OREGON HEALTH & SCIENCE UNIVERSITY
ORAL HISTORY PROGRAM

a project of OHSU's Historical Collections & Archives

an interview with:

Peter O. Kohler, M.D.

interview conducted on: April 21, 1998

by: Charles T. Morrissey

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Interview with Peter Kohler, M.D.
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Site: President's Office, Conference Room, Baird Hall
Begin Tape 1, Side 1

C.M.: This is Charles Morrissey on Tuesday, April 21st, 1998, about to interview President Peter O. Kohler of the Oregon Health Sciences University in a conference room in Baird Hall on the Oregon Health Sciences University campus.

If we go back almost exactly ten years ago from this April 21st, 1998, we find you still as Dean of the School of Medicine, University of Texas Health Science Center in San Antonio, but you had already made the decision to go to the Oregon Health Sciences University. Why did you make that decision?

P.K.: Which was made on St. Patrick's Day, by the way.

I saw this as really a place with a tremendous opportunity for growth in the future, that had a good reputation, had a lot going for it in the different schools, and frankly, I saw it as a real place where the institution could do great things for the future.

C.M.: Had you known previously about this university?

P.K.: Well, I had known of it, but I had never visited here until the search process began, and that was my first visit to Portland.

C.M.: On the 4th of April in 1988, a document was prepared entitled "Memorandum of Understanding" between the Oregon State Board of Higher Education and Peter O. Kohler, the new president of the Oregon Health Sciences University. I'm sure you're familiar with this.

P.K.: I am.

C.M.: And at the tail end is an item that certainly piqued my interest as an historian; the concluding paragraph on page 2 says, quoting here, "The Board of Higher Education is pleased that its support for Dr. Kohler's agenda has enabled him to reconsider his decision and accept the appointment as President of the Oregon Health Sciences University." What's this business about reconsidering your decision?

P.K.: Well, the way the process was run early on was quite a convoluted one, and frankly, I had become a little bit disenchanted with the way it was going, and I had dropped out. I had essentially said, "I am no longer a candidate."

The chairman of the search committee and one of the other members came to visit me in San Antonio in my office and convinced me that there was still opportunity here and that, frankly, a lot of things could be accomplished which I felt were important.

So after that, and I came back and visited again, we reached an agreement. But it was close, and frankly, I almost didn't come because things were going well in San Antonio at that time.

C.M.: Well, I notice looking at your C.V. that you became Dean at San Antonio in January of 1986, so in effect you were about 27, 28 months into your tenure there when you made the decision to come here. Was there any reluctance on your part to pull up roots from San Antonio after that short period?

P.K.: Well, I had been a dean at Arkansas for one year as an interim dean before going to San Antonio, and then I had served literally two full years in San Antonio before coming here.

I think what I appreciated at that time was that for an academic health center -- which has a rather unusual organization; it's been described as the least organizable type of organization that exists -- it is better, frankly, to be the President than the Dean of the Medical School. Now, absolutely it's critical that we have strong deans, but that seemed preferable to me, and I thought the direction that health care is heading really incorporates all the different kinds of health care providers and the institutions such as the hospital into one entity, and that was the attraction here.

C.M.: In your almost ten years here now, what has given you the most satisfaction?

P.K.: Well, we've done a lot of, I think, good things -- the institution has, and I have been pleased to be part of it.

There are a couple I think in particular worth highlighting. First of all, the Doernbecher Children's Hospital was one of my top ten priorities when I came here, and we almost had it when I started, as you may recall. There was going to be an arrangement whereby there

would be federal support combined with state support, and we would build a new children's hospital, which was badly needed at that time.

That did not come to pass, and frankly, the way we've done it is more gratifying because it was essentially a private-public partnership, and the fund rasing was done from the private sector. That's one thing.

The other big thing that I think has separated us from many other similar institutions is the formation of the public corporation. This is not well understood by many people, and frankly, to the average faculty member it's a transparent change in many respects. But this has allowed us to succeed, really, at a time when many other institutions are floundering because of managed care and a number of other things that threaten the old conventional way of doing business.

C.M.: Could you walk me through the process whereby this institution became a public corporation?

P.K.: Sure. It actually took several years. It did not happen overnight. The idea had been around for a while, why is the Oregon Health Sciences University part of higher education? It didn't seem to fit. It was one of the eight component parts of higher ed., as you recall.

The problem is the Higher Ed. Board, which has to be representative, could not be very well brought up to speed continuously, because there's turnover, on health care issues. And frankly, the health care market was changing dramatically with managed care coming into place to take over the old indemnity type care, which allowed academic health centers to serve a Robin Hood role, where they would basically have high charges for special functions and be able to take care of the indigent care, which is the other large component of the health care group for which we provide at the same time.

So the question had been: Why don't you become, quote, private?

We went through a planning process that included members of the Board of Higher Education, including the Chancellor, members of our foundation board, interested citizens, ex-legislators, a number of people who we thought could be helpful, and we looked at four options: One was to go all the way private, form a nonprofit private, like a 501(c)(3), another was to form a public corporation, which sits in between public and private and is defined by the statute, we could stay as we were, or we could merge with the Health Division -- which, by the way, had its own difficulties at that time.

This was in a time of tremendous downsizing on the part of the State. We wanted to be not only survivors, but we wanted to be very successful. So the inability to hire somebody when you badly needed them, all the regulations imposed on us, benignly, but nonetheless imposed on us by the State, represented a big problem.

So of these four options, we decided to go with the public corporation as the most likely.

Now, we had some external advisory groups then put together -- including one from the business community chaired by ex-Governor Neil Goldschmidt, who is currently on our board of directors, that was a very high-powered group, included Fred Buckman, who is the current chair of our board, John Gray and a number of other Oregonians who, I think, were highly respected.

We came together with a proposal, and our legal counsel at that time, Janet Billups, put together a draft. We went to see all the legislators, literally almost every single one, and to the Governor. And I'll have to give some credit to the prior Governor, Barbara Roberts, who had been very opposed to the public corporation conceptually, but when she saw the handicap that we had in terms of dealing with new things like the Oregon Health Plan, where we couldn't do things without requests for proposals that would have literally filled rooms in Salem, she said, "Why don't you begin thinking along these lines?" This was then adopted by the next Governor, John Kitzhaber, who is one of our graduates, as the logical thing for us to do.

It was also submitted by a rural Republican administrator, Senator Gene Timms, who was a tremendous sort of supporter for the institution. I would say that if Mark Hatfield is the patron saint of OHSU, which many people say he is, Gene Timms is probably the godfather of OHSU. And therefore we had bipartisan support in the legislature.

It still was not easy. We went down and testified before the Education Committee, again, all very well meaning individuals, but one of the senators said his model was a school district, and they did not understand how the president of the institution could be on the board. And frankly, they then voted for that not to be the case.

Our private group came back, Neil Goldschmidt and Fred Buckman, and said, "Of course this is the way it needs to operate. That's the way

health care organizations currently are structured." So they put me back on.

The process went through the senate with a vote of twenty-four to three. Twenty-four to three, and frankly, I felt if we had a little more time we could have gotten one more of those three, and we could have been at least twenty-five or so to two.

Then it went through the house unanimously, and one of the representatives said, well, she wasn't exactly sure that she favored it, but she wasn't going to stand in front of a train.

So we came through with overwhelming legislative support to try this new, I think, idea that would make us able to compete better in the private community. "Compete" is really a little bit of a misnomer because we collaborate in some areas, we compete in others, but we frankly have to derive a large part of our revenue base from the health care provision that we do.

C.M.: Any advice for medical school presidents elsewhere on what strategies to use to get a bill through a legislature so overwhelmingly successfully?

P.K.: Yes. Well, I do think there is one thing that we re-learn all the time, and that is it's very important for all people to have a sense of ownership about OHSU, and I think we've had some programs that have been very important in this regard.

For example, the accusation that academic health centers are ivory tower elitist arrogant institutions is pervasive. Everybody believes that to be the case around the country. We felt that one of our challenges was to make people in every corner of Oregon feel like OHSU was their institution, and we had the slogan "The 96,000 Square Mile Campus," which is the entire state, frankly, as our campus, and we've got programs going in every corner of the state, largely through the area health education center program, but also our curriculum now for the medical school puts people all over the state. The nursing school has four campuses that are statewide. The dental school is doing things around the state, and we do allied health education away from this campus.

So the one piece of advice is make yourself important to everybody in the state, and frankly, that will get you important political support and serve the function you're supposed to serve.

