she maintains by attending to those state system functions.

ASH: We talked a little bit about our becoming a university and somewhat about the growing pains involved in that, and then Dr. Laster

was with us for nine years after Dr. Bluemle, and at the time I recall people saying, well, Dr. Bluemle was sort of the business person, he had a business head and he could pull things together, and Dr. Laster was the visionary. I wondered if that's the perception that you?

ASH: Yes. I think that's very accurate and correct. Dr. Laster gets credit for a number of important changes, most important of which, I think, is the Vollum [Institute], which was the first free-standing research institute with primarily philanthropic support, and it has been one of the most well-recognized research units of its kind in the country ever since. Dr. [Richard] Goodman, who's currently directing it, is very proud of the fact that his faculty publishes in prestigious journals, and he'll compare it with MIT or Cal Tech or you name it. And it's correct. They do do that well.

ASH: So you attribute the development of the Vollum to...

KOLER: That's Laster's accomplishment, for sure.

ASH: Then Dave Witter. What would you characterize as his biggest accomplishment?

KOLER: What Dave did was, I think, unique. It was to pick up something that had been sort of languishing on the shelf, which is BICC [Biomedical Information Communication Center]. Dr. Laster had known that there was money that Mark Hatfield had earmarked to develop the so-called library of the twenty-first century, and he kept talking about it but not doing anything. And it wasn't until Dave came along as the interim president that he saw that as something he could move forward because he had the interest and the skills to think about wiring the campus and recruiting somebody who could, as you put it, be a visionary about what the library might become if you could use electronic management and in fact databases.

And as you well know, Bob Beck was recruited during Dave's tenure, and though he didn't stay very long until he left for Baylor, that was the genesis of what I think is one of the almost premier and unique

units on the campus right now. It's where we, I think, stand out as compared with many institutions in the sense that the State of Oregon has access to medical information electronically in a system that I think works very well.

ASH: And to what do you attribute Dave Witter's interest in that?

KOLER: Well, his background before he took the interim chair as—interim president role—was hospital management. He succeeded Don Kassebaum as the one who was responsible for managing the hospital, and he's a good number cruncher. He understands that you need to take careful approaches to managing bookkeeping and inventories and efficiencies of quick turnaround time, and so he was already attuned with the idea that you don't do things with pencil and paper anymore, you'd better be prepared to do it with reasonably powerful computing capability.

ASH: One of the things that we've only alluded to is the role of private funding and philanthropy for our university, and you've been on the MRF board, and I thought you might comment on that.

KOLER: The MRF has been sort of one of the underlying continuing sources of private support for research, for M.D./Ph.D. scholarships, but then there have been other significant bequests and donations that have had a real impact. Probably the Dotter Institute is the best example I can cite, where Bill Cook, who is a business person who's interested in the research work they're doing, largely because he then can benefit by marketing some of the technology, has been very generous in funding the Dotter Institute, where they're developing new approaches to x-ray guided, but not surgical, approaches to a whole host of different diseases.

There are other examples. The Ethics Center I've already cited. What else? The Doernbecher Hospital is probably the biggest single unit and structure that's solely funded by donations.

ASH: Has it always been?

KOLER: Has always been, yes.

ASH: And who raises the fundings?

KOLER: The Doernbecher Foundation. I shouldn't say that it's the sole source, but it's certainly far and away the major source. Some of the programs in Doernbecher are funded from grants or for indigent care, as is true for the other parts of the hospital, but the bulk of it comes from the Doernbecher Foundation, which is a subpartner, I guess, to the OHS Foundation.

ASH: And the history of the Casey [Eye Institute]?

KOLER: Is another example. As I think you know from interviewing Dr. [Kenneth] Swan, he was very effective in, first of all, having the dream of a free-standing self-contained eye center rather than just an eye department, and his grateful patients over the years among them have left significant bequests and donations, and Casey is probably the one who had the largest contribution that allowed that unit to be built; but he's only one of, I'm sure, several hundred such donors.

ASH: In that case it was—how does one go about getting that kind of funding? With Dr. Swan, it's former patients.

KOLER: What he was able to do was to give them an idea of what it was he wanted to accomplish, and then as the donations became available he invested them initially, I think, in equipment that he needed for his unit, but ultimately into a larger account that was allowed to grow until it was enough to appeal to some national philanthropic organizations that fund eye—well, it's really the Foundation for the Blind, I think, is the name of one of the organizations that also helped provide the funding that eventually led to the building of the Casey. You'll have to get the details from—and probably already have them—from Dr. Swan, but he was very effective in making that all happen.

