HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Lowell Euhus

Interview conducted June 12, 2006

by

Ted Merrill

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[Begin Track One.]

MERRILL: This interview of Dr. Lowell Euhus, of Enterprise, Oregon, was recorded on June 12, 2006, at the Historic Geiser Grand Hotel in Baker City, Oregon. This interview is made possible by a grant from the Oregon Medical Education Foundation. Dr. Ted Merrill of John Day, Oregon, is the interviewer. Dr. Euhus, let's start with a review of where you were raised and how you came to go into medicine.

EUHUS: I'm a native Oregonian, and was raised, basically, in the Willamette Valley area, living several places in that area, including Portland, Tillamook area, little town called Union Gap down by Sutherlin. And my father was a minister, a Baptist minister, so we moved around quite a bit.

Settled in Eastern Oregon the last two years of my high school career. Graduated from Pilot Rock High School. And then went on to Oregon State University to major in mathematics and premed.

I discovered in that short time in Eastern Oregon, in Pilot Rock, that it didn't have to rain, you didn't have to rust all the time. So when the time came to practice and settle later, Eastern Oregon was high on my list.

I went ahead after Oregon State and attended University of Oregon Medical School. Graduated 1968. And then I spent a rotating internship in San Bernardino, California. Three years with the navy. Some shipboard duty, but chiefly in Yokosuka, Japan, in the big navy hospital there. I received some excellent training and excellent experience there.

So went directly in 1972 to Enterprise, Wallowa County, to be in a general practice, family practice, there. I've been in Enterprise since then. I essentially retired about a year ago, but I still do part-time work.

MERRILL: You spent your entire medical practice outside of the navy in Enterprise.

EUHUS: That is correct. Wallowa County is my home. I chose Wallowa County because it was the type of practice I wanted, a rural practice where I would have lots of responsibility and lots of, wear a lot of hats, which is necessary in a rural area. But I was looking specifically, also, for an area near some mountains. I'm an avid backpacker and climber and outdoorsman. And Wallowa County has all of that. I had experienced some of that in Wallowa County as a medical student on a vacation and just fell in love with the area. Wallowa County is a very unique, very beautiful place.

MERRILL: Now you were in general practice, which at that time meant surgery, obstetrics, pediatrics. It covered all the needs of any possible patient.

EUHUS: A rural practice is unique, particularly when it's in a relatively isolated area like Wallowa County. You base what you do on your experience, and try to stay within your limits. It's really important for any doctor to stay within limits of your experience and training, and particular so in general practice, because it's so broad. But my practice was very broad. I think I had a very good background and training with my prior experiences. I did obstetrics and did quite a lot of surgery, and took care of the whole family. Obviously there are limits to what one can do, and that's what specialists are for. We referred a lot of patients, and still do, for specialty care.

In fact, that's changed over the years. I think I do less, fewer procedures than I used to, just by the nature of things. If somebody else can do it a lot better, then it's wiser to send them to that particular person or that particular hospital.

MERRILL: What changes have you seen in the medical practice, the type of practice, since you started there?

EUHUS: Changes in practice over the years I've been there are myriad, and it's hard to be specific. Basically, I think you could say everything's changed. There's an old adage that whatever you learn in medical school, you only use about 80 percent of it. You always have to be learning. You always have to gain experience and learn new things. Things change tremendously. The technological advances since I've been in practice are very astounding. It is just amazing how far things have come.

Ultrasound machines, for instance, were unheard of. CAT scans were a dream. When I first heard of the concept of a CAT scan machine, I thought wow, that sounds like something that will never work. But now we have a CT machine in Enterprise and use it. We have an MRI that comes in once a week.

Surgery things have changed. I used to do a lot of gall bladder surgery. And since laparoscopic surgery has come in, I quit doing gall bladder surgery. Technology has advanced markedly. The physical plant has changed to keep up with the technology, of course.

Patient expectations have changed markedly, also. A doctor used to be trusted quite a bit more than they are now. I think the news media has skewed that to a great extent. People expect a perfect result every time they have something done or see a doctor. And obviously that's a pie in the sky concept. Things don't always work out. But patient expectations have grown and grown. They expect perfection every time.

One area of medicine that's particularly obvious, I think, is in obstetrics. People expect to have a perfect OB experience every time. Expect to have a normal, perfect baby every time. The laws of anatomy and physiology dictate that that's just not going to happen.

For instance, at least 25 percent of pregnancies miscarry, and a certain percentage are going to have birth defects and so forth. And a certain percentage are going to have complications of labor and delivery. But if those happen, the public has grown to expect perfection, and if something adverse happens, then it's somebody's fault. And I see that, not only in obstetrics, but in most other aspects of medicine. Doctors are human. We make mistakes like anybody else. But a lot of things I've seen happen are just law of averages. Things are going to go wrong sometimes. But again, patients come to expect perfection.

MERRILL: Do you think that the tendency to malpractice suits has had a big influence on those changes? Patient expectation?

EUHUS: Malpractice is a subject you could talk on a long time. And certainly it's had a huge influence on how we practice medicine. There's a buzz word called defensive medicine in that doctors do order tests and do things sometimes just to be sure that, as we say, our rear is covered. You want to be sure that a lawyer doesn't have something to say, "You should have done that test," even though it may or may not have been indicated. So malpractice has changed markedly. Patient expectations have changed so there are, I think, more suits.

And along with the changes in attitude with more suits and more technology, more expectations, malpractice premiums have gone up. Malpractice insurance premiums used to be, I guess you'd say nominal. Now they've gone up tremendously. Oregon malpractice premiums have also gone up as the rest of the nation. I think we've perhaps been fortunate. Our legislature has been able to fund some of these malpractice things, or at least calm some of the premiums down, calm some of the insurance companies down with negotiations. And I think we're sitting better than some other states are. Nevertheless, a good percentage of the health dollar goes toward malpractice insurance. And I think a lot of malpractice is not necessarily malpractice when suits are filed. It has more to do with patient expectations and communication. A lot of malpractice suits have been shown to be associated with lack of communication or poor communication from healthcare providers.

MERRILL: What are some of the changes other than technology that you have seen in your practice in Enterprise?

EUHUS: Again, there are a lot of changes that have occurred in medical practice. Part of that is, has to do with the evolution of the way medicine is practiced and the way that new doctors and paramedical personnel, for that matter, are trained, and their expectations. When I went into practice, it was just expected and part of normal behavior to work long hours and at very poor pay. That was just what you did. And the work week was very long, and work day was very long, and night calls were very common. That has evolved in the 34 years or so I've been in practice that the hours are just not quite as long. There's more cross-coverage, hopefully, in our community, it's true, there are more medical people available to take, share the call. So the hours are not onerous.

The long hours, of course, cut into a lot of personal family time. And again, back in the 1970s and before, that was just part of the deal. That was expected. I see now younger doctors are not going to work that hard. They just expect time off. They expect cross-coverage. They expect, maybe not a normal 40-hour work week, but certainly a better work week with more family time. At the same time, they expect the same paycheck. They don't want to take a cut. They want the same pay that we received for many years doing 80, 90 hour work weeks, and being on call night and day. So that's some of the change that has happened in the practice, the way general practice is done, at least in Wallowa County.

MERRILL: Have you been satisfied with your decision to go into general practice in Enterprise?

EUHUS: A decision to go into general practice, again, the milieu that we practice in has changed, and the expectations have changed. At the time I went into practice, the expectations were you were there, you were on call, and expected to be there. And if you were in town, you could get called anytime. As that's evolved, particularly the last ten years or so, I've had a little more personal and family time. Of course, my kids are now grown, so they missed out on a lot of having Dad around.

Looking back, again, that was just what you did back in the 1970s, 1960s. Looking back, though, I think boy, I did miss out on a lot. I'm not sure I could have changed it at the time. Would I have changed it? I think if I did it over again, I'd just take off a few more hours here and there, just say I wasn't available and let my partner or somebody else handle some of those things.

I would have to say, though, that those first few years in practice, even though the hours were phenomenal and the responsibilities phenomenal, those first few years were extremely rewarding. I took care of the patient from onset of the illness to the end of the illness, and rarely turned over the care to somebody else, unless somebody more qualified or somebody more specialized needed to take over the care.

Now I may have one of my patients fracture a hip and I don't even know about it for a few weeks or a few days. Back then, I knew about it from the get go, and took care of the patient from the start.

It's a tradeoff. You really get close to your patients, and you're involved in their care, and your patients expect that, and a real relationship develops. It's a little harder to maintain that relationship now, I think, with patients and the way medicine is practiced. But again, for personal and family time, the way it's evolved certainly is a little better. And I see the young doctors insisting on that.

One of our, one of the things I'm very proud of in Wallowa County is being associated with a residency program, coming out of OHSU, the second-year family practice residents, and some medical students, too, come through. And I've heard several

of these residents, when they're done with the rotation, say, "Man, we really love your practice. We love the way medicine's practiced out here. We didn't know quality medicine could be practiced out here. But we're not going to do that. We're not going to work that hard." I've heard that refrain many times. So there's a lot of rewards, but there's some drawbacks, too.

MERRILL: You were involved quite a bit in the development of that program whereby residents come out to work with rural doctors.

