HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Bob Dernedde

Interview conducted October 14, 2005

by

Paul Frisch

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[Begin Track One.]

DERNEDDE: We're finished. I'm through. Thank you very much.

FRISCH: That's it. Good for us. How did you get to the Oregon Medical Association?

DERNEDDE: I got to the OMA by a friend that was the executive director way back in 1968 who called me up and said, hey, I was working for Lloyd Corporation at the time, worked Lloyd Center. And he said he wanted an in-house lobbyist. And I, quite frankly, was very apprehensive about going to work for him. Because I felt he was a little loosey goosey about things, so I was real apprehensive about it. Bob (Elsinore?) eventually talked me into it. And I had a great job at Lloyd Center. And they were trying to suck me into sticking around, because they wanted somebody to eventually manage the company after Dick Horne left. And Lloyd Corporation was a family-held company, and I didn't have a lot of confidence that the family was going to use an outsider for someone to succeed Dick Horne. So I opted to go with the OMA. I like lobbying. I like the politics. So I joined the OMA the twentieth of January, 1969.

FRISCH: Did you have much of a professional relationship with doctors prior to that time?

DERNEDDE: Not really. No.

FRISCH: Did you know much about medical politics?

DERNEDDE: I know (sic 'em?) about medical politics at the time. I knew about politics. And you know, politics in business and politics elsewhere pretty much got the same hue to it. You've got to learn the lingo and the issues and so forth. That eventually rubbed off.

FRISCH: You came here and you started doing lobbying. And then what happened?

DERNEDDE: [laughs] Well, the interesting thing, I was trained by a fellow by the name of John Misko. He was the professional lobbyist for the OMA at the time. And I was the in-house lobbyist. So my training was with John Misko. And I remember one time, John said I couldn't get something done. Well, I did. And he said, "Well, you just might make it." [laughs]

FRISCH: What was the medical community like when you got here, and how has it changed?

DERNEDDE: Well, I don't know if we have enough time to describe what the medical community was like when I joined. We had something under two thousand members in the medical association, probably twenty five hundred doctors in the state. And there weren't, you know, there were specialists, but not anything like the number of specialists today. I think what we've seen over the last thirty-five years is just an explosion of specialty orientation by physicians. And I don't see that it's ever going to stop. I find it rather humorous for a number of the categories that you see in the yellow pages describing various physicians. The public has no idea what some of these terms are. Yet physicians want to have their specialty described in the proper medical terms, so they do.

FRISCH: Like what?

DERNEDDE: Don't ask me that. [laughs] I don't want to insult anybody.

FRISCH: What was the leadership like? What kinds of doctors? What kinds of personalities? What was the focus of the organization? What did you inherit here?

DERNEDDE: Well, it's kind of interesting. When I started, I started while the legislative session was underway. It had been basically going for about a week and a half when I came on board. And when I arrived, there were no furniture in the office that I was assigned to at all. We were up on Park Place. And the office that I had was empty. There was a chair in there, and that was it. And I said, this is a nice welcome. But anyway, I'm going to Salem, and I can find more places to sit in Salem, because I at least knew my way around the capital.

But at that time, there were a number of physicians involved in the public policy arena. Guys like Clint McGill and Don Kelly, Max Parrot and Blair Henningsgaard, Roy Payne. And they were religious about reviewing the legislation and attending meetings. We would have public policy committee meetings that would go until two-thirty in the morning, every couple of weeks, just going through the details of legislation. We had to make some decisions on this as to what we were going to do with it. And you won't find that going on today, but that's what it was like then. I think the commitment was different. Of course, I think physicians were less in a position to feel that they had to be home at a certain hour. Kiss the kids goodnight or do whatever. There was more independence and I think the expectation of family participation was lower than what it is today.

FRISCH: Talk to me about Max Parrot

DERNEDDE: Great guy. Max Parrot, obstetrician, gynecologist, in Portland. He was president of the medical association sometime in the early '60s. He ran for the board

of trustees of the AMA. He was an AMA delegate, and ran for the board of trustees. Was elected. And served on the board. Was its chairman.

And then Max decided he was going to be candidate for president of the AMA. And quite frankly, we went, we put together a campaign, materials that we needed to run his campaign. We had little wooden parrots, and we had orange juice and filberts. We were running hospitality every night.

When we got to the convention center, we found out somebody was going to run against him. So we had to put on full court press. And the election was five days out, and we won by an Oregon landslide: two votes.

And Max was an incredible man. He was very much a gentleman, and very conscientious. He treated people very well. There wasn't anything pretentious about him, or uppity or anything of that nature. He wasn't an elitist. He owned a bunch of land out by St. Vincent's Hospital. And that became his retirement when he retired. And fortunately when he did retire, he didn't last very long. He died a couple of years after he retired. He was able to sell the land and build a house above on the bluff there at Forest Heights.

And I ran into his wife, we were in Bridgeport here last spring, right after they opened. I ran into his wife and his daughter. And Kathleen is still living in that house, that big house that they built. His daughter's living down in San Mateo someplace.

FRISCH: What kind of a mark did he leave on the AMA?

DERNEDDE: The AMA, quite frankly, internally was in turmoil at the time when he was chairman. And in fact when he was chairman, he was the guy that brought Jim Salmons in to be the CEO, the executive vice president of the American Medical Association. And the AMA had become a bureaucratic organization, like so many organizations are liable to become. Like the City of Portland. And Jim Salmons and Max Parrot were able to turn things around.

FRISCH: What about here in Oregon, when he was involved in the OMA?

DERNEDDE: Well you know, I wasn't here when he was president of the OMA. And most of the stories I've heard are basically hearsay stories. But I do know he was highly regarded, very much respected. Subsequently, one of his younger partners subsequently became the president of the Oregon Medical Association, Dick Allen, Richard Allen. But he was the young OB/GYN at the time who joined the (? Whitely?) team of obstetrician gynecologists.

But Max was well respected, highly regarded, and he understood medicines, medicine's role in relationship to patients. And he understood the politics that was necessary for medicine to, as an organization, as an entity to engage in in order to be able to deal with, with what Congress was dealing with with Medicare, Medicaid, and the

whole issue of reimbursement for physicians. He was very much a fee for service guy. And he played it well.

FRISCH: Blair Henningsgaard. I hear that name all the time. Don't know him.

DERNEDDE: Blair Henningsgaard was an internist in Astoria. And he was a very good comrade, so to speak, of Max Parrot and (Ernie Livingstill?). Another name. But Blair was an internist in Astoria. And his wife Edith and he were a great team. He was president of the Oregon Medical Association. I believe he followed Max Parrot and later became an AMA delegate and worked on Max Parrot's campaign. He also moved up the political chain of the AMA in that he was chairman of the American Medical Political Action Committee. And quite frankly it was Blair Henningsgaard and Max Parrot that created, or were the guys that created the Oregon Medical Political Action Committee in the '60s.

FRISCH: Was there more physician participation in the PAC then than there is now?

DERNEDDE: Probably. I think probably early on in the late '60s, early '70s, because there were fewer physicians and they were easier to talk with and convince, or arm twist or whatever you want to call it, I think that probably the participation was more like 15 to 20 percent, as opposed to whatever it is today. I know a couple of years ago it was down to less than 10 percent who participated in the political action committee. And I think there was more because they really didn't, or the profession as a whole, really didn't comprehend the necessity of pulling together in that fashion.

It's kind of like the whole notion of unions. You know, when they were talking about putting together medical unions. In fact, I asked our legal counsel at the time, Tom Coomey, to put all the paperwork together and be able to move into a union direction should the house of delegates want to go there. But the more I thought about it, the more I concluded that that would be a terrible mistake for a number of reasons. But most importantly, I think, in a union situation you'd have to have the mentality of one for all, all for one. And physicians are independent creatures. You know, they were the head of their classes when they went through school. And then they went into medical school and they were taught to think things through, to think it out, and then act according to your knowledge and information. Seek counsel, whatever it might be, but fundamentally independent. And to think that these people are going to go on an all for one, one for all mentality is just dreaming. It's not going to ever happen. Not in my lifetime, anyway. [laughs]

FRISCH: Oregon Medical Association has always had influence in politics, state politics, well beyond its size or its financial contributions to things. What do you think accounted for that?

DERNEDDE: Well, first of all, every legislator had a doctor. Secondly, I think, I think physicians have been revered, and it's an earned reverence. And I think that people

listen to physicians. And I don't know that those sidewinder comments that you get from some physicians who don't necessarily reflect the mainstream really stick with legislators. I think they really want, and legislators are like anybody else. They want to do the right thing. And when it comes to public health, when it comes to the issues that relate to people's lives and their ability to be cared for, I think they want to do the right thing.

Where the politics comes in is issues relating to influence, issues related to financing, compensation, divvying up the pie, turf tending and things of that nature, and that's where things kind of pull apart. But I think that the influence of medicine overall politically has been, as a result of where physicians and medical profession comes from. But they've got to convey their message. It can't just be those issues that directly affect physicians. It had to be issues that directly affected public health and safety. And you know, you can talk about some of these things. Seat belts, a public health issue, advanced by the medical association, first getting legislation passed that will require anyone under sixteen years of age to be in an automobile, to wear a seatbelt. And that was sometime in the '80s.

FRISCH: Brings John Tung to mind.

DERNEDDE: John Tung wanted seatbelts, and he talked the OMA into going for seatbelts for everybody, making it mandatory. And finally we got a referendum to the people and to pass. But John Tung was like a dog with a bone. And he was relentless. He carried the message and he wouldn't let– I saw him at times in Salem. He wouldn't let anybody by until they heard him out. Very effective, too. Neat guy.

FRISCH: Yeah. Neat guy. He was a challenge from time to time, for us.

DERNEDDE: Oh, yeah. But the deal was that medicine was involved in issues that far beyond those things that just affected the practice of medicine. But in basically making sure that the people of Oregon were safe, we, I remember we, I guess it was in the early '70s, we got legislation passed to allow minors to consent to medical care. Because there were a huge number of very mobile street people and kids that were constantly on the move. And they needed medical care, and there was no way you could chase their parents down. They had run away from home to get consent to take care of fundamental things, or surgical procedures, or whatever it might be. So we were able to get legislation passed to permit kids to be able to give consent for medical procedures. And the doctors couldn't force their parents to pay. But we were able to take care of kids. And that was a public health issue.

FRISCH: You also balanced to get informed consent. Do you remember what that was all about, what happened, go the informed consent law changed?

DERNEDDE: Well, the informed consent law, I think that the parameters were kinds of set by the Supreme Court and they were kind of loosey goosey and nobody really knew whether you had informed consent or not. I think it was in 1990, no, it was in

1975 legislative session when frankly we rewrote a large portion of the Medical Practice Act. And in that process, we were involved in trying to tweak tort law and straighten out the informed consent issue. So that's when we came out with the PAR conference, which was procedures, alternatives and risks. And once that was documented that they had a conference with the patient was required. Then it satisfied the informed consent law. To this day, that's the standard in this state.

FRISCH: I've heard you guys talk about the rewriting the Medical Practices Act. How come it had to be rewritten? And what was the role of the OMA in that? How did it change things?

DERNEDDE: Well, in the early '70s, when we were having the first explosion, malpractice crisis, we had to come up with multiple things. One was finding a new medical malpractice insurance carrier, another was kind of to deal with tort law, and another was trying to deal with those physicians who were troublesome. And we knew that we were going to have problems with the legislature and the personal injury bar over some of, some physicians who had problems. In Board of Medical examiners just didn't have the authority to do the types of interventions that were necessary to deal with some physicians in the state.

So Tom Coomey and I sat down and we, basically we got a copy of the Arizona Medical Practice Act and two or three other states. And we just sat down and I don't remember how many painful hours comparing, because they had had some improvement in their Medical Practice Act. And so we just basically took pieces and welded them together and came up with some of our own notions. And we literally redid the Medical Practice Act.

