

## SUMMARY

In this interview, Dr. Harold Osterud describes his involvement in the development of public health programs and education in Oregon. He was born in Richmond, Virginia. His father was Professor of Anatomy at the Medical College of Virginia (MCV). Dr. Osterud attended Randolph-Macon, the oldest Methodist college in America, and then the MCV. He served in World War II and Korea. He came out to Oregon, interned at Good Samaritan Hospital, and then worked in public health for the state. He went back east to the University of North Carolina to obtain a master's degree in public health.

He served as Health Officer in Coos Bay for three years, and then moved to Eugene. Dr. Osterud testified before the Oregon State Legislature to replace the elected coroner's office with a medical examiner; he served first in that capacity. He was also a physician for the jail and juvenile court. He worked with the Lane County Medical Society to establish the first local mental health clinic in Oregon, and wrote a proposal that resulted in the creation of first outpatient psychiatric units around the state.

In 1961, after six years in Eugene, Dr. Adolph Weinzirl offered Dr. Osterud an academic position at the University of Oregon Medical School. Dr. Osterud worked at the Crippled Children's Division (CCD) on congenital malformations and heart disease; he and Dr. Victor Menashe were the first to identify hypoplastic left heart syndrome. Dr. Osterud gives an account of Dr. Weinzirl's life and achievements.

The Oregon Medical Society resolved as early as the 1870's to form a state health division, but the division was not established until 1903; Dr. Weinzirl served as the State Health Officer. When the ophthalmologist Dr. E.C. Brown passed away and left his fortune to create a trust fund, Dr. Weinzirl created a new department at UOMS and began to teach full time. The department, which began as a basic sciences department, became a clinical unit around 1949. After Dr. Weinzirl died suddenly, Dr. Osterud took over as department chair.

At this time, Dr. Osterud was investigating what is now known as Sudden Infant Death Syndrome. In the late 1960's, Dr. Osterud helped develop a new curriculum, creating a child health block through which all students rotated for three weeks. Working with the Oregon Medical Association in the 1970's, Dr. Osterud created a program to recruit physicians for small towns and rural areas; the number of rural physicians increased by 75 percent over the next eight years.

In the early 1980's, Dr. Osterud and colleagues worked with the University of Washington and Portland State University to develop an MPH (Master's in Public Health) program. Dr. Mitch Greenlick eventually created a joint MD/MPH program at UOMS.

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Interview with Harold Osterud, M.D.  
Interviewed by Linda Weimer  
April 26, 1999  
Site: History of Medicine Room  
Begin Tape 1, Side 1

WEIMER: This is an oral history interview with Dr. Harold Osterud, and the date is April 26, 1999. My name is Linda Weimer, and we're in the History of Medicine Room in the old Library Auditorium Building.

We start off all our interviews asking the question of where you were born and raised.

OSTERUD: Well, I was born in Richmond, Virginia. My father, who was a West Coast graduate of the University of Washington, was professor of anatomy at the Medical College of Virginia in Richmond. And so I was born, and I've been around medical schools all my life [laughter].

We moved out to the country. My father never lived within the city, and we lived in a little town called Ashland, Virginia. It's about eighteen miles north of Richmond. It's a very historic place. It's Henry Clay's birthplace, and Patrick Henry lived there too, so it's a rather famous old place. It's had several names, but it's a small town. It's the site of the oldest Methodist college in America, and that's not a very large school even today, and today it is coed, but it was a school for males. It was Randolph-Macon, and its reputation there is very similar to Reed's here. It's really supposed to be a very fine school.

WEIMER: That's where you went to college?

OSTERUD: Yes. I went to college at Randolph-Macon, and then I went to the Medical College of Virginia in Richmond, and then I came—because my mother was an Oregonian, she was born here in 1886, and she talked to me about it a lot, so I decided to come out, and I interned at Good Samaritan Hospital. Then I went into the State Health Division's program for people in the public health field. I was assigned to the Wasco-Sherman Health Department for two years, and then I had to come in every so often for education, and they came out and worked with me. We didn't have a residency in those days, not in the public health. And then I went to the University of North Carolina for my master's degree and then came back here.

WEIMER: Well, we skipped a few details in your summation of your education. Let's get back to college. When did you decide you wanted to become a doctor?

OSTERUD: Oh, goodness gracious. I was five years old, and we were out in the back yard at Glen Allen, Virginia, before we moved to Ashland. It was just a very rural place. We grew peanuts. My oldest brother and my next brother and my sister—there were four of us at the time—we were out in the backyard, and they were talking. We had a big pile of bricks, and they were going to use it for building, and I climbed up on—oh, and they must have been about six feet at least. My sister and I climbed up on top, and the bricks came loose, and we fell. My brothers came up to see if we were injured, and my oldest brother says, “Well, I think I’m going to have to be a doctor.” And my next brother says, “Well, what am I going to be?” He says, “You’re going to be the dentist.” And my sister—and she did this—she said, “Well, I’m going to become a nurse.” And she did at U of W. She headed up their hospital infection program for many years. She had her master’s in nursing.