EUHUS: When I first came to Enterprise in 1972, shortly after that, my partner, Harley Scholz and I started accepting medical students and residents to come out to see a rural practice and experience a rural practice. These were students, medical students, and residents, in advanced post-graduate training after their doctorate. These individuals were ones who wanted to see a rural practice, wanted to experience a rural practice. So it was an ad-lib thing. They asked to come out to see a rural practice, and we were one of the active ones doing that.

Then in about 1990 or 1991, through the AHAC program and through some of the changes in rural health, we started receiving and training residents on a regular basis. I believe that program started in 1990, officially. So instead of coming out just for an ad-lib experience, the residents, second-year family practice residents, all of them came to Enterprise in rotation for about two months apiece during the year. And they were there about two months. And so it changed from a little bit loose to a structured program with more focused teaching and more focused individual approach to it. And it exposed these young doctors, all of the family practice residents at Oregon Health & Sciences University, to a rural area, to a rural practice. That's been a real epiphany, I think, in medical education.

About that same time, education, medical education at OHSU changed markedly anyway, for other reasons. But the residency program has been a real boon to our community. It's one of those win/win situations. The residents win, they get some training and experience a rural practice. The doctors win. We get some help, an extra hand. The community has an extra doctor on hand. The residents can handle the majority of things, and then we're available for teaching [glitch] hours of the day or night. And that's a fun part of medicine, sharing what you know with somebody. So that's been a real good thing. The community comes out a winner. The state of Oregon comes out a winner, because more doctors then have been exposed to rural practice, and more of these doctors are going to go into rural medicine. That has certainly been the case. When, I believe, I'm not sure the dates.

The family practice program at OHSU, then called University of Oregon Medical School, had been there nineteen years when we managed to make some changes in resident education. And that first nineteen years of the program, it was a very good program, but they had only sent one graduate of the program to Eastern Oregon. Since this program has been formalized, I don't have a number, but a fairly large number of

graduates have ended up in Eastern Oregon and other rural areas. So it was really paid off.

MERRILL: How long do the residents stay in Enterprise?

EUHUS: The first two or three years of the program, I believe there were six residents, and they all came to Enterprise in rotation for two months apiece. Then it was split off as the residency grew. They now have, I believe, eight graduates per year. Maybe it's twelve now. It's twelve now, I believe. And for a few years, half of them went to Hermiston and half to Enterprise. The last many years, half of the residents in the second year go to Enterprise and half go to John Day. So they all still get a very valid rural medical experience. You could even call it a frontier medical experience, I think, because John Day and Enterprise are both fairly isolated from other medical care.

MERRILL: Where do the residents stay when they come to Enterprise?

EUHUS: That's an interesting, it's interesting how the residents program has evolved in Enterprise. Back when we were just receiving residents on an ad-lib basis, we hosted them in our home or sometimes somebody else would volunteer to take them, when the program was formalized in early 1990s, at first, through the AHAC program -- AHAC stands for Area Health Education Center – the AHAC program had a lot of grants and things. And they funded some resident housing. We rented a place. We rented a house for the resident, which had space for residents. Some of the residents are single, some are married with children. Some of the spouses come out there, some don't, if they're employed in Portland or whatever. And the house was rented for several years.

As the funds from AHAC sort of dried up after a couple of years, we were facing a crisis in how to house these residents. And, to a certain extent, the students that would come out. We, our community and some leaders there, had the bright idea to develop, we considered lots of options. We developed an upscale dinner auction, which has been a yearly event since then. I think we're now in the tenth year. At the time, we needed to generate $3600 to fund this house. The hospital district agreed to fund the other half.

So we set up this dinner auction. The community people, businesses and so forth, would donate items or services. And the dinner itself generated some money, and then the items to be auctioned generated money. The first year we hoped to generate $3600. But the first year was $18,000. It just took off. So, and since then, every year it's grown. Now it's up to $80,000 or so generated each year.

So the first year, everything was obviously funded well. After about three years of that auction, the committee that was on this decided gee, why rent, let's build a house. So several years ago, we built, and by then, hospital foundation had been founded. And through the foundation's nonprofit status, a house was built. And this was built with funds from the auction, with funds, donations and so forth from the community, and donated labor. Several clubs donated labor, including Rotary Club. And individuals

donated, one individual donated the gravel. One individual donated the backhoe work. One of the hardware stores donated painted, and so forth.

We built this house from the ground up. The land was donated, actually, by a group. And built this house, and that's been the resident and sometimes student housing since then. It's worked out tremendously. Ongoing expenses are still paid for through the auction, the foundation. We even, another year, added on a garage to this. So it's a really nice house with a fantastic view of our beautiful mountains, situated on a hill just above town. It's a great little house and it's all just really appreciated.

MERRILL: Tell me how continuing medical education, CME, has been handled since you were there.

EUHUS: My philosophy is that you have to stay up in medicine. You can't just go along and practice, although you learn a tremendous amount from practice, from your colleagues and from doing things. You still have to have some didactic education. And that's always been available in one form or another.

When I went into practice, there were a lot of seminars around, family practice reviews and specialty seminars, and so forth. But that business has become a huge business. The medical education business has grown tremendously. Now there are courses everywhere in the world, across Oregon. So we make a big effort to keep up in education. I always attend a lot of courses each year and do a lot of reading.

But the choices in the 1970s were, there were plenty, but they were somewhat limited. Now there's choices galore. You can get an education experience in many, many places, and many different ways. Some of this you have to travel for. We actually set up in the 1970s a program where some of the doctors from La Grande 66 miles away, our nearest hospital, support, some of the specialties come out and give us some seminars.

And then, with the AHAC program, and even before that, there was a program which Dutch Reinschmidt, who was a very unique individual in the history of medical education in Oregon, Dutch Reinschmidt, Dr. Reinschmidt, set up a program of traveling education. Mostly through the university in Portland, where specialists would come out to rural areas. They'd go on a circuit and travel to Hermiston, La Grande, John Day, Ontario, Burns and wherever else, and would cover a topic for two or three hours. And that was excellent. We really had some nice education that way.

Later on, I believe in the 1980s, we actually, I believe, through that same program that Dr. Reinschmidt was heading up, with technology coming on, we actually had a teleconference type of thing. And I'm sure, I know this went around to John Day and other places, too. So at a set time, some morning, usually, the doctors and whoever else wanted to get in on this would gather in the basement of the hospital and have a teleconference where we could—actually, it was an audio conference at first, not a teleconference, the teleconference part came later. But audio conference where a doctor

would give a lecture, but it was two-way. We could ask questions, also. So that was very good. We received some excellent education that way.

Later on, as I said, there was a one-way television through the, it was called the EdNet, which came through the AHAC program, also, as I recall. And with the EdNet, you could see the doctor giving the lecture, usually up at OHSU. And then we could ask questions.

So education has evolved markedly. And Oregon has always done a great job of that. They have a family practice review every year, which has evolved into a very well done thing with lots of good information. And there are just any number of other things you can go to.

MERRILL: You'd mentioned Dutch Reinschmidt. What part did he play in the educational system there? Did you have [unclear]

EUHUS: I considered Dutch Reinschmidt a legend.

MERRILL: Would you start your answer again?

EUHUS: Okay. Dutch Reinschmidt was, I believe, his title at first had to do with medical education in Oregon. He was based at the university. Dutch Reinschmidt had a rural experience. He was a real country doctor. And I don't know all of his history after that, but he ended up at OHSU as their medical education director. And he was involved very much in the things I mentioned before to do with education across rural Oregon. And, I think, urban Oregon, too.

For instance, one, for some years there, I went up to the university to do a mini-sabbatical, or mini-residency. I'd go up for a year every three or four years, usually in cardiology. Dr. Reinschmidt would set that up, make all the appointments. And I worked with a cardiologist. I knew quite a few of the cardiologists, particularly Dr. Frank Kloster, who was chief of cardiology, a personal friend. And I would spend a week in cardiology, just learning what was going on. And Dr. Reinschmidt set that up.

And as things evolved in rural medical education, Dutch was right in the middle of it, and did a superb job. Dutch was a man of vision. He looked ahead, and he had a real knack for organization, and for team building, and just getting along with people. Around Dutch, you always felt good. He just got the maximum out of his people, out of his doctors who he was working with. But you felt like you were a part of what he was trying to achieve.

I really became acquainted with him in the early 1980s, when we were trying to increase our education efforts in Wallowa County. That was the first time I was associated. Then, in the late 1980s, when there was what I what I call a rural health crisis, and then a rural health movement to address that, Dutch Reinschmidt was right in the middle of that, helping form the AHAC program, helping form the network that was

necessary to achieve better medical care and better support system from the university and from the legislature through, essentially through the AHAC program. AHAC program was new to Oregon. It had been in the United States, I believe, for 20 years in various states. Our, as I understand it, the AHAC program across the nation was whatever each state made of it. There was a lot of variation. Oregon's was patterned after Dutch's vision, which was superb, I think.

We started working on that program, which I had never heard of, in the late 1980s. Rural health was in crisis. It was becoming a real burden, I think, to most rural doctors in Oregon. And I think across the nation. It was a real burden to practice medicine anymore. Still a lot of enjoyment, but the hours were getting real onerous, the reimbursement was poor. The support from the government was declining. That's a different story there, with Medicare and so forth.