C.M.: Do you have other pieces of advice?

P.K.: Well, I think that we try to look at problems with people and how they need to be solved and generally we understand that we are competitive in the local area more than the statewide, but we try to work, I think, with everybody, and we have devised, up until recently, the Switzerland strategy -- that has a little bit of a bad connotation right now -- but we have tried to stay neutral as the health care wars have waged on all sides of us.

C.M.: When you made the decision to come here in 1988, did you have any expectation that health care delivery in this country would be so dramatically restructured?

P.K.: No. No. I think that academic centers, as I mentioned, have tended to be somewhat isolated from the changes, but when managed care represents 80 percent of what's going on in your state, you cannot avoid this.

I guess I knew that it was possible, but remember, we have been through various cycles of what we thought was going to happen in health care, going back 30 years. First of all, there was the worry that it was going to be socialized, and then later on, not that long ago, four or five years ago, the federalization, the Clinton health plan was going to be the way it was going to go, and it was almost unquestioned that that was going to occur. Well, it did not.

Therefore, now we are in an era that's very anti-regulatory, and the market is trying to solve the problems. And I think it is solving some, and others are going unaddressed, and we're going to continue to see change occur, and I think the key is for academic institutions to be able to be organized in such a way that they can respond to change. And that is something that tends not to occur, either. Academic centers tend to have a lot of little component parts that do not see the value of being integrated with their neighbors necessarily. So we've been trying to build a unification here, which has been a slow process, that I think is going to be important for us in the future.

C.M.: How does one build a unification?

P.K.: Well, I think response to stress is helpful. As you know, this state has had two property tax roll-backs voted through by the public. These have resulted in less money coming our way from the State.

When I came here in 1988, our state support in the '87-88 biennium was 27 percent. The Board of Higher Education voted to hold

it there and move it up to 30 percent. It's now eight. And part of the reason it's that low is that we have been successful in the other areas. I mean, our research programs have been successful beyond, I think, anybody's hopes at that time. Our clinical programs have been doing well; they can still do better. But we have done well in terms of our overall budget increase, while the amount of money coming to us from the State has gradually diminished slightly, but as a percent of our budget it's down to eight, and will be lower than that in the near future, even though we hope to get more money ultimately from the State.

C.M.: What explains the success with the research program funding?

P.K.: Well, I think a lot of it has been building the infrastructure, and there is no doubt that Senator Mark Hatfield was very helpful to us in allowing us to have research space built. And the thing that we did here was build laboratories. As you know, Oregon is a very attractive state -- I call it a geographically privileged site; I have been to others -- into which you can recruit people if you have space to recruit them. And if you recruit the right people, you know, in all candor they can bring a lot of their own money with them.

So we've had the infrastructure build-out as a result of the Hatfield gifts -- and also private effort. Some of our buildings here have been built with private effort, as well, and that has allowed us to recruit outstanding people here to complement the outstanding people we already have in building the strength of the faculty.

Now, we are not a large academic health center, but our growth rate probably is unparalleled over the last decade.

C.M.: Who do you consider to be your most successful recruits?

P.K.: Well, there are several, and if this is being recorded, I don't want people checking through to say, "How come he didn't mention me?" -- that sort of thing.

C.M.: Well, overlooking some understandable omissions, which ones come readily to mind?

P.K.: Well, I think we've had a number of very important recruits.

I'll start with Dick Goodman, who heads up the Vollum. The Vollum Institute has, frankly, been our bright shining star in research in the early days, which allowed us to build our other programs. And frankly, Dick Goodman has done a superb job there in building that into

a very high quality scientific group whose reputation will continue to grow because they're mostly mid-level scientists at this stage, and so I see that as into the future really being a tremendous example of sort of the public-private partnership, early stage.

We've had a number of chairs come into the medical school that have been important. The new dean of the nursing school has been a very strong recruit. Frankly, getting the deans of the medical school, while they were already here, I consider that extremely important in terms of our ability to operate effectively.

First John Benson came in in an interim role. John Benson is a very distinguished national leader. He was president of the American Board of Internal Medicine for a long, long time. His heart is in this institution, and he put in two years after he retired that I think were very important to us.

Then Joe Bloom came from the faculty and has served as dean there and I think done a good job.

We've had some key chairs in the various departments of the medical school, as I mentioned, that have been important to us for growth, and perhaps the best example of putting together a successful team has been the central administrative team, which was done a bit by trial and error. Not everybody immediately fit in, but we now have a group that, I think, has common goals, is aligned towards success, and while their activities may be relatively invisible to the rest of the campus, I can assure you it makes this place run better than most academic health centers.

C.M.: OHSU, as you very well know, had a very strong reputation for family medicine, primary medicine, a rural outreach. Is it hard to transform an institution more into a research institution while still maintaining those traditional strengths?

P.K.: Well, you know, that's an interesting question because actually our reputation in primary care has been growing, and it's been growing because some of the people were allowed to do what they had wanted to do for years and had not been able to do.

Dutch Reinschmidt is a perfect example. Dutch was an associate dean in the medical school, and after I came all I did was say, "Dutch, do the thing that needs to be done." He knew exactly what to do, and he built our area health education program, essentially from scratch, with

the help of Dick Grant, an administrator there. And he also was very importantly involved in revising the medical school curriculum so that medical students rotated around the state.

Now, those are two things -- we had strong family medicine under Dr. Robert Taylor and with people like John Saultz, but those are two things that really allowed us to develop further primary care, and I think this feeling that we belonged to the state and vice versa.

That occurred at the same time we were building up the research programs. So those two things may seem incompatible, but in fact they can be done together. We're building strong research with the Vollum and then with the medical schools and the other; at the same time, our primary care problems are involving the entire state and serving, I think, the needs of the public there.

C.M.: Has the character of the student body changed at all as you've been making these changes over the last decade?

P.K.: I have a feeling that the students are changing somewhat, that they are more interested in primary care. A lot of our students are interested in things that you wouldn't expect, missionary work and so forth, so I'm not sure how much the student body has changed.

I think the challenge to us is going to be to take these students that come to us all enthusiastic about medicine and make sure they don't get hardened in the process to where they become -- you know, it's very difficult these days with the high cost, the debt that the students graduate with, having them not think too much about money - but to stay with the goals, the reason they went into the profession to begin with.

C.M.: Do you find more people are more interested in research careers as the institution develops its research capability?

P.K.: Well, I think so. We of course are building the Ph.D. program here, which is considerably larger than it was, and these are individuals who will go into research.

Our Chair of Medicine, Lynn Loriaux, is very interested in clinical research, as is our Chair of Pediatrics, Ron Rosenfeld. Those are two.

I'd say one of the things we're doing to is trying to be creative in looking at how we in fact can enhance our clinical research programs at the same time with the translational part, that we're building basic research. We're also trying to be innovative in areas like women's

health, putting that together; Dr. Kirk is very involved with that particular program.

Geriatrics is another area where I feel a great deal can be done. Our nursing school faculty is very strong in gerontology, and we'd like to be able to use that skill they have. And Kate Potempa, our nursing school dean, is very interested in doing that.

So I think that the interest in research is growing.

Oregon did not produce a large number of academicians in the past. If you take a look at what percent of our graduates are on faculties compared to the other institutions, we've been rather low. My guess would be that while we'll continue to produce strong clinicians, there will be more academicians in the future.

C.M.: Throughout your career you've been familiar with Duke, of course, having been a medical student there, with Baylor College of Medicine, University of Arkansas School of Medicine, San Antonio, and now OHSU. Can you make any comparative judgments on how they are either similar or different?

P.K.: Well, they are all different, but I do have some -- you know, I was at Duke in the '500s, at the time that the original faculty was still largely there. It was sort of interesting; many of them had migrated down from Baltimore at Johns Hopkins, but the faculty was still there. Duke is a very young institution. People don't know how far it's come in a relatively short period of time. Watching what they did there has always made me feel we can do some similar things here.

Baylor, of course, is really a medical school by itself, with some affiliated hospitals. So it's a different kind of academic health center.

Arkansas and the University of Texas are state-affiliated institutions with many of the problems that we had here, but their resources are different. They have each achieved things in different areas. For example, the clinical programs at Arkansas on a percent basis were much more geared up to produce revenue than we've had here. So I think there are things to be drawn from each place.

Texas, we of course enjoyed tremendous support from the State of Texas. When the support level fell below 50 percent from the State, there was a great hew and cry about how unfair this was. Well, anybody would love to get 50 percent these days.