And it was kind of interesting. Once we go the document completed, we shared it with the Board of Medical Examiners and the officers of the medical association and we said, "Hey, this is what we want to do. We want to have a telephone conference call with the Board of Medical Examiners and say this is what we've done with the Medical Practice Act to strengthen it, give you more authority to deal with issues of medical practice." And we need to do this to attach it with the tort reforms that we were proposing to the legislature, and we wanted to put it all in one package.

And we got on the phone and we did this big telephone conference call with the Board of Examiners. And there was a bit of hemming and hawing. And members of the board (?) but finally they said well, I guess we better go along with this. That was that. And we submitted to the legislature. And that part of the package sailed through. I don't recall an amendment to it, but that's been quite some time. It went straight through. And that gave the Board of Medical Examiners far more power and authority to deal with physicians that had problems.

And I think we did make a couple of amendments in the '60s or '76 or '77 that required the board to track physicians who had had malpractice insurance claims. And

here at the OMA, Paul Frisch is the guy that's been tracking them ever since and has a complete record of every case that's ever been filed.

FRISCH: Tell me something funny about Roy Payne.

DERNEDDE: Probably more complete than what the Board of Medical Examiners has. [laughs]

FRISCH: I think more complete, yeah. Tell me something funny about Roy Payne.

DERNEDDE: Roy and Anna Payne are two of the most delightful people that you'll ever want to meet. He's an internist in Milwaukie. His father was a doctor. And his practice was primarily in geriatrics. He dealt with older folks.

Some of the things that I remember about Roy, I don't know that it would be fair to tell. Maybe I need to think a little bit about this.

FRISCH: Think about that.

DERNEDDE: But he would, he had this old house in Milwaukie. And he raised four, I think it was four kids, two boys and two girls, in that old house. It was a great Halloween house, just a huge house. Covered by bushes all around, you know? But he was a guy that appeared to be always on call. He was always, maybe in later years he wasn't as much on call as he was when I knew him early on. Here's a guy that did his homework with medicine, did his homework with keeping up on changes in medicine. Did his homework with the Oregon Medical Association. He was former president, when he was vice president he was in charge of our scientific assembly. He was the president of the Oregon Medical Education Foundation for a number of years. He was just a guy that was involved and always did his homework. He always read things that I know the legislative committee would rely on. The legislative committee would rely on Roy Payne to review particular areas where he had expertise.

In 1967, the legislature passed a laboratory licensing law. And Roy Payne was instrumental in putting that together and helping get it passed. Prior to that, the medical examiners law had been rewritten. Roy Payne was involved in it. He was an interesting guy. He had a really deep voice. And whenever he got the inspiration, he would growl like a bear, you know– [growls] Grr! [laughs] And get everybody's attention, obviously. Neat man. I love him. He's a legacy in his own.

And he was involved in Clackamas County politics very deeply he was chairman of the Republican Party in Clackamas County. His wife Anna was vice chairman. And more importantly, Anna Payne and former congressman Wendell Wyatt were the co-chairs to Reelect the President Committee in the state of Oregon. I guess that was sometime in the '70s, I can't remember specifically. But they've lived a colorful and very

full life. And Anna is just, she can tell stories of things her kids did that just make your hair curl. [laughs]

FRISCH: When you talk about Clackamas County, what flashed through my mind was Dan Billmeyer. Why don't you tell us about what you remember of Dan?

DERNEDDE: Dan Billmeyer was another legacy unto himself. [laughs] He was a pediatrician. A rotund pediatrician. He never grew up. He was a kid all the time. And children just loved him. Smart, quick, very involved, totally committed to his patients. He was past president of the Oregon Medical Association sometime in the '60s, mid '60s. He was a delegate to the American Medical Association. Took him a long time to become a delegate. He was an alternate. He was probably the longest living alternate delegate to the AMA in history.

FRISCH: Hold on.

DERNEDDE: Why don't we just stop for a minute? I mean, in Vancouver.

FRISCH: I think he's in Olympia.

DERNEDDE: He went to Olympia. [laughs]

FRISCH: Let's finish up with our friend Dan Billmeyer.

DERNEDDE: Dan Billmeyer.

FRISCH: I remember him wearing that AMA vest with all the decals on it.

DERNEDDE: Well he, like I say, he was a kid.

FRISCH: The longest running, as you said, the longest running alternate delegate–

DERNEDDE: Alternate delegate. And finally he got elected to be a delegate. And I think he had competition, because he was kidlike. A perfect guy to be a pediatrician. He was jovial, he was jolly, he was Irish as Irish can be. And I remember when he was campaigning for the Council on Medical Service at the AMA meeting. We'd have to corral him to calm him down because we wanted him to get elected because he was a smart, smart man, he had a lot of common sense. But he was such a card, we had to tone him down. He didn't appreciate the fact that we asked him to tone it down and gave him direction. Sometimes he just basically said, you know, "To heck with you." [laughs] He went on and did his own thing. But he was a neat man. And his heart and soul was with medicine, and medical practice, and with kids.

I remember when he had to have a surgical procedure in his later years. And I'm up at the hospital to see him. He said, "I don't know whether I'm going to make it, Bob. But when I go, I'm going to go laughing."

I went to his wake. They had a wake for him. I couldn't go up to the casket and look, peer in. I didn't want to remember him that way. I wanted to remember him for his happy go lucky jovial self.

FRISCH: Well, Oregon's had a number of interesting governors and senators. You were around during the reign of many of them. Let's start with Mark Hatfield. How did Mark Hatfield play out in medicine? What's his legacy?

DERNEDDE: Mark Hatfield is a prince of a man. And I got to know Mark Hatfield when he was governor. In fact my son, Mark Dernedde is named after Mark Hatfield. And I remember when I was working with the *Oregon Voter*, a little magazine, that Travis Cross, who was his press aide, asked me if I would like to interview Mark Hatfield, to publish the first story on his position on Vietnam. So I had the pleasure of spending a whole afternoon with Mark Hatfield in the governor's office, talking with him and interviewing him on how he felt, why he felt the way he did about Vietnam. And then I published that story afterwards. And after I wrote it, I sent it down to make sure it was accurate. And I still have a copy of that story. But I was the first one to write about his Vietnam thing. But that's, had nothing to do with medicine.

His daughter is in medicine, and she went to medical school here. Much of the federal money that has gone to the university setting up here came out of Mark Hatfield's efforts. He was chairman of the Senate Appropriations Committee, so he had a lot of sway in getting some of the funding for new buildings. The Bick Building, and research buildings up there. And remodeling and infrastructure. He's got a lot to do with it. And it's appropriate that something up there be named after him. I think that is. I can't recall what it is.

FRISCH: There's a basic science building.

DERNEDDE: Basic science building, that's right. But he has been a good supporter of medical practice and medical research. He's also been, over the years, was a tough critic. He was not at all hesitant to tell the leadership of this organization when he felt they needed to step up and do something, or they were off base. There was no reluctance on his part. He was a straight shooter.

I remember one time, I was visiting Senator Hatfield in his office. And he said, "Have you got a moment?"

I said, "I've got whatever time you want, Senator."

He said, "I want to show you something." So we left his office, went downstairs, got on the train, trolley, and went over to the Capitol building. Went up the elevator and

went into the old war room in the Capitol, which is now the appropriations, it's where the appropriations committee meets when they need a caucus or something, as opposed to their formal hearings and so forth. It had just been redecorated. It was gorgeous. He was so proud of what he had caused to have done in that room where the appropriations committee met. But that was the kind of guy he was. He said, "Come on, I want to show you something."

My son Mark had worked for Mark Hatfield back in Washington, DC, as a doorkeeper for the Senate. Worked in Mark's office. But like I say, I've known Mark Hatfield. And I was delighted that Mark Hatfield was involved in my retirement. He was a neat guy.

FRISCH: What about Vic Atiyeh?

DERNEDDE: Vic Atiyeh. I remember Vic Atiyeh telling me, he says, "I wish I could have one year as governor when economic times were good." Oregon was in a recession when Vic was governor. But Victor Atiyeh appointed a Governor's Liability Task Force or commission. I think it was liability commission. I was appointed to it. And we came up with a series of measures to address the liability issues in the state. And Vic took the bull by the horns and said, "We're going to deal with this." Vic was a real supporter of medicine. He understood it. Unfortunately, he's been using a lot of it of late. But I have the greatest regard for him.

Plus the fact he's a great Boy Scout. He's been my hero as far as Boy Scouts is concerned. He's been one of the leaders in the Scout movement in Oregon.

FRISCH: Neil Goldschmidt.

DERNEDDE: [laughs] Neil Goldschmidt. There was a politician. Neil Goldschmidt was forced to, when he was governor, to, politically forced, to sign a piece of legislation that was the tort reform package that was passed by the legislature in 1987. And I have to give him credit. He resisted the pressure from the plaintiff's bar and from the AFLCIO, and a number of other left wing organizations to veto that. He resisted that and he signed the legislation. He was not the most accessible person to get to. But during that campaign for tort reform, he was there.

FRISCH: What do you think accounted for the OMA's influence on each of these administrations you've talked about? Was it personal?

DERNEDDE: Well–

FRISCH: You had unparalleled access to the governor's office ever since I've known you. The organization, through you or someone else. How did the OMA do that?

DERNEDDE: Well, you get, you acquire access to the governor's office by one, dealing with them before they're even a candidate. You know, most of these people that

run for political office have served in some other capacity. And you get to know them, you establish your credibility with them. And you don't bug them over stuff that's unimportant. You deal with them about those things that they care about. You get to know them. It's a relationship.

I always felt that most of the things we ever accomplished were based on relationships. Not on what you know, it's who you know. And you spend your time developing relationships, and being genuine about it. If you try to develop relationships that are artificial, people can see through that. There were some people that I just didn't want to have a relationship with. I didn't trust them, I didn't think they were sincere, they had different motivations, and you had to work around those. But the medical association's access to governors has been pretty consistent because we, as an organization, and the people who were responsible for developing relationships, did so.

Perhaps the most difficult one was Governor Straub. And he wanted to, interestingly, he had this notion of setting up this pricing system for hospitals. And he wanted to set up, but I can't remember what he called it. But it was a hospital rate commission type of notion. And Pete (Fleischner?), who was the CEO of the Oregon Association of Hospitals at the time, and I, worked very closely together to develop a strategy to deal with Bob Straub's notion.

And I remember one time we either requested or we were invited to meet with Straub in the governor's conference room, which is just the opposite side of the governor's office in the Capitol. And so Pete and I were sitting on one end of this big long table, and the governor was sitting on the other end. And he had all of his staff around. And we were telling them why setting up a rate setting commission was just a faulty way to go.

And he started to nod off, obviously not paying a big of attention to what was being said. So in those days, there were ashtrays on the table. And there was one sitting right in front of me. So I just put my finger on the edge of that ashtray, and I tapped it like that. Well, it went wobble, wobble, wobble, wobble all the way down, halfway down that table, and I didn't expect it to go. I just wanted to make a little noise and make him wake up. And it just wobbled, the whole staff along the edge there started laughing, and it was really hilarious. And he was awake for the rest of the meeting. [laughter] But getting access to him was not the easiest thing.

FRISCH: John Kitzhaber.

DERNEDDE: [laughs] John Kitzhaber. You know, I first met John Kitzhaber when he was a student up at OHSU. And he was a rebel rouser then, as a student. He was somewhat of a rebel when he was in the legislature, in the House. I can remember the first time I saw him in a committee meeting. He was wearing a bright red lumberman's like shirt. Where everybody else was dressed in a suit, there's John Kitzhaber, doctor, emergency room doc from Roseburg dressed like he was about ready to go out and chop a tree down. But he was an interesting guy, very independent, very thoughtful.

I think John, I don't think people appreciate the fact of what an intellectual he is. And he gives a great deal of thought to what he wants to do. I just saw him here two weeks ago and he said, "Hey, Bob, I've got a great idea for you." He said, "We need to get together so I can tell you about it. This is something that you probably wouldn't have been able to support when you were at OMA, but you might be interested now."