But I can remember for a few years colleagues would get together and talk about the conditions of things.

MERRILL: You had commented about a crisis in rural healthcare. Could you expand a little more on what you meant by that?

EUHUS: Family practice, general practice, was really my dream all my life to do that. When I got into medicine, that's what I had in mind. Even though at University of Oregon Medical School when I was a student, most of the faculty was specialist, were specialty. And there was a lot of antagonism about family practice and a lot of negative comments. Still, that was my dream.

And first many years of practice, it was very, very busy, and very dedicated. But as things evolved, in the 1980s it became a little more, or a little less pleasant. There was a lot of pressure from patient expectations, from malpractice situations. Well, malpractice ideas. And malpractice premiums. Medicare program and other insurance programs had changed markedly and the expectations and the reimbursement, reimbursement for family practitioners. And especially rural was very poor in relationship to urban practices and specialty practices. And we really felt we were getting the short end of the stick. And we were.

So with a lot of commiseration and so forth, and a lot of talk, we fumbled around for several years trying to figure out how to solve this, rather than just leave. A lot of doctors were leaving rural area. A lot of doctors were retiring and not being replaced. And it was very difficult to recruit. Why come to a rural area like you are practicing in for the poor money you can offer and all those hours that we work. It was hard to entice doctors unless they just really were in love with the idea of rural practice.

In medical education in the 1970s, I remember going to meetings and when you sat down at break time or lunchtime, doctors would all get together in groups informally and the common topic was to talk about, "Hey, I have this patient, what do you think?" Or share their information. You'd talk about patients.

By the 1980s, particular mid-1980s, I noticed a big change at meetings. All we talked about were the miseries of family practice. How conditions were changing for the worse. And we no longer, or rarely, talked about patients anymore. It was about the conditions we were practicing in, which were becoming kind of onerous.

We commiserated a lot, talked about what to do, and things were kind of going south. Our doctors at Enterprise had the bright idea, well, let's see if the legislature can help out. If we're not getting anywhere with what's happening, legislative support was very poor. I think support from the medical school was pretty poor for rural practice, family practice. Even though they had a family practice department, it was still, rural areas were not focused on.

We had the bright idea to contact some legislators on the statewide level and the nationwide level. The national legislators did not respond at all to our letters. And only one state legislator responded. That was State Senator Mike Thorne, who happened to be from Pendleton area. Grew up on a ranch there. So I think he probably had a kinship to rural areas.

I became friends with Mike after that. And he was one of those very unique individuals who just had a lot of charisma and a lot of expertise and a lot of ability to accomplish things.

Senator Thorne responded to our letter and agreed to come out and meet with us. And I can still remember meeting in our dingy little hospital basement conference room. Our doctors and Mike Thorne, our administrator. And we, to put it blunt, cried on his shoulder for about three hours. He's a very good listener.

When we were done talking about it, Mike said, "This is all news to me. Let's roll up our sleeves and go to work."

And things started happening after that. I never did know the personal story, but I think Senator Thorne went back to his buddies in the state legislature and shared some of this, and said, "We're not supporting those folks out there."

I think information filtered to the medical school through the legislature, because it wasn't long before we started getting some telephone calls from medical school administration and the family practice administration.

To make a long story short, that was in 1988. 1977, we met with Senator Thorne. And in the spring of 1988, we had set up a rural health symposium in Joseph, Oregon, in Wallowa County. As part of preparation for that, our staff, particularly Dr. [Scott K.] Siebe, one of my partners and his wife, set up a questionnaire. And they had some professional help to set this up, to sort of nail conditions in rural practice in Oregon.

And we sent this questionnaire out to all the rural doctors, particularly Eastern Oregon, some of the west side, and, I believe, to administrators. Now when you send a survey, I'm not a statistician or anything, but when you send a survey out, you only get a certain percentage back, as I understand. The return is always limited.

We received an amazing percentage back, telling me that we had struck a chord. This was a problem. We knew it was. But we received the questionnaire plus lots of personal comments about how bad things were going in rural health, particularly in family practice, in Eastern Oregon, particularly.

And using that information, and things that were felt to be ill with the system, this symposium happened in spring of 1988. This was amazing, too. The response was overwhelming. We had doctors from all over the place in Oregon. We had medical school administration people. The dean did not come, or the president, because a switch was occurring at that time. And I can talk about Dr. Peter Kohler in a bit, as he was key to what happened later.

He was just coming on board. Family practice, which was a fairly small department then, as far as their staff, sent representatives. OMA sent representatives. The Oregon Academy of Family Practice sent representatives. There were some state legislators, including Mike Thorne. Mike happened to be co-chairman of the Ways and Means Committee then, so he had a lot of clout. And his co-chairman, I should remember his name, but I don't, who was also very influential in what happened later, I cannot recall his name. they were the state legislators. And a few other representatives from around the state, including Jean Timm from Baker City. And there were a lot of other people there, the rural practice office, office of rural practice, and other people I'm not remembering.

And we had, I believe a two-and-a-half day seminar. Filled up our little convention center. And it was just an amazing seminar. Everybody shared their woes, shared their positive experiences. The proper people heard about the crisis. And things started to change.

And from that symposium, I think great things happened. Not that the symposium itself did it. But the right people heard this, and the right people in leadership were able to make things happen. A rural doctor who's out there practicing doesn't have time for all this politics. But the right people heard the message and things started happening. The family practice department took hold of this and really helped out in a lot of ways in enhancing this. The medical school in general revamped their curriculum somewhat, and family practice revamped their curriculum, somewhat, put in a more rural emphasis.

Dr. Dutch Reinschmidt was right in the middle of that, because he was stationed at the university. He became the first director of the AHAC program, which was really probably the one biggest key to achieving the goals that were laid out at this symposium.

The state legislature cranked in some more money, as I understand it, to help support this program and to actually fund another resident position so that residents could then come out on a regular basis to Wallowa County, and then later to John Day and so forth.

A rural tax credit was established. And that's been a huge thing in recruitment and retention of physicians. Tax credit if you're out there practicing in a rural area as a primary care physician, which can include family practice, internal medicine and pediatrics, you're eligible for the tax credit. And I think some dentists were, and nurse anesthetists, and some other personnel. That's a big carrot to entice doctors to stay.

On our survey that I mentioned previously, we found out there were a large number of doctors planning to leave their practice because of the conditions that were there. The tax credit sweetened the pot a little bit, because finances were a big part of why there was a lot of disillusionment with practice. And the education, the AHAC program really was a big thing, because that enhanced education in general. And gave much better infrastructure for education and practice of medicine out in rural areas.

Dutch Reinschmidt became the first director of AHAC, and the Office of Rural Health was firmly involved in this. And the Family Practice Department. We had firm support from all these people.

And the first AHAC in Oregon was a NEO AHAC, Northeast Oregon AHAC. That was in our area, obviously. So we were the prototype program. I was on the steering committee of the NEO AHAC, along with other community leaders, usually medical people. Very fine individuals, very talented individuals on this committee. Led by Dutch, and then the Family Practice Department, with input from the Office of Rural Health.

And we set up the first AHAC program, the NEO AHAC, in Oregon. It was a real challenge, but it was a lot of fun. And you could feel that you were going to make a palpable difference in what happened in Eastern Oregon. So that was a thrilling part. I was really proud to serve on that steering committee.

And then that transitioned to the actual NEO AHAC. And I served on the board of that for several years thereafter. Again, led by some of the talented individuals I mentioned. The NEO AHAC board was not only made up of some select medical people from around the region. It was made up of community leaders. People. Businesspeople, whatever. People that were tagged as crucial to their communities. And so we had input right from the communities from the get go. And that was really important.

And the AHAC, NEO AHAC program, evolved into quite a force. There was a lot of grant money at first. We hired a director named Sandy Ryman out of La Grande, and she made a big difference. She was a strong leader. And the NEO AHAC program was very strong. It helped educate doctors. It helped bring the residents, second-year family practice residents, out to rural areas on their regular rotations. All of them had to experience a rotation. It helped bring the third-year medical students.

That was part of the curriculum change. There was a widespread curricula change at OHSU. In general. And Dutch Reinschmidt had a lot to do with that. But specifically, each third-year resident was required to spend six weeks in a rural primary practice, primary care practice. Again, it could be family practice or internal medicine or pediatrics. And these third-year medical students, I think there's around 100 in a class, I'm not sure, all had to go and do this six-week rotation.

And that was amazing experience. Because, I think, the doctors in Eastern Oregon and Western Oregon and around, had to brush up and receive some training and teaching. There were some seminars to help us beef up our teaching techniques. And it's really fun to share what you know. I think, one of my personal philosophies, I think everybody in life has an obligation to share some of your knowledge with somebody else. And this was an ideal situation. I mean, I really love the practice of medicine. And being able to share it with somebody was really special. And again, it had a real benefit to our community, too, and to the university. We furnished some of their training, and the individuals benefited.