C.M.: You've mentioned curriculum twice already in our interview. Could you comment on the curricular changes that have occurred here since you began your tenure?

P.K.: Well, I think the deans deserve credit for that, but one of the very important things that has occurred is this early curriculum revision that has attempted to integrate the various disciplines into one continuum, and I think that has been very successful.

What it does is raise the question of, you know, what do the departments now exactly do, because it's both a good thing and a thing to be concerned about. The departments used to guard their part of the curriculum, and so Physiology or Pharmacology or Biochemistry, they always were fighting for the number of hours that they felt they had to have from the medical students.

Well, we've enhanced the Ph.D. programs here, so that's another outlet for teaching that lends itself very nicely to the basic scientists. For the medical students, we now have a curriculum that seems to integrate all these disciplines into what we hope is as nearly as possible a seamless experience in terms of what they need to know.

The other big piece that I have mentioned already is this rotation out to work with preceptors, who are high quality, carefully screened and monitored to make sure they're the cream of the crop in terms of preceptors.

So I think those have been two very important changes for our curriculum.

C.M.: You're satisfied that the preceptor system does work?

P.K.: Yes. A lot of work went into selecting very good people. In fact, we could use it more, and I think in the future a question may be will we use it more.

C.M.: With respect to students, could you comment both about minorities and women?

P.K.: Well, I think we have achieved much greater success with women students than we have with minorities at this point in time. Oregon does not have a large minority population, and we wrestled with this problem when I was in San Antonio.

The issue for minorities was largely how do you get people thinking about a health professional education? So we've done some things, such as with the School District here, to try to increase the interest and

preparation for minority students for a health educational career. And that's been the great hope, that we can do that to a greater degree.

With regard to women, as you know, we've had years when the number of women medical students was greater than men, so I think we've achieved a certain balance there. It has not yet translated into faculty equality, but I think that's really a matter of time. There are very capable women coming through the ranks, and there are very capable women who are already here.

But for example, when I went to medical school at Duke, we had seventy-two students, one woman. One out of seventy-two.

C.M.: An amazing contrast. What specifically have you done with the local school districts?

P.K.: Well, we've had a number of programs, again designed primarily to bring students along to think of health education as a career.

One of the early things that happened was that I was adopted by one of the high schools. So I would go down there to talk to these high school science students about a health professional career. I quickly learned I'd get a lot more attention if I took a medical student with me, a minority medical student, preferably. Dr. Hallick, who has been very interested in this issue as well, was also adopted by Benson High School.

So we tried from the early days to put together programs that again would get students visiting the campus, taking a look at what goes on here, and hopefully piquing their interest in a health career. I think it's been rather successful, but again, the pool of minorities in this state is relatively low, and we need to work very hard to keep the interest up.

C.M.: Who took the initiative to have you adopted by a high school?

P.K.: They did. I just was called one day and asked if I'd be willing to be adopted, and I said, "Well, tell me what it means exactly." But the school district did it.

C.M.: When you were at Baylor, as you may recall, Baylor at that time went to independent school districts, set up the High School for Health Professions.

P.K.: Right.

C.M.: Have you thought about a similar program here?

P.K.: Yes. As a matter of fact, we had one in San Antonio, also. In fact, the superintendent of schools who has just left, Jack Bierwirth, and I had a number of discussions about "Could we do this here?"

He was quite interested, but as you know, the same measures that hit our funding stream hit theirs, and the idea of converting an entire school over was almost too much for them to take on at that particular time.

End Tape 1, Side 1
Begin Tape 1, Side 2

C.M.: You mentioned Dr. Hallick a moment ago. Could you explain how she was chosen to be the Provost?

P.K.: On the basis of skill and talent.

It's been interesting: We've had a good mixture of people taken from the inside and from the outside. But Lesley Hallick displayed early on, I think, an aptitude for the types of skills that we needed for a Provost, and she came on as Vice President for Academic Affairs, and later on I appointed her as Provost, which is sort of an elevated title for the same academic programs.

But it was pretty clear that Lesley really had the skills that were needed. She had strong support from Bob Koler, no relation, who had acted in the Vice President for Academic Affairs role before, and we had a search process and she was the most qualified candidate.

C.M.: Any hesitancy about a Ph.D. and not an M.D. serving in that position?

P.K.: I don't think so, particularly if an M.D. is the president, and we have a dean of the medical school who is an M.D., as well. I don't have any reluctance or hesitation at all about that.

C.M.: With respect to outreach to rural areas especially, how important has tele-medicine been for you?

P.K.: Well, it has been important. I think there's a great deal more that we can do.

As you may know, I served on a tele-medicine committee for the Institute of Medicine, and the truth is that -- this great term "deliver the promise" -- the promise has not been delivered anywhere yet. There are a variety of reasons for that. One is the technology moves so

quickly, people have trouble evaluating it. But it has been very valuable for us, primarily in the nursing school in terms of their distance learning program for place-bound nurses.

I anticipate it will be much more valuable for medical education in the future, but to date we have tended to do it with more primitive forms of tele-medicine, like the telephone, as opposed to television or being able to send images back and forth.

C.M.: How important has continuing education been?

P.K.: I think that's been one of the great strengths at OHSU. Again, first of all with Dutch Reinschmidt and then Don Gerard, our continuing medical education programs have been a tremendous way to communicate with rural practitioners who are somewhat isolated, keep them up to date, and this is tremendously appreciated on their part.

So I think that's been a very good program for us.

C.M.: You're the only chief executive officer of a medical complex in a state that has a physician assisted suicide -- program?

P.K.: Well, the law has been passed, yes.

C.M.: "Situation" perhaps is a better word than "program."

How has that impacted on you?

P.K.: It has not. If you followed the assisted suicide debates and campaigns, you know this is something that's been voted on twice by the public, in the face of quite a bit of opposition. There are disturbing things about physician assisted suicide; on the other hand, there are people who are desperate for some kind of relief. As an institution we have taken a neutral position, which has tried to look at comfort care. And this has been really done by our Ethics Center, by Dr. Susan Tolle -- you know, they have said, "This law has been passed; we need to be able to understand what we will do with it."

We've had two faculty members in the same department who have tended to be the most public debaters on this topic, but frankly, I think the institution has not been tremendously affected one way or another so far by the legislation. And as you know, at the time we're talking right now, there have been only two known examples of that, neither of which were here.

However, I might point out that when the first one was announced, the media wanted to run up a truck to our campus and broadcast a message with OHSU in the background -- which kind of

reminds me of the e.coli poisoning that went on not long ago. You know, some poor guy ran a hamburger stand, and they needed some footage to back up the reporter talking about this e.coli epidemic, so they used his hamburger stand. And he called and said, "Nobody's been in here for days. Why did you do this to me?" And they said, "We just needed some file footage for the story."

We tried to stay neutral on the assisted suicide issue.

C.M.: Did the Center for Ethics get started after your arrival here?

P.K.: Yes. I was very supportive of that. I felt like this is an extremely important area in the new medicine that we practice. There are a lot of issues that require guidance. The students need this. I mean, there are not standard answers to a lot of the questions that are now being faced in these days of high technology and machines that can keep somebody alive for a long time -- when do you stop, how far do you go -- there are all sorts of reproductive issues that are difficult to deal with. And frankly, this has been a tremendous opportunity for us to draw on the experience of some of the older physicians who are now retired and are tremendous support for, I think, our students, in terms of problem solving in the area of ethics.

Dr. Tolle, again, has done a very good job of putting that together. We put it together. We got it endowed through the hard work of Dr. Tolle and others. But that's been an important resource to us.

C.M.: Is there anything in your own personal professional development that explains your interest in the ethical dimension of medicine?

P.K.: Well, I was an English major rather than a science major in college, so I had all sorts of unusual courses.

I'll have to confess that my father was an English professor, and I knew I was going to go to medical school, and he said, "You should take any curriculum except English because you have no aptitude for that." So of course that's what I took.

C.M.: To this day do you value the broad liberal arts education?

P.K.: Very much. I think that we need more of that, and frankly the Ethics Center is one opportunity to bring back some of that to the medical education process.

But I am one of those people who believes that we would do well to have much more of a liberal arts education for our pre-medical students.

C.M.: Was there any reluctance from anywhere in the University towards setting up the Ethics Center?

P.K.: I don't recall any. I think people were pretty much in favor of going ahead with it.

I do know that there has been some of that in some other institutions, who think it's sort of fuzzy and unrealistic and so forth. But as time has gone on, it's proved to be more and more important, and even the most negative individual about ethics, I think, has come to realize it.