I said, "Hey, John, I'm retired. I'm not going to jump on the bandwagon for anything but golf and tennis and play." [laughs] But anyway, he's still up to his thoughtful tricks. And a delightful guy who really worked hard, but he was his own master.

FRISCH: We knocked heads with him from time to time.

DERNEDDE: Oh, yeah. Well, I think where we first knocked heads with him was the Oregon Medical Political Action Committee had a meeting, and they had invited John Kitzhaber to appear before them. John, being his independent self, and a little feisty, basically told the OMPAC board that he didn't need them.

Well, Dr. Larry Hagmeier took offense to that. And only as Larry Hagmeier could do, just lectured him until he was blue in the face. Well–

[End Track One. Begin Track Two.]

DERNEDDE: John didn't appreciate that. I can remember another time when we had a meeting in this room. And Brad Davis, who was a county medical society exec here challenged John Kitzhaber in a very inappropriate way. And John just let him have it with both barrels in this conflict there. But fortunately John Kitzhaber, who was then Senator Kitzhaber, realized that that was just one guy and that we didn't agree with what he was saying.

But I'll give credit to Scott Gallant, who was the director of governor affairs to the OMA for twenty-some odd years, who had a very close relationship, personal relationship, with John Kitzhaber. And anytime, in fact, there was an article in the newspaper, in the *Oregonian*, that there were few people who could have open access to John Kitzhaber, and Scott Gallant was one of them. But Scott was smart; he didn't misuse that. And John Kitzhaber frequently would get on the phone and call Scott and say, "Hey, let's go have a beer," or, "Let's do this, because I want your counsel."

When John Kitzhaber came up with the notion of the Oregon Health Plan, the first person outside of his immediate staff that he consulted was Scott Gallant. And Roy Skoglund, who was a urologist down in Roseburg, past president of the Oregon Medical Association. And he wanted their reaction. And I was brought into that circle. And my fear at the time was we were going to have difficulty getting doctors to buy into this. What ended up being is Associated Oregon Industries first said they would buy into it, and then they backed out. And that was one of the legs of the stool of the Oregon Health

Plan was to have all the employers covering employees, having Medicaid cover those poor people and then having the third leg be a special insured program for people who couldn't otherwise get insurance, but would have a way to get it. And that were working. But the employer portion of the stool never materialized.

And that, but, let me back up here. But it was Scott Gallant of the Oregon Medical Association who led the formation of the coalition that actually got the Oregon Health Plan passed through the legislature. Credit goes to Scott. Now John Kitzhaber played a big role in it. But the nitty gritty, behind the scenes work, was done by public affairs guy of the Oregon Medical Association.

And the follow-through, the follow-up after it became law, and after it was funded, after it got into operation and had its horrendous difficulties, Scott Gallant was behind the scenes, trying to hold the thing together. The state was negatively impacted by federal law, federal rules, interpretation of the ADA, disabilities act, because the whole notion was to apply resources, medical resources, to those people that were going to benefit most from various procedures. And when the ADA got into the act and those were the activists that beat the drums for the ADA, they got into the act and challenged Oregon's approach. Oregon had to back off and say equal access to everything, irrespective of the act that this alcoholic, who's been alcoholic for thirty years and his liver was going and he was entitled to a liver transplant, irregardless of, no such word as irregardless, regardless of the fact that he wouldn't benefit that much by it.

But John Kitzhaber was a good guy and still is. He's still a rebel. He's still doing his own thing. And I kind of giggled that some folks were trying to get him to run against the current governor. I doubt that that would happen, but I think he's kind of enjoying the spotlight. [laughs]

FRISCH: We've talked a little bit about some of the legislative successes of the OMA. What were some of the notable things that we didn't get accomplished that we were really seriously trying to get done?

DERNEDDE: Everything we went after, we got. What are you talking about?

FRISCH: Never missed a boat, huh? [Dernedde laughs] Did we get rolled somewhere along the way? [Dernedde sighs] Well, I remember one. The osteopaths.

DERNEDDE: Oh! [laughs]

FRISCH: The osteopaths rolled us.

DERNEDDE: Oh, yeah.

FRISCH: Jeff Heatherington.

DERNEDDE: That was in–

FRISCH: ’85? ’87?

DERNEDDE: ’87. 1987 when the tort reform package was being put together. And we were in the final weeks, in fact, the final week of, we had the votes on the committee to get it out, get the package out. But Jeff Hetherington, who was with the osteopathic physicians, wanted to get something that he could tell his members that he got for them. Proposed something to Senator, or was it Representative Dick Springer at the time. I think it was Representative Dick Springer. And that was that a malpractice insurance carrier had the right, anybody and everybody, membership could not be a criteria for–

FRISCH: Condition.

DERNEDDE: –or a condition for participation in the plan. And that was a stab at the OMA’s sponsored plan with C&A Insurance, because that required membership in the OMA and adherence to some policies and procedures and conditions. So Jeff thought he had pulled a good one. And I viewed it as a poison pill because with that, if we were to turn around and say, “No, we won’t support this thing,” then we would kill the tort reform and that’s what Dick Springer thought we could accomplish because he was the plaintiff’s attorney, he was an opponent of tort reform.

Well, we immediately, that is, Paul Frisch and I got together with our attorney Tom Coomey and said hey, what about federal legislation that allows us to create a group purchasing plan? Can we utilize it? And it didn’t take too long to get that confirmed that we could. So we applied for a group purchasing plan and we bypassed the poison pill and did our own thing.

FRISCH: The rest is history.

DERNEDDE: The rest is history. Funny thing, I ran into Heatherington and told him. I said, you know, “That was a spiteful attempt at destroying–” [noise in background] Probably a doctor. That was a spiteful attempt at destroying tort reform for a very narrow gain that he could have claimed without really carrying it through, and without even discussing it with us in advance. I would never forgive him for it.

And I think probably a couple of years ago he said, “You just won’t let me forget that, would you? Will you?”

No! Trust is something that I respect. If I can’t trust somebody, I don’t respect him. That’s just the way it is.

FRISCH: Along that lines of those things, let me throw a name at you, ask you what you can recall. Peter Nathan.

DERNEDDE: [laughs] He just died. I just read his obituary in the paper weeks ago. In fact, I cut it out and mailed it to Bob (Elsinore?), who at one time was the executive director of Multnomah County Medical Society. Peter Nathan was a gadfly. Went to medical school in Switzerland. Grew up in New York. Moved to Oregon. Why, I never could figure out. He was a hand surgeon. And he was a relatively young guy.

But he had a malpractice case and he didn't like the idea that his peers were going to review that case. And he didn't like the idea that I was privy to that case. And he challenged my credentials. I was a CEO at the time. Larry Hagmeier was president of the medical association at the time. So he challenged me. But that was my job, to get things prepared for the committee to review the case. So then he decided that he was going to challenge, we went ahead and reviewed the case. And once the case got started, I got up from the committee and I left. I said, "There's no need for me to sit in and listen to it and antagonize you." We weren't going to do anything about it anyway. So I stepped out. Well, he didn't like that idea that I was even aware of the case.

And then he challenged Dr. Hagmeier. Challenged me. And then he started a publication called *One Man's Opinion.* I still have a full set of his *One Man's Opinion.* Pretty nasty stuff. But you know, like every profession, like every occupation, like every business organization, you always end up with somebody who likes to stir the pot. And you have to learn to tolerate them, ignore them. Sometimes they're pretty hard to ignore.

He decided he was going to run for president of the medical association. And that's when Bob Loomis, Dr. Bob Loomis from Eugene, says "I'll not allow that. I'll run against him." And Bob Loomis ran against him and (won handily?).

I'll never forget when we were counting ballots at the old medical society building on Park Place. And Dr. Jack Bataglia was one of the ballot counters. And Dr. Nathan was looking over his shoulder, and somehow he'd lost his footing and fell on him. [laughs] And that really ticked Bataglia off. "You can come in here and watch. But you sit over there." It was funny. I just howled.

FRISCH: Then he sued us, didn't he?

DERNEDDE: Yeah, he wanted to know why I had terminated an employee. And I don't even remember who it was or what the circumstances. But that was my prerogative as the CEO. And he was just looking for something to stir the pot. So then he wanted all the salaries of all the employees, what their benefits were and so forth and so on. Well, we had a covenant with the employees that what they earned and what they received as a benefit was a matter of the leadership and the employee and no one else. It was not public information.

So he filed suit to acquire that information. So we went through depositions and all that stuff. He had meanwhile written some pretty derogatory things about some of the leadership of the medical association in his *One Man's Opinion* about me and so forth. In

fact, I had one lawyer tell me, he said, "Hey, you've got early retirement here if you want to sue him."

And I said, "I have no interest in doing that."

Anyway, his lawyer finally got to him and said, "Hey, you better back off or you're going to lose everything you've got." And he had quite a bit, because he had inherited quite a bit from his parents.

SIMEK: Sorry, I need to interrupt you here and change tapes.

FRISCH: Take a break.

DERNEDDE: Peter Nathan is not somebody who fits in the public interest.

[End Track Two. Begin Track Three.]

DERNEDDE: Okay. Am I facing the right way? My butt's getting tired. You didn't provide any cushion. You gave me a little wine, but no cush.

FRISCH: You want to take five minutes and get up and stretch?

DERNEDDE: No.

FRISCH: We'll just keep going. We could be here till five. Let's talk about OHSU. OMA has played a central role in some things that have occurred up on the hill. Tell us about the ones that you think were the most important ones where OMA caused things to occur up there that probably wouldn't have occurred without our involvement.

DERNEDDE: Well, Oregon Health Sciences University, when I first came, was small potatoes when it comes to medical schools around the country, compare it. And the faculty up there was pretty ingrained. They all had their little fiefdoms. And trying to manage that operation was probably impossible at that time. OMA had probably a third of the doctors up at the medical school as members of the OMA. Two-thirds were not. Not unusual with academicians not to be involved in the day to day operations of real life.

But I recall when the doctors that were involved in practice wanted to create a department of family practice, create a residency program for family practice. Train more family physicians with higher expectations of production, rather than just four years of medical school and going to one year, an internship in a hospital setting and then be out on your own. They wanted more training for family practice.

Well, the dean of the medical school at the time didn't support that notion. In fact, he resisted. Dean (Holden?). And there were some pretty influential docs who were in practice. One of those was Merle Pennington, from Sherwood. Another was Laurel Case

from Medford. Anyway, I had arranged for a meeting with the leadership of the Joint Ways and Means Committee in Salem to hear these gentlemen out about the creation of the department of family practice of the medical school. So basic–

SIMEK: This is an important story and [inaudible]

FRISCH: Do you have, let's just pick it up from the beginning.

DERNEDDE: Where did we– well, Dean (Holme?) –

FRISCH: Joint–

SIMEK: Some pretty influential doctors, including Laurel Case from Medford–

FRISCH: And Joint Ways and Means.

DERNEDDE: I had arranged for a meeting with the leadership of the Joint Ways and Means Committee. Not the full committee, but the leadership. Which included the speaker of the House, president of the Senate. And I think there were probably eight from the Ways and Means Committee, to meet with Dr. Pennington, Dr. Case, and I think, I can't remember who the president of the OMA was at the time. But there were, had three doctors down there, myself, and members of the Ways and Means Committee. And this was in the back room behind the Capitol. Can't do that anymore.

But then, we met, and Dr. Pennington, Dr. Case, presented their case to the Ways and Means, and that dean was stalling and really needed to develop this program. We had this huge shortage of physicians in Oregon. And we were going to have to grow our own. And this was a way to do it. So we convinced the Ways and Means Committee that this was the way to go. So the Ways and Means Committee in the footnotes to the medical school budget put a condition on everything that this budget was conditioned on the creation by the dean and the medical school of a department of family practice. So it was done.

And Holman, I never spoke to Holman again. [laughs] I don't think he would speak to me, either. But we were able to accomplish it. And the Department of Family Practice was created. And interestingly, one of the two gentlemen that were at that meeting subsequently became the chair of the department of the residency program, and that was Dr. Case from Medford. And then a few years later, Dr. Pennington retired from his Sherwood practice and joined the faculty up there and was part of the faculty.