But the students came out on this rotation. And many residents and students would leave the rural areas feeling that wow, this is an option for my career. Before then, medical education was focused on specialty training in a university. You rotate through specialties. You go through neurosurgery and internal medicine, pediatrics, on down the line. And family practice exposure when I went to school was nil. I actually asked to go out and work with somebody a little bit to get some experience and see what it was like. There was no family practice experience. A rare attending physician was a family practitioner. But most were specialists. And again, there was a lot of negative attitude about family practice, particularly rural Eastern Oregon.

I can remember one of the well-known cardiologists at the university, on rounds, making a very derogatory comment about Eastern Oregon doctors. (laughs) I was wanting to go to Eastern Oregon, so that really caught my attention. That attitude has changed, I think, and the university now has focused more on rural practice.

But to get back to the primary thought before I digressed, the idea of rural practice was very intimidating to these individuals. Wow, you're out there without a support system, without specialty care in some areas, and you're on your own too much. A lot of these young individuals wanted to have a specialist in their back pocket, available right then. And that's just not the way medicine's practiced out in the rural areas, lots of times.

But I could see these young individuals leaving the practice, the students and the residents, with the attitude, hey, I could do that! With a little focus and training, I could do that, too. And that has happened. In the first 19 years of the program, one graduate went to Eastern Oregon as a family practice residency. Now, many individuals have settled in Eastern Oregon and other rural areas. So it's made a big difference.

The Family Practice Department has grown tremendously during this time. I'm not sure, but I'm going to say there were six faculty members in the early 1970s. Now there are many. I don't know, probably 30 or so. And they branched out to communities in the Portland area, and have a much bigger presence at OHSU on the hill, as far as the patients they see and the referral basis and so forth. So the AHAC program really has achieved a lot. And it's ongoing now.

The cardiologist at OHSU, there was a, as I recall, there was a patient referred from Eastern Oregon with some type of cardiologic problem, some serious problem. OHSU, University of Oregon Medical School at that time, was the referral center for the state, even though there were other big hospitals in Portland and so forth, they received a lot of referrals. And whatever was with this patient, I don't even remember the details, or if there had been errors in judgment, but whatever had happened with this patient, the cardiologist made a comment offhand, on rounds, that this patient came from Eastern Oregon, and you know about those Eastern Oregon doctors, they don't practice very good medicine. And again, that was really striking to me because I had spent two years in high school in Eastern Oregon, and I had a lot of respect for my family doctor in Pilot Rock, Dr. Richard Cook. So that was a statement that kind of hurt. And I was planning as a very likely consequence of my career to go to a rural area in maybe Eastern Oregon. So that comment was kind of painful.

I think that statement is not true at this point in time. And I don't, being a student, I guess I can't comment how true it was in the 1970s, but I think that was an unfair comment. I don't think it was true then. All doctors, a doctor who hasn't had things go wrong or hasn't made a mistake is a myth. Medicine is not a black and white science. You can do everything you can to keep up and educate yourself and practice and pay attention and go the extra mile, and things still can go wrong sometimes.

MERRILL: Have you had any feedback in recent times from doctors at the medical school or in urban areas about their opinion of Eastern Oregon doctors or rural practice now?

EUHUS: I think the concept of what goes on in Eastern Oregon and rural areas in general, across the United States, has changed. Part of that has been, I think, an increase in education, in education efforts and education opportunities. But part of it has to do with keeping up with medicine and expectations, and the availability of consultations and specialty care. I can get on the phone usually very quickly and get a second opinion from somebody. That's been true always, to some extent, but it's a lot more of a network now, and I think specialists just realize they're going to get those calls and expect to deal with that. So I can get a second opinion just about anytime.

I think that the attitudes about rural practice and rural practitioners and what happens in rural areas has changed. I think there's still a little bit of a negative attitude. But overall, it's changed.

I can recall a few years ago, probably within eight or ten years, a cardiologist from Spokane calling me. Being rural, we ship out a lot of patients if they need to seek specialty care by ground ambulance, if it's within reach and the timing's correct. But we ship a lot of patients by air, particularly cardiology patients.

And I don't even recall the particular patient, but it was a very complex patient who needed a pacemaker, and a lot of other things going on in the medical situation with this patient. And I received, later, a very gratifying call from the cardiologist, who said, "You down there are amazing in your small hospital." He said, "You handled that case just like a cardiologist would." That kind of feedback is really nice to get, you know. Not that we do everything perfect.

So there's an attitude change, I think, and I think we're more appreciated. And the University of Oregon, Oregon Health Sciences University, certainly, I think, has a different attitude now. Really a collegial, more collegial atmosphere. And help is easy to get up there. And consultations are easy to get. And they're not so blunt as they maybe used to be.

MERRILL: One thing that's changed in medicine is the percentage of women doctors. Has the increase in women doctors in your area, affected your area any?

EUHUS: There's been a big change in people who train for medicine, I think other fields in our society. Females are much more common in medical practice and in medical schools now. Recent statistics I've read are that over 50 percent of medical students now are female. That's a huge change. It's been a little bit of an adjustment for, I think, other doctors, but not too bad. I've always had a lot of respect for the female physicians that have been around. In my medical school class of 64 or so, we had three females. And I didn't really distinguish personally between the males and the females as far as abilities or talents or whatever. But I know there have been some biases.

I can recall a surgeon I worked with in some of my early years in medicine who said that females in medicine, there's got to be something wrong with them to go into medicine. I didn't agree at the time with that statement. But there was an attitude around, I think.

I think that attitude, the females that come out to Enterprise in our residency and student programs say there's still some bias, but it's certainly not like it used to be. And I think most doctors anymore, at least the ones I'm aware of, accept them as equals and so forth.

However, it does upset the demographics of the situation a little bit in practice. There's been a switch in the expectations and what doctors want in a practice in the 1990s and in the 2000s now. Younger doctors are just not going to work as hard. They want as much money or more money for doing less work. They don't want the hours. They want more personal and family life time. I can't fault that. It's a different era. It's a

different paradigm that we practice in. So I can't fault that, but it's certainly different than what I grew up with in medicine.

Females, I've found, also have different expectations. The gender obviously brings with it different aspects in life, including the ability to bear children. And that plays a role in the nurturing of children and the raising of children. Not all, but a lot of female physicians want to have more time off. And I see and hear of more females who share practices, who do part-time practices, and thereby do have more of a family life and personal life.

In Enterprise, in Wallowa County, we currently had recruited a few years ago a female physician to my office who's full-time and does a very good job. And she happens to have a husband who stays at home and does a lot of the child rearing, I guess. This doctor I'm mentioning also, obviously, is involved in child rearing. But she does practice full-time.

There are two new females that just came about a year ago, and they are sharing a practice, basically. And I hear of that happening elsewhere.

We're soon to get another female practitioner in September in Wallowa County. This is really going to change the balance, male:female ration of the practitioners. I think that's going to change some of the patient expectations. Females have been forced, if you will, to see male practitioners for many years, because that's what was available.

I've had several male patients comment that, "I'm not going to go see a female." One patient, we do a lot of consultations curbside downtown, in Safeway and on the street. And one male patient told my wife last week, "What's with all these females coming in? I'm not going to go see a female!" So there's a change in what people are going to have to put up with or expect. And I guess it's up to each individual what they're going to do with that.

I do know that the majority of the residents who come through the program in Enterprise now are female. I don't know about John Day. I haven't done an actual poll, but I think the majority are female in the residency program. So it's going to be a whole change in pace for our nation, I think, as these doctors get out into practice and some of the males start retiring.

MERRILL: Now Lowell, tell us about the emergency medical system in Enterprise when you arrived there. Is it the same as it is now?

EUHUS: Emergency medicine has, with everything in medicine and in life, has changed markedly since I went into practice. When I went to Wallowa County, we had an ambulance service through the hospital. Volunteer. At that time, across the United States, I think trauma care, particularly, and emergency care was, by current standards, somewhat primitive. Although by standards then, I think Wallowa County had it about as good as anyplace else in rural areas. But these people were volunteers, called from home

when a call came in. They transported patients to the hospital, and also to other places if they needed to be sent to La Grande or Walla Walla or someplace for specialty care.

Air ambulance was also quite different then. Air ambulance services now are very sophisticated and very expensive. Back when I went to Enterprise, our air ambulance was done by the FBO, fixed base operator, at Enterprise Airport. Bud Stangle, who was a bush pilot flying legend himself. Bud, incidentally, taught me how to fly years ago.

But Bud had a 206, a Cessna 206. And that was our air ambulance. A 206 is a high-wing Cessna, six-seater. And we would take out the two most rear seats and then one of the other ones and fit a stretcher in there. Of course the fee was standard fee Bud charged for doing any commercial work, so it wasn't that expensive. And we would transport patients various places.

The ambulance service, thinking about that reminds me of two stories. I had a, in the 1970s, a very ill newborn I had just delivered. Had respiratory problems. So I rode with the ambulance, in the ambulance, with this infant, to Lewiston. Now the highway from Enterprise to Lewiston is quite a highway. There's three different grades which are famous for scaring people. Lots of curves. Lots of elevation loss and gain.

I was in the back of the ambulance and the old ambulance swayed a lot. The parents were following the ambulance in their car. And we were helping the baby breathe. And our equipment then was not nearly as sophisticated as now. We didn't have a respirator. We were breathing for this baby by hand. Baby was intubated. And midway through the rattlesnake grade curves, I got sick. Had to jump out the back of the ambulance and vomit. Of course this upset the parents. "Is something wrong? Is something wrong?" Anyway, we made the rest of the trip and the baby did survive and did well thereafter. So that trip was well worth it.