And I didn't, by the way, find anything like that here. This is an important part of our educational process.

C.M.: Could you elaborate on how retired doctors are helpful on your ethics program?

P.K.: They have a seminar series where cases are presented and discussed, and our senior physicians from the community come to that and participate, and frankly, they're the leaders. Some of them have been on the faculty, others were in practice, but I think it's a tremendous opportunity for them and for us both, to get their collective wisdom.

C.M.: It's interesting that people who came of age professionally before ethics became such a major concern within the medical educational community should be so well equipped from experience to deal with these issues.

P.K.: Well, I think they learned it through practice, and frankly, they understand the importance of it.

Some of these people are in their eighties, high eighties. I'm not sure what their educational experience was in those days, but I think that the tremendous amount of information really began to come along in the '50s and '60s and '70s, to the point where there was a true information overload, and there was an effort to cram as many facts into people's heads as you possibly could, and anything that appeared extraneous to getting the best score that you could on that anatomy test or that biochemistry test that you were going to have to take tended to drop out of the curriculum.

I think we're seeing a return now, as in the new information age you don't have to memorize everything anymore; in fact, we want people to be able to problem solve, to know how to get information, and as we all know, the information changes. The old saw about fifty percent of what you learn is no longer current in the near future is, I think, still true today.

C.M.: With respect to access to information, could you describe for me the process whereby the BICC was established?

P.K.: Well, I will have to give all the credit for the BICC to Leonard Laster, my predecessor, and I think also to Dave Whitter, who was vice president at one time, and actually acting president for a while.

Len Laster viewed the BICC as the library of the 21st Century, largely electronic. To that was added a lot of other informatics as a curriculum, special master's programs there that would take advantage of the new information resources that were coming along. Into that was built opportunities to do more analysis of health care as it was being practiced.

We'd like to see that developed further, but frankly, we have a very strong group here in that area. Tele-medicine is part of that, and there are some very good examples, Doug [? - 1290] and his Dermatology program, that I think are quite valuable to us.

But all that sort of came together as the information age was beginning to peak, and I'm not sure where the peak is and I don't think we're there yet, but it's still growing.

C.M.: Are there other components of the legacy you inherited from Dr. Laster?

P.K.: Well, I think the Vollum Institute was also conceptually his. Now, he was interested in recreating NIH. I don't know whether you're going to talk to him or not, but it's sort of interesting, he has told me about this. He and I both come from an NIH background. I was there for nine years, as a matter of fact -- eight years; excuse me -- eight years in the NIH. And there was a perfect opportunity to take basic research and apply it in clinical situations.

He saw the Vollum as an opportunity to do that, and I think what it has done is allowed us to create a phenomenal group of researchers there, and they have allowed us to bring in the other recruits that I mentioned around the campus.

Now, one of the things that we've added more recently is the Hatfield Research Center, which is for clinical research, and in many ways it is a lot like the NIH Clinical Center in that there is basic research on the bottom floors and clinical research on the top floors. So we've created another version of that here, which I think happens to be a very good model.

C.M.: Any other parts of the Laster legacy?

P.K.: Well, since he wasn't here when I came

I think that he was beginning to try to move the research programs forward. They had some extremely strong researchers, but it didn't have much laboratory space, and frankly, OHSU had not had a huge amount of NIH funding when he began to try to effect this change.

So I would say that spirit of trying to increase research was another thing that the institution inherited and I then inherited from him.

C.M.: One of your objectives when you first came here was to move this institution into the top 20, actually, in terms of research.

P.K.: Right.

C.M.: And I've read somewhere that you feel you've passed the top 40 milestone?

P.K.: Right.

C.M.: I find this amazing because the competition is so keen.

P.K.: Right. As you know, the top 20 has had very few changes over the last ten years or so. We're in the process of doing two other relatively innovative things, just as we speak, that will put us clearly into the top 40 and close to the top 20, and we will continue to move upward.

Our long-term timetable to get into the top 10, if we make it that far, is about 20 years from now. But we're going to merge the Primate Center into the University; it has been a separate freestanding entity, which currently is a subsidiary of OHSU.

It originally was run was by the Medical Research Foundation. We merged the Oregon Health Sciences University Foundation with the Medical Research Foundation. Merging foundations is a real interesting activity, I might point out. But that worked well. And in doing that, we inherited the Primae Center, which the foundation, then, moved over to

the University approximately a year ago, with the idea that ultimately we would merge it into the institution.

That's one thing. They have been very successful. There's a very strong director there, Dr. Susan Smith, who has built that program quite nicely. In fact, I just came from a meeting there this morning. And when we merge them into the University, we will be increasing our annual grant revenue by about $18 million a year. We passed a milestone of $100 million this past year, $100 million dollars of research support per year, which compares with something approximately 20-some ten years ago.

The other innovative thing that's occurring is the Neuroscience Institute, the Dow Neuroscience Institute from Good Samaritan Hospital, the Legacy Health System, is transferring to OHSU. That's another $4 million of support, and it's an area that complements our strong neuroscience program already.

So by doing these, we will be aggregating some strong research programs and gaining about another 25 percent in terms of our overall research support.

By the way, we should have logically had the Primate Center, anyway. It's been a somewhat artificial separation, but it is doing very well right now and seems timely to merge it to OHSU.

C.M.: I need to have you elaborate on the difficulty of merging foundations.

P.K.: Well, let me just say that each develops its own character, strongly committed to that particular piece.

We were fortunate to have most individuals see the great value that could be achieved by putting two foundations with similar interests together, but there always are personalities involved, and one of the people who served a very important bridging role in bringing this together was Paul Bragdon, who had been President of Reed College for quite a long period of time. He at that time was president of the foundation, and I think he saw the great value that could be achieved by doing these two together.

The OHSU foundation had somewhat greater assets. The Medical Research Foundation was somewhat older. So you had the distinguished old foundation and the distinguished new foundation that had to come together and choose a name. Right there -- somebody came up with

this idea that it would be called the Oregon Health Sciences Foundation, and that would satisfy both sides, which in fact it did.

But there were still lots of concern that would we treat the priorities of the previous groups appropriately. And one of the things that was of concern to some of the Medical Research Foundation members was would we continue the small grant program, which was open to people not just at OHSU but statewide. And in fact we have done that.

So one of the things I feel is very important is always to carry out your promises, so that you have credibility and therefore trust can be developed. And I think that has occurred in all these situations.

C.M.: Could you comment on the relationship between OHSU and various philanthropic institutions -- for example, the Robert Wood Johnson Foundation?

P.K.: Well, the Robert Wood Johnson foundation is headed by an individual who is a general internist, Steve Schroeder, and they're very interested in primary care and how to increase minorities in health care education, all similar to our own interests. They were interested in curricular innovation and development.

So we have had several grants from that particular group, I think because our priorities are aligned with theirs and we were doing things that they felt were meritorious and deserved support. And we were glad to take it.

C.M.: Are there other foundations where your priorities and their priorities have largely coincided?

P.K.: We have tended to work with almost all the foundations to a relative degree. I think that certain foundations have slotted support -- for example, the Pugh Foundation helped our dental school. But the local foundations have been very helpful to us in a variety of ways. Murdoch Foundation, Meyer Foundation, Collins -- all have provided important support in different areas.

One very interesting foundation was the Ford Family Foundation, which is just newly created. In terms of getting the keystone gift for the Doernbecher Hospital, we had to deal with Ken Ford, and I don't know if you've ever met the man, but he did not hear at all as far as I can tell. So we went down to visit him in his factory in Roseburg; we flew down to see him. And for about ten minutes I pitched the

Doernbecher. He didn't act like he even heard what I was saying, and sweat was starting to roll off at that point in time. I wasn't sure that the message was getting through at all.

Finally, I gestured somehow and knocked over my coffee, which he thought was humorous, and we started talking a little bit more. He sort of indicated that he might be willing to provide a gift for us, but then we could never get together.

J.S. May, who headed the Doernbecher Foundation, and an individual named Ron Parker who worked for him, at that time was his chief financial officer, were trying to get us together, but he would take off and go somewhere else every time a meeting was scheduled.

Finally we got together at the Arlington Club, and I sat facing the door, and he sat facing me. He started asking me questions like how long had I been here, how long was I going to stay, how much money did I make, and so forth. People would come and sort of look in the door, and they'd hear this conversation going on, and they'd sort of gracefully back out, because I literally had to shout to him to make sure he could hear this.

