HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Jim Kronenberg

Interview conducted April 18, 2006

by

Teresa Bergen

Interview with Jim Kronenberg
Interviewed by Matt Simek
Date: April 18, 2006

[Begin Track One.]

?: We're rolling and recording.

Okay.

?: (?) camera and (?)

SIMEK: All right. This interview with Jim Kronenberg took place on April 18, 2006 at the Oregon Medical Association which was at that time at 5210 SW Corbett in Portland. This is one of several interviews conducted by the Oregon Medical History Project on a grant from the Oregon Medical Education Foundation at Oregon Health and Science University. The interviewer's Matt Simek. Jim, thank you for sitting for this brutal inquisition. [Kronenberg laughs] As we usually do, we'd like you to give us an overview of your early years, from birth to your entry into the medical field.

KRONENBERG: Okay. Unlike an awful lot of people I know, I'm actually a true bred and born Oregonian. Been here all my life. Educated here. I was born at Good Samaritan Hospital in Portland in 1944. And my mother had a very difficult pregnancy, mainly because, certainly at that time, she was pretty old to be having children. She was thirty-five years old, my dad was forty-five. And she spent the last month or so before I was born in the hospital, actually in the hospital, which was fairly common with difficult pregnancies in those days, I guess.

And one of the interesting stories is my father worked here in Portland, so he spent a lot of time with her after work and the like. And one of the things he got in the habit of doing was walking several blocks down to Burnside to visit a new fried chicken stand that had opened called the Ringside. Which it opened in 1944, actually that spring before I was born. And I think most people who grew up here in Portland will say that the Ringside over the years has been, at least in terms of homegrown fancy restaurants, *the* place to be.

At any rate, we lived in Northeast Portland on Alberta Street until I was three. And then my mother and father bought ten acres from my mother's father, who had a section of land between Boring and Damascus, about thirty-five miles from Portland at the time. And he bought a ten-acre slice, which is where I spent the rest of my childhood, which was great. I didn't walk five miles to school, but I did walk two miles to school, back and forth. And I had the original two-room schoolhouse, first to fourth grade in one room, then fourth to eighth in the next room.

Had a great childhood. I have a lot of wonderful memories of growing up as a real farm kid. When I go out there now, it's depressing. Because it certainly is no longer farm

country. And most of the animals that I remember, the deer and the elk and the bear and the occasional mountain lion, of course, are long gone. But had a great childhood. And went to high school in Gresham, which was about seven miles to the north. And at that time, the Gresham high school district went all the way to Sandy and over to the Clackamas River and then across to 122nd to the Columbia River. It was a huge school district.

In those days, most of the kids were farm kids that came from the hinterland. I think there were probably three thousand people in Gresham proper. And I remember on Powell Boulevard, there was a stoplight in Main Street. And Powell Boulevard and you'd go down Powell, and the next stoplight you would get to when I was in high school was on Eighty-Second. So it was truly farm country.

I went to the University of Oregon. And I majored in journalism. I'd always wanted to be a reporter. And I spent enough time in an internship with the *New York Times* in San Francisco at the end of my college career to conclude two things: first of all, I did not want to be a reporter. And second of all, I did not want to live in San Francisco, so I moved back to Portland. I worked at several positions before I went to work at the Oregon Medical Association in 1969, the last of which was as assistant director of public relations for what is now the Port of Portland. And that was a great experience. And like most young people in those days, I enjoyed that job very much. But I was offered the job at the Oregon Medical Association. And it constituted a raise from six hundred dollars a month to eight hundred dollars a month, which was mighty big money. Particularly since my wife and I had a baby. So I felt compelled to take the job.

And my former employer, when I told him I was leaving, said it sounded like a great opportunity. But he said, "You know, I'd stay at this next job for a while because I wouldn't want to get a reputation as a job jumper." Which today is really funny. But anyway, I had a lot of respect for that gentleman, Fritz (Timmon?), who was a historian and author in addition to his public relations work.

SIMEK: How long had you been at the port at that time?

KRONENBERG: About eighteen months. Which up till then was a pretty long job for me. So when I came to work for the Oregon Medical Association, I thought I should stay for a while. So here I am, almost thirty-eight years later, still at the same job.

SIMEK: Let's back up a little bit into your childhood. I wonder about how did it come about your entry into medicine, your interest in medicine. Did you have an interest in medicine as a child? Or was it just a job?

KRONENBERG: Absolutely, it was absolutely serendipitous. Because my relationship with physicians up to that time was almost nil. We went to, the family went to an osteopathic physician in Gresham, a Dr. Sherwood. And I had the usual childhood illnesses, which he took care of very nicely. And managed to be able to take out my tonsils twice, I remember, he didn't get it right the first time. And then when I went to

high school, my best friend in high school was the son of a local physician, Alan Fisher, who as a matter of fact just recently retired. He was, at one time, mayor of Gresham. So when I needed to go to the doctor, which wasn't very often in those days, I went to see Doc Fisher, usually at his house, so we could go swimming in his swimming pool afterwards. And he gave me my college physical. And that, basically, was the end of my experience with doctors. Until my daughter was born, which is a great story I'll tell you sometime.

And then I took this job. I actually took it because I knew the then executive director of the Oregon Medical Association, he offered me the job. As a matter of fact, at the same time he offered Bob Dernedde a job, who eventually became the executive director himself for some thirty-five years.

SIMEK: Who was the head of the OMA then who offered you–

KRONENBERG: He was a fellow named Bob Bissell. And Bob had been working for the Oregon Medical Association for about ten years under the tutelage of Oscar Miller. No, that's wrong. Excuse me. Roscoe. Roscoe Miller. And Roscoe, I think, may actually have been the longest employee, rather than me, unless I want to work for a while. I think he actually worked a full thirty-eight years for the OMA before he retired. Fine fellow. I kept in touch with Roscoe after he retired. And he lived for another fifteen years or so. He was a very interesting guy.

SIMEK: What impression did you have of doctors in general back then, if you had an impression at all? Or did you just not think about them?

KRONENBERG: Well, until I came to work for them, and then I began thinking about it very seriously, I didn't know very much about physicians. Fortunately, I and my family had not had much experience with them up until that time. That's changed over the years, particularly as I've aged, but I felt a certain sense of, I suppose, maybe even inferiority. Because I knew they were well educated, and I knew they were well compensated. And at least in my experience, they tended to be sort of lions of the community in terms of their work as mayors and city council people and health officers and the like. So I was maybe a little intimidated at first.

That's something that over the years I managed to disabuse myself of totally. Actually they're pretty regular guys. And these days, to an increasing extent, regular gals who have a very high degree of respect, generally, for the skills that other professions and other occupations have. And my experience has been very pleasant, generally, with physicians. Because as soon as they figure out that you have a skill set that they don't have, and that that can be useful to them and to their organization, why there isn't a sense of inferior or superior kind of activity side. Physicians come in all shapes and sizes. They come in all kinds of temperaments and obviously clinical specialties and the like. Some of them are arrogant. Some of them are very mild mannered folks. But in general, the one thing you can say about physicians is they're smart people. Because by the way that

they're selected and educated, they've got to have a superior intellect. And that's always been important to me, and a pleasure to work for them for that reason.

SIMEK: I remember as a child that (?) family doctor and having some rather interesting theoretical treatments and so forth, such as diathermy treatments. I wonder if you remember from your childhood some treatments that you may have had that are no longer used or what you may have thought of later on as odd or interesting.

KRONENBERG: I think the only recollection I have of that was I had adenoids. And at that time, if you had adenoids, tonsils, they took them out at the same time. The first time, they just took my tonsils out. But I continued to have difficulty breathing and lots of colds. So they decided that the tonsils hadn't gotten totally totally excised. So they decided that they would do a tonsillectomy and an adenoidectomy.

And they got the tonsils that time, but apparently they didn't do a very good job with the adenoids. So I remember going to a specialist, I assume probably an oto-larynologist, I'm not sure, who inserted these long wires with sort of brushes on them that were dipped in some kind of radioactive material. It sounds scary now. And stuck them up my nose. And I guess it worked, because it killed my adenoids. But I've actually asked specialists in oto-larynology what was being done, at least according to my recollection, and they had no idea. So that, I guess that will be a mystery that dies with me. I haven't had any bad experience because of it, but I remember it very clearly. I can even take you to the office building in downtown Portland where the procedure was done.

SIMEK: It was an office procedure?

KRONENBERG: Yes it was.

SIMEK: Do you remember the anesthesia? What was that?

KRONENBERG: There wasn't any. There wasn't any. He just stuck those wires up my nose.

SIMEK: I mean for the tonsillectomy.

KRONENBERG: Oh, for the tonsil, I remember that very well. It was ether. There wasn't any question about it. And I remember that terrible nauseating sweet smell. And of course, I had to have it done twice at different times. And that was the worst part of the whole thing. Because I sometimes still have nightmares about that smell. The good part both times was as soon as you were wide awake, you got peppermint ice cream. I remember I liked that. That was good.

SIMEK: [laughs] Okay. Let's make a transition to the OMA. How did you go about getting selected by the then director? And was that at the same time that Bob Dernedde came?

KRONENBERG: That's right.

SIMEK: Just about that whole period.

KRONENBERG: That's right. And Bob and I have had a lot of fun about that over the years. I was the assistant PR director, as I said at what now is the Port of Portland. Then it was called the Commission of Public Docks. And Bob was the public relations director for the Lloyd Center. And I had met him at various meetings and get togethers with public relations professionals, even though we were both kind of rookies. But he'd been around for a while. And I remember Bob and I had been interviewed by the executive director. And then we were asked to meet and have lunch with the Oregon Medical Association's president, J. Richard Raines, Dick Raines, a radiologist here in Portland, I guess to get the final sign off. So Bob and I had a very pleasant lunch with Dr. Raines at the Multnomah Club. And Mr. Bissell. And then it was announced that he apparently had given us both the nod. So the executive director offered us both positions, which we took.

And I always joked about it. I started on the tenth of January, 1969. Bob Dernedde didn't start until the twentieth. So that made me the senior person, even though I was five years younger than he was. And I have held that over him to this very day. Not only did I start before him, now that he's retired, I lasted longer, too.

SIMEK: When you came to the OMA, what were the OMA's functions?

KRONENBERG: You know, that's interesting, because they probably weren't a lot different than they are now. I think that the biggest difference in terms of the range of services and activities that we have, probably are two. First of all, when I came to work for the OMA, I was one of seven employees. Now we have something on the order of twenty-five. There have been times when we've been closer to fifty. So we have a lot more people doing basically the same functions.

I think the big difference was that perhaps the biggest single event or activity that the Oregon Medical Association had when I started, and was one of my duties as a staff person, was the planning and the production of an annual meeting. And in those days, that was probably the premium opportunity for physicians from all over the state to get together to get some continuing education. There weren't state specialty societies. There weren't well established continuing education programs available to physicians in their own hospital. So they either went out of town for their continuing medical education, or they came to the Oregon Medical Association meeting.

So it was a meeting that started, I believe, on Wednesday and went all the way through Sunday. And the great majority of the meeting was devoted to scientific presentations. For a number of years, the Summer Memorial Lectures were held in conjunction with the OMA's annual meeting. We would have three and four thousand people attending the meeting, which is pretty remarkable because at that time, we only

had seventeen hundred members. Physicians would come from other states. Some of their staff, nurses would come to the programs. It was just a high old time social event. We had banquets and dances and that sort of thing.

I remember one of the most challenging parts of the meeting was taking care of something on the order of a hundred, hundred and fifty commercial exhibitors. Drug companies and medical supply companies that would come to hawk their wares to the physicians, because they were all in one place. Sometimes I wondered in the early years if there was anybody back in Klamath Falls to take care of patients, because they all seemed to be at that meeting.