One ambulance trip in the air ambulance had a visitor actually to the county collapse downtown in a restaurant. And I was in the emergency room. Treated the patient. She became lucid and ambulatory. This was before the days of CAT scans, MRIs and so forth. One could do a brain scan if you were in Portland or a large city, but we didn't have that technology. Brain scans had a lot of limitations anyway.

At any rate, I checked this patient over and didn't find anything. Was just about ready to release her, and she collapsed again, and did not regain consciousness.

So I arranged with Dr. John Raff, who was the dean of neurosurgeons in Portland at that time. He was well regarded, had been one of my mentors, actually the mentor of every neurosurgery resident and student to go through OHSU. I called Dr. Raff. He agreed to take the patient. So I rode in the Cessna all the way to Portland breathing for this patient, manually breathing for the patient. Unfortunately, she had a brain hemorrhage and did not survive, ultimately. But that was the kind of air ambulance service we had. And sometimes we had to be the ones on hand to do that.

That has evolved into a much more sophisticated system, as has all emergency and trauma care. Now our ambulance is still volunteer with the guidance of a nurse director and one dedicated full-time paramedic, EMT 4. But the volunteers are still there. And I can't say enough about the volunteers. They commit their own time and money to training. And the training is extensive in this day and age. They commit their resources. They're willing to be called away from work. And their employees, by and large, are willing to let them go long enough to do the ambulance ride. And the pay is minimal. They get paid by the hour, as I understand. But very functional, and very talented bunch of people.

And I suspect Wallowa County is the same as a lot of other rural counties in Oregon and across the countries. The individuals just have to commit themselves to their community to do that.

So the ambulance service is more sophisticated, the equipment is more sophisticated. And now we would not transfer a patient in a Cessna. It would almost be malpractice. Instead of a $300 bill to fly to Portland, it's now $12,000 or $15,000 to take a sophisticated air ambulance. Of course the technology and the service and support system is much better, and I wouldn't want to go back to the old days, but they certainly were functional for that time and age. They now send out very talented nurses and pilots. The nursing staff are critical care nurses, usually. Or, if the case demands specialized neonatology nurses, if it's a newborn and so forth.

So the system has evolved, as has the care I provide in the emergency room. There's a lot more technology and a lot more things available and things to do. And a lot more resources. Things we might not have transferred in the 1970s, we do transfer now because that care is needed. More specialized care.

Our ground ambulance, thinking about that reminds me of one incident that happened, probably in 1980s. When our ambulance personnel would travel to another city, often several hours, they of course required a meal at some point. And so it was common to stop at a restaurant and have a meal, or at least get Chinese food to go or something.

And I sent a patient out to La Grande one time, and the EMTs, before they took my patient out, said, "What do you want us to bring from La Grande?"

And I teasingly said, "Well, bring me a number four from Fong's."

Several hours later, the ambulance pulls up in front of my house and delivers a number four. (laughter)

MERRILL: Was the EMT service and ambulance service in place when you went to Enterprise in '72?

EUHUS: The ambulance service was in place. Before that time, as I understand it, the funeral home, the undertaker actually provided the ambulance service. It was actually the coroner for the county, too. But the undertaker provided the ambulance service. I'm not even sure how it was staffed at that time. When I came, it was staffed by volunteers who underwent the routine training at that point in time. And it was under the auspices of the county hospital, basically.

MERRILL: What kind of trauma cases do you handle in Enterprise, and what kind do you ship out?

EUHUS: I tell my students and residents, have told them for years, that you never know what's going to come in the door. We see everything in Wallowa County. We don't see the volume you might see at a bigger hospital, obviously. But you have to be ready to handle anything. You never know what's going to come in the door. So we see it all.

As far as trauma, you name it, I've probably seen that trauma or some variation thereby. Car wrecks, obviously. And we have to triage or treat the patient. Sometimes if the trauma is not too far, not too serious, it's a patient we can keep in our local hospital. But we do transfer out a lot of patients. We have to be ready to wear a lot of hats. You have to be ready to put in a chest tube or do whatever is necessary to try to stabilize a patient.

Education in emergency care has changed a lot. It used to be whatever you had picked up was what you knew. And I can recall having worked at hospitals where the emergency room doctor was a psychiatrist or a urologist and expected to handle all kinds of things. Now it's evolved so people have some specialized training in emergency care.

The so-called ATLS program has made a big difference. There was a nationwide push several years ago to try to improve trauma care. Advance Trauma Life Support, ATLS, was initiated. And I think most ERs now require doctors to have that. And ACLS, Advanced Cardiac Life Support. And sometimes pediatric PALS and so forth.

So that has changed. My expertise has changed. When I came to Wallowa County, I think it was average or, I like to think, above average. And currently, with requirements to keep current in all the courses, you do keep up with things. So we wear a lot of hats, and are expected to wear a lot of hats. But we're also expected to transfer patients when they need it. So it's evolved a lot in that regard.

MERRILL: Are there any especially memorable cases that come to mind?

EUHUS: When I came to Wallowa County, I had never really practiced in a rural area, although I'd done emergency work and had done a lot of emergency coverage in the navy. I had never seen a chainsaw laceration. I have seen chainsaw lacerations to every part of the body since then. And those are sometimes a real challenge to repair. Chainsaw is not a clean cut. It often chews things, and often you have these parallel chatter lacerations, and they're often very dirty. So chainsaw laceration is something you learn to

be somewhat expert on. I've sewed up or dealt with lacerations every part of the body, and some fatalities, too, unfortunately. So that's a thing.

Another thing we see that's very serious, in addition to motor vehicle accidents, are what I term horse wrecks. Generically we take this in Wallowa County to mean horse and cattle incidents. I suppose sheep, too, if that occurred. But horse wrecks are very common. Very serious, often. Sometimes fatal. A lot of serious injuries, and we transfer a lot of those patients out. Of course, some accidents with horses or cows are minor. But we've seen a lot of serious things.

For instance, one injury which I was told in my training and all the way through my career was very rare, is an open book pelvic fracture, where this often comes from getting bucked and then coming down on the saddle horn, or coming down on a rock or something. And the pelvis and/or hips may be fractured. And the front of the pelvis, this so-called symphysis, the pelvic comes in front in the pubic area, comes together, and there's a thick ligament there, the symphysis pubis. And with enough force, that can split. And that's called an open book fracture. I think I saw one of those in my first 15 or 20 years of practice. And then in about a year to a year and a half, I saw three of those. Very serious injuries, usually. In fact, our hospital recently had two more. So it's very common. But the horse wrecks are really common.

As an aside to that, when the medical students, third-year students, come out, they're expected to do a project, a written project, research something local. And one year I thought it would be interesting to assign a project of horse wrecks. And this paper became kind of famous around the state after it was done for this student.

What we did was for three years, pull the charts in the emergency room on horse wrecks. Compare that to motor vehicle accidents, MVAs. And it turned out we had, I think the car wrecks had perhaps a few more fatalities, actual deaths. But ignoring the deaths, the serious injuries, the horse wrecks, there were more than there were car wrecks. It was rather an amazing statistic, which I had suspected, but now we'd proved it.

MERRILL: You were also, in addition to taking care of patients, you were the medical examiner. What used to be called the coroner.

EUHUS: The coroner system in Oregon was present for many, many years. And was usually some interested individual or appointed individual, maybe a doctor, maybe an undertaker, or maybe an EMT, somebody who was interested in it. I'm not sure the year, but Dr. William Brady, who was the state medical examiner in Oregon for many years, revamped the system, as I understand it. And the system that I joined when I became medical examiner in the old days, now it's coroner, when I became medical examiner in 1975, the system was the medical examiner system. There was a state medical examiner, who was Dr. Brady at the time, who was a very unique individual, and very talented. And very helpful. He was really good source of information for me.

The system around the state, each county had a medical examiner, a doctor appointed. And I took over that duty in 1975. And I am still the medical examiner. That has been a very interesting facet of my career. Some really fascinating cases, and some cases that are not so much fun. A lot of blood and gore, unfortunately, sometimes. And unfortunately, a lot of suicides over the years, and a handful of homicides, some of which were very noteworthy. And then some just rather fantastic episodes that happened that you'd only read about in books, usually.

MERRILL: Could you relate some of those fantastic episodes?

EUHUS: One episode that I recall being involved with as a medical examiner, I was actually sitting in church. And before we had beepers, the sheriff would come and get me out of church if there was some kind of case I was needed for, or if the hospital needed me. Sometimes they'd call the church, but somebody had to run back in the back and answer the phone before pagers and so forth came about.

So the sheriff also pulled me out of a lot of basketball and football games and other things. But called me out of the 11 AM service. And there had been a death in the Wenaha Wilderness up north, just south of the Washington/Oregon border. A hunting death. And as it turned out, this was the son of a prominent citizen of orthopedist of the Seattle area. And medical examiner cases are public information, so I'm not spilling any confidential information here. They were hunting in this area. They'd come in from the Washington side and thought they were hunting in Washington. Turned out they were actually, at least where the death occurred, was in Oregon. And this was a long way away from Enterprise by any mechanism. On foot or horseback, you had to ride in or walk in.