Then they looked at me, and they said, “Well, you’re going to have to be the undertaker” [laughter]. And I said, “I will not be an undertaker, I’m going to be the doctor.” And I made up my mind, and I never changed it [laughter]. So that’s the first—I have to admit I thought about other things, but I never really thought seriously about anything else.

WEIMER: You went to medical school at the Medical College of Virginia?

OSTERUD: Yes.

WEIMER: What was it like back then, and what was the year?

OSTERUD: Well, goodness gracious. I was nineteen years old. That sounds ridiculous.

WEIMER: That sounds very young.

OSTERUD: Yes. And it was World War II, and I volunteered—my draft number was going to come up anyway, but I volunteered at nineteen and went to Hanover County Courthouse, was transported from Hanover County Courthouse—that’s where Patrick Henry made his speeches; it’s a beautiful old place—and went to Richmond, passed the physical, and was sent to Fort George G. Meade in Maryland. I got there on December 19, and the first thing they had me do—when I was still in my civilians—was scrub a floor. I scrubbed a colonel up on top of his desk because I didn’t even look where I was going, scrubbing. I won’t forget that.

The next morning I went in, and a young corporal looked at my career up to that time, and he knew that I still had two hours to go before I got my bachelor’s degree. But anyway, he looked at me, and he says, “Well, I know where I’m going to assign you. You’re going to the quartermaster corps.” I said, “Why?” He said, “Because you’re a butcher for Safeway,” and I was. I worked every Saturday, as a kid, at Safeway. I put in twelve- to fourteen-hour days. And I said, “No, I’m going to medical school.” He says, “You can’t.” He says, “In order to go to medical school, you have to already be

accepted.” So I pulled out my acceptance signed by Colonel Dixon, who was actually in charge of the military unit, and he was a physician, admitting that I was to go to medical school in the Army. So as a private first class, I went to start my medical school.

I got to Richmond on December 24. I reported in to Colonel Dixon, and he laughed. He said, “There’s nothing for you to do until the second of January. You can do whatever you please.” So after going into the military on the nineteenth, I came home for Christmas on the twenty-fifth [laughter]. And that was unheard of in World War II.

WEIMER: I can imagine, yes.

OSTERUD: So I lived at home for the first year and a half. And we started school, and then it was very concentrated and it was going all the time. It never stopped. And so I went to college for six straight years without a vacation because of the war. Not only true of me, it was true of nearly all the students who were there.

And so I started at the Medical College of Virginia, and the first person I met was my father, and he gave us the introduction to the practice of medicine, because he was the professor of anatomy [laughter], and he was a Ph.D., not an M.D. So that was the way I started medical school. I stayed in medical school. If you flunked one course, you were immediately taken out. I was lucky; I didn’t flunk any. So I stayed there.

We had six months between our junior and senior year after we were discharged. I was discharged in my mid-junior year, because the war was over 1945, and we had six months’ vacation for everybody at school because the faculty was just absolutely tired out of teaching without any vacations. So I just took a two-month elective in radiology and another two-month elective in internal medicine, so I spent four weeks there. Then, on graduation, I came out here.

WEIMER: During the war years, when you were in the Army at medical school, did you have to wear a uniform?

OSTERUD: Oh, yes. Oh, yes, we wore a uniform until I was discharged. People couldn’t figure that out. During the evening and on Saturday I played local softball. In the summer, of course. I was in medical school at the time, but living at home. And I played softball in my military uniform [laughter], because we didn’t have uniforms when we played, but we had a little league. I played for the Ashland Laundry team [laughter].

WEIMER: It sounds like fun.

OSTERUD: We played at night, under lights. It was fun.

And when we were discharged, we were sent back up to Fort George G. Meade in Maryland, same place we were inducted, and we were discharged there, and they said to us, “Well, you’re discharged, but you’re not leaving the reserve. If we ever need you, we’re going to call you.”

Well, after my first two years at Wasco-Sherman in The Dalles I went back to the University of North Carolina to the School of Public Health to get my master's degree, and in March I got a notice from the military that I was to report for duty. The dean of the school asked them to let me finish, and so I was allowed to finish, but I went straight—I wasn't even allowed to stay for graduation. I went straight to Texas, down in San Antonio. They have a large installation there, a large hospital. I was there for only two weeks. I got my orders to go to Korea the first day—or at least overseas, the first day I got to the hospital there. It was Brooke Army Medical Center. So I didn't stay in this country very long at all. I went straight over.

WEIMER: To Korea?

OSTERUD: Yes.