And we made a decision in 1977, excuse me, 1974, to discontinue the scientific programs. And this was really, I think, in response to the fact that more and more hospitals were developing their own continuing medical education programs for the staff physicians in-house. Certainly all of the big hospitals here in Portland, and then Salem hospital, then Sacred Heart, finally Rogue Valley in Medford had full blown continuing medical education programs.

Some of the disease-oriented societies, such as Easter Seals and the American Heart Association, Oregon chapter, and so on, began to do outreach programs in the smaller communities. So the need for a general medical education meeting on an annual basis sort of began to go away. So we made a conscious corporate decision to sort of defer to other organizations the responsibility for providing continuing medical education to our members. And we began to focus more and more on socio-economic, as you very well know, risk management kinds of activities. Not only for physicians, but for employees. In order to help them cope with running a medical practice, which is essentially running a small business, in an efficient and effective manner.

And I think that's the biggest change that I've seen, because that kind of education for physicians was frankly virtually unavailable before we started doing it here in Oregon. If you wanted an education in business, you went back to college and took an MBA. But over the years, the practice of medicine, the business practice of medicine, as well as the clinical side, has become so much more complicated and so much more subject to regulation that to run a successful practice, the physician really has to know a lot about the books and collections and scheduling and all that sort of thing. So we felt there was a niche there that needed to be filled. And so we made a conscious decision to begin offering that kind of programming.

And now some thirty years later, it's obvious that we were on the right track. It's difficult for me to think of a hospital, even a very small one, in the state now that doesn't offer some level of continuing medical education on a regular basis for the physicians who practice there. Virtually every specialty you can name has a state specialty society that puts on one or more educational programs for its own members each year. Oregon Health and Sciences University Department of Continuing Medical Education puts on an enormous number of programs. So there are lots of opportunities for physicians that didn't exist back in the '60s and the '70s or even the '80s.

SIMEK: We're going to go back and look at the evolution of the academic portion of this a bit later. One of the things, while we're at this point, there was a clear difference between the academic and business portions of medicine. And that was one of the differences when you came to the OMA. How did the academic community and the clinical community, well, that's not to say that university isn't clinical. But how did the academic versus the city, the town/gown thing, how was that when you first came? And how had that changed?

KRONENBERG: You know, it's been interesting. When you talk about town/gown, you really have to talk about Portland. Because as you know, the only medical school, at least in the last couple of centuries, has been here in Portland. And I've seen the best and the worst of town/gown relationships wax and wane over the years that I've worked with physicians. There were some times when there was real tension. And there have been some times when I think it's fair to say that at least in terms of their perception that the medical school faculty was seen as elitist and sort of looking down their nose at the physicians in the community. On the other hand, I think that academics tended to view the practicing physicians as more interested in the economics of medicine as opposed to advancing the science and the art.

And as sort of a neutral observer, I think probably they were both wrong. I think the interesting thing now is that clearly, if not at the physician to physician level, there is an institutional tension between the health systems, the major health systems in Portland, and OHSU. Because, as a matter of fact, the model for a medical school and a health sciences university, not just here in Portland, but throughout the country, has fundamentally changed. I mean, the clinical faculty at OHSU is in the business of practicing medicine, as well as teaching and research. And that was not the case not too many years ago. I've seen that change really remarkably. So there isn't any question that the physicians affiliated, for example, with Legacy Health Systems downtown, or Providence health systems, or Adventist, see themselves in competition with Oregon Health and Sciences University. And that competition is real. That economic competition for patients, particularly patients who have insurance, is very real. So that's been probably the biggest change I've seen over the years.

SIMEK: One of the things I want to make sure to cover while we're in this interview is two aspects of insurance, too. And we may not cover it all at this moment, but I certainly want to get into this in some depth. And those two aspects are the evolution of patient insurance, healthcare insurance. And then also the evolution of malpractice insurance. And so which one of those would you like to tackle first?

KRONENBERG: Well, actually Oregon has some unique and some interesting uniqueness in both areas. But let's try malpractice insurance first, and let's just put it in perspective. When I started with the OMA in 1969, if you belonged to the Oregon Medical Association, you got your malpractice insurance through, the OMA, which had a group program. Or you got it as a rider on your home insurance or your auto insurance. It was sort of a throwaway. And at that time, physicians who participated in the Oregon

Medical Association's endorsed program, paid four hundred dollars a year for their premium.

At about that time, things began to change in the medical/legal system, I think, not just here but throughout the country. And soon after I came here, the company that had been writing that insurance for something like forty years suddenly got out of the business. And we were left to find a new carrier. And that relationship with actually a very small, private insurance company in Hawaii lasted less than a year and they realized they were in a pit because the perception of risk they were assuming based on claims and based on severity of lawsuits began to change very rapidly.

SIMEK: Who were those first two companies (?)

KRONENBERG: Oh. Oregon Auto. Oregon Auto was the company. And then, let's see, I believe it was Hawaiian Insurance was the casualty company based in Honolulu. And then–

SIMEK: And Oregon Auto had been–

KRONENBERG: Had been there for, I think, from the '30s. And had an OMA-endorsed insurance program.

SIMEK: At one point, they were the only malpractice insurer.

KRONENBERG: Yeah. But the truth is that a lot of physicians worked with their local agent, their State Farm or whatever. When they bought auto insurance and they bought insurance for their office building and their medical building and their home and so on, that the malpractice coverage was just thrown in. It was not that big a deal. And that's obviously changed rather remarkably.

But I remember the other really significant change that was made at that time, which was 1970, those who did surgery, which in most cases was assumed to be a higher risk, suddenly were asked to pay eight hundred dollars a month in premiums, while those who didn't do surgery only had to pay the four hundred.

And then we began to see after that, after Hawaii and insurance left the market, we established the relationship which lasts until today with CNA Insurance, a very, very large international insurance company based in Chicago. In 1971, actually. Then we began to see, not just here, but across the country, the practice of rating groups of physicians by clinical specialty based on underwriting data that suggested that certain physicians and certain specialties were at higher risk than others. And so it was only fair that those that were viewed as higher risk paid higher premiums. So you began to see classification of physicians.

We had our first quote "crisis" around 1975, when we were beginning to see physicians in the high risk specialties. And an example might be obstetrics and

gynecology, or neurosurgery, which are still today at the very top of the food chain when it comes to the cost of malpractice insurance, who were paying four and five thousand dollars a year for their coverage. We won't talk yet about what the limits were, because that's the other thing that's changed so remarkably. I believe that if you bought a standard insurance policy, the coverage was for a hundred thousand dollars for any one incident, and three hundred thousand dollars for a year. And we've seen two things since then. There have been some very good periods of time, and some very bad.

But over the next thirty-five years, we've seen two things change. First of all, the limits of the insurance that you can buy, that is, how much insurance you could buy, and then the premium. It's gone kind of full circle. Because one of the things that is frustrating to physicians, particularly those in higher risk specialties is it's very difficult to get as high a limit as they would like to have to truly, to truly protect themselves and to protect their personal assets from judgments.

SIMEK: What would those limits be that they would like to have?

KRONENBERG: Well, I remember a time when an awful lot of physicians, particularly the high risk specialty, would have ten million dollars worth of coverage. You may be able to get that in the specialty market, but in general the limit of policies that you can purchase here in Oregon is five million. And when you have, when you have judgments perhaps a dozen judgments above five million, in recent history, the physician begins to wonder, what am I really buying this insurance for at all if in fact my assets, my personal assets, may be subject to these judgments.

So it continues to be a very difficult time for physicians with respect to how much the insurance costs, number one. Number two, what kind of limits they have, whether the limits really truly protect them and their personal assets. And then, finally, in many cases, whether they can find the insurance at all.

The market right now is, for a variety of reasons, seems to have stabilized. We went from 1999 to 2004, really, where we had a huge escalation in the cost of the insurance, the availability of insurance, the limits offered, also the form of the insurance where you couldn't buy insurance that protected you for something that happened in a given year forever. So-called occurrence insurance, as opposed to the kind that is generally available now is called claims made. And the coverage is good only so long as you have the insurance in place. So if something, if you're successfully sued for something that happened in 2000 today, you better have the same insurance in order to have coverage for that incident, that claim, when the claim was made.

SIMEK: What do you think changed to make the insurance of the litigious nature of delivery of medical care so different at the end of the twentieth century than it was at the beginning?

KRONENBERG: Well, I have a lot of personal theories. And that's probably the best place to begin, because there are all kinds of theories out there. But the first thing is

that by its own record, since World War Two, physicians' ability to deal with human disease and injury has increased almost exponentially year after year after year. And the system's ability to deal with what formerly were sure death if you were diagnosed to a high probability that you're going to live, is a combination of a whole lot of things. Certainly, certainly the advances that have been made in the last sixty years with pharmaceutical substances. Second of all, the new technologies that have come into place in terms of surgical instrumentation, diagnostic instrumentation, particularly in the area of the imaging. That is, we used to have X-rays. Now we have the equivalent of three-dimensional X-rays in real time that move. It's just kind of scary all those things that have happened.

And physicians, and nurses, and other healthcare professionals during that time have concomitantly become more skillful with a larger fund of knowledge to work with, to deal with these diseases. And at a certain point, I think what's happened is, the public really has an attitude that they're bulletproof because the healthcare industry has all of this equipment and all of these substances, and they can cure anything. When in fact, everybody eventually dies. And I think that we're a long time from changing that. And I'm not sure that we should mess with that, anyway. That's a personal opinion. But I think that that's the first thing. I think that people have come to expect a level of perfection and a level of satisfactory outcome for their interfaces with the healthcare system that's unrealistic. Because to some degree, that can be laid on the industry and on the professionals' shoulders. Just because they've had this incredible track record, the sky's the limit. That's one thing.

I think, at least in my lifetime, I have seen our society become more litigious generally. It isn't just the medical profession. The typical response today to what when I was a young man or even when I was a kid, would have been "Let's see if we can work this out," is, "I'm going to get a lawyer and sue you." And I don't think that that's a healthy environment, particularly to the degree that it has affected healthcare in a relatively small state, which has a history of having very volatile experience with the cost of medical malpractice insurance. Not just for physicians, but for hospitals and for other healthcare workers. At a certain point, you begin to wonder if you're reaching that point of diminishing returns. If it becomes so expensive to provide medical services, then why not go someplace else?

And one of my concerns as I contemplate my own retirement is there is ample evidence that there is actually a level and perhaps even shrinking number of practicing physicians in this state. For a variety of reasons, the malpractice climate is not the least of those. But there are a variety of reasons I'll tell you. So what, then, if this is viewed, as it is by some specialties, as a hostile place to practice, how will we attract new young physicians to this state to replace those that are obviously subject to ravages of age and retirement and being run over by buses and have to do with attrition.

I'm very concerned about Oregon's infrastructure in a number of ways, as a lifetime citizen here. One of the most dramatic, I think, is the ability or the potential for

us to have a real crash landing in terms of simply having adequate medical services available for a growing and I will also say an aging population in a very small state.

SIMEK: As the twentieth century ended, one of the big burning questions was, what about rural medicine under the malpractice conditions that existed where an OB, if an OB delivered the 101th baby, they would jump into a different category.

KRONENBERG: Right.

SIMEK: Or if a family practitioner, they would jump into a different category. And their premiums would suddenly be thirty thousand dollars a year for that one baby. The option was to send the mother forty miles to a different town where they happened to have a hospital. So describe the circumstance at the end of the twentieth century where going into the twenty-first century, many of those doctors, as you suggest, were considering not practicing certain areas, or not practicing in Oregon.

KRONENBERG: There are a couple of things. First of all, I don't claim to be an expert on the medical workforce. And I would defer in that to somebody who I think is probably the preeminent expert on the subject in the state, Karen Whittaker, who for many years has been the director of the Office of Rural Health at Oregon Health Sciences University. But I do know enough to know that based on a number of studies that have been done, including those that Karen has done, that there are two very sobering things going on in rural areas. The first thing is that the average age of the physician in that community, and take any community you want, is increasing. That's not surprising, because they may still be there, but there's no young ones coming in behind them. And of course, if you take a group and you determine their mean average age, you take all the ages and divide by the number of people.