Anyway, his son had not come back to camp one evening. So the next day he went out to look for him and after looking a long time, he finally found him. Didn't know what had killed him. Thought he might have fallen. And actually, as it turned out, the son and the father had a pact. If one of them were to die out in the wilderness, they decided they'd just bury him right there. Which of course was, modern medicine, illegal mechanism, it was not legal, I guess.

So the father actually buried the son and packed up. Started back home and after he was part way home, he called the sheriff back in the county where this had happened and told him about it. They called our sheriff.

So that afternoon, we flew up there. Hired the FBO to fly up there. And we picked up the father, actually, in Washington and flew back. He showed us where this was. He'd marked it with a marker down in a canyon. This is rough country there, by the way, really rough. Rough canyon country. And so we spotted this hat that was marking this spot down, almost to the bottom of a big canyon.

And the next morning at about three or four AM, we took off in a car. It's about a four to five hour drive around there. Made the mandatory stop in Walla Walla with the policemen, the sheriff, for the donuts. And then went on to Dayton and met the Forest

Service people. Then we rode horseback in about eight miles, I believe. Then we hiked, looking for this canyon. It was a little hard to find on the ground, compared to the air.

Finally found it. Exhumed the body. And eventually then called in helicopter support. This would have been a terrible transport up to the hill. There were some search and rescue people that came in with us. So we eventually used the helicopter to lift the body out.

Now I was looking to a big ride by horseback and car back home. So I asked to ride in the helicopter. But I was down in the canyon. The helicopter was on top. So they agreed to nab me off the ridge. So I made it about halfway up on a knife ridge, getting back up to the top. And the helicopter came, balanced on one runner. I jumped in and we took off. Made it back to Enterprise. That was quite an adventure.

Turned out that this fellow, near as we can tell, had actually fallen off a cliff there. Tumbled down and died right at the spot. So it was a tragedy, but it was one of those adventures of my career.

MERRILL: Are there any other notable medical cases that you'd like to recall?

EUHUS: I was taking care of an elderly man in a hospital who had been my patient and friend for years, with terminal cancer. And the family had come around, some from California and so forth. And the daughter made a statement, "Well, he'll be leaving this life for a better one." He was a man of very strong Christian faith. Went to the same church I went to, go to.

And the wife of this gentleman didn't quite hear it and she said, "Did you say he'll be going to a different wife than this one?" (laughs)

Another incident that I recall, a patient that I had several years ago, was a lady who could be termed a real character, and very vocal. I fondly remember her in many aspects. She used to bring a pan full of home-baked biscuits into our office every month or two that were just delicious for our office staff. Anyway, there was nothing out of bounds for her as far as what she would say, pretty much.

I was sitting in the nurses' station at the hospital one evening, and she showed up at the counter there and said, "What do you think?"

I said, "About what?"

She says, "My new breast implants."

I said, "Well, I guess they're okay."

She said, "Come here." So I walked over there, and she took my hand and placed it on the surgical site and said, "Now what do you think?"

I said, “Well, I guess they’re okay.” (laughs)

One incident I recall, I still get a lot of mileage out of this story, telling people. Our nursing home is adjacent to the hospital. You just walk through the door and you’re in the nursing home. And I had a patient there, elderly male of 102 years of age who, you weren’t always sure he was getting all that was going on around him.

And I also had a patient at the same time who was an elderly female who was pretty deaf. And she would frankly get on some people’s nerves. She’d walk around the nursing home stomping, just making a lot of noise. Had a cane, tapping it all the time. It was pretty noisy.

I was over there making rounds one day and it happened that between the nursing home and the sitting room, visiting room, there was a little narrow pathway of about ten or twelve feet. And this elderly gentleman was sitting there in his recliner just looking like he was asleep. And you never knew quite what was going on in his mind.

And from the other direction, here comes this lady, stomping along. So here’s the man. The lady’s coming. She got right in front of him, and he sticks out his foot. (laughs) He was pretty irritated by her noise, too, I guess. (laughs)

MERRILL: How did she do?

EUHUS: She didn’t trip, fortunately. It was, I forget, solved the problem before she tripped.

MERRILL: You had mentioned earlier, you were going to say some more about Peter Kohler.

EUHUS: In this rural health crisis that happened in the 1980s, at least, that’s my term for it, a lot of things happened. And we’ve discussed some of that before, with changes that made life in rural medicine better. A lot of people had key roles in this, including the Family Practice Department people, the Oregon Health and Sciences University people, legislature, etcetera, etcetera. Dutch Reinschmidt.

Right about that same time in the late ‘80s, early ‘90s, Dr. Peter Kohler, who is still president of OHSU, came on board as president. And at least we were told that one of the reasons, obviously Dr. Kohler is extremely talented and has done a lot for the university, he had a specific interest in rural medicine. Had a background in AHAC programs. So his job there and his onset as president was really a great thing to happen at that time. The timing was right, because he was very willing to work with a situation and see that the rural health emphasis happened.

Dr. Kohler became a good friend. And he actually came out to our hospital dinner auction fundraiser several years. In fact, the first year he managed to have the OHSU

Foundation donate some money directly to that first year. And he would come out and participate, sometimes speak, sometimes just be there in support at our auction. So Dr. Kohler had a lot to do with the success of the rural health enhancement program and AHAC development and so forth. He's a very fine individual. Talking to him is just like talking to your next door neighbor. He's a very respected and important individual, but it's just like being down home when you're talking to him, also.

MERRILL: Did you know Bruce Carlson?

EUHUS: Bruce Carlson, Dr. Carlson, was an Eastern Oregon doctor. Dr. Carlson was very influential in some of the rural health actions and policies. I knew him a little bit. I can't say he was real close. He was not directly involved in that NEO AHAC program, which I sort of cut my teeth on politically. So Dr. Carlson had a lot to do with rural health and development of programs, and the Office of Rural Health and development of use of physicians' assistants and so forth in rural Oregon.

MERRILL: Did you have physician assistants in Enterprise?

EUHUS: We have had physician's assistants and nurse practitioners in Enterprise. In the 1980s, when things were so tight in Enterprise and Wallowa County for medical care, we were really shorthanded. There was a time there, I won't go into the circumstances why, but my partner and I were essentially the only ones covering the emergency room. In addition to a full time practice, it was so burdensome. It was terrible. I would never want to relive those years again. But we felt that was our obligation to serve the county and serve the community, so we just did it.

We couldn't find any person to recruit over that year or two, and so we actually went out and recruited a physician's assistant. And we helped train her internship. But she was able to help us handle the emergency room, the simpler cases. And that was a real godsend for a year or two there. She was with us for a long time, actually, and did a really good job. I have a lot of respect for PAs and nurse practitioners. They definitely have a role in modern medicine.

Later on, it's evolved so we've had some other nurse practitioners. Currently, I believe there are two full time nurse practitioners in the county, and one part-time pediatric nurse practitioner. So they play an integral role in office practice, and occasionally in the hospital. But currently we have enough staff that the ER is staffed adequately by physicians.

MERRILL: Do you know Glen Hannon?

EUHUS: I do not know Glen Hannon.

MERRILL: Was Dr. John Kitzhaber involved at all in the rural health system?

EUHUS: Dr. John Kitzhaber was our governor, as you know, for a long time. And he was an emergency room physician, basically. He was governor during a lot of this rural health movement that happened. I don't know that he was ever directly involved in it. He was involved, a shaker and mover in a lot of healthcare in Oregon, with the Oregon Health Plan and so forth. But I never was aware that he was very much involved with the rural health program or with the AHAC program.

MERRILL: Was Mark Hatfield involved in that at all?

EUHUS: Mark Hatfield, at the time of this, I believe at the time I went to Enterprise, he might have been governor. I don't know his exact years. When the rural health movement in the late '80s, 1980s, came about, he was a United States senator from Oregon. And he was peripherally involved, not really directly. But I'm sure from what happened in funding and so forth, he did have a hand in guiding some of that funding. Also, Senator Bob Packwood was involved in some of that, too.

At the Rural Health Symposium in Joseph that kind of turned the tide in 1987, Packwood, Senator Packwood did send a representative. And I believe Senator Hatfield might have, also. So I think their hand was in some of this, but not directly involved.

Senator Packwood did a lot of fact finding and so forth in rural Oregon. I remember testifying at least twice before him and his committee. He traveled around Oregon to rural areas and tried to give feedback. So he was involved in a lot of this decision making, I think, at the top level.

MERRILL: Can we have just a brief intermission?

SIMEK: Sure, yeah.

MERRILL: I just wanted to—[pause]

SIMEK: Okay. Rolling.

MERRILL: How do you see the future of medical practice, rural practice, going now? And what problems are available?