ASH: The reason I'm asking you is because you have this broad campus-wide involvement. You mentioned there was one particular

donor for the Dotter Institute who was very -- who gave money. Was it Dotter who again had a personal relationship with that?

KOLER: Mm-hmm. Yes. Charlie Dotter was a remarkable person. He was probably the youngest full professor ever appointed on this campus, and he was very ingenious. He could anticipate the potential to use catheters and radio-opaque dyes and even balloons, in ways that nobody had thought of before. There were some parallel developments that occurred in Germany, but I think Charlie Dotter was probably the originator of most of the techniques that now are done in the Dotter Institute, and it's a whole discipline in itself with people being trained to do just that as their career map.

ASH: Do you know if the major donor was someone who had been treated?

KOLER: No, I think he became interested in what Charlie was doing because he was also developing medical devices, and virtually anything that Charlie developed had the potential to then be marketed for other people to use, and the revenue stream from that is really a business that Mr. Cook manages and then contributes back to the source, if you will.

ASH: That's very interesting because it's very different from the Casey.

KOLER: Oh indeed, yes.

ASH: What about the Vollum?

KOLER: The Vollum has been pretty much self-sufficient from the original Vollum endowment, plus what they've been able to obtain from research grant support. There probably has been some additional fund-raising to add to their endowment, but I think they've been largely effective in getting adequate support from research grants, mostly NIH.

ASH: Since I didn't get to interview Dr. Laster, I'll ask you. Who is Vollum?

KOLER: Okay. Howard Vollum was one of the developers of the oscilloscope. He and his partner, Murdoch—I think this is not apocryphal—in the immediate postwar era in a garage which one of them owned, and based, I guess, out of some fairly new developments that dealt with radar, which was first developed during World War II, conceived the idea of needing a scope that would allow them to measure waves. And the original oscilloscope that they patented at that point in time was the basis for the Tektronics industry, which has grown to a megamillion business.

And both of them, or their families, then felt they should give something back to the community, and Dr. Laster was very effective I think in persuading Howard Vollum and his wife—Howard's now deceased—that the best contribution they could make to the university would be to *de novo* put in place a first-rate basic research institute.

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

ASH: And so it was Vollum who had that vision?

KOLER: No, it was Laster. Laster, just as he had the vision of the library of the twenty-first century, felt that the direction that most advances would occur in basic research was in understanding the brain, and therefore neuroscience was what Ed Herbert was asked to develop when he was recruited as the first director of the Vollum, and following his premature death, he then was succeeded by Dick Goodman who's currently the director.

ASH: So Dr. Laster enticed Howard Vollum into giving a certain amount of money. Did that pay for the building, or was that an endowment?

KOLER: It was both building and endowment. There probably were some Hatfield dollars that came into that as well, but most of it was private money.

ASH: It's a beautiful building.

KOLER: It is. They're outgrowing it now.

ASH: Also, we haven't talked about the buildings and space. Am I wearing you out, or can we ☐

KOLER: I'm hanging in there.

ASH: Can we move on to that? Because you've seen the campus since you were a medical student☐

KOLER: That's correct.

ASH: ...almost continuously as it developed.

KOLER: And it's not been an easy ride. Virtually every one of those new structures has required some kind of negotiation or struggle.

The VA Hospital, the new VA Hospital, is probably the premier example. Neil Goldschmidt was then mayor of Portland, and he thought it ought to be built over on the Emanuel site, and that was during the—I'm trying to recall whether Dick Jones was interim president, or Laster was here already—but they were able to dissuade the powers that be that it made more sense to locate it adjacent to the University because it is almost an integral part of the clinical and teaching facilities. And it is a beautiful building. And then John Kendall, I think, gets credit for persuading the VA central office to build the bridge that connects the new VA with the University Hospital.

The CDRC [Child Development and Rehabilitation Center] is an interesting story. It's much more ancient. Dick Sleeter, who was then an associate dean in the School of Medicine, a pediatrician who was interested in taking care of kids with developmental disabilities, was able to persuade the Health and Human Services office to build that building and to fund the programs, among which was the first clinical genetics unit. Partly because Dr. Jones and I helped him write the grant and were able to justify the need for it, that's where we did much of our early clinical genetic work, was in the newly built CDRC building.