So what that tells me is that the physicians out there are getting older. And nobody's coming in to replace them in a regular, orderly fashion. Now there are some exceptions. But generally, I think if you look at rural Oregon, you see an aging population of physicians. And not just physicians, but also nurses who perhaps, arguably are more of in a crisis mode than the medical community in this state is. And what that means is, the simple passage of time means that sooner or later, the situation will get critical. And those physicians who were at the end of their career retire. And I've seen it happen in small towns several times. If one physician retires and there are four left, that means they have to split the load now four ways instead of five ways. Pretty soon that becomes intolerable and another physician leaves the community. Then there are three. Then there are two. Then there are none.

I remember the most dramatic time, it was very early in my career where in John Day, in a matter of two years they went from six very active, very vigorous physicians to none. And you cannot live in a place like John Day–

[End Track One. Begin Track Two.]

KRONENBERG: –that is literally hundreds of miles from alternate medical care. Without, number one, a hospital, and number two, physicians to provide services. And if you take that in a more mega sense, if you have enough of those communities, those communities will die. And that's a very scary thing to me, particularly to someone who loves rural Oregon. And who grew up in what was rural Oregon and who remembers it very fondly. I'm very concerned about the future of rural Oregon as it directly relates to the availability of medical services in those small communities.

SIMEK: Was there, at the end of the century, was there a large incidence or what was the size of the incidence of physicians who were retiring young and starting alternate careers out of medicine?

KRONENBERG: That's an interesting question, and I'm not sure that there's really hard data on it. I again would defer to Karen Whittaker, who has studied this very issue. But it's my sense, anecdotal, in dealing with physicians every day, that many of them have a sense of angst about whether they want to continue doing this until they might be expected to retire. And that's one of the things that I have seen. Again, this is anecdotal and I have to talk about physicians who I know well. Which frankly, given my long association with them is literally thousands of them. I see more and more physicians retiring that I know retire earlier than I would expect. In many rural communities, it used to be that a doctor would practice until maybe they were seventy, seventy-two, seventy-five, depending on their health. Because they really loved it, they enjoyed it. And obviously they felt of use to their community. I'm not seeing that anymore. The physician who works into his or her late sixties or seventies in rural Oregon is becoming pretty unusual.

SIMEK: This is a good place, I think, to ask about the physicians themselves. Because it's not only the length of time, it seems, they're willing to practice. It seems like the very nature of being a physician is changing, of your expectations of workday and dedication and family life and so forth. The whole idea of a physician from the turn of the nineteenth century to the turn of the twentieth century made a dramatic change. Although over a number of years, but it seems like that change is accelerating. How has the nature of being a physician changed?

KRONENBERG: I can really, I think, put that in parentheses with my won experience with physicians. 1969, when I came to work for the OMA, first of all, almost every physician that I dealt with was a man. And of course I was relatively young then, and they all seemed quite old. Now they all seem quite young, which shouldn't surprise either one of us.

But it was kind of an interesting experience. When I came to work for the OMA, there were sixty standing committees. And I think I provided staff service for probably twenty of them. I went to a meeting every single night: Monday, Tuesday, Wednesday, Thursday, Friday, week after week after week. And not much of a break in the summertime. And the meetings would start at seven o'clock. We'd have dinner and the meeting might be over at eleven or twelve o'clock at night. It was really exhausting. And

you'd have twenty or thirty doctors on this committee. And those doctors would go home, go to bed, get up the next morning and go to the hospital and do surgery or round on their patients, attend some kind of meeting associated with the hospital, go to work, see their patients in the office until five or six. And then come back to another medical meeting in the evening. And how in the, how they could sustain that, these were not the outliers. This was the typical physician. And this was how they lived. And at the time I wondered, do they have a personal life? What do their wives and kids think about this?

Well, it's interesting to talk to some of those wives and kids now. They're grown up or, in the case of the wives, old and have been friends of mine for years. They didn't think very much of it. But that's the way it was. That's not true today. It's changed remarkably. It is very, very difficult for us to get physicians to serve on committees at all. I don't suppose there's more than, there's probably less than ten standing active committees in the OMA. It's very difficult to get them to come to a meeting. We become more and more reliant on telecommunication. As you know, we have the ability to video communicate in real time. And that's largely in response to demand from physicians, since we are a statewide organization. To provide them with an alternative to sitting on their behinds for the five hours in their cars to get here, and then driving back and going to work the next morning if they happen to come from Baker City.

And younger physicians now, about half of whom are female, younger physicians just will not do that. They won't spend the time at the meetings. They want to go to work, take good care of their patients, go home, spend time with their families. From my standpoint, that's a little frustrating, since I work for a volunteer organization that's life blood is the volunteerism of our own members. But on the other hand I think are these young physicians who comprise the majority of our membership now, better, healthier people than they were thirty, forty years ago? I think probably they are.

So it's not bad or good, I suppose, on either side. It's just different. Physicians are different people than they were forty years ago.

SIMEK: How does that work into the change in the health insurance business? Especially the change that we've seen over the past thirty years. But I'm sure before that as well.

KRONENBERG: I think that probably the biggest single frustration that the typical physician has is their sense of frustration with how healthcare is paid for. Be it Medicare, be it Medicaid, be it other government programs such as Tricare and Champus, be it private insurance, workers' compensation. They all entail huge bureaucracies. They all entail the completion of all kinds of forms and in many cases the physician has to have permission of the insurance company to do a procedure or a diagnostic test that he or she in their own clinical judgment feels is appropriate. So I think if you talk to the typical practicing physician, he or she will tell you that less and less time is spent on taking care of patients. And more and more time is spent on essentially the bureaucratic paperwork administrative side of medicine. That must be incredibly frustrating to people who got all that education so that they could help people and then see themselves torn between being

able to actually spend quality time with their patients and doing all the stuff that's necessary so that the patient or the physician or both actually get paid for the services that have been provided.

And the single greatest complaint that we receive from the public about physicians on the telephone and letters and so on, or some variation is, the doctor doesn't spend enough time with me, the doctor doesn't listen to me, the doctor ignores my concerns. And as far as I'm concerned, personally, that's almost totally, totally driven by the pressures that are placed on physicians and on patients to fill out papers and to satisfy the needs of the insurer rather than the needs of the insured or the person who's actually providing the service. Other than that, I don't have strong feelings about it.

SIMEK: In the '80s, one of the things that I saw in the OMA and OMA physicians, OMA members that I saw starting to generate, at first, a quiet panic, was the advent of managed care.

KRONENBERG: Yes.

SIMEK: How did that come about, and what was the reasoning behind it? And where is it today? How did it start to work itself out?

KRONENBERG: It's very interesting, because Oregon is kind of a microcosm, and particularly Portland, a microcosm for what's happened all over the country. Perhaps in Oregon and particularly in Portland to the extreme, we have had quote "managed care" since World War Two through the Kaiser Permanente health system. And that, as you know, was originally a system that was designed to provide healthcare for badly needed workers and their families to keep them on the job and healthy and working here in Portland in the shipyards.

And after the war, they continued to provide a health maintenance kind of insurance approach, using a closed panel of physicians. That is, physicians that contracted with them exclusively to provide insurance to their subscribers. And they also had their own hospital. So it was kind of a close system.

And I remember when I started back in the late '60s, there was a definite, well, to say the least, a tension between physicians at the Permanente clinic and physicians in the larger community. They did not like each other. As a matter of fact, the physicians in quote "private practice" saw the Permanente physicians as being inferior. And in some extremes even communistic because they didn't get paid by the unit of services they provided. They worked for a salary for the Permanente clinic to provide care to Kaiser Permanente patients.

And a funny thing happened. At a certain point, the pariah became the model in this town and in this state. And it had to do with what we're still seeing. And that was an increasing dissatisfaction on the part of the employer as to how much they had to pay for health insurance. And insurance companies responded to demands for stability or even

lowering of the cost of health insurance premiums for their employees and the employees' dependents by coming up with a more efficient model.

So the insurance companies, the quote "private" insurance companies here in Portland and a couple in Eugene and so on thought well, what will we do? And they looked across the river and they saw Kaiser. And they thought we'll do Kaiser.

And so suddenly, all of the insurance companies essentially stole the Kaiser model. They said, okay, we're going to contract with you physicians and you hospitals a set rate per month. That's all you get. If you don't spend it all, why then you have money to take home and feed your kids. If you spend more, that's tough. That's how we're going to play the game.

And so suddenly, the whole system in Portland and then it sort of spread out across the Willamette River, or across the Columbia River into Clark County and Vancouver and on up toward Seattle, Seattle moved down this way, it went down the I-5 all the way to Medford. Suddenly, most privately insured people were insured under some variation of an HMO or other provider risk model. So the physician in the hospital actually was being paid based on their efficiency. In other words, how little money they could spend. And that's not quite how the Kaiser Permanente model worked, but that's how it was played out in the rest of the community.

It was an incredibly difficult time for many physicians and some hospitals. We had, one of the responses was that physicians in a state that historically had practiced in small groups or solo practice began to group up. And all of a sudden where a very large group of physicians practicing together might be fifteen, we had groups of a hundred, a hundred and fifty, three hundred, five hundred, that kept grouping together to get bigger so they'd have more clout with the insurance companies in negotiating their rates.

And unfortunately, the very biggest of those actually became so big and so preoccupied, I think, with getting big and having clout, that it eventually fell on its own weight and went bankrupt. Very disturbing thing. Very similar thing happened to a huge clinic in Medford in the southern part of the state.

So the response on the part of the healthcare community and the insurance industry was, this is the way it's going to be. But the interesting thing is, the people weren't buying it. The patients weren't buying it. Maybe it did make healthcare more efficient, but people didn't like it. They didn't like it. And so we've seen a complete back out of that kind of capitation model to the practice of insurance companies contracting with a group of physicians on some kind of discounted fee for service basis. So-called "preferred provider" groups. Either with individual contracts or with groups of physicians such as an independent practice association. Or some of the large, free standing groups that are still around in the state. So the market's very different. And it's kind of come full circle.

Now as far as I can tell, the original HMO model when all this happened, Kaiser Permanente continues to do quite well. But the people that I know there will tell you this

was a very difficult time for them, and a time that they had to make some basic adjustments in how they did business because of the competition for price that was squeezed out of the market by all of the other insurance mechanisms basically emulating what Kaiser was doing. So it was a real shake out for the medical community and the healthcare community in Oregon. And it's changed very fundamentally. And I don't think it will ever be quite the same.

SIMEK: We'll take a pause here to change the tapes, but when we come back, we'll want to look at the–

[End Track Two. Begin Track Three.]

SIMEK: Okay. We're continuing the interview with Jim Kronenberg, April 18, 2006, at the Oregon Medical Association in Portland. One of several interviews conducted by the Oregon Medical History Project on a grant from the Oregon Medical Education Foundation, the Oregon Health and Science University. The interviewer is Matt Simek.

We're going to pick up on tape number two, which this is, where we left off on tape number one. We were talking about managed care and where that was going and the results in the community. One of the things that it seemed to me was that in my business, in the media business, one of the things that happened was you have all these glorified views of what the medical community is, and more and more of them all the time. He started out with Dr. Welby and Dr. Kildare, and so he got into the surgery, and he got into the home life of what a wonderful– and no matter what problem, and you see that now with House and with similar, and even reality shows, no matter what problem came up, whether it was snakebite or auto accident or serious disease, doctors found a cure, and that was it. Very, very little, death was vanished. And that, on the one hand, the view in the public's eye, compared to the view of the doctor's eye, that they were being asked to do more and more for less and less, with an administrative load piled on top of it, those two views were quite at some odds with each other. Did the public ever find out about the other? And how did that happen?