At that point he agreed to give us $3 million for the Doernbecher, which was our single biggest gift at that particular point in time.

But I didn't know we were ever going to get it. You know, fortunately for us we did have a chance to talk to him because unfortunately he died relatively soon after that, and now the Ford Family Foundation has been set up and is working its way through what its priorities will be.

C.M.: How much of your time as President have you given to development?

P.K.: Probably about fifteen percent or so. I have been, I think, more interested in policy and evolution and frankly have done a little less fundraising. It has come in spurts, and I'm always supportive when it's prepared.

We have been working through the ideal setup for the foundation, and we have been through some changes there, as you know, which are not over yet. We have just recruited an outstanding individual to be the Vice President for Development and President of our foundation.

It was interesting, this year we had an ice storm, and two very important recruitments were underway, and two people came during

our only ice storm of the year, and we've landed both of them: One will be the Vice Provost for Research, Dr. Martinez Maldonado, who is a minority, highly placed member of the administration, which I think is very important, and also David Mitchell, who will be the Vice President for Development. He's a superb fundraiser, and we realize that we need to build this part of our resource base.

The foundation has done well. The institution has had some tremendous helpers from the foundation over the years. Betty Gray has been -- she's the godmother to go with the godfather. We've had people committed -- a man named Charlie Ellis, who's been with the foundation as long as I've been here; I mean, he's longstanding. A number of other individuals: Brian Booth, who's been there before. So there are just a lot of people who have been very committed.

C.M.: How important has the alumni relationship been for you?

P.K.: It's been very important, although I think there's an area there where a great deal of improvement could occur.

The alumni in the dental school and the alumni in the nursing school have been much more generous in terms of their support for the institution than the medical alumni, and we've had discussions with the medical alumni association about how can we do better.

One of the things that I believe can be the case as this institution becomes clearly one of the best, which it is, then I think it will stir a little more philanthropy, and we're already beginning to see some of that now. But that's a very important part.

We have a lot of very loyal, committed alumni in the medical school, but I think there are a large number of alumni out there from whom we hear very little, and we'd like to be able to contact them, as well.

C.M.: Let me go back to this matter of how you spend your time. You said you gave about fifteen percent to liaison with philanthropic institutions. How's the other 85 percent divided up?

P.K.: Well, in the early stages, a lot of it really was looking at how to coordinate us here. A fair amount was spent with higher education, which truly was not that productive, but it had to be done.

We have spent periodically large amounts of time with the legislature. I think we are at this point in history warmly regarded by the legislature, who thinks of us, you know, kindly and wants to support

us, but they'd rather support us with moral support than money. But still there are a lot of issues. We were just down in Salem earlier this week -- or last week, to testify. Frequently they want to hear from us now about how we're doing, But still, that relationship is one that needs continuous work.

We meet with the various constituent parts of the campus frequently. We do have a high quality administrative group with Jim Walker, who is the CFO of the hospital, Tim Goldfarb, Lesley Hallick, and so forth, that get together and look at how we're doing.

A large part of what I have to be concerned about, though, is the integrity of our revenues, and that means our clinical programs: how are they working? So I work with Tim Goldfarb and Jim Walker and the deans fairly extensively on that.

One of the other very important things that's occurring right now, which when I was recruited I was told would never happen, but they've done it themselves, is the 30-some practice groups that comprise our array of faculty practices, of every different stripe: corporations, foundations, sole proprietorships and partnerships and what-have-you, are all coming together as a single group.

That's going to help a great deal their practice and the institution in terms of the joint planning that we need to do for the future, because I see us in the future taking advantage of our expertise in certain areas and being able to say directly to people, "Would you like to get your health care at OHSU?" So making sure that we are set up to do that is an important component part that goes along with the academic programs, of which you hear probably a great deal more, and also the research programs that we're developing.

C.M.: Could you explain to me why Tim Goldfarb and Jim Walker hold the positions they do?

P.K.: Well, Jim Walker was the CFO of the hospital. Now, hospitals have not been that well organized necessarily, but they're far better than educational institutions in terms of having budgets, having procedures in line so that you know where you are at any one time, using accounting that's appropriate for modern businesses and so forth.

Jim I saw as somebody who had great qualities there. We did have another CFO prior to Jim -- in fact, we had two others that just didn't work out. And so Jim describes it -- are you talking to him, by

the way? Because he tells this story which I think is apocryphal that I invited him to have this position and he declined, and then I said, "Well, that's fine, but I'm going to get somebody else, and then you'll report to that person," and he reconsidered and decided that he would do this.

I don't think that's the way it exactly happened, but he is somebody with common sense that I think now is putting into place a process that can be used -- works very closely with the Dean of the Medical School, Bloom, and the other deans, in terms of really creating something there that can allow us to adapt to all this change.

Tim Goldfarb is somebody who is trusted sort of by everyone and gets along with everyone, so there is a case where he was early on the acting hospital director, became the hospital director, clearly had the confidence of the staff, which is not easy for a hospital director; there's a natural antagonism there -- and I felt was somebody that could really add substantially to the team.

C.M.: When you mentioned that you go to Salem and deal with the State, there is only one other CEO of a medical complex in America who, when he goes to Mt. Peilier, Vermont, deals with a Governor who also is a physician; that's Howard Dean, a pediatrician. You're dealing with John Kitzhaber, not only a physician, but one trained here at this institution.

P.K.: Right.

C.M.: What has that meant in terms of your relationship with the State?

P.K.: Well, it's been good. He was supportive of our program.

John's experience here must have been a very interesting one. I wish I had been here when he was a student because he describes himself as an ex student rebel or radical back in the '70s, and on the other hand, he's a very thoughtful individual. His beliefs are right. In fact, I'm just going off to give a talk, and I pulled a speech that he had given to our students at graduation on the social contract and how important it is that we serve as well as doing the other things -- that I think his heart is right. And frankly, he has dealt with us, he believes; now I think we're not very high on his radar screen, and I would like him to continue to be interested in what we do, because he's going to finish being Governor as a relatively young man; then what's he going to do? He is on our faculty.

But it's been helpful. Obviously he has an understanding of health care that exceeds most physicians as well as most governors, certainly.

C.M.: I would think that would be extremely helpful.

P.K.: Yes.

C.M.: Are there members of the legislature, likewise, who are conversant with what you're trying to accomplish here?

P.K.: Yes. And I think, again, we have a very high level of trust built up with a number of key legislators of both parties.

I think that in this particular state it's a Republican-dominated legislature currently, and the Republicans tend to be in the rural areas for which we have done a great deal. That's why a senator from Burns was the one who put in Senate Bill 2.

By the way, Senate Bill 2, that's a good number. When you're Bill 2002, that's somewhere that came in late. Senate Bill 2 -- I don't know what Senate Bill 1 was that year, but it's a high priority. That went through that easily, I think, because we did have widespread support from both parties.

But there have been Democratic legislators who have been very supportive of us, as well, wish us well, and I think that's been critical to keep that spirit of good will up and support for what we're doing.

Remember, we're in the safety net still. And we also are becoming very important in terms of the biotechnology spinoff opportunities that we create for the State. So these are two again kind of different functions that we serve but are very important to the State.

C.M.: I want to ask about biomedical spinoffs. How much of that have you done, how successful has it been?

End Tape 1, Side 2
Begin Tape 2, Side 1

P.K.: ... technology spinoffs is to really have, first of all, a receptive administration.

I'll give you a little historical vignette. Before I had gotten to the University of Texas, San Antonio, one of the faculty members had invented a little coil-like stint that would hold arteries open. He took this to whoever the patent review lawyer was that worked for the

institution, who thought this was not worth the $5,000 that it might cost to get a patent on this.

This particular faculty member then went to a cocktail party where he found somebody who had created a restaurant chain -- in fact, it's Fuddrucker's restaurant chain, a man named Jim Romano. He said, "That sounds interesting to me," and the next thing the University knew, he had sold that to Johnson & Johnson for $3 million. He bought an estate and a Rolls Royce will his share of the money, and parked it right out front.

At that point I said, "We're not going to make that mistake if we can help it in the future, and so we need to have a place where the inventions are protected."

So we tried to cerate -- and it has to be self-funding, which makes it a little bit -- like much of what we do, we don't get any extra money to do this. But we've created an office that will allow us to patent inventions, and the number that we have been patenting has been almost exponentially growing over the last few years because it all depends on the scientific research that's going on and the new discoveries that are made.