What other tales do you want to hear?

ASH: Who funded the CDRC building?

KOLER: It was federal money.

ASH: Federal money. Well, there was a long period of time, it seems, when the campus was the Medical School, the Mackenzie, Baird and University Hospital, before the BICC, before the Vollum, before the courtyard, before the VA. At least in my memory it seems like there was a long period of time there when

KOLER: Nothing seemed to happen.

ASH: Yes. And I wondered why.

KOLER: We can speculate. I think Mark Hatfield is probably the principal mover that allowed much of it to happen. In terms of the School of Nursing, certainly, he can take almost full credit. For the new neuroscience building, I think, is solely federal money that he's managed to attach as a rider to the funding bills. The addition to the Basic Science Building is both state and federal. BICC, as you know, is mostly federal. Doernbecher is all private, the new Doernbecher. So it's a mix.

ASH: I'm still curious. So it must have been that relationship with Hatfield, then, that sort of kicked off this new era.

KOLER: Mm-hmm.

ASH: And when did that all begin? When did he start thinking about us?

KOLER: Well, he's my contemporary, and he wasn't really in a position where he could do that until he'd been in the Senate for quite a while. Then he became the chair of the appropriations committee, I think, and it was a Republican Congress, that he could then start making the case that rather than building bombs or battleships that some

money ought to be allocated for health care. On that rationale, he was very successful.

He's not unique because our sister university to the north had a similar beneficence from their then-Senator who did a like sort of earmarking of federal grants that allowed the University of Washington to do a fair bit of building in their medical complex.

ASH: It almost seems like when NIH was building and we were getting grants, that was the same time we were not building. And that almost seems irrational because usually grants mean you need more space.

KOLER: You're right. And the golden years during the mid-'50s when grants were very easy to get was kind of the nadir in terms of new building.

ASH: So what was it like for you as a researcher?

KOLER: Well, we were much more crowded and getting by with more primitive facilities than are now available. D.W. E. Baird promised me to remodel that old space in what then was Mackenzie Hall every time my grant got renewed, but it never seemed to happen.

ASH: But there was a certain amount of funding from the State?

KOLER: The State did put up—I think, the original Research Building, and the Basic Science Buildings are state money. And while those were about half and half teaching and research, it did allow for some expansion in research.

ASH: I think it must be very striking when you've seen the campus as I've seen the pictures, basically the fountain and Mackenzie Hall and Baird Hall, compared to what it is now.

KOLER: Yes. It's dramatic. So Lesley Hallick still thinks that they can put more buildings up here, but I'm not sure where.

ASH: In the air? I have some general questions.

KOLER: Can I have a break?

ASH: I could use a break, too. [Break]

ASH: All right, we were talking about—where were we?

KOLER: General. You had a few general things at the bottom, and then we were going to be, I think, done. Is that about right?

ASH: That's right.

KOLER: I don't mean to rush you, but I think that's where we left off.

ASH: Space. And very little have we discussed the town/gown relationship, but that's something that I wanted to explore a little further with you.

KOLER: Okay. Are we on it?

ASH: Yes.

KOLER: It's never been a problem for me because I came from an era when we were taking our private patients off campus, caring for them in mostly Providence [Hospital], and our indigent patients on campus, and I felt that I was interacting with colleagues in both settings. It was very open and friendly and cordial.

There was a period after the new hospital for the Medical School, as you intimated earlier, where the Multnomah County Society and the faculty on the School of Medicine were not on good terms, and it was largely competing for a population pool that was limited, more so in some specialties than in others.

But John Kendall, I think, diffused that a great deal when he was dean by taking a much more—well, coming from a background where

he'd been at the VA and then had been dean and then was interested in identifying mentors for the newest iteration of the curriculum, in which students are expected to go out and work one-on-one with physicians in the community, he built some very good bridges at that point in time. He became president of the Multnomah County Society, and I think as I perceive it now, we have probably the most cordial and collegial interactions of town and gown of any large city I'm aware of. Now, you've heard that before from others, I suspect. That's my view.

ASH: Well, no one had mentioned Dr. Kendall before or the Multnomah County Medical Society. What about the Oregon Medical Association?