KRONENBERG: No, I don't think the public has figured it out. And obviously I have a point of view about that, given my affiliation with the healthcare community and with physicians, specifically. But it continues to amaze me the disconnect between the expectation of the public and the reality of the provision of medical services in this country, in this community, in this state. That there's a total disconnect. I mean, it just isn't like that. You know, and the critics, the critics, the pundits at every level criticize the system because it's so expensive. It is expensive, particularly in terms of its portion of the gross national product. This is the most expensive per capita healthcare system in the world. I would take the position that it's probably also the best, and you get what you pay for.

But the difference is that critics of the healthcare industry tend to blame the wrong people. We are a society that's fat, that's out of shape, that permits anybody with fifty

dollars to carry a gun, that drinks too much, that eats poorly, and that takes terrible, destructive drugs for recreational purposes. How, I ask you, is that the fault of the friendly neighborhood family physician? So the medical profession is, and the healthcare industry generally, is accused of somehow doing something wrong because the life expectancy of both men and women in this country is much lower than it is in a number of other first world countries because we continue to have, relatively speaking, high infant mortality rate, all of these things. But you know, the question is, when a pregnant woman is taking crack while she's getting ready to bear a child, how is that the responsibility of the physician and the nurse and the other people who deliver that baby?

You know, it's criminal. We expect too much. But we, as a society, are not willing to do the things that would improve our health generally. If you want to decrease the cost of care in this country, take care of yourself. Myself included. You, too. And we do a damn poor job of that.

SIMEK: I've heard it said that the health of the citizens of Oregon, or the health of Americans in general, is improving, but it's an artificial health that's improving. It's health because of drugs and procedures and surgeries, not a fundamental health improvement, which is deteriorating because of weight and diabetes and all of the things that go with excess.

KRONENBERG: Right. You know, one of the most interesting things to me being something of an amateur historian, having an interest in medicine and healthcare, the single most seminal issue in terms of improving the health status of people in the United States and increasing their longevity was clean water. Clean water. That's what did it. The second thing was improved diet.

Now one can make a case, depending on his or her political point of view is that we're poisoning water, and that we've gone too far with improving our diet, which is why we're all fat. So I guess what goes around comes around eventually. Because if you look at a benchmark time when health status in the United States improved, at least here in Oregon, it was the very latter part of the nineteenth century and the first part of the twentieth century when the state and the municipalities, courtesy of physicians I will emphasize, began to ensure that people had clean water to drink. And that made all the difference in the world. Not just here, but all over. If you look at places that today are truly deathtraps, that have very, very low length of life spans and very high infant mortality, it almost always has to do with two things: water and nutrition.

So there's some real lessons to be learned here. Are there excesses in the healthcare industry? Do some doctors make too much? Are hospitals moneygrubbers? Are the drug companies bad corporate guys because they charge so much for their product? In some cases, yes. But ultimately, the main reason, in my opinion, that our health system in the state or in this country is not as good as it could be, is our own damn fault.

SIMEK: We have met the enemy and he is us.

KRONENBERG: That's correct.

SIMEK: I do want to pursue the historical aspects. But before we go there, I'd like to finish off the insurance thing and just ask you about this innovative Oregon plan developed by a governor who is himself a physician.

KRONENBERG: That's right.

SIMEK: And how that came to be and how that relates to other forms of, or what its provisions are and how it relates to other forms of insurance.

KRONENBERG: I think that the Oregon Health Plan, at least from my jaded point of view, was the single most innovative attempt to reform the healthcare system that we've seen in this country to date. Perhaps what Massachusetts is doing as we speak will be even better. But the Oregon Health Plan as it was conceived and originally operated, truly, truly, was an innovation that could have made all the difference in the world. It failed for a variety of reasons.

SIMEK: What did it do?

KRONENBERG: Okay. There are several things. First of all, there was sort of a critical mass of public and private commitment to the idea that there ought to be a system that provided healthcare insurance, not healthcare – that's a very important distinction – healthcare insurance to everybody in Oregon. And that was the basic idea. It had really three legs. The first one was that those people who qualify for traditional Medicaid coverage, that is, the federal program that provides funds to take care of poorer people, both categorically because of illness or disability, but also a certain segment of the chronically poor population. If you augmented that and included some of the working poor, people who work part time, people who did casual labor and things like that, you put them all under the Medicaid program. And then secondly you required all private employers to provide a basic healthcare benefit as good as the Medicaid program. And then finally for that small but very important group of people who had medical conditions that were uninsurable, you had a pool where they would be able to obtain health insurance coverage on a rotating basis where the various insurance companies that did business in Oregon would have to take a certain percentage of those people that had conditions that were medically uninsurable.

And the basic idea with the Oregon Health Plan part is the public part was essentially the thinking of Governor Kitzhaber even before he was governor, which, very early on, I think physicians and their organizations here in Oregon bought off on was that we cannot afford Cadillac health insurance coverage for everyone. What we need to do is to provide them with basic health insurance. And we should put our money in the place that will do the most good. And that's where the idea of essentially pairing diagnoses with procedures or services and then ranking them and funding those that had the highest degree of success in solving the problem, then going on down to things that were less and

less important in terms of truly making a difference in whether the patient number one, would live. And number two, the quality of life that they would have.

So not surprisingly, the first thing on the list is that if you have appendicitis, the treatment of choice is an appendectomy. And the alternative, if you don't have a treatment, you die. Or if you don't die, why, you have a burst appendix and you have an extraordinarily expensive surgery and recovery while you recover from the effects of peritonitis. Pretty slick idea. And then on down, things that would do the most good. Things that by and large are preventive in nature. That is, services and procedures that are designed primarily to avert the worst outcome down the line. A good example would be giving a high priority to providing number one, adequate prenatal care to pregnant women. And number two, providing well baby care post partum so that perfectly normal, well babies would stay that way until they got into grade school. That was basically the idea.

So you had this ranking system. And then you took the amount of public money that was available. And you said how far down the line can we fund. And if it's below this line, we won't provide services. Now that translated to the private sector. But you have to offer an insurance program that covers these services down to this line. Then you're in compliance with the law.

And then the final part was the offering of insurance to those who were, by definition, uninsurable, who had needs but simply no one, on one in their right mind would provide insurance with them unless they were compelled to.

And the first wheel that fell off was actually following through with the employer mandate. So you continued to have a number of people in the state who were working all right, and who were paying taxes and everything else. But for whatever reason, their employers chose not to buy health insurance. That mandate was never enforced.

The second wheel that fell off was I think even though at its height the Oregon Health Plan was covering an enormous amount of people, for a while we had the lowest rate of uninsured folks in the entire United States. Now we're near the top, which, I think, is very telling. What happened was, Oregon had another of its famous and prolonged recessions. And the legislature, looking at other priorities, said we can't continue to put the same amount of money in the Oregon Health Plan. And they went back to what they'd always done with the Medicaid program.

If there's not enough money to go around, there are two things you can do. Either you can increase eligibility requirements, thereby shaving some people off the bottom that you don't have to be responsible for. Or you can reduce, or at least hold the line on the cost associated with providing reimbursement for physicians, for drugs, for hospitals, for all that.

And of course, the legislature did both. So all of a sudden you have an increasing, a huge, burgeoning number of uninsured folks in the state. Most of whom, by the way,

were working at jobs, but no health insurance. So we've gotten to the point now where I believe that the uninsured rate here in Oregon is somewhere around 60 or 70 percent, one of the highest in the country. And we have this huge population of people with no insurance. And, in most cases, no means to provide for healthcare. When it's a choice of feeding your kids and paying the rent or taking your kid with an earache to the doctor, in most cases you're going to pay the rent and feed the kids. I mean, that's just the way life is. Until, ultimately, your child has a full blown, life threatening ear infection, and you take the child to be seen in the emergency room.

Absolutely though, the most expensive place that you can provide medical care in this country next to the operating room, which is where many of those people end up, or in intensive care. But you know, using emergency departments – and this goes on all over the state – using emergency departments as essentially the care of last resort. If you get desperate enough, you'll go to the emergency department, and you'll be seen. Because the law says you have to, you have to be seen. But it does nothing for follow-up, nothing for routine, ongoing care. Nothing for well baby care, prenatal care, immunizations, all that basic stuff that can be demonstrated actually improves the quality of life and saves life.

So, you know, unfortunately, the Oregon Health Plan was a wonderful idea. And I think if you ask physicians, even today, whether they, here in Oregon, given their experience with the Oregon Health Plan, whether they still buy into the basic idea, prioritizing healthcare so that the most effective services are available in those with marginal or no value or not, you'll find overwhelming support. And you'll find support to this day, despite the pathetic support that's gone to the Oregon Health Plan. If simply we could cover our costs by seeing these people, which is what we were promised originally. We won't make any money on these patients, but we'll break even, and that seems fair to us as a medical community or as a hospital. You'll find great support to it for this day.

?: [inaudible]

SIMEK: Are we picking it up a lot?

?: Not that much.

SIMEK: Okay. Okay. All right. Also in terms of major programs, the one other that comes to my mind is the advent of the trauma system in Oregon. Describe that a little bit, and what kind of a change that's made in healthcare in the twentieth century.

KRONENBERG: I think that again, to me, at least, as a lay person who has more than casual knowledge of it, I think that this has been a critical advance, not just in Oregon but all over the country. I think it's particularly important in a state like Oregon, which a number of the states west of the Mississippi are. Lots of land, not very many people. There's a principle in trauma care that we've all heard on television: the golden hour. And the idea is, if you're in a terrible automobile accident or you've been shot or you've fallen or whatever, the thing that will kill you is not always the underlying injury,

but rather the shock that your body sustains because of the injury. The pain and the trauma involved.

So the idea has been that if you can get these people to a place where you have trauma people trained in dealing with trauma, particularly surgeons and emergency physicians, that the likelihood of their surviving if they're gotten there quick enough are infinitely improved. And I think all the data clearly demonstrates that that's exactly what happens. And clearly you can't have a level one trauma center where you have not only surgeons but anesthesiologists, emergency physicians, orthopedists, neurosurgeons, in some cases cardiologists and other medical specialties, plus all the highly skilled nursing personnel in every small town.

So the idea is that you have different levels of trauma service. And in Oregon, there are two places where you have 24/7/365 access to level one trauma care. So you have all those specialists just sitting there waiting for you. And that's fundamentally what they do. They're on the premises of that particular hospital 24/7. And they're available. And they, in both cases, have enough backup so the number one trauma surgeon has a backup. And there's a backup behind him. And they move into place as the demands on the trauma system expand. So, for example, on Saturday night, there are probably more instances of trauma in Oregon than there are any other time. So the fact is, if you're the number three trauma surgeon on call for this time, it's pretty likely that before the night is over, you're going to end up physically in the ready room to do the trauma. So that's level one, and that's at Emmanuel, Legacy Emmanuel Hospital, and then Oregon Health and Sciences University. So they along with trauma, level one trauma services in surrounding states, provide services based on, level one trauma services, based on geographic area.

And there are level twos which have a decreased requirement for having all of those physicians physically there. They have to be so close, I think you have to have a surgeon there. But you don't have to have a neurosurgeon, but the neurosurgeon's, got to be within twenty minutes. And so on. Same with anesthesia and the like, down to level three.

And then the state is, like it is in every other state, it's divided into districts. So that, for example, if there's a terrible traffic accident, let's say, between Roseburg and Eugene, with multiple people involved, depending on triage, that is the assessment in the field of how badly they're hurt, some will be flown to, for example, Emmanuel, usually by helicopter, another one to OHSU, the less severely injured patients will go to the level two trauma services in Medford and Eugene, maybe even over to Bend, which is the other level two. So it's a system that depends on speed and then having resources both human and in terms of equipment that you need to save someone's life who's suffered a traumatic accident. That's basically how it works.

SIMEK: And it's gone well.

KRONENBERG: It's done very well in this state. I will say in some cases despite some very, you know, some very difficult issues that have to do with other issues we've discussed, such as the cost of malpractice insurance, the availability of the insurance, and the sufficiency of the workforce both now and in the future.