EUHUS: I believe rural practice is in another new crisis these last few years, and I think it's headed for more of a crisis. This has to do, again, with reimbursement. I think there's a lot of pressure from third party payers and Medicare. And reimbursement is going down. The government keeps threatening to drop Medicare reimbursement. I can already tell you that when we see a Medicare patients, we don't make much money from that. And I think it's the third-party insurance which tends to pay our salaries now. Medicare, for the amount of time you spend with a Medicare patient, the reimbursement is very poor. I may see the same reimbursement for seeing a patient with tonsillitis or an upper respiratory infection, which doesn't take very long, on the scale of time, compared to the Medicare patient, same reimbursement, who may have hypertension, diabetes,

heart disease, on literally 15 different medications, and it takes a lot of time. Medicare assigns a fee for that which, for the time spent, is not much. And then they say, “Well, we’ll give you 80 percent of that.” So I think there’s a problem there. And then yet they’re threatening every year, they say, “We’re going to cut you back 4 ½ percent this year.” So that really hurts when you’re out there treating a lot of elderly patients.

The demographics in Wallowa County have changed. The population there is about 7,000, and has been since 1972, when I came. However, a bigger percentage of those patients are now elderly or Medicare patients. There are fewer families, which has led to an education and school crisis, which is a whole different subject, trying to keep our schools afloat. But there’s a lot more elderly patients, retirees and so forth. The population, again, stayed about the same.

So Medicare patients desire treatment and need treatment, and we give the treatment. And we just, we don’t really ask about the fees, except to gripe later about it. But I see a crisis increasing there in reimbursement.

And third-party payers usually follow behind, not too long after, and say, “Well, Medicare’s doing this. They got by with it, so we’ll do it.”

Medicare was a very laudable thing back when it was initiated. The purpose was clear, to treat elderly patients who didn’t have the funds or resources. It’s evolved into just a giant gorilla, I think, which is, takes a lot of money to fund. It now covers everybody over 65. And some other patients, disabled before that. And that takes a lot of money to fund it. And yet, they’re not funding it appropriately.

At the same time, it takes alto more money to fund medical practice. Whereas in the 1950s, let’s say, a patient with hip arthritis would be given a cane and some aspirin and sent out the door, now a patient with bad hip arthritis ends up with all these treatments and then a total hip prosthesis, perhaps. Which is very expensive. Very fantastic development, but this technology is not always funded. There’s a lot of press about, and a lot of political banter, and a lot of media approach of medical care is too expensive. Well, of course it is. This is fantastic technology. Some of the same technology that got man on the moon and so forth has occurred in medicine. It costs money. But the reimbursement system hasn’t kept up with that. They’re saying it’s too expensive, so we’re not going to reimburse that.

I see a real crisis coming up increasingly there, because technology is only going to burgeon. Dr. Kitzhaber’s, one of his plans with the Oregon Health Plan was to ration, if you will, medical care. That was a somewhat noble idea, also, but didn’t fly for lots of reasons. And the Oregon Health Plan is basically broke now because they just couldn’t fund some of those things. And people who thought they were under the wire, there was a limit on what was funded, lobbied and whatever. So a lot of those other things are now covered. Actually, the last few years, some of those are not covered, actually, the last few years. Some of those are not covered, because there’s not enough funds. I think there’s a reimbursement problem.

There's a malpractice problem. People have grown to expect perfection. And if something goes wrong, the first thing they say is, "I'm going to sue," whether there's any right or wrong. Our legal system has very little to do with right or wrong or justice. It has to do with who has the best lawyer. What does having a good lawyer have to do with right or wrong? "A good lawyer got me off." Think about that. That's a stupid statement, really.

But the malpractice crisis, there was a real malpractice crisis back in the '80s. And that was part of the rural health crisis, actually. They threatened to do away, or they threatened to increase obstetrical malpractice and surgical premiums. They were threatening to have us pay $50,000 a year for malpractice premium. Well, that's ridiculous. No way I could fund that. Anyway, the legislature got on that and managed to avert that, so the premiums weren't so onerous. They still were more than we wanted.

I think a lot of communities have solved that by helping the doctors pay for obstetrical coverage. Help pay their premiums. And that's one thing that kept Wallowa County afloat, was some help in paying the malpractice premiums. Otherwise, you could not afford to deliver babies, with the volume we do up there. So that's a crisis I see coming.

There's another crisis in obstetrics I see. That is training. The family practice doctors come out of training now, not all of them are highly skilled in obstetrics. There's a difference between practicing obstetrics as a family practitioner in a larger city where you have immediate backup, perhaps, from an obstetrician. To be in a rural area, I don't have backup except by phone. And so I think there's a different level of training.

Not only that, it's very difficult to get obstetrics training in a lot of programs. And it's extremely difficult in a lot of programs to get C-section training. If you're going to be doing obstetrics in a rural area, you have to be able to do a C-section. Or have adequate backup.

And I've seen this happen several times in doctors who've come to Wallowa County in the last 20 years. They may have some obstetrical experience, but they have no C-section experience. So one of the more experienced physicians has to be available at all times. And that's sometimes a little bit difficult. But we've made it happen so far pretty routinely.

But a lot of the new doctors coming out just don't have C-section experience. I think that's a crisis. It's very difficult to get that training in training programs. The obstetricians want the training and they want to do the C-sections and get the training. And so the family practice doctor often gets shoved in the back corner and doesn't get the actual experience. I don't know how, that's going to have to be a change in the paradigm again. I don't know how that's going to happen.

The same thing has happened with surgery, but it's not quite so emergent there. A lot of trauma surgery we refer out anyway. And we have a general surgeon in Enterprise now, but it's not a trauma surgeon. There are specialists now called trauma surgeons in a lot of the big city hospitals, level one trauma centers, have a trauma surgeon rotation on call. So we refer those patients out. And often we can stabilize those patients until they get to the trauma surgeon, or the neurosurgeon. Obstetrics, you can't do that sometimes. When there's something going wrong and the patient needs a C-section, you have to do that right now, or very quickly, anyway. And if there's nobody there to do the C-section, that mother and baby are in jeopardy. So I see that as a big crisis.

I think the supply of rural doctors is going to decline some, unless reimbursement improves. The hours work, the workload has declined somewhat. I think more doctors have come out there, and then call is being shared more. So I think the younger doctors are taking more time off. That's a mixed blessing. I think it's very good, in a lot of respects, to get more family time and personal time. My own family, frankly, was shorted in a lot of that. And I think a lot of doctors back in the '70s and '80s, that was true. Now the younger doctors are pretty insistent on having their family time.

The downside of that is, you lose some continuity in care. In the 1970s, I was responsible for a patient from office to hospital, the emergency room hospital, after discharge from the hospital. I was it, except on the rare occasion that I was out of town. If I was in town, I was on call. And even after we'd developed a better emergency rotation, or different one, still I would get called out all the time to handle my patients in the emergency room.

That has changed. Now one doctor's in the ER and handles that pretty routinely. And handles the patient admission. For instance, if I had a patient with a fractured hip back in the 1970s, I knew about it right away. Now I may not find out about that for days or weeks, just as an example. So the continuity is not quite as good. I think medical care is still good, but continuity does have a real positive thing to be said for it. You lose some of that.

I see that in big city hospitals from some of my personal experience with family. A lot of family practitioners and internists and other doctors in hospitals in big cities now do not hospital work. There are now doctors called hospitalists, I guess that's the way you pronounce it, who, family doctor may send the patient to the emergency room or to the hospitalist, and they take care of the patient in the hospital. The family doctor has nothing to do with it, or the internist, as the case may be. I think, I know a lot of continuity is being missed there.

My mother's had some medical experiences, not too pleasant, the last few years. and I've talked to several doctors while the patient's in there, in the hospital, while my mother's been in there, and the continuity's lost. One hand doesn't know what the other one's doing. and often that's made up eventually. But sometimes it's not good for patient care. But that's the paradigm that's being done now.

MERRILL: Let's back up a little bit now. Tell us how did you decide to go into medicine? Where did that decision come from in the beginning?

EUHUS: My choice as medicine as a career, the initiation of that is a little vague, but I think I can come up with some rationale. When I finished high school, I was, I had been very much influenced by a mathematics teacher in high school. So I thought I'll go to Oregon State University, Oregon State College, then, and I'll take mathematics. So I did. I graduated with a math degree, and did very well at math.

But about my sophomore year I thought, I'm not sure I want to do this for a living. And I got to thinking what else could I do on a scientific bent. And I decided on premed as an option, still getting a degree in mathematics, as it turned out.

I think my influence to do premed, looking back, it wasn't so much of a conscious influence, but I think the leading force there in my decision probably was a family doctor as a child. We didn't see the doctor much, just occasionally. But when I was, I believe, a seventh grader, I had polio. I was, as I recall, the first victim in Columbia County. I lived in a little place called Kalama, outside of Rainier, Oregon. And I had polio. And I was pretty much paralyzed in my legs. And at that time, polio was treated by bed rest.

I remember being in Portland with my parents on some business or something, and limping down the street. And my dad said, "What's wrong with you? Quit limping."

So a day or two later, it hadn't gone away. So they took me to Dr. Duvall, who was a family practitioner in Clatskanie, Oregon, right there. His office was up a set of dingy steps, you know. Walked up the steps.

He diagnosed polio. And put me to bed for a long time. I was so weak. Went through physical therapy thereafter. And Dr. Duvall was involved in the aftercare to some extent. But most of that was physical therapy, Portland once a week, and then at home.