Now, we have spun off at this point in time maybe six to eight small companies. They're in various stages. Many more are sort of in the works, and there we're again trying to have someone who understands the science and is able to talk to the venture capitalists, who are a whole different group of critics; I mean, they have criteria that are different from grant supporters, I can assure you of that -- and allow us to have more in that particular area, because we see it as having great benefit for Oregon, particularly if we can keep them here.

Now, the Primate Center has extra land out there, and one of the things we'd like to do is recruit to Oregon some of the research arms of some of the large pharmaceutical companies, which could have benefit both to us and to them. So we have some targets out there that we would like to be able to bring to Oregon.

C.M.: You mentioned how important the science is, which is apparent, but also is the culture of the workplace important? Do you want your people to think entrepreneurially?

P.K.: There is a shift that's gone on in terms of thinking. In my day, if you did anything that had a commercial benefit to it, it was

almost like, you know, you'd abandoned the cause and you're therefore less worthy. That's all changed, and I think that it's important for research to justify itself.

Now, this does get complicated in the age where secrecy needs to be involved, trade secrets, when can you publish what you find and so forth. So there's a balance to be achieved there, and I think we certainly don't want to chase headlong after the commercial end and abandon the very important grant stream from NIH, which we think is really the best way to measure success for our research programs.

So again, it's sort of walking between those and having the right level.

We've just recruited this new Vice Provost for Research that we hope will be able to help us achieve this balance and fill in the gaps.

C.M.: I noticed reading your C.V. that you've been -- you are, I guess, currently very active in the Portland Chamber of Commerce, you've served on a bank board, I think you've been on a Mayor's special committee to develop things entrepreneurially; does that all reflect your interest in this institution?

P.K.: Yes. I think that it is important for us not to be isolated. So when I started to answer your question earlier about what do I do with my time, more and more it has been involved with some of these local and national activities. I serve on the Association for Portland Progress, the Chamber of Commerce. I've been on the City Center 2000, on the Mayor's Business Roundtable. I'm on a variety of local things. I chair the AHEC board, I chair the Primate Center Board. All these take time.

I'm involved with the Northwest Health Foundation, the new foundation that has been created, two national groups working on increasing funding for research, including Funding First, which is the Laster foundation group that Mark Hatfield chairs. I'm on the National Center for Research Resources Council. I'm the Association of Academic Health Centers chair-elect; I'll be the chair as of September of that particular group. I do various things for the AAMC.

I travel too much; you know, I'm doing too many of these things right now. But I think they all have some benefit to the institution, or I wouldn't do them.

C.M.: This may seem like an odd question, but do you enjoy all this type of work?

P.K.: Yes, largely. I do feel like I've been traveling too much lately, though. I would like to stay here more and sort of watch after what goes on here.

The group around me, though, seems to be happy to have me traveling. But I do take a computer, and I'm in constant communication with what goes on here, even on vacation, which I guess is different from a lot of people.

C.M.: Again with respect to some of the things I read to prepare for this interview, I notice an emphasis on the way you have increased the faculty involvement in the governance of the University.

P.K.: Oh, yes.

C.M.: Where was that situation when you came here; where is it now?

P.K.: Well, I think it was more or less symbolic in the early stages, and I think it's really important -- one of the secrets to getting change to occur is to get everybody to buy into the process. So for the public corporation, for example, the faculty council heard about it, the faculty senate had this as a topic for debate. By the way, we talked to the unions, we had the unions on board. Literally there was no campus opposition, but all this required a lot of explanation and a lot of, I think, understanding on the part of the campus at large in the terms of the value of doing this versus not doing it.

Now, if you say to some of these people now, "What's the public corporation done for you," they may not be able to tell you, but I can assure you things are better than they would have been otherwise.

C.M.: I didn't realize as a stranger here that you did have unionized employees.

P.K.: Oh, yes.

C.M.: Many?

P.K.: Yes. The AFSME union has about 3500 members, and the Nurses Union has about 900. So we have two large unionized groups.

I meet with the president of AFSME once a month, just to talk about how things are going. And you know, one of the things we're trying to do is to get everybody to understand that we'll get farther together -- you know, the culture of working together cooperatively will get us farther than I think bargaining, because one of the things that happened after we became a public corporation is AFSME went out on

strike. Now, this was a little surprising to us because they'd supported the public corporation. We in fact had given them better raises than the rest of AFSME that worked for the other parts of state government were going to get, and we didn't have anything more to give. So it was a very short strike.

But I think almost from that came some better understanding of how we could work together. We have a labor-management committee that works to try to iron out problems before they become too severe.

C.M.: Besides the monthly meeting, how much of your time and attention do you give to union-management relationships?

P.K.: A fair amount. I mean, I don't directly do that; that's under Jim Walker at the present time. But I keep track of how it's going and so forth, and we're seemingly in bargaining all the time.

This is one of the issues that comes up with the merger of the Primate Center is they have about 200 and some employees out there that have no union. Their fringe benefit package is less, but their salaries are higher, and the question is how do you balance that with what we have here. So we're working that through.

C.M.: Going back to foundations, are there others that you want to mention that have been particularly helpful?

P.K.: Well, I think -- I can't think of any that are really -- I mentioned the three local stand-out's, and I think there are others that have not been helpful. The Robert Wood Johnson Foundation plus the local ones have been certainly the best to us, and we've gotten other support from additional ones, as well.

C.M.: Any pattern to those who have not been helpful?

P.K.: I would say that certain foundations have tried to change the world independently and create a new way to do education. Well, that's an okay goal, but you have to have an enormous amount of money to really make an impact. So I think some foundations have tried and failed. I'd rather not mention who they are, but I can tell you when the camera's off who I think falls in that category; there's one in particular.

C.M.: Well, maybe you can answer in our next interview.

We've talked a lot about recruitment; to turn that around a bit, has retention been a problem at all?

P.K.: A slight problem, but not nearly as bad as you would think. We've tended to hang onto our best people here with a very few

exceptions. I don't know if that's quite right. There are a few people who have left that we were not okay with seeing them go. Most of them it's worked out for everybody's benefit.

But this is a tremendous place to live, as you undoubtedly know, and people have less here -- you know, our salaries are not up to the national norms yet. We would like to put them there, but they're not close in many instances.

C.M.: Does that spin off in terms of a tremendous sense of personal loyalty among so many of the people working here?

P.K.: To the institution?

C.M.: To the institution.

P.K.: I think there is quite a bit of that. I know that there are always problems that are occurring. The academic institutions are in great ferment nationally right now.

Sitting where I do, on the board of the Association of Academic Health Centers, I see story after story of what's gone wrong. A big, private institution buys your hospital, or you split it off because you think that's a better model. You know, all this division and then re-aggregation that's going on, trying to find the best model, has been difficult nationally, and change creates stress. So I think for a place that's been through as much change as we have, the faculty and the employees are surprisingly at ease, particularly in view of the fact that we're not up to the national levels yet in terms of compensation.

C.M.: I have no idea if this true, but in Oregon is there a sense of competition between this University, the University in Eugene, Oregon State University in Corvallis, or any other of the state institutions of higher education?

P.K.: I don't think we're very -- we don't have overt competition. We do collaborate in certain areas, but we're separate enough that it's really not a problem.

There are some competitions going on, as you know, but we're not part of it. In fact, we're part of a group -- I'm part of a group of local presidents that have been talking about can we cerate a virtual university, can we create something like what is present in Seattle in Oregon by putting together a combination of publics, privates and quasi-public like ourselves.

C.M.: Do you have an answer to that yet?

P.K.: If everybody can gain from it, we will do it, and the question is how much time do we have to commit to such an enterprise.

But I'm very attracted to the idea, and I think a key always is leadership, so if the right person takes this on as something they want to achieve, I'll bet we could do it.

C.M.: Back to philanthropic institutions, you were at one time an investigator for the Howard Hughes Medical Institute

P.K.: Yes.

C.M.: ... and very recently you had the first person here, Susan Amara [?], become an investigator for the Howard Hughes Medical Institution. Is this something you would like to cultivate?

P.K.: Absolutely. That is a very important source of support. We actually have two. John Scott has now joined Susan Amara as our second individual, and we would like to be able to enjoy the same sort of support that other institutions get.

The Hughes Institution is very interesting. They're quite secretive -- and I was one of their two first investigators at Baylor, when I was on the faculty at Baylor. And they divided all the research centers in the country up into groups where they would have a red light, an amber light or a green light. And I know that when they were first considering us, we were in that amber light category. I think we've hopefully converted to a green light by now.