For example, there were periods in 2004 and 2005 when the trauma service in Medford which, remember, serves a huge geographic area, all the way into Nevada, Northern California, to the Oregon Coast. This huge like hundreds of thousands of square miles. That's where you go if you have trauma down there. And basically they went to a system where the trauma system was shut down at that hospital on Thursdays and every other weekend. And that's because they didn't have sufficient neurosurgeons in the community to physically be able to staff on a 24/7 basis the facility. Not because they didn't want to, because there weren't enough of them. They physically, in terms of their ability to stay awake and sustain themselves, there were not a critical mass of neurosurgeons in that community for a while. It was terrible. It was a terrible experience.

SIMEK: How much of that was a result of malpractice (?)

KRONENBERG: I think in the case of Medford, probably 90 percent. You'd have neurosurgeons there. And they'd say, first of all, there aren't enough of us. And second of all, I'd take trauma call. And essentially that's a twenty-four hour per time commitment. And then the next night I'm number two. And when am I supposed to take care of my own patients? And particularly when I don't receive, in many cases, any compensation at all for taking care of people who've been severely injured and have to go into the trauma system. I mean, I can't really afford to continue to do this.

Now neurosurgeons have a way like obstetricians, gynecologists, to avoid a huge amount of the risk associated with their very specialized practice. And what a lot of obstetrician/gynecologists have done in response to the increasing cost of malpractice insurance is simply say, I just won't deliver babies anymore. Never mind I spent four years of training learning how, I just won't do it anymore. I'll just practice gynecological surgery and my premiums will decrease by 50 percent.

Neurosurgeons can do the same thing. The say, I'm not going to do closed head trauma. I'm not going to operate on people's brain. Well, the typical doctor says, "Neurosurgeon, not going to work on your brain? That makes no sense." But nevertheless, they, too, can cut the cost of malpractice insurance in half by not doing brain surgery. Which is sort of the fundamental reason you have a neurosurgeon in a trauma situation. Because it's the closed head trauma that, after dealing with a traumatic experience, is the thing that hits many people. Particularly in automobile accidents.

SIMEK: One of the reasons for the high cost of the malpractice premiums was non economic damages. And there have been several moves to limit economic damages in the state, which doesn't really affect the patient. The patient will always be taken care of. It's the non economic or punitive damages, so-called punitive damages, which were attempted to be limited. And once again, it seems like the public doesn't draw, and

they've been all defeated. It seems like the public doesn't draw the link between limiting non economic damages and no longer having an OB/GYN in Eastern Oregon because they can't afford the insurance premium for delivering babies. Is that ever going to be linked, do you think, in the public's eye?

KRONENBERG: I think in terms of the larger picture of assuring and insuring an adequate medical workforce for Oregon long term, ultimately a solution to this, to this malpractice problem has to come about, one way or another. We have experience with a cap on non economic damages. Which the legislature passed in 1987 and the Supreme Court finally got around to ruling was unconstitutional in 1991. During that period of time, that twelve years, the cost of malpractice insurance, in most cases, particularly in high risk categories such as obstetrics and gynecology, decreased as much as 70 percent with no apparent, with no apparent damage on anybody except the fact that, first of all, the insurance was affordable. So it encouraged people who had the specialty skills and education and training to do what they do.

And second of all, there were lots of options. I mean, during that period, I think at one point there were like thirteen or fourteen different insurance companies that would offer physicians malpractice insurance policies. Now for all intents and purposes, we have two. I ask you, just like any other thing, as a consumer, would you rather be able to shop among, for example, thirteen suppliers of audiovisual equipment, or two?

SIMEK: Let's shift gears a little bit.

KRONENBERG: Okay. [laughs]

SIMEK: Yeah, this is intense and I'm sure it's draining in a way. So let's go to something a bit more fun.

KRONENBERG: Well I'm going to eat when I'm done, and you're not.

SIMEK: Oh, okay. [laughter] Let's go to something a little more fun at the moment. While we were talking before the interview, you gave a wonderful summary of the evolution of, first of all, of medicine in the early days of the state. And then the evolution of the organization of medical care in the state in the 1800s and the early 1900s. And if you would repeat that for the camera, that would be wonderful.

KRONENBERG: Okay. I think that the place to start, mainly because there's a local hook that some people someday may be interested in following up on. Probably the first event in the evolution of healthcare here in Oregon can be associated with the Lewis and Clark expedition. And the fact is that despite that arduous trip and the travail that they went through, the fact is that only one person died on that expedition. And the interesting thing about that is an orthopedist here in Oregon named A.G. Chuinard had a lifelong interest in the Lewis and Clark expedition. And at one point, after he had retired, wrote a book called *Only One Man Died.* And it was an attempt to try to sort of chronicle based on the journals and all the other data that was available the health aspects and the

medical aspects of that remarkable expedition to the West Coast from St. Louis. At any rate, it's a book that people are really into this ought to try to find. It's pretty hard to find, but it's a fascinating book. The prose is a little turgid, but it's good information. And it really is an account of a remarkable thing.

The next thing I think of is probably Dr. John McLoughlin, who was a trained physician and apparently quite a good one for his day, but who mainly was the factor, that is, the general manager of the Hudson Bay Company, from England that had a huge fur trading and trapping operation that was based in Vancouver, Washington. And besides offering respite for explorers and trappers and the like, why, he also provided medical care. After the borders began to evolve out west here, and the Hudson Bay Company went away, back to Canada, Dr. McLoughlin settled in Oregon City and practiced medicine there until his death.

We have here in the OMA building a painting of him. He was probably the most forbidding man that I've ever seen. I swear, in that painting, his eyes do follow you. But at any rate, as it turns out, he was, for his time, a really remarkable physician, and really one of the founders, without question, of Oregon and of the whole Northwest.

SIMEK: Was he not the first governor of Oregon Territory?

KRONENBERG: I think you're right. I won't go there, I don't think so, but maybe you're right.

And then I think that the next thing that really sticks in my mind was, particularly after the Civil War, there of course had been the Oregon Trail. A lot of settlers came here. But after the Civil War, there was an influx, apparently, of a number of businesspeople and professionals, including physicians. And we began to get arguably speaking enough physicians to go around in Oregon and in Washington and in Idaho. And one of the things that happened that I'm particularly interested in was the founding of the Oregon Medical Association, which was actually in 1874. And at that time, when it was founded, it was the Oregon State Medical Society. And it was a group of physicians who had actually been to recognize medical schools, generally on the East Coast or in Europe, who were somewhat put upon by the fact that there were an awful lot of people who called themselves physicians who had no training and no particular skill.

So they banded together to form the Oregon State Medical Society to do two things, two important things. The first was to form a state licensing authority which would review and pass on the bona fide credentials of those holding themselves out to be physicians. So the public had some idea that this physician actually had the training to deal with disease and injury.

The second thing that they did that I think was in some ways even more seminal was, their second reason for being was to cause a state health authority, the Oregon Board of Health, to be created. And its primary and originally its sole responsibility was to begin to insure that everyone in Oregon had a source of potable water. Because back then

the big killer was cholera, which is a waterborne disease. So that was the beginning of the sanitary system here in Oregon. And I think if you talk to most medical historians they would say there are two things that have probably had more to do with the improvement of the health status of the United States or, for that matter, Europe, and the longevity, the average longevity of the people who are born. The first is clean water to drink. And the second (ball?) is an adequate diet. And I don't think that the Oregon State Medical Society can take any great credit for the diet part. I think that had to do more with the fact that this was then a country, and continues to be a country that can really produce food in great quantities. But the issue of clean water and adequate sewer and sanitary facilities, in this state, at least, is largely to the credit of the medical community.

Then the other thing that I think is interesting, and I don't know if you want to go here at this point, is how medical education has developed in the United States, or in Oregon. Originally there was a medical school in Willamette, at Willamette University in Salem. And not too soon after, why one was started here in Portland.

SIMEK: Was that not the first medical school west of the Mississippi?

KRONENBERG: I believe that's true. The one at Willamette, yes. And one thing led to another, and the one here closed for a while but it opened. And eventually the two merged and they moved to Portland. And they eventually they were located originally in Northwest Portland. And then they were given a land grant on Marquam Hill, which is where Oregon Health and Sciences University continues to be. And that, to my knowledge, is the only medical school that we've ever had has been really the combining of those two medical schools into one.

SIMEK: Do you know about when that land grant was?

KRONENBERG: I think that it was before the First World War. I'm a little shaky on the exact dates. But I think the move up on the hill was before the First World War. So sometime in the teens, probably. I may be wrong about that. And, of course, as we know, like Topsy, it's certainly grown over the years. And now it has a school of dentistry and a school of nursing, and several other health-oriented professional schools in addition to the medical school. And I'm told it's the largest employer in Portland, among other things. And so it's undergone a real evolution over, relatively speaking, a short period of time when you think of the medical schools, for example, of Columbia or Harvard or Yale. They've been around since almost revolutionary times. It's come a long way, baby.

So it's interesting to sort of put that in perspective, because I think what's interesting to me is you had the formation of a state medical society at about the same time that a formal medical education system came into play and began to develop. And what's very important about that is that, for many years, as a matter of fact, well into the '40s and '50s, even when I started the OMA, a huge amount of the teaching of medical students and of resident physicians, was not done by medical school professors but by physicians practicing in the community. And to a great degree, you know, that's still true.

Particularly with resident physicians and physicians in training. There are residents who rotate through St. Vincent's, Providence St. Vincent's, Providence Portland Medical Center, and through the Legacy health system hospitals. And there are also residency programs in various specialties at those hospitals. And although they're paid professional physicians who are responsible for their education, the quote "attendings," that is the people on the medical staff, the physicians on the medical staff, still do a huge amount of the teaching and actually the tutelage of those students. So it's a nice combination.

But I remember when I started with the OMA, I was struck by the number of physicians from really, relatively speaking, far away, like Medford and Grant's Pass and Pendleton, who were on the clinical faculty at Oregon Health and Sciences University, University of Oregon Medical School, as it was called then, and who regularly drove to Portland to participate in the teaching of students and residents. And you still have, I can still think of at least one physician from Medford who regularly comes up and participates in teaching at the medical school.

So the Oregon Medical Association and its predecessor, the Oregon State Medical Society, has been sort of involved in, over the years, in trying to improve the standards of quality of physicians who practice here, number one. Number two, to improve the public health through basic public infrastructure. And then number there, in providing a system which gives, first of all Oregon students the opportunity for an education as a physician or a nurse or a dentist.

[End Track Three. Begin Track Four.]

KRONENBERG: But also gives us first shot at keeping students here after they complete their education.

SIMEK: One of our interviewees was talking about the buckboard physician and the little black bag. And he was saying the little black bag started off very small because all you had was some sulfa and some this and that, a stethoscope, and that's about it.

KRONENBERG: That's right.

SIMEK: And then the bag started growing as more and more drugs were added and so forth, and cardiac cocktail, as one would put it.

KRONENBERG: Yeah.

SIMEK: And then got to the point where they couldn't carry everything. So the bag started shrinking again because they would have just the essentials, knowing that they had to go somewhere else for the drugs, and now the bag has disappeared altogether.

KRONENBERG: That's absolutely right.

SIMEK: They'll have maybe a stethoscope in their pocket, and that's about it.

KRONENBERG: That's absolutely right. You know, the interesting thing is one of the things that I remember most acutely in the thirty-seven years I've been here is that it was rare to see a physician in this building, or in our original headquarters up above Multnomah Stadium, Civic Stadium, excuse me, that didn't show up from work with a stethoscope either around his neck or over his shoulder or in his pocket. I very rarely see them anymore. And I wonder why that is, because they're all still using them. That would be an interesting thing to explore sometime with a senior physician. Where have all the stethoscopes gone?

SIMEK: Well, okay. You've brought us up now to about the turn of the nineteenth century, about the turn of the twentieth century. And now we're approaching World War One. And how did things change? I remember, I think it was Harold Osterud, saying that the early public health officers were issued hand guns because when they did a quarantine, by gosh, they meant it.