But Dr. Pennington was an interesting guy himself. He was chairman of our council on medical education. He was the guy that along with Dr. Al Henderson in Hood River who pushed along the creation of what we called circuit courses where we would take faculty from the medical school and run them all over the state to meet with physicians in Ontario and in Heppner and Hermiston, Coquille, and Coos Bay, all over the state, in rural areas, to put on courses in medical advancements. And we ran a huge

circuit course program through our Council on Medical Education. That was Merle Pennington. Then he went, subsequently went with the Department of Family Practice. And now it's a thriving department.

Another one was when we wanted to see created a Department of Continuing Medical Education at the medical school. Now, we didn't have resistance. But we didn't have any money. So what we did is something similar. We went to the legislature and said, the OMA will pledge twenty-five thousand dollars a year for five years to match whatever the legislature could put up to fund the Department of Continuing Medical Education. And that's how it came about. And the OMA did its five years. In fact, I think we went on a couple of years beyond that to make sure it had a good start. And that's now the Department of Continuing Medical Education. The medical school is a thriving organization. And Dr. Julius Reinschmidt was the guy at the school who headed the Department of Continuing Medical Education for a while.

FRISCH: Tell me a little bit about him, and also I want to hear something about our friend in the public health department who was responsible for all the great work force surveys. He just passed away.

DERNEDDE: Harold Osterud, what a delightful guy. Dr. Reinschmidt was a doctor's doctor. He ran a federal program at the school in health planning before he got involved in continuing medical education. But he was head of the Department of Continuing Medical Education. He was very involved in the AMA. He was on the OMA Board of Trustees for years. He was a practical guy. And I never forget, sometimes public health people would come to, before the association, whether it's (?) or whether it was a public health and safety committee, and they'd whine about the federal requirements to do this and this and this. And Dutch Reinschmidt would say, "Ah, quit bellyaching." He said, "You just get around it, and you work around it, and you tolerate it." And he's right. You just couldn't let your feathers get all fluffed up. You just had to deal with reality and all that paperwork and all that bureaucratic humbug and get the job done.

He was a delightful man. In fact, the medical association named its boardroom the Reinschmidt boardroom after he passed away as a tribute to him. Just an absolutely delightful man. I was very, very fond of him.

FRISCH: We also owe a great debt to Harold Osterud. He did so many things in the public health arena of the school. He was really the guardian of the physician work force data that we've relied on for years. Tell us something about Harold.

DERNEDDE: Harold Osterud, Dr. Harold Osterud, was a public health physician from the word go. Not only was he a public health officer in Clackamas County, he was in Washington County for a while. But he was the professor of public health and ran the Department of Public Health and Preventative Medicine at OHSU for years and years and years and years. A delightful, delightful man. He knew more about public health than anybody. Ed Press was another fellow that was a state health officer at the time.

But he was also a statistician. And we had spent a lot of time when we had this physician shortage in the '70s, trying to figure out how we could deal with reality. We had to know what we had in terms of the quality and the quantity and the age and the mix of specialists and so forth. There wasn't any data. Board of Medical Examiners didn't have anything. So Harold Osterud and I decided we needed to do this. So we, I think we asked the Oregon Medical Education Foundation to fund the first publication. And Dr. Osterud did all the research. We did surveys of physicians and then subsequently a few years later got the Board of Medical Examiners to include the survey in their annual relicensure thing to put a little more weight to it so we got better participation. And that worked when something, had to pay their annual registration. And there was a survey from the Board of Medical Examiners. They responded. So we got better data.

And as a result, Dr. Osterud plowed through that stuff just like a horse with a new bale of hay. He just chewed on that stuff and came up with all kinds of data and so forth. And it was valuable information. Because not only did we quantify how many doctors we had, we quantified how much time they were working and what specialty areas. We had it down by demographics, by community. Those doctors that were traveling, it was a good number of physicians who had a regular office, and then one day a week they'd travel to Florence, and see patients in Florence. Or they'd travel to Seaside, see patients in Seaside. Who were specialists.

And Harold was able to document all that. So we had some pretty solid evidence. And we used that information when we went to the Ways and Means Committee about the Department of Family Practice, and why we needed to do this. We used that information to get funding for the circuit courses and the Department of Continuing Medical Education. Because these people couldn't leave. They couldn't leave their communities to come into Portland or go to Seattle or San Francisco to get up to snuff on changes in medicine.

FRISCH: Because there was no coverage.

DERNEDDE: There was no coverage. They had to be there for their patients. So a lot of this was going on. And Harold Osterud did that, did that, did that year after year. And we had a, we had a person working here by the name of Karen Whitaker. And Karen subsequently became the director of the Department of Rural Health up at OHSU. And continued the health manpower studies through the Department of Rural Health, because that's where it's most meaningful.

And Harold, to the last days of his life, was massaging data about medical manpower in Oregon, always coming up with a new scheme. Let's do it this way, let's do it that way, let's include this, include that. I'd meet with him about every six months and we'd talk about it. Some of his ideas weren't going to fly, and I told him so. And as soon as I said, "That's not going to fly, Harold," that was all. It was over. He'd never come back with that same one. He'd just go off in a different direction. He was a wonderful man. I miss that man. He was a real human being.

FRISCH: I miss him, too. There's another guy up there that I miss is Bill Fisher. Tell us about Bill. He was a president of the association. He was up at the Department of Family Practice. His family ran a mortuary. Tell me what you know.

DERNEDDE: Well, Dr. Bill Fisher grew up in Albany. He was a product of OHSU. He was in private practice for a number of years. He gave up obstetrics. And when he gave up obstetrics, he lost something. He just didn't feel he was fulfilling his mission as a physician. So he joined the medical school faculty as part of the Department of Family Practice. Great guy.

He was a nitpicker. If we needed something edited, we asked Dr. Fisher to look it over. In fact, we didn't even have to ask him. He would do it before we could ask him. And he would dot i's and replace commas and so forth and so on. Challenge conclusions and so forth. But that was great. In fact, whenever we had something of high technical nature that was really clinical, staff would go to Dr. Fisher and ask him to take a look at it. And make sure that we didn't overstate or understate a case that had clinical overtures. And he was superb at doing that for us.

He worked up at the medical school in family practice for a long, long time. And when he retired from the department, he came to work for the OMA doing some work here as a medical director for some of the programs that we had. And he continued to be our chief nitpicker. A great guy, a true cowboy. He loved to go to dude ranches and I'll never forget his memorial service, which was here at the Oregon Medical Association building. At the very end, played a cowboy tune. I'm sure he was kicking up his heels in heaven what that occurred.

And that also reminds me that when Pete (Fleishner?), who was the president of the Oregon Association of Hospitals, when he died rather suddenly, his funeral was up at the Episcopal church in Northwest Portland. And at the end of the service, they cranked up that organ to as high was it would go and played "Amazing Grace." And the seats vibrated. And it was a great salute to a really neat man, Pete (Fleischner?).

FRISCH: What do you think are the transformational events in medicine in Oregon? Things that, from the public's perspective, made a difference in the way and the direction that Oregon went.

DERNEDDE: Well, some of the big changes that took place, I can only reflect on the things that I was directly exposed to or involved in. OHSU was one that, it was not a real stellar institution in comparison to other schools when I first came to the medical association. Today, it is. It is very much a stellar organization, and I attribute that to about three presidents. There have been more, and most recently Dr. Peter Kohler, who had a vision that has been phenomenal, just phenomenal. But that has expanded not only the research side of things, but the quality and quantity of medical services that are available to the people. Not only of our state but of our region.

And probably more so for rural parts of Oregon, where the doctors in rural Oregon have a place to refer patients who have some pretty complicated medical conditions. And they're accepted willingly at OHSU, and they've got some wonderful people up there. It's amazing how they've been able to attract and hold the quality of physicians at OHSU that they have today.

And I mentioned earlier that only about a third of the doctors in the clinical faculty when I first came were members, were involved in organized medicine in any way, shape, or form. Today the entire clinical faculty are members of the Oregon Medical Association. And that is a tribute to the leadership of the medical group at OHSU. Particularly–

FRISCH: And to you.

DERNEDDE: And particularly Dr. Henry DeMots. And who was a retired–

FRISCH: Oh, the OB? Kirk? Paul Kirk?

DERNEDDE: Paul Kirk! Paul Kirk was the other physician who was involved in getting everybody at the school involved in organized medicine. And both Henry DeMots and Paul Kirk felt that if OHSU was going to have the reputation and the attractiveness of the medical community at large, that it was going to be the leader in new procedures and new ideas, it had to be involved in what was transforming and going on in the real community. So they wanted to tie it all together, and they did. And we came up with ways that it could be done, and it was a success. That occurred about the year 2000.

FRISCH: It's held together.

DERNEDDE: And it's held together. That's great.

FRISCH: Another event which is crucial is that Oregon, if not the most significant player in managed care was certainly among the very top states, top number of states. What happened? How did that all come about? And while you're there, talk to me a little bit about the transformation of the relationship between the medical association and Kaiser. Because it didn't always have the level of respect that perhaps it does now.

DERNEDDE: [sighs] That's an hour's worth.

FRISCH: Well, so we'll do it.

DERNEDDE: Then I'll have to pee before that. [laughs]

FRISCH: Well, I have to have some more water.

SIMEK: You want to pause now?

DERNEDDE: Yeah, let's do it. And turn the air conditioning, it's getting a little warm in here. [laughs]

FRISCH: Just ever since, you know, there was this moment when they were thinking about bringing him on board that he was really enthusiastic. And I think that whole process took it out of him.

DERNEDDE: Well, he tried it twice.

FRISCH: And he discovered something. Well, yeah, but we discovered something. And that was that–

SIMEK: (?)

DERNEDDE: [laughs]

FRISCH: Um, I want to talk about–

DERNEDDE: We were talking about things that were–

FRISCH: Transformational. Big deals.

DERNEDDE: Transformational. I mentioned medical school and what's happened. I think that's had a great impact. Medicare has had a huge impact, but not just in Oregon. That's all across the country. It has had a huge impact on medicine, the rules and regulations that have evolved over time just have grown so much that participation in Medicare by physicians is troubling. The what ifs and why you can and can't do certain things for your patients make it exceptionally difficult. The reimbursement level is almost welfare-like. And as a result, doctors are not too willing to accept Medicare patients. And now I'm a Medicare person, and I'm concerned about that. I really am. I have, personally have a lot of contacts in the medical community, so it's not as troubling for me. But for those people who are, who just don't have relationships like I do, it's got to be scary when they're trying to find a new physician or to find somebody to deal with with their problems or issues. And it's not just reimbursements. It's the complicated regulations they're associated with. And Congress has done nothing but add on to it. And the federal government has complicated it. It's just bad for patient care. And as we get more and more older citizens who are under Medicare, it's going to be that much more difficult.

FRISCH: What about managed care?

DERNEDDE: In the late '70s, mid to late '70s, a number of physicians, particularly in Portland, tried to form their own little managed care arrangement. And Congress was talking about managed care. They were trying to give preferential treatment to HMOs. This had a lot to do with what Kaiser was doing. And we had a secretary of HHS in Washington, DC who was advancing some of this stuff. And we had

doctors who were trying to create their own little managed system outside of the insurance programs, OPS and Blue Cross, that had been very supportive along the way.

The very first one was Portland Metropolitan Health, which went into receivership. And a lot of doctors took it in the ear. But it was the Oregon Medical Association, its legal counsel, that managed to go to the receiver and make sure that the physicians were appropriately treated in this receivership. And it worked. And doctors came out okay. But they kept creating these little insurance-like organizations, thinking that they could do better than what the insurance industry could do. And there were some physicians who were just bent on being leaders to carry this stuff out.

And all this evolved to the point where in the late '80s, the early '90s, we had this incredible amount of managed care in this state. More so than in most other states. And led by physicians. Unfortunately, their intentions were good, but their business skills were just sadly misplaced, or they didn't have any.