C.M.: Any particular steps you undertake to try to develop that relationship with the Hughes Institute?

P.K.: You know, in these instances the key is the quality of the science. As the quality of the science improves, their interest in us increases.

Dick Goodman has done a good job in cultivating a relationship with the administrators there, and I think that will stand us in good stead for the future. But really it's the quality that they care about.

C.M.: In terms of national perceptions of OHSU, do you sometimes feel that you're perceived as a minor light between the University of Washington above you, Stanford, University of California at San Francisco below you?

P.K.: I think we have had some of that problem. I think we're overcoming it. But, you know, the reputation tends to lag behind the actual quality by some number of years.

I can remember Johns Hopkins, for example, was always a premier institution, but it took a dip back about the time they were trying to recruit me as a faculty member there, actually, but their reputation remained as strong as ever. And then they re-created themselves into one of the premier institutions of the country, but they weren't that way, you know, continuously.

Now, I'll use an example here. My own area of endeavor when I was a scientist was endocrinology. We have one of the absolute best endocrinology groups in the country here. Yet when you go to -- oh, I'll just give you an example. We have had three successive presidents of the Endocrine Society, which is a 7,000-member group, from Oregon. Two of them have been at the Primate Center, and so maybe they don't understand that's related to OHSU; one of them was Lynn Loriaux, who was chair here -- but Susan Smith, Michael Kant and Lynn Loriaux were three presidents in a row. That wasn't the right sequence, but --.

And our programs are also extremely strong. Ron Rosenfeld is an endocrinologist, and we have some very strong people in the Department of OB/GYN; Dick Goodman's program is really endocrine-related. There are a number of others. When you say, where are the strongest programs, we're still not up in the top twenty, yet we're probably in actual fact somewhere in the top three.

Now, I think that will gradually hit the level of consciousness here at some point in the future, but it's been interesting to me to see that lag phase occur. And part of it may be that we are kind of at one end of the country. We are a smaller institution, but very high quality, and I think we're getting a level of appreciation, certainly on the West Coast, but also now on the East Coast.

C.M.: You've lived here now for almost a decade. Have local, regional perceptions of OHSU shifted in any way you've noticed?

P.K.: I have a feeling that we're viewed much more kindly now than we were in the past. You know, there was a period there where it seemed like there was no news except negative news. I think we're past that, and generally we're doing a lot of good things that tend not to be as newsworthy -- because, you know, "if it bleeds, it leads" is still sort of the watchword -- but a lot of important things with Doernbecher, with our other programs that I think have given us a little more warm and fuzzy feel than we had before.

C.M.: With respect to media coverage, how has it been with you and *The Oregonian* for last ten years?

P.K.: It's been pretty good. We've had our occasional problems, but by and large I think *The Oregonian* has been pretty supportive.

C.M.: And other media?

P.K.: You know, they've been okay, also. The thing that sometimes surprises me is when the reporter comes to do a story, often they have no idea of the context. Now, that's not always true, but frequently, you know, they're just assigned by some editor, "Go find out about whether the blood supply is safe," or whatever the current problem is, and they'll try to get something together. They want you to speak in sound bites, and then they'll try to put something together that runs 30 seconds or maybe a minute on television, and that's it.

So am I disappointed in the level of understanding of what we are by reporters? I no longer am disappointed, but I used to be. So I've gotten over it, I guess, is what I can say.

C.M.: Somewhat hardened?

P.K.: Well, I wouldn't say hardened, I'd say resigned. Seasoned, might be the best thing to say.

By the way, there are some very good reporters, but they don't tend to be assigned always to us. I mean, there have been some really good ones that have come through, who do appreciate -- and it's been interesting to me, they've tended to come at us more from a business perspective, though, than from the science -- although it's a combination.

C.M.: It's interesting when you say no news except negative news tends to prevail, it's been my limited experience it's very hard to get good coverage of positive news, like a medical advance done in your own laboratories, because it's not controversial, and so much reportage centers on controversy.

P.K.: Right. I watch the media flagellate themselves over this very issue frequently, so that's why I say I'm sort of understanding now.

C.M.: What comes through in this interview is I think you are a very sincere advocate of being a comprehensive consensus-builder. Is that a fair description?

P.K.: I think so. I think the whole institution has to function together, and there are inherent divisions in academic health centers that need to be bridged and brought, you know, more together. I think the future is going to be not necessarily that we have to be monolithic in our approach, but we have to at least be very much coordinated, and therefore trying to get everybody to understand the value of that is extremely important, and that is the consensus-building part.

C.M.: Do you find yourself being a mediator quite often?

P.K.: Occasionally; not as often as you would think. There's a recruitment going on right now that I'm finding out about that has not gone as well as I would think that I think can be solved fairly easily, and so I guess I'm going to serve in a mediator role there occasionally.

C.M.: You sketch a university that seems to be quite unified, and as you know, from coast to coast many of them are not.

P.K.: We're much more unified than most. I think there is a lot of interest here in what's happened at OHSU versus other places because we do seem to have done okay, if not well, in a heavily penetrated managed care environment. I mean, I don't know what the word "penetrate" means when it's 80 percent; "encapsulated" may be a better word.

Our research programs are growing much more than the national. By the way, there were some studies out recently about how managed care affected research programs negatively; we're an exception to that. And we're also very much involved with primary care and trying to resolve the rural and urban needs of the community.

So I think there are a lot of people interested in how does that work exactly, particularly -- you know, academic health centers are tricky institutions to govern. The turnover rate on our board, the board of directors of the academic health center -- attrition is high, shall we say. But it's nowhere near as high as deans of medical schools, which turn over even more rapidly.

So these leadership positions are interesting, and therefore it's very important that everybody be headed in the same direction to make progress.

C.M.: We have, perhaps, over-focused on outreach to rural areas. You just mentioned urban areas; could you elaborate on that?

P.K.: Well, the underserved areas tend to be either rural or urban, and as part of the area health education center program, the last piece to come on board was the Columbia-Willamette section, which is largely urban.

But we've been involved in clinics of all types all around the city all along, and we do serve that safety net role that's critically important, I think, for the City and County. What happened to us twenty-some years ago was the County Hospital was sold to us for one dollar, probably the best deal they ever made, thereby abrogating their sense of responsibility to inpatient care for county residents who could not pay. They still had a clinic setup, and there's been some discussion more recently about whether they would in fact give up their clinics. I don't think they will, but the City doesn't do much in terms of indigent care, and only one other hospital does very much in the city. So we in fact are the safety net to a large degree.

So I think that particular issue is one that we have to struggle to make sure we can make ends meet while we serve this particular function, without much help from the City or County.

C.M.: That must be hard.

P.K.: Well, it's hard for everybody.

I belong to another group I didn't mention called the Blue Ridge Academic Health Group, which is a think tank for people who -- it's a combination of business and academic. But the last problem we addressed was indigent care, and how do we nationally resolve this because the number of uninsured in almost every other state except Oregon is going up. So the indigent care problem becomes greater and greater in most other locations around the country.

The Oregon Health Plan has helped here, and part of that, frankly, has been the insurance coverage piece that it's provided that people don't even know about, they think it's just Medicaid. So I think there are some things that Oregon has done well, and I'll certainly give John Kitzhaber credit for trying to create a plan, which in view of his national reputation, was quite courageous.

We get knocked all the time for the Oregon Health Plan. I go out and defend it as a good thing, and everybody in Oregon pretty much thinks it's the right thing to do, with some exceptions, but nationally you'd think we were pariahs of some sort.

C.M.: In some biographical materials you've put out about yourself, you've emphasized health policy as one of your primary interests, yet coming up through the pipeline as a medical student, at NIH, at Baylor, Arkansas, San Antonio, did you have much exposure to this in order to prepare yourself to be active in the health policy field?

P.K.: Not really. I served as chair of the Oregon Health Council about four or five years ago. I was actually appointed there by Barbara Roberts, and became extremely interested in health policy as part of that. And we went out around the state listening to people express their concerns about health care and what was needed and where it was going and how do you resolve that.

You know, I came up with a different solution from the Oregon Health Plan as a way to solve this. It was not implemented, and maybe at some point in the future it will come back.

C.M.: Am I correct in saying of all the member institutions of the University there is not a public health school?

P.K.: We have the Department of Prevention and Public Health, but it's not a full-fledged school. We do in fact, however, have a Master's of Public Health degree program in conjunction with Portland State and Oregon State and this department. So we are achieving part of what a school would achieve, but yet we do not have one.