KRONENBERG: Yeah. Right.

SIMEK: So in the early part of the century, the practice of medicine was now coming into its own. And official recognition, physicians were organizing into a community to give official education and public health. And then World War One.

KRONENBERG: Right.

SIMEK: And so how did all of the, in the teens, how did we change?

KRONENBERG: Well, the first thing, which is not unique to Oregon, but the first thing that happened with World War One is a whole boatload of physicians became soldiers and went away for a period of time. Either to Europe or to various bases, training bases, and military installations here in the United States. I think that's the first thing. I mean, obviously I wasn't there, so I don't know that much about it. But I know that anytime there's a war, there tends to be at least a quantitative downward fluctuation in the available number of physicians and nurses and other healthcare providers in each community in the country. So that's the first thing.

But the thing that, I have a particular interest in this, first of all, because I actually recall the recollections of my grandmother, who was a licensed practical nurse and of an age that she was practicing during World War Two. And also, I've read a lot about it because I think particularly in view of the public's increasing fascination with avian flu, we may need to learn some lessons of the past. And that was the huge impact of the influenza epidemic. Actually, it was a pandemic, all over the world, that struck during World War Two, or World War One. And its effect.

And one of the interesting stories that I remember was that as Dr. Osterud mentioned, there were, one of the major things that public health officers did was quarantine people. Well, influenza was so pervasive that you couldn't quarantine people.

And essentially, the way that the public health system and the medical community dealt with it is that they soon ran out of hospital beds for these people. And so they began to institutionalize these patients to be able to concentrate their resources in terms of nursing and in terms of medical care. Because the truth was, at the time, there wasn't much that healthcare could do for someone with that virulent form of influenza. They would put them in large public buildings, in essence to be able to concentrate those physicians and nurses who were still standing. Because so many of them had succumbed to the disease. But they could sort of make it more efficient.

For example, my grandmother told me when I was a child about spending almost six months on pretty much constant duty, except when she was sleeping and eating, at the downtown Portland auditorium, where there were some seven or eight hundred changing all the time as some died or some got better and left, influential patients where there's no place else to put them. Because the hospitals were full and the sanatoriums were full. And they needed places where they could, where the health establishment could concentrate its resources. And that must have been a remarkable time to practice medicine. Because like a lot of other things that have happened in the twentieth century, there wasn't anything physicians could do for these people. Or very little.

And one of the most remarkable things about the rest of that century is all of those diseases where essentially there was nothing I could do, which explains the small black bag. It's been eradicated. It's no longer an issue. If you think about it, even though some Third World countries, there are still outbreaks of polio. For all intents and purposes, polio has been gone in this country for twenty-five years. And it began to be eradicated in the early '50s.

And I'm getting ahead of myself, I realize that. If you look back on cholera, scarlet fever, whooping cough, a little bit more mundane thing, unless you've had it, mumps. Polio. All of these diseases that essentially have disappeared. Largely because of immunization. But to some degree, because the physicians and other healthcare workers have become wiser, become smarter about how to identify those patients, how to case find, how to do vectoring so that they can isolate the people who've been effective and so on, and kill off the disease before it becomes more widespread. And you know, that's not very technological stuff, but it's real fundamental. Public health people in the medical community have been very smart about over the years eradicating or controlling what could have been pandemics by doing good infection control, number one. And number two, by being able to vector possible people that, someone who is ill has been exposed to. So that those people can be isolated and sort of keep a handle on it.

SIMEK: Along that same line, influenza, then tuberculosis.

KRONENBERG: That's right. TB, I remember very well from my childhood, driving by a huge tuberculosis sanatorium on the way from Gresham to downtown Portland for our monthly shopping trip downtown. I mean, it was a huge building. It just went on and on and on. And it was full of people who had tuberculosis. For which very little could be done, from a practical standpoint.

By that time, of course, there was some role for pharmaceuticals, particularly the penicillins and the like. But in general, if you had penicillin, if you had tuberculosis, you got over it or you didn't. And now, it's ironic, but the powerful, powerful (psyfilus foruns?) and derivatives of penicillin that have been developed over the years since the Second World War, have virtually eradicated it. The problem is that people who have it, could be me, could be you, are so dumb they don't have enough sense to take the whole dose. And so if they are infected with TB, there's a tendency to not take an adequate amount of what will get rid of it permanently. And all you've done is just strengthen the potential of that bug who mutates and gets used to the thing, gets used to the drug, instead of killing it. Until eventually we're going to have a strain of absolutely unimmunilizable, I guess it would be, strain of tuberculosis. Of something that just can't be cured. And it's an interesting thing to think about. But you know, the incidence of tuberculosis in the United States here in Oregon is increasing rather substantially. And yet it was a disease that twenty years ago, most doctors would say oh, that's gone.

SIMEK: I remember the big vans, the X-ray vans–

KRONENBERG: Yeah, I do, too.

SIMEK: –checking for TB. And then there was the little skin test, which was much better. So in the '50s, the (word?) was polio.

KRONENBERG: That's an interesting time, because I grew up then. And I remember at my little grade school out in the country, the public health nurse, then they were called school nurses, would visit once a year all of the grade schools in Clackamas County, came out with her little vials of Salk vaccine and immunized every kid in the school. All sixty of us. And that was the end of it. I mean, there was, you know, it didn't require the parents' permission, it didn't require anything. You just got the shot, that was it. Closed case. And being a farm kid, with all of those farm pots, all those stock pots, as they were called. Almost every good sized farm had one. What that meant was after you had that shot, you could start swimming in the summertime in those filthy stock pots that, of course, for kids that age was just a joy to behold. Because you didn't have to worry about being infected with polio.

I remember children I started grade school with that contracted polio before the vaccine was actually widely available who went on, went to school with me. Fortunately, I didn't get it. Most of my friends didn't get it. Then we got the immunization and now for all intents and purposes, it's a disease that doesn't exist in this country.

SIMEK: There was a real panic about that, wasn't there?

KRONENBERG: Oh, yeah. Yeah. I remember a real treat when I was a little kid was we would meet my dad who still worked in Portland at Blue Lake Park. And then it was a private park out on the Columbia. Every once in a while in the summertime. In the early '50s, we quit doing that. The families would all meet with their husbands who

worked in Portland, and we'd have a big picnic and then everybody would go swimming, all that kind of stuff. And that ceased, I think, for all of the '50s until the Salk vaccine became available. Because it was quite clear that people who were swimming, kids, particularly, who were swimming in Blue Lake, were contracting polio. I mean, there was a direct cause and effect.

And I think that was a very interesting time in my life. And I remember even though I was just a little kid, I remember it so acutely. I can remember what the nurse looked like when she shot me. It was pretty interesting.

SIMEK: Aside from–

?: You're at 58 minutes.

SIMEK: Yeah, we can wrap this part. Aside from the many diseases that are lumped in with the cancer category, we haven't had anything like polio since then, have we?

KRONENBERG: No. There are a couple, there are several diseases that have pretty much disappeared that were childhood diseases that you and I could have had, like mumps, rubella. I think measles, particularly the fact that it's been eradicated to the point that it's no longer a problem for pregnant women who would have terrible birth defects, immunization for rubella probably is right up there with major things that have pretty much been eradicated from at least this country since the '50s.

But I remember I had mumps when I was about, I don't know, six, seven years old. It was pretty terrible, but now you don't have to worry about it unless, of course, your parents are so stone dumb that they won't let you have those childhood immunizations for some crazy fear that they're going to drop dead or something.

SIMEK: And then there are things like AIDS, but that's not something that is the mysterious killer like polio or influenza.

KRONENBERG: No, but you know, it's interesting because of course the development of AIDS has been something that's happened during my career from the very beginning. And I would say that there was that same level of fear about exposure to AIDS. It was generally originally associated with homosexual males. And I think that the truth is that that sent maybe a bad message to a lot of people about how to avoid AIDS. And it seems to me that probably what really brought it into the mainstream, at least that I remember, and began to change people's attitude about AIDS and HIV (?) positivity was Arthur Ashe, the tennis player, who obviously got it from a transfusion associated with some surgery he had. And unfortunately he died at a very young age. But I think that changed a lot of people's attitude about AIDS and the importance of adequate treatment and prevention. And as you know, we've gone through periods where it was an absolutely major concern among teenagers, particularly black teenagers. And fortunately,

the public health system, education, has sort of kept the lid on it. And it's never become the pervasive pandemic that people thought.

But in the early times, it was real scary stuff. I mean, and it affected physicians, too. I remember us having debates in our policy making bodies about what a surgeon's responsibility was if he was operating on a patient that had AIDS. And more important, what if during a procedure, he cut himself. Was he ethically and legally bound to discontinue during surgery? Just exactly what was the response of the individual practitioner when treating AIDS patients, or in terms of protecting themselves, or if they did have some kind of contact that might lead to an infection, what would they do about it? What would be the response of not only the individual, but the larger medical community to deal with it?

SIMEK: I remember one of the indicators of– we'll pause now. One of the indicators of concern that I remember was the nature of the jokes about it.

[End Track Four. Begin Track Five.]

SIMEK: If you want to take notes, too, about things you want to talk about during yours, you're welcome to do so.

?: Okay. Rolling, recording.

SIMEK: This interview with Jim Kronenberg took place on April 18, 2006, at the Oregon Medical Association, Portland. This is one of several interviews conducted by the Oregon Medical History Project on a grant from the Oregon Medical Education Foundation, and the Oregon Health Science University. The interviewer is Matt Simek. This is number three of what looks like will be three. And Jim, one of the most fun parts of these interviews, to me, is getting to the who's who and who's what, and talking about who you know and where they've been and what you know about them. And so you in your capacity have known hundreds of thousands of physicians over thirty years, thirty-eight years of your career. And some of them, no doubt, have stood out in your mind. So I have a list of those that I know about that I'd like for you to tell us something about. If you have some amusing anecdotal stories or just tell us a little bit about who they were, what they were about or some things that give a little human character to them, that would be, that would be nice. Because we know about their professional side, but we don't always know about who they were as people.

So I would just start off with a fellow named John Benson.

KRONENBERG: John was somebody that I only knew by reputation until about six or seven years ago. And then I became, I think, close friends with him. We spent a lot of time together. We were working on developing a professorship chair, an endowed chair for Dr. J.S. Reinschmidt. And he was on the committee, and we sort of became bosom buddies. He's left the community. I don't think John will ever die. He is, I mean, he is, just seems to be invincible. The guy looks like he's about fifty-five. And he's in his

eighties, I think. But a remarkable guy with this dry, dry sense of humor. Just make you laugh out loud. Wonderful man. Wonderful man. And certainly in terms of his standing in academic medicine in this country and his leadership of his own specialty, internal medicine, where at one point he was, for a long time, executive director of the American Board of Internal Medicine, which is a place that historically has been reserved for really outstanding practitioners and teachers in that particular specialty, John has been a real credit to not only the educational community here, but certainly the clinical community. He was a real leader. There's no question about it.

SIMEK: You invoked the name of Dr. Reinschmidt.

KRONENBERG: Dutch Reinschmidt, I think, of all the remarkable people I've met, I have a deeper and a greater sense of respect for him than anyone I've ever met. He was, without question, the hardest working man I ever met. I never saw anyone with such energy. I mean, he was this little round man with glasses and thinning hair. He was a dynamo. He was just incredible. He was superman in a bad brown suit. He truly was a remarkable man. I think he had influence more than any other single physician on the affairs of medicine in this state in the latter half of the twentieth century. In every aspect of medicine. Rural healthcare, educational reform at the medical school, a new curriculum for the students. He led the way. His influence with legislators and the public regulators with interest in health was absolutely phenomenal. If you had a really bad job to do, you asked Dutch Reinschmidt to do it, that really needed to be done, because you could count that it would be done. He was a leader of the Oregon Medical Association without question. A leader of academic medicine at the medical school. And you will find physicians to this day in rural Oregon that will have the same effect as I'm having [sounding choked up]. He, I mean, he was just a remarkable man. I've never known anyone like him. And I consider him a very dear friend. All things about Dutch, no matter how much he knew, no matter how much raw intellect he would bring to a problem, not only at the state but the national level, because he had that same kind of respect nationally. One thing about Dutch was he was genuine, he was real. You got what you saw.