Then there were IPAs that were created because the Oregon Health Plan came around, and so there was at risk. I always felt that if you were going to go at risk, there had to be an up side and a down side. But in the health care arena, if you accepted a risk, it was very little up side. It was mostly down side. And yet they went into it out of fear. So many of them went into it out of fear that they were going to lose their patient load. And you know, they had mortgages, and they had this and they had that. And they were concerned that they were going to be left behind.

The medical association tried to do a number of things in training physicians on how to deal with managed care, how to practice within managed care. We went so far as to try to set up an electronic network that to this day I think was a wise move, even though it didn't work. But to try and help physicians deal with this fast changing environment of risk taking and management of patients where the doctor was at risk for whatever the win/loss was, economically.

Fortunately, much of this managed care thrust has backed off. Regents, Blue Cross/Blue Shield, which was a heavy participant in the '90s, they had their own HMO and they were trying to force everybody into it, they backed off and said hey, this isn't working. Providence Health System still thinks it's the cat's meow, and they're forging ahead. Kaiser Permanente hasn't changed its way. It's been doing what it's been doing all along, and they're going to continue to do what they do all along. But I don't know why everybody feels they have to compete against them. Let them do what they're doing and let it be.

FRISCH: One of the things that, the term "capitation" was a popular term back there where the doctors received the money and they were responsible for spending it. If they spent less than they took in, then they got to keep the difference. If they spent more, presumably, they had responsibility for those things. But the effect, as I understand it, was that we became much more efficient in the delivery of healthcare. And when the feds

started setting amounts that could be paid by state or by area, we ended up kind of on the short end of the stick. Could you talk a little bit about that?

DERNEDDE: Oregon probably more than most other states was more economical in what they charged their patients. Oregon physicians were generally more sensitive to what their patients' needs were, and what they could afford. And I think we were more efficient overall in delivering medical care. So when the federals come along, or came along, and said for managed care and capitation, Medicare or whatever it might be, this is how much you get, Oregon, because this has been your experience, Oregon got shortchanged.

And to this day, we're living with that shortchanging. Now some of it is our own fault. You go back to Medicare, the creation of Medicare in the mid '60s, one of the provisions of the Medicare law was that physicians were to be reimbursed, or their reimbursement was to be based on their usual customary reasonable levels in the various jurisdictions around the country. So what that meant was Oregon – because it was not a high charging state, it was more efficient, and a number of other things – ended up getting less from the government. And to this day, physicians in Oregon receive less in compensation. Now this is thirty-five years later, forty years later. And that same circumstance is impacting Oregon physicians. And that's why so many of them in Oregon are saying, "I can't afford to continue to have a number of Medicare patients." Because of the low reimbursement.

Congress has refused to deal with hit. Administration after administration has refused to deal with it. They only deal with it piecemeal. Our senators really haven't been, they've given a lot of lip service to it, let me put it that way. And it's the same with our congressmen. They talk the fine line, but in reality they just have not produced.

FRISCH: So the audience understands, that can mean that you do the exact same procedure or the exact same treatment in Oregon and in another state, like New York or someplace else, the amount that the physician is paid is less.

DERNEDDE: You can have a cataract done in Florida and have it done in Oregon. And the compensation to the physician that does it in Florida will be twice the amount that it is in Oregon. Now it may be a little more expensive to practice in Florida than it is in Oregon–

FRISCH: Not that much.

DERNEDDE: But not that much. And that's the inequity that all goes back to the mid '60s when the AMA insisted on the usual and customary reasonable in the locale. And we are still, to that day.

Now the AMA came forth and tried to get the relative value reimbursement system based on all kinds of factors. And that was adopted and adopted by Congress but never funded to the level that it would be implemented to this day! And so it's tilted in

the wrong direction. But there are more congressmen from Florida and California and New York than there are from Oregon or Utah or Wyoming. And those states also experience the same problem.

FRISCH: When you talk about something called professional standards review organizations, could you talk about how that came to pass? What OMA's role is, was, is, in it? And where it is today.

DERNEDDE: Sometime in the mid '70s, Congress adopted a professional standards review organization legislation called PSRO. And the purpose was to provide professional review of medical services provided to Medicare patients and Medicaid, welfare patients. And Congress funded this through, or from the social security tax, or the Medicare tax. And each state was to create one or more professional standards review organizations. So the Oregon Medical Association [audio trouble, inaudible] Excuse me.

FRISCH: Whoops. (Wobrock?) was here two weeks ago. What an interesting interview. And they probably need to know what that meant to the public.

DERNEDDE: Yeah. And this wasn't, professional review organizations were aimed to provide a quality check on services that were provided to Medicare and Medicaid patients. It was alleged to be a quality check, but as it turned out, the federals wanted to put some pricing factors to it without legal authority, I might add. In any event, the Oregon Medical Association felt that it ought to be involved in creating an organization that would look at medical quality in a fashion that made sense. And so it created the Oregon Foundation for Medical Care.

Multnomah County Medical Society decided it was already involved in quality assessment. And their president at the time, Dr. John Bussman, was vehement that there would not be a statewide professional service organization, that Multnomah County should be left to do its own professional review, and the rest of the state could do its own.

So to make a long story short, there were two professional standards review organizations in Oregon, one embracing Multnomah County and another embracing the rest of the state. I was assigned to create the one outside of, or the one that didn't include Multnomah. And we call it the Greater Oregon Professional Standards Review Organization. And I was very much involved in its creation and its operation.

Well, the federals didn't like the idea that an exec of a medical association was so deeply involved in the creation and operation of a professional standards review organization. This was supposed to be, you know, outside of the profession. And they viewed it as the fox guarding the chicken house. Well, who's better capable of assessing quality than physicians? So it's a large peer review process of reviewing data and making sure that patients are getting the kind of quality that they should be getting.

I spent a great deal of time with that. Finally hired a fellow by the name of Bob Berry from Blue Cross to serve as the executive director. And once he got involved, I

stepped aside. And we rented a space across the street from us to house the greater Oregon PSRO. We needed to have a medical director to assure the quality standards. And so we hired Dr. Noel Rawls who was the public health officer for Clatsop County and a former president of the medical association, to serve as the medical director of the greater Oregon PSRO. And he did a great job.

When the Oregon Medical Association moved to its present headquarters, we accommodated the greater Oregon PSRO by providing space. And so they essentially moved in with us. And we always had a very close relationship. And Bob Berry and I have been great friends for years and years and years. And in fact, I just had lunch with him this last spring.

After a while, the two PSROs merged and became one. The person most responsible for that merger was Dr. Bob Hare, another great Oregon physician, former president of the medical association.

FRISCH: Who was a diabetologist?

DERNEDDE: Whose specialty was diabetes. He and his partner, (? Page?). in fact, they created the Gales Creek Camp for Diabetic Children. And to this day, it's a very well run, functional camp for diabetic children.

But anyway, Dr. Hare was a highly respected physician. He was able to bring the two organizations together to create one. And that's the way it is today. And while the whole process is a little different today, the fundamentals of doing quality assurance primarily in hospital settings, continues.

FRISCH: What does it mean to an Oregonian that the PSRO movement took hold and continues to this day?

DERNEDDE: Well, I think at the time it provided a bit of assurance that patients were properly cared for in the hospital, as well as in various disease entities. I'm probably overstepping my bounds in suggesting that perhaps it's outlived its usefulness. I'll probably get a telephone call for this. But there's a point of diminishing returns. It's costly to run these review systems. The systems are in place. They're being reviewed. If the proper framework is put together, you don't need to have this huge organization doing this stuff. It can be done, because its effects have been accomplished. Its goals have been accomplished. I just shot myself in the foot. [laughs]

FRISCH: Yeah. Don't worry about it. I think they'd be the first to tell you that they dropped 25 percent of their staff last month.

DERNEDDE: Well, their funding's dropping out. But you know, Congress is great at creating new institutions. And when they've outlived their purpose, their usefulness, they're great at continuing. Because they were such a great idea at the time. [laughs]

FRISCH: That they didn't want to let go.

DERNEDDE: I'm drinking wine. You're not going to film me.

FRISCH: No. It's not filming.

DERNEDDE: You're going to ace this out.

FRISCH: Bob, I think what was so amazing about your work was that there were times when something, you felt something was the right thing to do. And you would throw the weight of your organization and your personal and professional weight behind it. And it would happen. I want to talk to you about Loretta Loeb. And what Loretta set out to do. And what your role and the OMA's role was, and why that was important to–

[End Track Three. Begin Track Four.]

FRISCH: –the folks here in Oregon.

DERNEDDE: Loretta and Felix Loeb, two psychiatrists in Portland. Delightful people. They had a notion that they needed to do something about Portland gangs. And they were exploring what can they do as a specialty of medicine. They understood part of what goes on, the psychology of the gangs. But they wanted to do something to try to help people exit gang activity and not return and become a useful citizen. And they met for quite some time with Portland police, the county sheriff, social workers, a small little group of concerned psychiatrists looking for what they could do. And they finally came up with the idea that in order for gang members to truly exit gang activity, they had to remove the symbols of ganghood that were attached to their body in the form of tattoos. And some of the vulgarities that you would find on their necks and their faces and their hands and so forth, no employer is going to hire anybody that has vulgarity across their knuckles. And if they had gang symbols on their hands and their face, they were always going to be (paid?).

So this committee of the Oregon Psychiatric Association went to the psychiatric association board and said this is what we want to do. We want to create a tattoo removal project to remove tattoos from gang members who voluntarily chose, maybe with a little coercion, to exit gang activity. And the notion was that they would do it in the community as well as McLaren, the girls' youth detention center in Salem.

So I personally thought that this was a really novel approach for the Oregon Psychiatric Society, which had spent most of its time looking at itself as opposed to doing something in the community. And I talked to the Oregon Medical Education Foundation. I said, you know, we ought to take a look at this and provide a repository within the Medical Education Foundation for whatever funds are raised and be supportive of this project. Because truly, if you really want to get somebody out of the gang life, you had to remove those impediments to their departure.

And the Medical Education Foundation board agreed. So I sat down with Dr. Loeb and helped her put together, ran applications to buy lasers. Laser equipment to remove tattoos. Meanwhile, she had been in contact with representatives of the dermatology society to get volunteer and their support, because it took a dermatologist to remove, physically remove the tattoos. And so the psychiatrists were dealing with the emotional side of this and finding the source and getting the physical part of the actual removal done by qualified dermatologists.

And they were able to get some funding. They got funding from two large foundations. They got, I think, eighty-five thousand dollars from the Meyer Trust. And the Tucker Trust put some money into it, and so forth. And the sheriff's office and the police department were very supportive of what we were doing.

And so as it turned out, they were able to buy two large state of the art lasers. One was located at Emmanuel Hospital. And another was located, and was mobile, down at McLaren. And had dermatologists who volunteered to go ahead and do the actual removal. No removal was done without the approval of the police department. Because they needed to have assurance that this person was not just doing this to pull a fast one with the police department and so forth and so on. So all those checks and balances were put into place. Then they ran a great program for quite some time. Then, unfortunately, another psychiatrist basically dropped a bomb and killed the program. But that's another story. But that was a great project that lasted for some time and accomplished a great deal.

And I don't know what happened. I think we turned the, we turned the equipment over to Outside In.

FRISCH: Right.

DERNEDDE: And Outside In took possession of the lasers and dealt with the Oregon Dermatological Society to continue doing this. But I don't know what's happened today, what transpired.

SIMEK: Can you give just a little more detail on, without names or anything, but what was the argument against this that (?)

DERNEDDE: [laughs] You don't really want me to do that.

SIMEK: I don't?

DERNEDDE: No. The word "jealousy" would come in. And I just don't want to go there. I'll do it whenever the red dot isn't showing on that thing. [laughs]

FRISCH: Cover the red dot.

SIMEK: I can turn the dot off.

DERNEDDE: No, no, no, no, no, no, no. The volume is still on.

FRISCH: Bob, I'm sure that there were some other things that I might not be aware of that you took an interest in that benefited the public that the medical association got behind. Can you think of some other things that were like that? Because that was such a great project.