WEIMER: Were you in a MASH unit? What were your orders?

OSTERUD: Well, when I first—I had the most backwards career of anybody in the military, I'm sure. Because of my public health training and my master's, I was asked to come and become medical inspector for all tactical troops trained in Japan. I was sent to Sendai, and my wife—I had married her when I was in The Dalles. We had one child, and she was supposed to come to Japan and join me. Well, three days before she was to leave, I got orders to leave a position that called for a full colonel—and I was a first lieutenant—to go to Korea.

Well, they flew me over to Korea and landed first in Taegu—that's where the military headquarters were actually located. They were not in Seoul. I was told I was going to take the position that called for a lieutenant colonel, directly under General Westmoreland. I was there only two days, and they said, "No, he's got to go to I Corps. They need a person right now." I Corps had about three or four divisions under the corps. I went there, I was there for two days, and they said, "No, you're going to go to the Third Infantry Division."

So I went from what—that position called for a lieutenant colonel, and the position was preventive medicine officer of the division and physician for the headquarters, so if the general got sick, I had to treat him. Anyway, so I went there and filled a position that called for a lieutenant colonel or a colonel—the one who was head of it then was a colonel—and so I stayed there, and I was there for a long time.

During the war I was with the Third Infantry Division, and we were on the front lines, of course. Whenever we went into a battle, I had to cover a battalion aid station. We put it as close to the fighting as we could get. And so I have to admit that much of my career I enjoyed, especially the mosquito control and the rodent control and a whole bunch of things like that, but I have to admit I did not enjoy seeing people get shot. I once had over a hundred casualties in forty-five minutes.

WEIMER: Oh, that's overwhelming, isn't it?

OSTERUD: Oh, it's just terrible. I never will forget that day. But I had to follow behind them. I went back to headquarters after that.

The general was relieved, because those fatalities came when he did not call off the air strike on Kelly, which was the hill they were trying to take from the Chinese and the North Koreans. That hill was only about two miles or less from the hill—we had a trench, just like World War I. I was even in the trench. The Chinese abandoned the hill quickly, and our troops had no opposition when they went up on it, and the general forgot to call off the air strike, and so those casualties I had were from our own air force.

When this happened, that general was immediately relieved of his duty, and they brought in another general from Japan to take over, and he called a meeting for all of his headquarters staff, and we all went. I was there, and I saw him. He looked at me and he looked at another officer, and he says, "What's a first lieutenant doing here?" And he says, "Well, he's acting division surgeon." I was in charge of the entire thing there for a while, even though I was a first lieutenant. Physicians were very scarce in those days. Anyway, he looked at me, and he said, "For God sakes, at least make him a captain." And so they made me a captain and immediately sent me to the—because I was replaced at the headquarters with a colonel, and they sent me to be physician in the battalion aid station for the Thirty-fifth Field Artillery, and that was the last four months of my stay.

I was in Korea for nearly eighteen months. So I went there, and so I ended my career in a position that called for a first lieutenant, and I was a captain [laughter]. So I went absolutely backwards.

WEIMER: Well, after the eighteen months, were you relieved?

OSTERUD: No. I came home, and I still had about two months. I wasn't sure where I was going to end up, because in those days when you did that training program at Oregon, for every year in the training program you owed the state two years. So I owed the state of Oregon six years.

WEIMER: Because of the military?

OSTERUD: No, no, this is for the residency training.

WEIMER: Oh, residency training.

OSTERUD: We don't do that anymore, but they used to do that, and so I had to come back to Oregon.

I wanted to anyway. Dr. Harold Erickson was the health officer. He's a graduate of this school, and he's probably one of the oldest living graduates. I'm not sure he isn't the oldest one. He's well up into his nineties now, and he graduated in the thirties.

Anyway, he told me that they would probably want me to go to be health officer in Coos County, Coos Bay. I didn't tell the military—I was sent immediately down to just outside Monterey to the large military base there, and I was there for about two and a half or three months, but I didn't say anything about my discharge. I was waiting to find out about where I was going to go, and then one day they looked at me and found out I'd been there two months longer than I was supposed to be [laughter], so I was discharged. I put twenty-six months in instead of twenty-four.

And then I came to Coos Bay. I was their health officer for three years, and then Dr. Tony Triola, who was the health officer in Eugene for Lane County, died very suddenly from a coronary—he had diabetes—and they asked me if I wouldn't consider going to Lane County, so I did. My wife really loved it because she's a graduate of U of O anyway. She didn't want to move to Portland. So I went from Coos County to Lane County and Eugene, and it was a very exciting time. We started some very, very interesting things.

WEIMER: Well, tell me about some of them.

OSTERUD: Well, one of the things that I did, I became the first medical examiner in the history of the state.

WEIMER: We had not had a medical examiner before then?