KOLER: Oregon Medical Association has always, I think, been very professional in how they've managed their affairs. They've included faculty in their various committees and working groups, and I don't sense that there's ever been any real rift in which there was a school versus downtown member difference. That's been my view, but that's how I perceive it.

ASH: I also have this area of information needs and technology and changes over the years in the way you dealt with searching the literature and meeting your information needs.

KOLER: Sure. And it's like night and day. My earliest work was done with a typewriter, a secretary, and a xerox—not a xerox, a mimeograph, even to the point of grant applications, and I wonder in retrospect how we ever accomplished it. Now I'm almost as able to work from here at home as I am if I'm at the office by virtue of being—by remote-hooked into the network; I can just do e-mail, I can send attachments, I can conference call, and effectively be available any working day, whether I go to the campus or not. And I think it's remarkable that it's really such an easy life to live with all those capabilities.

The other thing that's, I think, also remarkable is the transmission of teaching material, the School of Nursing in particular, but others are

using very effectively, to remote sites with that same video and satellite kinds of technology. You know that better than I, but it's been an impressive change.

ASH: So in the beginning when you wrote an article, most of them were cases and you would do a literature search or someone would do a literature search. Did they use *Index Medicus*, or did they have the librarians do it for them?

KOLER: No, I would do it myself. I would keep my own bibliography, that is, papers that I knew were relevant to the area I was working in. I'd read the current literature, which I still try to do, but I don't keep any reprints anymore because it's so much easier to access it. I don't do much library work from the remote sites. If I want to look something up, I usually come in and use the library. But I know many people do library searches by computer now. They even have programs that will allow them to pull out the relevant bibliography for a paper they're writing from a dataset that they have in their C drive.

ASH: It used to be, then, that you would go to the library and do your own search in *Index Medicus*.

KOLER: Mm-hmm. I never had anybody that I assigned that responsibility. I tried to be on top of it myself.

ASH: And is that the way most of this faculty did it?

KOLER: I think we relied on the librarians in those days if we got stuck, but I think we all felt responsible for keeping on top of the literature.

ASH: This is probably my last question before I ask you if there's anything else I missed. What are you proudest of your accomplishments related to OHSU? Hard question, I know.

KOLER: I'll show you a picture. If I can find it.

ASH: Found it. And it's the Casey Eye Institute update.

KOLER: That's my daughter on the front.

ASH: Oh, this is your daughter. "Beginning of the end of glaucoma, Dr. Mary" -- oh, Dr. Mary Wirtz is your daughter, "who recently mapped the first gene associated with glaucoma." That is really exciting. And you're mentioned here.

KOLER: You'd be proud of it too, wouldn't you?

ASH: Absolutely. "This subject was accomplished by Mary, her father, Robert Koler and I..." this is Dr. Samples talking "...traveling to evaluate patients throughout Oregon and Washington." And this is winter 1997. So your influence is still being felt, very much so. And with the IRB?

ASH: That is a project that I took on and got, I think, in some semblance of order—not that I did it alone; Drs. Elms Sutherland and Leslie Bevan made major contributions, but at least we got it functioning well.

And now I just go as an IRB member. I don't have to chair it anymore because Dr. Jones is in that role.

ASH: So you'll be spending a little more time on the oral history project, at least this year. I mean, we have sort have sucked you into this all of a sudden.

KOLER: That's fine. I don't mind. I, in fact, at Pete Kohler's recommendation organized the emeritus faculty—because they weren't communicating with each other or with the faculty senate, which is really their home base—a little over a year ago, and they enjoyed that first luncheon that we hosted for them then so much that Lesley Hallick thought this was an ideal group to sort of pull into your project on oral history. Most of them have lived through it.

ASH: We still have a lot to go over when I look at that list. I finished working on the matrix and there are a lot of names where I don't know how to contact people.

KOLER: If we can help, let me know.

ASH: After Lesley prioritizes, then we will definitely be needing your help.

KOLER: I'd be happy to do that.

ASH: So we're at the point now where you tell me if there's anything I haven't covered.

KOLER: It's beyond me; it's escaped me if there was anything that came up during our conversation, but if I can have the opportunity at a later date, if something comes to me, I'll seek you out.

ASH: Well, you know my e-mail address, and we will send you the transcript, and if you've thought of anything in the meantime, you can just add to the transcript, or we can do another interview.

KOLER: Fair enough.

ASH: Easy to find.

KOLER: Come again.

[End of Interview]

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