And I think in college, I think, that experience hit me. Gee, that was a good experience. Here's a doctor out in a rural area who did a good job and diagnosed a case. I would have probably trouble diagnosing a case of polio in my office right now. I'd have to think pretty hard because it's a rare disease. And at that time, polio was becoming epidemic around Oregon. But it was the first case he'd ever seen, I suspect. I don't know that for a fact. But I think that influenced.

I went into premed, and then did the requirements for the premed program and then applied to Oregon Medical School and was accepted.

I grew up in mostly rural areas. Spent a few years in Portland off and on, when my father was in college and so forth. But rural areas, small areas. So I was a rural boy, kind of a farm boy. And there was little doubt in my mind after living in some cities for training and so forth that I wanted to go back to a rural area. And specifically a mountain

area, because I had taken on climbing and backpacking and hiking as a primary hobby by then. So rural areas were where I really wanted to go.

MERRILL: Have you ever regretted the decision to go into medicine?

EUHUS: I've never regretted the decision to go into medicine. I've never regretted the decision to go into family practice. That's where I belong, I think. This may sound sort of weird, but I think I was born to be a country doctor. It just fit me really well. It's just been a rewarding practice.

As I look back, and I see what's happening to medicine now, and family practice, and rural family practice, I think man, I sure spent a lot of hours involved and my family sure didn't get my attention like they should have, and my personal life, in some respects, didn't get the attention it deserved. But those were sure rewarding years. So if I did it over again, I'd probably take a little more time off and just insist on somebody else covering. But back then, you covered your practice, except on the rare occasion when you left town.

MERRILL: What do you see as the main reward for those years of practice?

EUHUS: Patient relationships. Looking back on the years, I think that's pretty clear that that's the biggest thing is the relationship you have with patients. They rely on you. You're friends, by and large. You feel responsible. You feel good when you're seeing people through an illness, or through their lives, or through their family crises. It's a good feeling to be participating in that. You can be part of something that nobody else gets to be part of. You get to see an individual and their family at their best, and at their worst. And you get to share in things that nobody else shares in. And of course you keep that confidentiality, but it's a real reward to be in the middle of that and be counted on.

MERRILL: In a rural area like that, your patients are your friends, and vice versa. Did you ever take care of your own family members, medically?

EUHUS: In a rural area, pretty soon everybody knows who the doctor is. Although I don't know everybody, I know a lot of people. And a lot of the people that are my patients are my friends. And you have to develop a little bit of impartiality, I guess, is the word, and be able to distance yourself from that when you're treating them. It's still part and parcel of what you're doing – there's my friend – but you still have to distance yourself from that while you're focused on their problem. You have to distance yourself from the emotion. And for whatever reason, my personality, I've been able to do that pretty well. Later on, I might have some problems dealing with it emotionally. But at the time, I've been able to do that quite well, I think. You could ask some of my patients, see if they feel that way. But I think that's true.

Family, there always was another doctor in Wallowa County, one or more. But most of us evolved into treating our own families for minor things, and sometimes major things. I was able to distance myself from that at the time, too, I think. There's a lot of

advice given by other professionals and doctors and teachers not to treat your own family. But I would challenge anybody to look back on my career and say I mistreated my family, or over treated them, or whatever. I did treat my family a lot. I took out, I had three children. I took out the appendix on two of them, and I did tonsillectomies on two or three of them, I think. So yeah, I treated my family. And actually I feel like that was a credible job, and feel like that worked out fine. And sometimes there wasn't much choice. Somebody was not around. I was it, anyway.

SIMEK: Let's pause here.

You okay with this?

EUHUS: As long as they don't kick her out. (laughs)

Okay, anytime.

EUHUS: I would just take up on the story. One night when I was on call in the emergency room, a motor vehicle accident, and MVA happened. And I don't at this time recall the patient's injuries, because this was probably 15 or 20 years ago. But we worked our way through the problem. And the patient needed a transfer, as it turned out, to Walla Walla, which is 110 miles away. And all the rush in a trauma case like that, you may cut off the clothing, you work your way through IVs, tubes everywhere. And when all was said and done, we got the patient loaded on the ambulance. Off to Walla Walla. And the patient eventually did very well and survived and did fine.

As I, after I wrapped up my paperwork and they were cleaning up in there and everything was winding down, about 1AM it was time to go home. So I reached in my pocket for my keys. And my car keys weren't there. And I remembered, I made a mistake in my earlier discussion on that. We actually transferred the patient by helicopter. We used to have a helicopter sometimes come in and land right at the hospital. It was a very tight spot, but the chopper pilots were very skilled. And to do that, a call would go out for everybody to move their car. So I just handed my car keys to one of the nurses, said, "Go move my car. I'm busy with this patient." So she moved my car.

So my car keys were in her possession. And she says, "I don't know where they are." So I got a ride home some way.

The next day they found the car keys in the patient's boots over in Walla Walla. (laughs) So I got them back eventually.

MERRILL: Looking back on your years of practice, is there anything you would do differently today? Or make different decisions along the way?

EUHUS: In reviewing my years in practice, I think family practice is where I belong, in a rural area. But I think I would take an extra day off now and then and take a little more vacation. And I probably would have invented cell phones sooner in medical

practice. Because they're a nuisance sometimes, but boy, they have freed us up tremendously. I can leave the house, leave the community, within reason. Be out ten miles from town, whereas in the past, that was not an option sometimes. You just couldn't leave. You had to be tied down right there. The cell phone has opened up a lot of options.

It's saved some lives, my cell phone has. I took a friend once climbing Mount Joseph, which is my favorite mountain in Wallowa County. I've climbed it every year since I've lived there, 34 times now. And took a friend up. First time I'd climbed with him. He had had a history of heart disease, but was doing well, as far as I knew.

And we made it up the mountain, almost up there, and he started getting sick. Thought it was his stomach, which is a common thing with heart disease. Anyway, after being just below the summit for a while, it became obvious he was having heart disease, after we'd watched for a while. He couldn't even walk. He was having chest pain.

So I whipped out my cell phone and called and had a chopper come up and pick us up off the mountain. Got a ride back to town. So that was another adventure in a helicopter.

But anyhow, as far as changing practice, I would probably stop and smell the roses a little bit more. Probably take a little more time off. But again, there's a tradeoff with the continuity of care and so forth. But that's the trend now, and I can't fault the younger doctors for wanting more time off. And I probably would do the same. But again, that was just expected. That was the way you practiced medicine back then in a rural area.

MERRILL: So if you were clear back in your schoolboy days, do you think you would have made any different choices along the way? About going into medicine or family practice?

EUHUS: I think I made the right decision, going into family practice, and particularly rural practice. I think that's where I fit, where I belong. Looking over the years and seeing and experiencing lots of things, and seeing lots of people, and hearing lots of things, reading lots of things, and examining other people's careers, I don't see anything else that I would rather have gone into as a career. I don't see anything that I would have done as well at, I think. I think family practice is where I belong.

MERRILL: Not any specialty.

EUHUS: No. We all go through that, of what specialty should I go into, or whatever. And I considered some specialties. I considered ENT from some good experience with mentors I had, an anesthesiology once. But family practice is what appealed to me, and where I belong, I think. I like the wide variety, the challenge. I like the idea of wearing many hats. Sometimes it's very frustrating, sometimes it's very challenging, and, occasionally, very scary to be on the spot with something you may not

have the expertise with. But my philosophy there in a rural area, somebody's got to do it. And I can probably do it as well as just about anybody. And whether that's a true statement or not, I don't know. But you have to approach it with that idea or you shouldn't be there, I think.

MERRILL: Two quickies. Any advice you would give to somebody coming into medicine now who wanted to be a doctor? And any advice you would give to patients on how to get the best use out of their doctor?

EUHUS: (laughs) Those are hard.

MERRILL: Twenty-five words or less.

EUHUS: Yeah, right. [pause] I've helped train a lot of students and residents in family medicine. And a lot of them ask for advice. And a lot of college students, or high school students, ask for advice on whether they should go into medicine or not. And for many, many years, I was very enthusiastic, saying, "Yes, you should. That's a very good field if you have the wherewithal and stick-to-itiveness and so forth to do it."

The practice of medicine is still valid and noble, and I'm quite fond of it, obviously. I still can tell students and residents that. But I think there's a lot of downside, some negative things, with issues of reimbursement and hours and malpractice and support system and patient expectations and so forth, to name a few things. And so I generally temper my advice to students and tell them the downside. Say, "Here's things you'll be dealing with. Are you sure you want to do this?" And let them make their own decision. Again, very valid profession, and I'm very proud of our medical profession. But it's not the same as it used to be, either.

For patients dealing with the medical system, it's really difficult, because there's so many options. I still think a lot of things should go through the family medicine doctor, rather than go directly to a specialist. Because then you're, the whole patient is being examined and taken care of. If you go to a specialist right off the bat with your sore throat, they're not going to appreciate some of the other nuances of your health and your care and your medicines. They're not going to take advantage of some of the heart disease aspects, and what they're doing with this disease they're treating. So there's certainly a place for specialists, I wouldn't want to be without them, but I think the family medicine doctors should be the coordinator in most medical care.

MERRILL: This ends the interview of Dr. Lowell Euhus, of Enterprise, Oregon, recorded on June twelfth, 2006, at the historic Geiser—

[End Interview.]