C.M.: And do I understand correctly, have you recently started a Physicians Assistants' program?

P.K.: Yes, we have.

C.M.: Any coincidence in the fact that that concept and program is rooted in your *alma mater*, Duke University?

P.K.: In my old mentor Eugene Stead. Actually, I'll have to confess it is not.

We did believe, and still believe, collectively -- and Lesley Hallick was the person who was perhaps most involved with this -- that there was a very important role for physicians' assistants in terms of the health care system that we have, as well as nurse practitioners. And I think we train nurse practitioners now and physicians' assistants.

To me, these are going to be very logical in terms of the interdisciplinary practice of health care of the future, that we're going to see, and frankly, part of our role is to be able to provide whatever the people

are that are going to be needed for the future, and physicians' assistants are an important group.

C.M.: Why do you think it's going to be interdisciplinary?

P.K.: Well, I think that the way managed care is likely to evolve and again, the last person who thought he could read the future that I know was fired a few days later and never saw it coming -- I think the way that health care is likely to go is going to have a component of prepayment in there. So we will be looking for ways to address comprehensive needs, hopefully prevention, which has really gotten short shrift in the way we practice health care, with the sort of disappearance of public health facilities and county health services -- unless you can write a grant to get it funded; I mean, it's been a very tenuous funding program for them.

So I think that we're going to be able to see various combinations, which already exist in a lot of areas, where you may have an office with three physicians, a nurse practitioner or two, and a physicians' assistant, all of whom get along quite well and complement each other in such a way that, frankly, there's a more even provision of care.

C.M.: This may seem like an odd question, but what's it like managing an institution on a hilltop like this one?

P.K.: Well, I used to worry about being characterized as "on the hill" or "the hill" or "pill hill," but I think the geography mainly bothers me because it's so expensive to build anything here. It must cost us a premium of about a hundred dollars a square foot to hang these buildings off the mountains. That's why the Primate Center is such an attractive piece of land to us: it's flat, and we see it as what we're going to call the West Campus of the future. We're going to have some of our research buildings there.

We also have clinics studded around the city, as you know. We're not extensively going to develop those further.

But the hill -- you know, we have a good view, we can see Mt. Hood, I think it helps when we're recruiting, but it's hard to get up here; we have only a two-lane road, and today it was blocked off one lane.

So I would rather be on the flat land myself.

C.M.: Well, I asked that question partly because I have spent so much time in the Texas Medical Center, which is as flat as a pancake, as you well know.

P.K.: Well, I enjoy the mountains and the snow. I think our geography is one of our great advantages, but getting up and down this hill sometimes is a little more difficult than it ought to be. And parking, as you undoubtedly know, if you want to get one hot button for everybody involved, it's parking up here. And as we grow -- as you perhaps know, we've added ...

End Tape 2, Side 1
Begin Tape 2, Side 2

C.M.: In terms of your personal time, what do you read to keep yourself informed professionally?

P.K.: Well, I'm in the process of reading a book on aging that just came out that I think is quite helpful. I read all sorts of things. One of the things that I'm reading or have recently read was *Undaunted Courage* by Stephen Ambrose, which I thought was an excellent book.

I do a lot of journal reading, and as books come along that seem to be relevant to us in special areas like --

Another thing that I didn't mention, I'm chairing another task force for the Institute of Medicine on quality in long-term care. Now, this incorporates nursing homes, assisted living, independent living, home health care, all the above, Alzheimer's care and so forth.

It's become pretty clear that we don't have a solution for this rapidly growing part of our population, and when the baby-boomers hit 65 and older, we're really going to have to deal with some new stresses on the health care system. So I'm interested in everything that relates to aging and how we can carry out care better in the future than what we do right now.

Now, this is going to be awkward because states have capped nursing homes, because nursing homes were running -- you know, they were breaking them in terms of the budget. But we're going to have to find some way to take care of older people, be they healthy or not. I'd like to see that be part of our educational programs: How do we train people to take care of folks who are in nursing homes, home health care -- and I would like to see us create some kind of new care site or spectrum of care, and we might do that in Portland or we might do this with some collaborators in another part of the state, like Medford.

So I think it's important for us to continue to be innovative.

C.M.: Any comment on how a chief executive officer tries to inspire innovation in a large institution?

P.K.: Again, I think it comes through trying to have the right people in leadership positions. That to me is the most important thing, is to have a very strong team that functions well. I think we have that. And frankly, they then deal with their pieces.

I think maybe there's a need coming up to do a little bit of this, but we don't have convocations and institution-wide celebrations. Recently, in view of some of the cuts that the hospital is having to make to deal with the cost issues, I've been getting feedback that they would like to see more of Tim Goldfarb and myself and they would like to have some bigger meetings that would be opportunities to talk about where we're going, what we're doing, why we're doing it and how we're going to succeed.

C.M.: In terms of your own personal biography, how does a person born in Brooklyn, New York, graduate from high school in Vicksburg, Virginia?

P.K.: Well, that is interesting. My father was an English professor, as I mentioned, at Virginia Tech, and in those days you only worked nine months of the year at a college, and so in the summer he had off. And the difficulty with that is you didn't get paid.

C.M.: And you were born in July.

P.K.: And I was born in July. He went to New York City and worked for CBS radio writing the story line for soap operas. So what he would do, he would write a story line and then some scriptwriter would come along behind and fill in the dialogue. And that's what he would do every summer. So he'd go up in the summer and write enough for a year -- these are not very complex, as I understood what he said about them, didn't take too much to do that.

And I was born in Brooklyn, which is where -- my mother was actually from Brooklyn; his family was from Pennsylvania, as was hers, but my grandfather was a physician in Brooklyn, and they would live with them during the summer, and that's how I happened to be born there.

But I left Brooklyn at age two months, and hence I have no Brooklyn accent.

C.M.: I noticed. Why did you choose to go to the University of Virginia as an undergraduate?

P.K.: Well, in those days college professors did not get paid a great deal. In fact, I can remember when my father got his raise that got him $5,000 a year, and that was -- you know, we were glad to have it in those days.

He had told me that I could go to any institution at which I received a scholarship, and University of Virginia offered me one. That's how simple it was.

C.M.: Why the choice for medicine?

P.K.: Well, I'd been at Virginia for four years, I had been in state, and I was sort of interested in Duke as an option, and so I applied there and to Virginia and ended up going to Duke.

C.M.: And why medicine as a specialty?

P.K.: I started out pre-law, and in about two months I converted over, thinking that this was actually a very interesting opportunity to work with people, which I enjoyed doing, and I thought that being a physician would be perhaps the greatest thing you could do.

C.M.: I need to clarify that. Did you start at Duke in the law school?

P.K.: No, no, no. At Virginia.

C.M.: You started at the University of Virginia as a prospective pre-law student?

P.K.: Yes. It didn't take very long for me to change.

C.M.: And the fact that your grandfather was a physician, did this have any bearing on your choice?

P.K.: I think it might have made some difference, yeah. I think that it clearly planted some sort of seed with me that this might be the right thing to do.

C.M.: What kind of physician was he?

P.K.: Family practitioner.

C.M.: I think Everett Koop comes out of a similar background in Brooklyn, New York.

P.K.: Is that right?

C.M.: Do you feel, as the years have gone by, that you've moved away from medicine in terms of being a researcher in exchange for

becoming an administrator? Are there trade-off's involved there, satisfactions and dissatisfactions?

P.K.: Well, up until and through the time that I was the dean at San Antonio I was very involved in the teaching program, and I did do some of that here. But in all candor, I felt like I was learning more from the students than they were learning from me, and a great contribution I could make -- you know, somewhere I passed that threshold, I had the experience, you know, I had the old stories, and I'd seen a lot and I had a lot of that kind of wisdom, I guess, but frankly, I was not able to keep up as much with the newer things that were occurring in terms of diagnosis and treatment, and I felt it was better for the students to have somebody more current for the attending.

I think, by the way, that's an important thing for all of medical education: The education needs to be provided by people who are at the top of their game, not by people who themselves have to be educated back by the students.

C.M.: Am I omitting to ask you anything you'd like to cover in this interview?

P.K.: I'm not sure what might be added that hasn't been covered already. I'm very pleased with the way things have gone here. I think that OHSU is destined for greatness, and I've enjoyed being part of the process and hope to continue on for a while to see how it goes.

C.M.: Well, thank you very much. I appreciate this.

P.K.: Thank you.

End --Tape 2, Side 2