DERNEDDE: Well, it was a fun project at the time. Although it became–

FRISCH: It was kind of burdensome.

DERNEDDE: It became, well, I felt like I was a counselor.

FRISCH: Right.

DERNEDDE: But I, you know, felt that the people that were involved in it were really doing it for genuine reasons. And there was no self service in this thing whatsoever. Furthermore, I liked Dr. Loeb and the people she was working with. A delightful person. So that was, that's kind of a fun thing.

FRISCH: Were there some others like that that you remember?

DERNEDDE: Oh, there's so many people. One of them just entered the room. Dr. Roy Payne. But I already told you about him.

FRISCH: We talked all about him. [laughter] Let's talk a little bit about women in medicine. How have things changed? Tell me a little bit about your relationship with Ginny Burke, and her time as president of the association. What you see as some of the progress that you made, what are some of the things that are left to be done?

DERNEDDE: Women in medicine. Obviously the few women that were in medicine in the '60s, '70s, really struggled to get where they were. I heard stories about how hard it was, the sexism that went into their residency program, and some little smart remarks that naturally happened in the '40s and '50s and '60s. But the survivors were really impressive, tough physicians. One of those was Dr. Genevieve Burke, an anesthesiologist down in Oregon City. She grew up in Baker, I think it was Baker, on a farm, ranch. A working ranch. She didn't take any garbage from anyone. And she was a delightful human being. She went up to (?) to become president of the Oregon Medical Association. She was a delightful lady. But even then, she didn't take any garbage off of anyone.

The sad part for Genny Burke was she ran for the state senate. And she would have been a great senator, but she lost that election. But more sadly was that she had serious degenerative eye problems. And she lost pretty much all of her eyesight. And as a

result, she had to retire. And she backed out and became somewhat reclusive because she just couldn't get around. She couldn't see and so forth. Basically took her out. But she was a delightful person.

There were other physicians, women physicians, who came up through the really, what you would call the school of hard knocks. They were great, great doctors. In the '70s, the school made a conscious decision to start opening up more, it wasn't just OHSU. Medical schools around the country were trying to recruit more women into medicine. For the most part, they responded. To this day, I believe that the medical school classes have a majority of women.

One of the things that I had said to the dean of the medical school who was a woman, for a short period of time, was you know, it's great that we have a number of women that are involved in medicine. But you need, the dean needed to look at the number of students who were training in terms of what their eventual productivity would be once they got out of school and their training. Because the evidence that we were seeing is that many of the women who went into medicine after they finished their training were job sharing, were limiting their hours and not working in the old traditional way that many men in medical practice conducted themselves.

But it wasn't just that. It was also that a number, a large number of recent graduates and those completing residency programs in the male population were seeking forty to forty-eight hour work weeks. And so the productivity of the product that was coming out of training was not like what it used to be. It used to, in the '60s, you could count on a physician that went into practice, they were fifty to sixty hours. New product wasn't doing that, as a rule. There were those that were. As a rule, they weren't.

So that's why I was trying to convince the dean, you've got to increase the number of student slots. Because you look at what the product was going to produce in terms of medical care once they're out, the school has increased the number of student slots. But it's going to take a long time for this to transition out. But there are a lot of women in practice that are doing great jobs. There are a number of specialists. I find it rather interesting that there are some women who are in orthopedics. Well, orthopedics requires a lot of muscular ability when you're doing procedures. So the women who are in orthopedics have to be pretty strong physically.

FRISCH: Another one I think about–

SIMEK: Let me go ahead and stop you. We are at the end of the tape here. Before we get into another one–

FRISCH: Good. Hey, Roy!

DERNEDDE: Oh, a pee break! Hello, Roy Payne!

Hey there, guy.

RoyFRISCH: Hello
[End Track Four. Begin Track Five.]

FRISCH: Beatrice Rose.

DERNEDDE: Another great woman physician in Oregon was Dr. Beatrice Rose. She was, she spent a good deal of her career up at OHSU in the Department of Public Health, in preventative medicine. And she came up through the school or hard knocks. And she was nobody's fool. She was one incredible lady. Sensitive, smart, but tough as nails. She was married to a physician who was a highly regarded cardiologist, Dr. Leonard Rose. She's now living down in La Jolla, California. Her husband, Dr. Leonard Rose, died this last spring.

I remember her way back in 1970 legislature, when the abortion issue was a hot and heavy item in Salem. And she took on all of the naysayers toward this issue. And she did it very successfully.

When we had to put together, as a compromise, an informed consent document for hysterectomies, because there was a period back in the late '70s, early '80s, when the media jumped all over the issue of too many hysterectomies.

FRISCH: And this California woman, physician, came up and browbeat–

DERNEDDE: Testified, yeah.

FRISCH: Testified at the legislature.

DERNEDDE: I don't remember what her name was. Huffstinger, Huff something.

FRISCH: Yeah. Huffstinger?

DERNEDDE: Anyhoo, she was–

FRISCH: Huffnagle. Vicki Huffnagle.

DERNEDDE: Vicki Huffnagle. And she came up, giving a bunch of statistics and data about too many hysterectomies done, and being done on women that didn't get, had not been given informed consent, and didn't know that their uterus was going to be removed, da da, da da, da da. Well, this stuff was bogus, or fraught with a lot of bogus data. In any event, in order to avoid the passage of legislation, and women's issues were big in the legislature at that time, so we agreed that we would produce a document that would be an informed consent document for women to review before they agreed to a hysterectomy.

And Dr. Beatrice Rose agreed to take on that task with a group of physicians. And she did a remarkable job. Produced the document. We sent it out for review. And she did it in a very professional manner and so that when the end product came out, the OMA printed thousands. And they were distributed all over the state. I believe they still are being distributed. This is twenty-some odd years, twenty-five years later. They've been revised. And Dr. Rose was involved in revising it and updating it. And it is still being used today. She's a remarkable woman.

FRISCH: So instead of being subjected to scare tactics, etcetera, the public has a resource that's medically derived and gives the plusses and the minuses of things.

DERNEDDE: And it's a document that has a lot of illustration. Written in a way that those who are not high level of education can comprehend what it says. It's well done, and it was something that needed to be provided, although not in the manner in which it was. But it's being used today by OB/GYNs and surgeons all across the state.

FRISCH: Tell me about another medical couple, Joan Tanner and her husband. They were quite fixtures around here.

DERNEDDE: [laughs] Yes. Dr. Joan Tanner was a family physician. A member of the Academy of Family Physicians. A volunteer up at the medical school. She had her practice in Hillsdale. A really neat lady. Her husband was an ophthalmologist who was a cantankerous type of guy. [laughs] I mean, he just didn't like to be told anything. When OMA had a requirement that physicians perform so many hours of continuing medical education in order to belong to the association, Dr. Tanner came to the board of trustees and basically said, "You ain't going to tell me what to do. And I'm not going to turn all this stuff in. Yet I do all this stuff, but I'm just not going to turn it in."

Anyway, I can't remember whether the association kicked him out or whether he resigned in the process, I don't recall. But he never did return, even though we did away with the requirement for continuing education, that notwithstanding, Dr. Joan Tanner remained in the organization. She was secretary-treasurer of the association on the executive committee. She was a tough lady, too. She did come up through the hard times where women really had to struggle to survive going through medical school and training, and dealing with a male-dominated profession. She's still around today, and she's a character. In fact when my mother was dying, I called upon Dr. Tanner to care for her for the last few weeks of her life.

FRISCH: Yeah, she's an amazing woman. OMA played a role in–

DERNEDDE: I get these off. I'm sorry. I need to put them on, you guys. I'm sorry.

FRISCH: No, that's no problem.

DERNEDDE: I'm sorry. I didn't realize they were on my nose.

FRISCH: OMA's played a role in a number of really interesting initiatives that the citizens of the state have pursued. Sometimes we were in the forefront of that, sometimes we were responding to it. But one of the ones that's interesting to me is the whole right to die deal. What was OMA's role? And what were some of the things that came out of the whole initiative process that led to physician-assisted suicide?

DERNEDDE: That was a pretty emotional time for the association. This whole right to die or physician-assisted suicide. There was a lot of soul searching going on in the House of Delegates. It just went on and on and on. And a number of physicians basically changed their views during all the debate that went on this issue.

The association had problems with the legislation because there was a lot of ambiguity and so forth. When the law was finally adopted by the public, the voters, we went through a process of analyzing the legislation to make sure the physicians wouldn't be caught in a bind if they had recommended or were involved in prescribing medication that would, I don't know what you would call it, medication, I don't know if you could call it medication, it was a medicine. But a lethal dose. And so we developed a number of amendments in the legislature to clean up the act so that it would be workable. And even when it was brought up again to the voters, put it down again and said we're going to have this. The association struggled, and the physicians in the state struggled over this whole issue. The passion that I saw in the House of Delegates for patients that were dying was pretty remarkable.

FRISCH: The association has always been a strong proponent of women's right to choose whether or not they have an abortion, etcetera. I think we've always debated these issues at the House of Delegates along the lines of those that saw this as a right to life issue and those that saw it as a fundamental choice issue. How did we manage all that? How did it come out? Are we a pretty good reflection of what the citizenry of the state are?

DERNEDDE: It was a lot of gingerly walking across pretty hot glass on a number of occasions. But we surveyed our membership, the physicians of our state, and said, this has been our policy. But the whole issue of a therapeutic abortion was a decision that had to be made between the patient and her doctor. And that was the posture of the medical association from way back to 1970 forward. And despite many attempts, particularly by those who were in the so-called right to life camp to overturn that. But we did surveys of our membership. And the surveys came back like 80 percent of physicians in the state felt that this whole issue was an issue between patient and doctor. And the results of those surveys that we did supported the position of the OMA House of Delegates. That was the case. This was an issue, irrespective of what you thought about it, it still was an issue between patient and doctor. That's, I think, pretty much the position of the association today.

FRISCH: Today. You didn't used to be able to buy condoms, except through vending machines.

DERNEDDE: What do you mean, "you?" [laughs]

FRISCH: We.

DERNEDDE: The public.

FRISCH: The public didn't have a chance to.

DERNEDDE: That's right. You had to go to a pharmacist to buy a condom and ask some fellow or little old lady behind the counter for rubbers.

FRISCH: And what role did the association play in all that? And what was the thinking of the doctors on that one?

DERNEDDE: Well, it's pretty obvious that venereal disease – this was before HIV was an issue. Venereal disease and pregnancy was the result of unprotected intercourse. And the medical community and the House of Delegates basically said, hey, you know, you've got to deal with reality. So sometime in the mid '70s, we advanced legislature to permit the sale of condoms by machine. And that legislation passed, kashoom! So now you see condoms hanging on the shelf at Costco and in restrooms, restaurants and gas stations and anywhere else. So at least they're readily available to the public. And hopefully it has had a pretty significant impact on the spread of venereal disease and pregnancy.

SIMEK: Now you have to go to a pharmacist to get your cold medicine.

FRISCH: Now, now, now.

DERNEDDE: That's a whole other issue on which I'm going to (zip?) [laughs] That drives me nuts, but I can understand why.

FRISCH: Let's talk about some other, in the area of public health, let's talk about some other things. We were discussing helmets. This was a very contentious issue in terms of people's right to dress the way they wanted, function the way they wanted. Here the legislature's trying to tell me to wear helmets. What role did physicians play in the passage of legislation about that? And what was our role? And how did it all come out?

DERNEDDE: Well you know, first of all, there is an element within our state who feel, or which feels, that whatever you do to your body, or make yourself exposed to, is your problem. And you're free to do whatever you want, period. But when people who are riding motorcycles or bicycles come into contact with a stationary object and end up with severe head injuries, they end up in the emergency room. And when they end up in the emergency room, the cost for the services and the medical care that is provided to those people is borne by all of us. We all pay for that. And there was, emergency room physicians were telling us over and over and over and over, "We've got to protect these

people from themselves." Because the number of head injuries was so severe and so costly. And if they did survive, the rehab was incredible.