SIMEK: Another academic, Dan Labby.

KRONENBERG: I didn't know Dr. Labby very well. I pass on him, I think.

SIMEK: Tom Miller.

KRONENBERG: Oh, Tom. There's another interesting guy. Tom has been involved, here at the OMA, I think longer than I, which says quite a bit. He was a very active family physician on the east side, practiced for years at Providence Portland hospital and several other east side hospitals. But his real forte was his leadership in providing really high quality, useful, measurably effective education for physicians and their employees in risk management from the standpoint of providing them the tools and knowledge to help them avoid those circumstances that very often lead to medical

malpractice lawsuits. I think he's probably as well known for his expertise in that area outside of the state of Oregon as he is here.

You know, to this day, Tom has been retired for a very long time, to this day, it's a rare week that I come to the office here and I don't see his car at least once, sometimes all week. He has contributed literally thousands of hours to this particular mission, which is a very important one. I for one think there's no question he's done some good.

SIMEK: One of your old friends, Harold Osterud.

KRONENBERG: Hal Osterud is another remarkable man for several reasons. First of all, he was another guy like Dutch. What you saw was what you get. He was a very accomplished and noted expert on public health, there's no question about that. And everybody's guru about workforce issues. No question about that. But the man did not have one ounce of guile. None. What came out of his mouth was the same to you as it would be to the president of the United States. He wasn't arrogant, I don't mean it that way. But I think he was constitutionally unable to shade the truth. He told you what he thought. And you know, he was almost always right.

SIMEK: Ed Press.

KRONENBERG: Ed Press was someone I met very early in my career. He was, I believe he was the last true state public health officer. After Ed, why the state administrator of health services, or as they call it now, the health (division?), generally was a lay person or some other professional. There was always a head doctor, but not as the public health officer. Ed was, and as a matter of fact, he is, a remarkable guy. He's another physician who I think may live forever. He's well into his nineties now. And I swear he does not look one bit different than he did in 1969 when I first met him. He, Ed had a lot of interests, but probably the one I remember the most was a lot of physicians are obsessed with tobacco and with smoking as a public health problem. And Ed was no different as a public health officer, he saw it as a huge problem. But here in Oregon, and at the national level, particularly at the American Medical Association, his thing was not just cigarettes. But it was cigarettes that went out when you weren't puffing them. He was the first person that I ever came across that thought that cigarettes ought to extinguish if you weren't puffing them. He was more interested in the potential public health risk of fire than he was about the long term use of tobacco. This was a real obsession with him. It was really kind of cute. I always, I shouldn't speak of him in the past tense, because he's sure still with us. He and his wife spend part of the year here and part of the year in Florida. And I always look forward to seeing both of them, because I'll tell you, they were made for each other. And both of them may outlive me.

SIMEK: I'm going to take a little sip of water here.

KRONENBERG: Oh, sure.

SIMEK: Dick Raines? You mentioned Dick before, and I had some interesting stories about him when you were first–

KRONENBERG: Right. He was my first boss, in that he was president of the Oregon Medical Association when I came to work here in 1969. And I guess it was his okay, his nod of approval after he interviewed me at lunch before I was hired that got me the job, for better or worse. And I've remained close with Dick over the years, although he's not been active in the OMA for a very long time. He is truly a remarkable fellow. He was a radiologist by clinical specialty, and very active in radiological circles at the state and national level. And I believe he was president of the county medical society here in Portland as well as being president of the OMA. And he had a very high (tighter?) for meetings. He's getting along in years now, but it's pretty hard to find any kind of public gathering that civic minded people here in Portland, particularly those that have some medical or healthcare aspect, that he's not there. I'm beginning to miss seeing him at those meetings, and it's too bad. He's in relatively frail health.

But really a remarkable guy with probably the most acerbic, dry sense of humor. He's one of those people who can tell you something. And you didn't know that you'd had your head cut off until you sneezed. I mean, he had this wry sense of humor and just loved to nail people. And he was so subtle that you didn't know he was doing it until you started thinking what did he say to me? I treasure my memories of Dick Raines.

SIMEK: One of the intriguing things that George Saslow told us in his interview was practicing psychiatry pre-thorazine.

KRONENBERG: Right.

SIMEK: And the rubber rooms at the state hospital, and so forth.

KRONENBERG: Mm hmm. I didn't know Dr. Saslow very well. The interesting thing, to me, is he knew me. And that always, even in the early days, I mean, this guy was a real lion in the psychiatric community at the national level as well as here in Oregon. I mean, he was the senior guy. And I would see him once in a while at the medical school or a medical meeting, even when I was young and early in my career. And he'd always say, "Hi, Jim, how are you doing?" And I don't suppose I had seen him for twenty years. And he happened to be here doing an interview with you some time ago. And I walked by and I didn't even get it out of my mouth and he said, "Hi, Jim. How are you?" A remarkable faculty for remembering names and faces.

SIMEK: Gene, oh, no, let's skip him. Tom Griffith.

KRONENBERG: There's two. One–

SIMEK: The one you know.

KRONENBERG: I know them both. [laughs] Okay, I think you're talking about Dr. Griffith who was the president of the OMA in 1930, which is a very, very long time

ago. One of the coups that I count is how many OMA presidents that I actually know. And he died soon after I came to work here. He was from the Dalles and I lived there and I visited with him for a while one afternoon with another senior colleague who, from that community, and got a chance to chat with him. I'm proud to know that I actually knew a president of the Oregon Medical Association who was president, therefore in the middle of his career, something on the order of almost thirty years before I came to work here. And fourteen years before I was born.

SIMEK: Well, dipping into the past, Albert Kinney. What was his claim to fame?

KRONENBERG: Well, actually, there's one I didn't know. Dr. Kinney, as it turns out, was perhaps unique in the entire history of medicine and medical organizations in the United States. He was the first president of the Oregon Medical Association in 1874. He was the fiftieth president of the Oregon Medical Association in 1924, which is just astounding to me. And the other astounding thing is that he was president of the Oregon Medical Association in 1874 based on his reputation as perhaps the finest surgeon in the Willamette Valley, the one who was called to do difficult cases from Longview to Eugene because of his prowess as a surgeon. He was only twenty-four years old when he was president of the Oregon Medical Association.

Someone once told me that he was such a good surgeon because of his experience during the Civil War. And once I found out how old he actually was, I realized it was doubtful he was doing surgery at the age of ten during the Civil War. But Dr. Kinney, after he was president, he was from Astoria. And he practiced in Astoria for many years. And obviously he did more than medicine. He started a bank, and it was a very successful bank. And he and some other businesspeople from Astoria and from Portland provided the financing for and eventually (runned?) and owned a railroad that went from, the original railroad that went from Astoria to Portland, which I find quite interesting. And obviously at some point he thought he should move to Portland in order to watch his investments and the like. And for a while he was president of one of the major banks here in Portland. At the same time, he was the fiftieth president of the Oregon Medical Association. Pretty remarkable, I think.

SIMEK: Olaf Larsell?

KRONENBERG: Dr. Larsell was actually an anatomist, a PhD anatomist of some national repute at what then was the University of Oregon Medical School, now OHSU. And his claim to fame was that he wrote a book called *The Doctor in Oregon,* which, unfortunately, is out of print because it was actually a fascinating book about the history of medicine, healthcare, in Oregon, actually from the Lewis and Clark expedition to about 1957, when it was published. And a lot of what I know about the times before I worked for the OMA or for heaven's sake, I was even born, came out of that book. And I would have loved to have met him. As books of that particular time and vintage, particularly, by a PhD anatomist go, it was very well written. Really an interesting book that you could actually pick up and read, not like some of the tomes that I've read on, particularly on medical history. Some of them get pretty dry. He was a pretty good writer

SIMEK: William Brady.

KRONENBERG: Bill Brady was the state medical examiner. That is, the physician, pathologist responsible for supervising and in many cases doing the autopsies on Oregonians who met with some kind of suspicious death. That was a big part of his job. But the main part of his job was overseeing this network of county medical examiners. And to this day, there is a physician in each county who is designated by the state medical examiner to investigate, do an initial investigation of the circumstances of people's death. Bill is an interesting guy. He's a very, very interesting guy to talk to. He would be a good subject for one of your interviews, Matt.

SIMEK: He is a candidate.

KRONENBERG: That's good. That's great. He is a very, very urbane, very, very articulate man, you'll find. One of those people I really admire who can speak not in sentences or paragraphs, but pages. He's had a very interesting life and has done some very interesting things. He has not been state medical examiner for a good long time, but continues to act as an expert witness, as far as I know, in death cases as clearly an expert anatomical pathologist.

SIMEK: Was he often at odds with the powers that be?

KRONENBERG: Oh, yeah. That's why he's not the state medical examiner anymore, I suspect.

SIMEK: Mark Hatfield.

KRONENBERG: Senator Hatfield is sort of in the Dutch Reinschmidt league, as far as I'm concerned. As you know, I was born and raised here, so I was born and raised with Mark Hatfield. As it happens, why Senator Hatfield and I are of the same political persuasion, so I particularly like him. Not because he's a Republican, but because he's a moderate Republican with halfway good sense. And he demonstrated that on very ably as the governor of the state, and is arguably the most distinguished senator from the state of Oregon. He's always had a health, an interest in health and medical care. Given his seniority and his position of authority over the years with the United States Senate, obviously he has been an extraordinarily important benefactor for Oregon, and particularly for Oregon Health and Sciences University. He, I think anyone who knows his story, including, certainly, Dr. Peter Kohler, would agree that the university exists as it exists now and it will in the future in no small measure to the influence and the power that Mark Hatfield had. Besides that, Mark is a very fine man. It's pretty tough, it's pretty tough regardless of your politics, not to have respect for Mark Hatfield. At a time when it's pretty tough to have respect for most politicians.

SIMEK: Peter Kohler?

KRONENBERG: Dr. Kohler is not one of my, one of my buddies. But I have admired him from afar for a very long time. I think his influence on, not just the behemoth that the Oregon Health Sciences University has become over his term, but also his influence and his guidance in making the university, not just the medical school but the whole university, reach out to all areas of the state. In terms of his, although it was Dutch Reinschmidt that did the hard lifting, the heavy lifting, it was really a vision of Dr. Kohler's that he discussed with our leadership very early on to create the AHEC system that has served the state of Oregon physicians and the medical community and rural Oregon so very well.

There are a lot of things that you can say about Peter Kohler, but I think one of them is someday I think someone will look back, I think he needs a look back. Someday somebody's going to write a biography of Peter Kohler that will fully have his impact on this community and on this state. And I think it is not an understatement to say as of this very moment that the single most influential and important single person in the recent history and certainly the immediate history that we'll see in the next ten years, is probably Peter Kohler in terms of his impact and his effect on this community.

SIMEK: You chuckled before when I mentioned the name Fran Storrs.

KRONENBERG: [laughs] That's because you have yet to hear her laugh. Fran Storrs, Fran Storrs, you have to be of a certain age, but I think you are, you may remember an opera singer who was on television back in the '50s named Helen Traubel. Think Helen Traubel when you hear Fran Storrs' laugh. She has this laugh that when she's at a meeting downstairs, we can hear upstairs. She is one of the funniest ladies that I have ever met. I consider her a very dear friend. She is perhaps one of the most distinguished academically distinguished member of the OHSU faculty. She's a dermatologist of absolutely international repute. She is an absolutely charming person. Probably as much fun to spend quality time with just chewing the rag as anybody I know. She's a great woman.

SIMEK: In her era, it was very difficult for a woman to go through medical school.