So we advanced legislation that was submitted to the legislature to require helmets on, initially, bicyclists, and then motorcyclists. Let me tell you, the motorcyclists went berserk. They didn't want to wear those helmets and block their vision, da da, da da, da da. And we got the legislation passed. Since then, there have been numerous attempts to repeal the requirement on the motorcyclists. In fact, Governor Kitzhaber vetoed legislation to repeal it. But the motorcyclists had no appreciation for the fact that when one of their fellow cyclists was involved in an accident and had a head injury that it was costing the healthcare system hundreds of thousands of dollars just to keep them on life support, not to mention everything else that went into effect. It was very costly.

So that passed. And a lot of kids today you see them with helmets on. In fact, when I see a kid riding a bicycle without a helmet, I get a little angry about it. Where's the parents, allowing the kids to ride, knowing full well that if they fall, they could bang their head pretty good. I even have a helmet when I ski. And I know there's been attempts to get legislation requiring people to wear helmets when they ski. It's not a bad idea.

FRISCH: Well, carrying that thought a little bit further, I know that OMA played an enormously important role in the development of the statewide trauma system. Could you kind of give us the background on that? What it means to the citizens of the state of Oregon that we have one now?

DERNEDDE: Well, up until we had a formal trauma system, hospitals were the recipients of whomever the ambulance brought in. And without regard to whether or not there was sufficient qualified staff available to deal with the kind of trauma that was coming in. We also knew there was a finite period of time that you had after some kind of a traumatic injury to deal with that in order to save a patient.

At the same time, there were a lot of people who were driving ambulances, untrained. They had a chauffeur's license, they could drive an ambulance. Pick people up off the street, throw them in, run them to the hospital. There were a lot of physicians who said hey, we've got to do a better job of having ambulance attendants better trained. And so then came the emergency medical technician. And there were training programs set up.

And finally the OMA advanced legislation to require licensure, a certain level of licensure be done by the Board of Medical Examiners for emergency medical technicians And then the qualification of hospitals to serve as specialized trauma centers that could deal with serious problems. And so it took a long time, but finally we got a trauma system legislation passed. And now hospitals have to qualify at certain levels to fulfill the trauma system.

The fortunate part about our trauma system is that this whole liability issue has resulted in, at least in Medford, where we just couldn't, we didn't have enough neurosurgery coverage to be able to support the level of trauma service that was required in the Medford area. That was two years ago. I'm not sure what the circumstances are today. But I suspect that things haven't improved too much and, you know, what do people do when you don't have the kind of staffing that's necessary to deal with trauma? You let them die. That's not, that's not good public policy. But quite frankly, I don't think we're going to solve the trauma system. I don't think we're going to solve the problem of healthcare costs. I don't think we're going to solve the problems of physician shortages in this state until we deal with the liability issue. And so far, the public has not been willing, or has the legislature in recent years, been willing to address it.

FRISCH: One thing we have done, well, there are a couple of things I want to talk to you about. One of them is proliferation of nurse practitioners, physician assistants, the whole concept of the mid level provider. What role did the OMA play in that? And how do you think it's turned out?

DERNEDDE: [laughs] Well, early on, the OMA was a little schizophrenic about the physician extender, particularly the nurse practitioner. Because first they started, they posed it, and then they switched. It was a House of Delegates decision, it was close votes all the way along the line. But ultimately, the nurse practitioner law was passed. And nurses were allowed to practice independently, and they do today.

At the same time, the physician assistant program was adopted by the medical school. And I think Pacific University out in Forest Grove has a physician assistant program. And these are basically physician extenders. They initially were, it was argued that we needed to have them to provide coverage in the rural areas. Well, it was pretty obvious that those who went in to become nurse practitioners and physician assistants were just as eager to be in metropolitan areas, enjoying the fruits of being an urbanite, as most other people who live in metropolitan areas. So they didn't stretch out into rural areas like they sold themselves that they would. Although a number did.

But I think overall, it's been good extension. A lot of physicians are using PAs and nurse practitioners and specialized nurses in the various types of practice that they're involved in. And the Board of Medical Examiners spend a great deal of time overseeing what physician assistants are qualified to do. I can't speak to how much the nursing board oversees the nurse practitioners. But there's been a huge extension.

I think when it comes down to those people who want to practice medicine but didn't have the ability or the opportunity to go to medical school so they are doing other things or they end up going to some other type of institution, chiropractic, naturopaths, acupuncturists, whatever else they might be. The thing that I always worried about all along is people don't know what they don't know. And if they haven't had the exposure, if they haven't had the training, they just read books or whatever it might be, they may only know part of it. I've always felt that that was a hazard that in this day and age we don't need to afford.

FRISCH: Robert Landauer has taken great delight as the editorial, the head of the editorial board of the *Oregonian*, has taken great delight in pummeling the physician community for what he sees as a lack of proper oversight. Can you kind of share with us, because most people don't understand this, how you personally and how the association generally took an active role policing poor care? Some of the things that we were able to accomplish by our responsibility under the statute to report this information to the board, how the board responded.

DERNEDDE: Well, there's two sides to this story. And I'm not so sure that the introduction to it is going to be in such a way that my response is going to fit.

FRISCH: You just make it fit however you want.

DERNEDDE: Well first of all, Robert Landauer, he writes for the *Oregonian.* He used to be the editor of the editorial page. He ought to do like I've done: retire and get the devil out of the way. If Landauer, it's the old business of casting the first stone. Journalism, I think, over the last twenty-five years, has just deteriorated in terms of ethics, standards, in terms of all these other things that are sort of like moss growing on the public's hind end. Journalism, you can't, the style of journalism, when I was in school, when I was going to college–

FRISCH: You're a journalism major.

DERNEDDE: I was a journalism major. And we always had to verify, if we were going to write a story and somebody told us, we had to find out from some other source that what we were told is correct. And if it was correct, if it was right, we wrote it.

Not today. If somebody rumors something, it's reported. And it's broadcast media, it's print media, it's the works. And I think that Landauer ought to, if he's going to start criticizing any institution, he ought to start criticizing his own first. But more importantly, it's time for him to go play ball for something else and get out of this harangue of stuff. His opinions aren't worth that much. How's that for strong feeling?

FRISCH: Okay.

DERNEDDE: All right. Policing one's own. I already mentioned about the Board of Medical Examiners and having more powers to be able to do things. The Greater Oregon PSRO was involved in policing its own. Medical association had, and some county societies, not all, had committees that reviewed practice of other physicians. Hospitals had review committees.

One of the things that is probably done much better today than it was earlier was people who were doing things that they probably ought not to be doing, not seeking consultation and so forth, being watched more closely. I always felt a little uncomfortable about physicians who did not have hospital privileges. Because they were functioning

without any peer review. And I was troubled by that. So with the physicians of this organization, what I was wondering, what's going on there. And you know, that required a little bit more oversight from the Board of Medical Examiners.

FRISCH: So the association worked with the board to try to expand that.

DERNEDDE: That's why we wrote the Medical Practice Act in the mid '70s. Then again in, I guess it was the late '80s, early '90s sometime, the Board of Medical Examiners was getting a little too high handed in what they were doing. And so we had set about to reign them in being a little bit too aggressive, and too nasty in their approach. And we were trying to come up with a balance and change their ways. And so we did some more rewrite of the Medical Practice Act and jammed it through.

Meanwhile, the Board of Medical Examiners wanted to become an independent agency. And the medical association was very much opposed to that, felt that there should be oversight by the, and the only way you can do oversight over an independent board was through budgeting process. And so we felt that that should remain with the legislature because it was our opportunity to go to the public and say hey, they're spending money on things we're paying for. The doctors in the state were paying for the operation of the board. And so we needed to provide some checks and balances. You know, everything we have in our system of government and system of service is full of checks and balances. And when you remove the check or the balance, you get a dictatorship. And that isn't something that we particularly care to have in this country.

FRISCH: Well this is sort of a side note to the discussion about policing. The association, before I came aboard in the mid '80s, embarked on a venture involving health professionals. And I believe we got involved in assisting with physicians who had drug and alcohol problems. The outcome was a positive outcome, because we found a solution and found a way. But there was quite a bit of turmoil about it. Could you tell us a little bit about the association's role in helping physicians with drug and alcohol problems?

DERNEDDE: Well, the medical association's role in dealing with physicians who had drug and alcohol problems was rather extensive. First of all, addiction is a disease. At least, that's what I've been told. And you have to treat the disease like any other disease. And you just can't cast people away. You've got to try and save them. And so the Board of Medical Examiners was between a rock and a hard place, because when they found that anybody was drinking, whether or not they were truly an alcoholic, but were having a bottle of wine in the afternoon, they looked at that pretty–

FRISCH: [whispering] seriously.

DERNEDDE: Pretty seriously. Whether or not the person was practicing. So they were taking a pretty heavy handed approach to–physicians were self medicating. There were some physicians who were self medicating, and they became addicted and the Board of Medical Examiners came all over them like a big dog. Rightly so. But the rehab

process was a tough nut to crack. So we created a program where we monitored the rehabilitation.

FRISCH: What was it called? Something monitored?

DERNEDDE: Monitored treatment program.

FRISCH: There you go. MTP.

DERNEDDE: Monitored treatment program. And it was initiated by Dr. Kent Neff, who was the psychiatrist who got hung up on this addictionology type of stuff. And convinced the association to create the monitored treatment program, which we did. And at one time, we had around a hundred and fifty clients. A lot of them.

FRISCH: They'd come here to the association?

DERNEDDE: They'd come here to the association, or we would go out to their place of business and make them provide us an immediate urine sample. And it wasn't scheduled or structured that they knew about. But it was as far as the committee that was overseeing the monitored treatment program.

So we were going out and monitoring. And the unfortunate part about it is that most of the– and they had to pay for the laboratory expense. And we billed them for the lab. And many of these folks just didn't have the resources or they skipped town or whatever it might be. It became a real drain on the organization.

Finally we had to decide whether to cut it loose or create something else. And fortunately we were able to create something else at the same time we cut it loose.

FRISCH: That's the health professionals–

DERNEDDE: The health professionals program now exists and does a great job. I believe the dentists are involved in it and others. And it is a great treatment and monitoring program.

FRISCH: And if you don't, if you perform within the HPP, then the Board of Medical Examiners or the other licensing boards don't know about you, in effect.

DERNEDDE: Yes. If there's an intervention by another physician and you voluntarily agree to participate in the treatment program, then the Board of Medical Examiners is prohibited from taking action. But if you fail to abide by the contract you sign, then we turn you in to the Board of Medical Examiners, who they come down on your, temporarily suspend your license, hold a hearing, da da, da da, da da, go through the whole process, making your life pretty miserable.

FRISCH: I remember there was quite a struggle in the House of Delegates over a number of meetings where we'd present the information that the program was in the hole to six figures. Nonetheless, they just wanted to keep going. So getting this legislative fix was quite a coup.

DERNEDDE: Well, it was quite a coup because I was the bad guy. I kept saying, "Hey, economically, we're going in the tank!" We're building this huge deficit running this program.

FRISCH: For a few people.

DERNEDDE: For basically a hundred people, a hundred and fifty people. And everybody else is having to pay for this program. The advisory committee that's running it is not taking this financial issue very seriously. And they never did. They never did. But we came up with a scheme to create a professional program and to get the legislature to buy off on it, the Board of Medical Examiners to buy off on it. It passed, became law, and it is funded by, the administrative part of it is funded by a piece of the licensing fee. And of course, this drives the State Board of Medical Examiners nuts, that a piece of their budget goes to this program, and they don't have any oversight over it. It's just really a unique system but it works.

FRISCH: Go to a three thousand foot level with me for a minute. We've talked about some of the giants in medicine that you've had a chance to be with. Today's physician leader in organized medicine, how are they different?

DERNEDDE: Ooh. How are today's leaders different?

FRISCH: What are they looking for that may be different than the leaders that you've talked about?