KRONENBERG: That's absolutely true. But I think that, if you will, the measure of the doctor probably has something to do with the circumference of their head. She's a very smart woman. She is a very assertive person, which in my early career was an attribute that nearly all successful female physicians had. They were strong people. And it's not like Fran is nearing her dotage, but she has been around for a long time. And she's one of these people like some other female physicians I've dealt with over the years, that proverbially can hunt bear with a switch.

SIMEK: Like Mildred Thomas.

KRONENBERG: Yes. Dr. Thomas, much quieter, entirely different kind of person. Very dignified with, again, like most people I really like, a dry sense of humor,

very self deprecating. Her influence, particularly in her specialty very early on in a specialty which now is one where women are in great demand, obstetrics and gynecology. At that time, she was really a pioneer. There were a couple before her. But in my early years, she was the only board certified obstetrician/gynecologist, at least in Portland.

She was very active in the OMA. She never became involved in the politics. She was interested in, not surprisingly, maternal and child health, and served in that capacity on a number of committees over (the years?). I have very fond memories of her.

SIMEK: And the OMA president Ginny Burke?

KRONENBERG: Ah! [laughs] That was a pistol. Another person who could hunt bear with a stick. Just no question about it. Ginny was an anesthesiologist. And in her time, particularly early in her training, an operating room was not a particularly good place to be if you were interested in polite society. And Ginny, I can assure you from personal experience, could give as good as she got. She could swear like a sailor. She wasn't afraid of anybody, which may have to do with the fact that she grew up in John Day and Baker City and Burns. And she had a remarkable career.

The interesting thing is, even though it's been a number of years since she was president, she was not the first female president of the Oregon Medical Association. That actually happened for reasons that I've never been able to really figure out. Because it was long enough ago, it was very difficult to figure out just exactly the dynamics. But apparently the first president of the state medical society in the United States who was a woman was a woman named Grace (Swaggart?) Kent, who served as president of the OMA I think in 1944. I may be wrong about that.

But the interesting thing, the tie in, was that Jenny, when she was actually an intern, she spent some time at Sacred Heart, where Dr. Kent had retired. And she had an opportunity to meet her. Although she said there was no cause and effect relationship, she was encouraged by Dr. Kent to pursue very vigorously her opportunity in organized medicine. And to recognize for what it was, a very important part of one's professional career. So there was kind of a tie-in between our first and our second female OMA presidents, although they were nearly forty years apart.

SIMEK: Speaking of John Day and assertive, how about Lee Harris?

KRONENBERG: Ah! I first met Lee when he was an ER physician, emergency department doctor, in Eugene. And he subsequently moved to Burns and did a general family practice. He was a cowboy. There's just no question about it. I always, I knew Lee and kept in touch with him up until the last four or five years and I've kind of lost track. But I understand he has passed on. But he was an iconoclast. He was the absolute quintessential Eastern Oregon doc. He wore cowboy boots and he had a cowboy hat and he knew what they were for. He was very outspoken. He had a great sense of humor and enjoyed poking fun at his colleagues from the city. He was made for John Day.

SIMEK: I'm going to skip through some of these, or we'll never get past this. But some of them sort of stand out, like Gus Tanaka.

KRONENBERG: Yeah. Gus is, Gus is right up there with Dutch Reinschmidt. He is a remarkable man. He was president, I believe, the third year I worked here at the OMA. Maybe the fourth. And I had an opportunity, then, since I was a junior person, to spend a lot of time with the presidents. Because basically I was his driver for a year. And in those days, we went to visit every county medical society. Which means, including all four physicians in Burns, Oregon. And we'd spend weeks at a time doing this.

One of my fondest memories is in those days, Gus smoked big, stinky cigars. We would be in my car, and in those days, I drove a lot faster than I do now. Well, not too much. But I did drive fast, particularly when I was on the open road. And I remember, I remember watching Gus sitting in the passenger seat with his cigar clenched in his mouth, smoke coming out both hands, and absolutely mesmerized by the road and how fast we were going. He never said a word. He never said a word.

He and his wife, Teddi, are among the two kindest, most hospitable people that I have ever known. I don't, you've met him, and I guarantee you if you drive through Ontario this very day and you call him up and say, "Hi, Gus, or Teddi, Matt Simek, I'm just driving through, wanted to say hi," you'll spend the night there.

He was an absolute, an absolute deity in that town, and still is. He is the physician's physician, the surgeon's surgeon. Really a remarkable guy.

SIMEK: And coming out of a Japanese internment camp.

KRONENBERG: Yeah. How anybody who had his experience during the Second World War could have the attitude and the absolute dedication and love for this country, I do not understand.

SIMEK: Yeah. Roy Payne.

KRONENBERG: Ah. I think after I came to work, Dr. Payne was probably the first doctor I met. It shows you how long he's been involved. And it was his perhaps dubious duty to break me in as a staff person, because I was responsible along with him as he was the chair of the annual session, which in those days was a five-day fair of scientific programs, exhibits, socializing and politics that I swear every physician in the state went to. And he sort of broke me in, I guess.

Roy and his wife, Anna, and as a matter of fact, their children, who are all grown now, some of their grandchildren and Saundra and I still remain very friendly. We used to go spend every Christmas, between Christmas and New Year's, with them at their beach place. Actually with another doctor couple who had a place in Arch Cape, and they

had a place in Seaside. We sort of stayed in between. Because it was basically 24/7 party time. Very fond memory of those people. They're fine, fine people.

SIMEK: John Kitzhaber.

KRONENBERG: I first met John when he was a medical student. And he approached me with another earnest medical student. I remember he had glasses and he was real skinny and he had kind of a bad complexion. Real thick glasses, too. And anyway, they wanted the OMA to support some, I think it was zero population growth or something. We had a nice chat and I introduced him to the officers. And then flat forgot about him. Until maybe ten years later, no, it was less than that, maybe six or eight years later, when this emergency physician from Roseburg ran for the legislature. It was the same guy. And as we all know, he eventually became president of the state senate and served two terms as governor. He was, without question, the author of the Oregon Health Plan. Certainly the impeller, if you will, of getting that thing actually in policy.

And according to my wife and a lot of other women, he's one good looking guy now. So he's grown up a lot since he was a medical student. John is, he's another person, what you see is what you get. He's a very personable man. He has a great sense of humor, by the way. He's a very, very funny man.

My colleague, Scott Gallant, our director of government affairs and John sort of adopted each other early in their careers and are very fast friends to this day. I think just as when he was governor and president of the senate, why John keeps his own counsel now. It will be very interesting to see what the rest of his life is like. Because he's far too young a man to be done.

SIMEK: Noel Rawls.

KRONENBERG: Noel Rawls. Well, Noel Rawls was the second OMA president that I worked with. He was a cigarette smoking, profane public health officer from Astoria, Oregon, when I met him. And he doesn't smoke anymore, and he's well over ninety, but he's still profane. Incredibly funny, and tells the most wonderful stories about being a public health officer in Astoria in the '40s and '50s and the '60s where, you know, where basically, what that meant in then what was a very, very busy seaport, was treating the local girls and the sailors from all over the world for venereal disease. And he used to say, he says, "I never go out my back door without at least, with less than 10,000 ccs of penicillin on me." Great sense of humor. A very, very forward looking guy. Interestingly enough, although he was quite plainspoken, I think was viewed by his contemporaries in the state public health establishment as certainly a colleague, and a very respected one at that. He was a remarkable guy. I enjoy every time I get to see him.

SIMEK: So instead of going on all afternoon, I'm going to read you the rest of the names on the list and ask you to maybe pick two more, three more, and you choose which ones you'd like to talk about. Ralph Crawshaw, John Kendall, Harvey (Clevitt?), Earl Labernoy, Richard Miller, Nelson Niles, Sister Monica.

KRONENBERG: Let's start out with Sister Monica. Sister Monica was neither profane nor loud. But that woman could kick butt, I'll tell you. She was one tough administrator. She was a kind, gentle, sweet woman with ice water in her veins. There was not a physician in Eugene, where she was the administrator for many years at Sacred Heart Hospital, medical center now, who did not respect her and who were not afraid of her. I don't know why. But it seemed like wherever Sister Monica was, different activities at the state level, with the state hospital association in her own community in Eugene, somehow Sister Monica almost always got her way. Having said that, I don't think she had a mean bone in her body. But she sure knew how to use her influence.

SIMEK: Did she carry a ruler with her at all times?

KRONENBERG: [laughs] No. She didn't need a ruler.

SIMEK: And of the others?

KRONENBERG: Let's see.

SIMEK: Crawshaw, Kendall, (Clevitt?), Labernoy, Niles–

KRONENBERG: Yeah. Let's try Crawshaw. Ralph is still around, so I have to be fairly polite because he may see this somewhere. Ralph is a psychiatrist who was trained in New York and he's from New York. If you listen to him very carefully, you can tell he's from New York to this day, although he's in his eighties. He is, I'm sure, a fine psychiatrist. But his real forte was taking on causes of all kinds, of all sorts. For example, he's been a prime mover with another physician who's been retired for thirty years, but it still very active, in preserving the watershed for Portland. Ralph has been prime mover in that, with a number of other people, for many, many years. He has had a role in trying to, in various ways, to encourage the public, through a variety of sources, not just here in Oregon, but throughout the country, to come together and coalesce and tell us as a healthcare industry, not just physicians, but as an industry in the supportive infrastructure, exactly what they want out of healthcare. He is a marvelous writer. He has published a number of magazine articles in a variety of places that show that his opinions and his rationale for the way he sees the world are respected by some very important people. I think he's been an enormously positive and very powerful influence on the course of how this medical community sees itself, particularly here in Portland. How the psychiatric establishment relates to the rest of the medical profession. Where in some places, that's not a close relationship.

And certainly he's had an influence here at the Oregon Medical Association in terms of policy making. I look, as a matter of fact–

[End Track Five. Begin Track Six.]

KRONENBERG: I look at Ralph Crawshaw who's just retired after some thirty-five years on our board of trustees, which is remarkable in itself, as kind of the conscience of the OMA. A very, very fine man. Very thoughtful guy. Seems to be able to get, like you, get stuff out of, good stuff out of other people. And I guess that's what psychiatrists are supposed to do.

SIMEK: I think so. Okay. Last of the list. Tom Cooney, Al Starr, Don Trunkey, Laurel Case, Bucky Shields, Robert Kohler–

KRONENBERG: Oh, Tom Cooney.

SIMEK: (?) and Bob Grinell

KRONENBERG: Oh, okay. Tom Cooney became the general counsel for the OMA I think in 1971, if memory serves me. And he replaced a Portland attorney who had had that position for something like thirty-five years. And the reason that Tom Cooney got that job was because of his reputation as a defense attorney in malpractice cases, primarily. And the very high regard that he was then and still is held by the legal community in this state.

But the main reason he got his job was he was told by Bob Dernedde, who made the decision to fire the former general counsel, his problem was, he tells us that we can't do things. "What I want from you, Cooney, is I want you to tell us how we *can* do things."

And Tom heard that well, because that's what he's been doing now for almost forty years. He is, without question, the funniest man I have ever met. He is a cornball from the word go. He likes funny hats, clown shoes, and all that kind of stuff. And there isn't anything that he won't make fun of. But what makes that okay is the first person he always makes fun of is himself. He is a self deprecating man who uses his razor like wit to cut his own throat all the time, and I like that. The final thing is, he's a brilliant attorney.

And I think that the fact that the state bar association has twice, in my memory, cited him as the outstanding attorney in terms of ethical performance of any attorney in the state, says a lot about our choice in general counsel.

SIMEK: This interview with Jim Kronenberg took place on April 18, 2006, at the Oregon Medical Association, Portland. It's one of several interviews conducted by the Oregon Medical History Project on a grant from the Oregon Medical Education Foundation, Oregon Health and Sciences University. The interviewer was Matt Simek. Jim, thank you so much. What an eye opener. It's been delightful. Okay.

[End Interview.]