DERNEDDE: You know, I don't necessarily believe that today's medical leader is any different from yesterday's medical leader. I do think that years ago, physicians were more willing to spend a greater amount of time working up the ladder of leadership. Whereas today, working up the ladder is a quicker period of time than what it used to be. But in terms of the quality of the person, I think there are fewer people that are willing to give the time it takes to be a medical leader. Because it is time consuming. And very demanding. People are trying to run a practice and be a medical leader simultaneously. It's tough. It's a very difficult thing to do. Particularly if you're trying to raise a family at the same time.

FRISCH: One other point, I guess, that I want to get at is it seemed, perhaps that in the past, individuals were less concerned with their own agenda than the good of the order than perhaps maybe there had been in the more recent past.

DERNEDDE: Well, you know, there, years ago, I keep saying that, but my sense was, is, that if you were a physician, you were married to that profession. You may have

had a wife and family, but you were also married to that profession. And when you were called, you were called. When you were on call, you were on call. If something came up, you cut and ran. Right to where you needed to be. And if you were on call for a long stretch of time, you were on call for a long stretch of time. And you were gone for long stretches of time.

I mentioned earlier that physicians would, public policy committee would stay until 2:00, to 2:30 in the morning reviewing legislation. You wouldn't find that today. They wouldn't do that. Ten o'clock and they're out of here. But that was a different type of time, a different type of commitment, a different type of relationship with family, and a different ambition. I think that physicians, they're no different than the population. They have a different lifestyle, they're more connected with their family's needs, in a more timely fashion. And so their desire to participate in affairs of organizations, professional organizations or trade organizations, whatever, is limited to the disposable time they have.

You know, there was a time when the OMA House of Delegates met Friday, Saturday, Sunday. House of Delegate would meet Friday night and they would spend until midnight in the opening session going over everything that they were going to look at the next day, in excruciating detail. The next day, we would go through these hearings and go through all that stuff again. And these reference committees would write up the reports and the recommendations, and then grind this stuff out at night. And on Sunday morning, these reports would come out, and they'd go through all that stuff in excruciating detail again until past noon. And they wouldn't tolerate that today. Wouldn't. You just have a handful of people there, and they were the ones who'd be obligated to be there.

So we changed over time. We slowly changed the way things were done so that we could accommodate the expectations and the needs of people.

FRISCH: And yet, in addition to that, there might have been twenty or thirty resolutions.

DERNEDDE: Oh. In 1983, no, 1973, I was looking at a handbook not too long ago, forty-four resolutions.

FRISCH: And at the end of your term?

DERNEDDE: Six.

FRISCH: Six.

DERNEDDE: But you know, a lot has to do, and this is not just OMA, any organization. I think a lot has to do with how responsive the organization is day to day to day to day to day to day. Years ago, organized medicine responded to the House of Delegates. What they said, this is what we want to do. And everything was passed on to

the next House of Delegates before any action was taken. That's not the case today. Things move too quickly. The executive committee, the Board of Trustees, is empowered to act on behalf of the board. The board is empowered to act on behalf of the House of Delegates. Because you have to. Events and things happen too quickly to rely every six months on a group of people to come to a consensus.

A lot of people say, what good is the House of Delegates? To me, it's the way to build a consensus. And if you don't–

[End Track Five. Begin Track Six.]

DERNEDDE: –build a consensus, you don't have a unified body. So it is at least medicine's way of having representation from all of the counties in the state and all the specialty societies to come together and deal with issues that affect the profession as a whole. And come to some kind of consensus yes, this is the way we want to go. And then that becomes the guide for everybody else.

It's like Congress. Sometimes it's miserable, painful, to listen to the debate. But ultimately what they do is come to some kind of consensus, even though it's one or two votes. I personally feel that as far as private organizations, it's nuts to try to run a professional organization or a trade organization where your votes are split by five to four or whatever it might be. I think that's destructive. You've got to have consensus.

FRISCH: I'm going to run some names by you and give me just kind of off the top of your head a couple of quick thoughts about them. Gus Tanaka.

DERNEDDE: One of the finest men I've ever met in my life. Gus Tanaka is a surgeon from Ontario. He's one of the very first physicians in the medical association that I met. I met him before I was with the OMA. I was with Associated Oregon Industries, this must go back to 1965, '65, '64. And I was invited to an OMPAC meeting as an allied organization representative. And I sat across from young Gus Tanaka and his delightful wife, Teddy. That's when I first met him. He became president of the OMA in the early '70s. He's been like a brother to me. I love the man. And his wife, too. He's now in his eighties. I talk to him by email probably every two or three weeks. I was out in Ontario a year ago and stopped in and spent a couple of days, my wife and I spent a couple of days with him. And in fact this morning, I opened up a can of peaches. Not a can, but a jar of peaches that Teddy Tanaka had canned this last year, so I enjoyed those.

FRISCH: Bucky Shields.

DERNEDDE: [laughs] Bucky Shields, a surgeon at St. Vincent Hospital. Great man, good surgeon. He was a tough dude. I love him. He's still around. Big smile. This smile that goes from ear to ear. But don't ever cross Bucky Shields. He had a great role at the OMA. He was chairman of the medical legal committee. And that's where a group of lawyers and a group of doctors got together and hammered out issues of conflict that existed between the two professions. And believe me, they existed. And Bucky Shield

was the tough chairman. And he had the duty. If a doctor was out of line, pick up the phone or walk over to his office or drive to his office and say, "You're out of line. You've got to do it this way." And you know something? They did it.

FRISCH: Tom Riordan.

DERNEDDE: [laughs] Tom Riordan. Tom was president of the American Medical Association in the late '90s, I guess it was. Tom was president of the Oregon Medical Association in the '80s. Tom is a really interesting guy. General practice physician out in East County, Multnomah.

FRISCH: Boring, Oregon.

DERNEDDE: He lived in Boring, Oregon. On a nursery. And he, in his spare time, was creating a nursery. And he created a huge nursery. Raised nursery stock. And his boys worked for him. He subsequently sold the nursery to his boys and he's living on the farm, loving it. But he, it's really interesting. Tom, delightful man, well thought of, well connected with the business community because he was also a businessman in the nursery business. So he was well connected. And well connected in the city of Portland. He was part of the Rose Festival Association. He was a judge of floats in the Rose Parade. Smart man. In fact, too smart. His brain functioned so much faster than his vocal cords and his lips. And he had a hard time getting words out because his mind was going so fast. Delightful guy. I really enjoyed working with Tom and helping advance him to the OMA Board of Trustees and the AMA presidency. Going through a few wives with him. He's just a neat man. And he really cared for his patients and took good care of him. He was a guy that really was very strong on the quality side. He was very critical of anybody that stepped beyond the quality issues.

FRISCH: Another Tom. Tom Hoggard.

DERNEDDE: Tom Hoggard. Another president of the Oregon Medical Association. Family doc. Practiced medicine over on Knott Street, Thirty-Third and Knott, for a long time. He retired to, oh, right around the year 2000, 2001 or something. Here's a guy who, even though he retired from practicing medicine, quite frankly, capitation and managed care burned him out, just burned him out. Sad, sad state of affairs. But anyway, he worked part time at a medical office in Troutdale.

But here's a guy who has been all over the world as a volunteer for Northwest Medical Teams. And he loves doing. He says, "You know what's so neat about it, Bob?" He says, "I can do for patients all over the world, even though they have a hard time communicating, what I know best. What little resources I have, and I improvise to be able to take care of their needs." He says the saddest part about the most recent assignment he was on with the tsunami in the Indian Ocean was most of the problems with the survivors was desperation. He couldn't do anything medically to help them. They lost their family, they lost their kids, they lost their neighbors, their house, their home, everything was gone. They were desperate. They were left alone.

He was down in the Convention Center in New Orleans and I think you ought to talk to him and ask him to describe some of his experiences, particularly in New Orleans. How disorganized things were down there. I don't want to put words in his mouth. He has been in Afghanistan and Iraq, Croatia. He's been in West Africa.

FRISCH: South America.

DERNEDDE: I don't know if he's been– yeah, he was down in Guatemala and–

FRISCH: Yeah. Central America.

DERNEDDE: Vietnam. He's been to New Guinea. He spent a month in New Guinea, up in the wilderness where they eat people. [laughs] And the amazing part about it, his wife, Mary Burry, who is also a physician, radiologist, goes with him. And she's learned a lot of other things in medicine rather than radiology because she's had to serve as an anesthesiologist, she's had to serve as a surgeon, she's had to do a whole bunch of other things.

FRISCH: Well, he's found meaning in medicine.

DERNEDDE: He's found meaning in medicine and volunteering because–

FRISCH: Service.

DERNEDDE: It is service. And he's a Rotarian in Portland, a dear friend, and I love that man. He's great.

FRISCH: John Alsever.

SIMEK: We have about five minutes of tape left, so if you have some critical questions that (?)

FRISCH: This is not. I don't have any. Do you?

SIMEK: There's one that I would like to hear. And that is (?)

DERNEDDE: Yi, yi, yi. I don't know if that is a question that I can answer. Where do I see it going? I think medicine's future, there's always going to be a future for medicine. The real question is, can we afford it?

SIMEK: (?)

DERNEDDE: Can we afford the kind of medical care that we expect? And will we have enough horses, physicians, nurses – because we've got a shortage of both – to take care of all the people's needs into the future. I have some real reservations as to

whether or not the stars are aligned right in terms of where the money goes to support medical care and services and our ability to be able to deliver. Because let's be realistic here. We're dealing with here. I keep hearing the word "aging population," but people don't understand what that really means, what the demands are. And what our expectations are, and what our legal liability is to provide care. You know, we've got hospitals that don't have enough nurses, and they put their emergency room on divert because they don't have enough. Now it may be that they aren't willing to pay the nurses overtime to have staff available to be able to take patients in the emergency room. But to go on divert. So that means the hospital, or the ambulance driver, has to take it someplace else. Take the patient someplace else. A loss of time. But we're seeing that all over now. And it's only going to get worse.

So the future? I think there's going to be more specialization. I mean, medicine is just incredible in terms of expansion of technology and knowledge and so forth. At the same time, we had this huge expectation that all these services are going to be available to us, when in fact I don't know that we're going to have the manpower to deliver it. And womenpower.

FRISCH: Anything else, Matt?

SIMEK: (That's it?)

DERNEDDE: I can say amen? [laughs]

SIMEK: Pretty close. We still have three minutes.

FRISCH: I want to talk to you about Rosemary Egan. Ronald McDonald House is such a big part of our culture today, we don't even think about it. But there was a time when it didn't exist. And who is she? And what role did she play in the establishment of the Ronald McDonald–

DERNEDDE: Well, Rosemary Egan was the wife of a physician. She was president of the OMA auxiliary, now called the alliance, which are the spouses of members of the association. But the alliance, auxiliary, had decided that they wanted to put their efforts into the creation of a place for the parents of critically ill children, mostly cancer patients at the medical school where they could be close, so the parents could be close to their kids. And so Ronald McDonald Foundation of the McDonald Corporation had helped fund Ronald McDonald houses in a few other places around the country. But there was nothing in the Northwest. So the auxiliary at the time said this is a project we want to get behind.

Well it came down to they found a piece of property and they bought it. The medical association was supportive of what they were doing. And Rosemary Egan was president of the auxiliary at the time. She became the so-called project manager. Bless her heart, gave her a tin cup as a reward one time, because she went around collecting money and begging support and so forth all over the place. And she went so far as to

mortgage her home to supply the guarantee on the loan to acquire that Ronald McDonald House facility up at the medical school. Now there's courage.

FRISCH: And commitment.

DERNEDDE: And commitment. She was one incredible lady. She's a neat person.

FRISCH: Well, that's a good note to end it on.

DERNEDDE: Halleluiah.

SIMEK: Fifty-nine minutes and thirty seconds.

DERNEDDE: Halleluiah. I feel like I'm sweaty. [laughs] I don't need this.

FRISCH: Let us hang onto it.

SIMEK: You still have half a glass of wine, Bob.

DERNEDDE: Huh?

SIMEK: You still have half a glass of wine.

FRISCH: Bless your heart.

[End Session.]