OSTERUD: No. No, it was coroner. Well, what happened—when that happened, I lobbied for it, because I did not like the way deaths—the health officer—we did all of the vital statistics, and we would have people coming in, we had no evidence of why they died, and the coroner didn't know either, and we were limited as to how much money we could spend on autopsies and so forth. Even back in those days for an autopsy it cost \$125.

Anyway, I decided we needed to do that, so I went to the State Legislature and testified before the Legislature, and the Legislature bought it. But it required a change in the constitution. They had to eliminate the elected coroner's office and put in an appointment to be appointed, at that time by the State Health Division, to become the medical examiner.

Well, Bob Straub was commissioner. He was later governor of Oregon. Bob Straub was commissioner, and he called me into the office, and he said, "We've got too big a problem with our coroner. He has had a stroke. His family won't give up the position until he either dies or something. He can't function."

I knew him. His funeral home was in Springfield. Well, one out of every six deaths ended up as a coroner investigation, one out of six, and so they wanted to keep it because they got most of the funerals.

WEIMER: Oh, because the coroner worked at a funeral home.

OSTERUD: Oh, yes. He was the director of the funeral home, that particular coroner was.

WEIMER: And, then, all the examinations were done at the funeral homes.

OSTERUD: Yes, that's right.

Anyway, but he tried to avoid doing autopsies, and sometimes I questioned seriously the accuracy of how the person died, because it was one out of six. In other words, if they had not been attended by a physician prior to their death, just right before it, if their death came suddenly or unexpected or if it were from violence of any type, automobile accidents or drownings, killings, anything like that, it immediately became a case. And so Bob Straub called me up and said, "You're going to become a medical examiner, even if it isn't going to be legal for almost two years."

So I did it for about—oh, before I came to the Medical School, and that was an interesting thing to work on. It certainly is an improved system, there's no question about that. It's now joint with the police, but it's always been with the police and with the health division. Now their officers are right in the police department, because the police then could not go out and move the body. I had to go before the body could be moved. It was awful.

WEIMER: You got to see all the gruesome details.

OSTERUD: Another thing that I did that—one of the things that we saw, I was also physician for the jail and for the juvenile court. I did general medical care in those two, as well as being health officer for the county, and we saw a great deal of disturbance in the juvenile facility. Kids were just—well, they were mentally ill. And so I worked with the Lane County Medical Society. They got a grant, and we established the first local mental health clinic in Oregon.

WEIMER: That's amazing. What year was this?

OSTERUD: Oh, that was 1957.

WEIMER: And we hadn't had one before then?

OSTERUD: Psychiatry was just in its infancy. There weren't very many psychiatrists. Most of them worked at the state hospital. And so all we did, if they were really, truly psychotic, we just sent them to the state hospital. And the health officer was frequently one of two physicians that would have to hold a hearing.

Well, we saw a lot of people who didn't need to go to the state hospital but who did need therapy. So the Lane County Medical Society actually made the application, got

the grant, and provided us the money. We only had one psychiatrist in Eugene, and he came and worked for us. We had two clinical psychologists, a psychiatric social worker, and a psychiatrist, and three beds at Sacred Heart Hospital, where we could put people who were in an acute condition.

The commitments in those days were held with one of the judges in the county, but when we did that, Governor Hatfield wondered if that type of clinic shouldn't be extended to the entire state.

At that time the State Health Division had Dr. Waterman and his wife, and he ran the whole psychiatric program for the entire state on a local basis, visiting health departments, but without any opportunity of doing anything except give quick advice. It was too big. He certainly was in favor of approving it, too.

So Hatfield appointed a committee. Dr. Saslow, who was head of psychiatry here, was on the committee. We had quite a few people on the committee. Some were attorneys and others were in the social side and some were in the psychiatric side, and I was in the public health side. Well, they asked me to write what I thought needed to be done on a community level, so I did, I wrote it, and I proposed that we develop eighteen community psychiatric clinics in the entire state, with the county paying half and the state paying half. Believe it or not, George Saslow said, "It's a good idea, but nobody's going to buy this." The State Legislature bought it hook, line, and sinker, and so we created the first outpatient psychiatric units.

Today, they're still going. Some are in the health division; at Clackamas it's still under the human services. Others now—in Multnomah I think it's still done on a private contracting basis, but we still have the units. But unfortunately, they have not been supported as well as they should, and in order to get in you almost have to go to the state hospital first. I've had people who are totally psychotic and that I've tried to refer in directly, and I could not get them there. So it is not an adequately supported program.

WEIMER: Is that a disappointment to you that, after you got it set up, funding is inadequate?

OSTERUD: Oh, sure, it's a disappointment. We had a good one in Eugene, and Eugene still has a good one. It increased a good deal in size. We went from three hospital beds to a full ward, because in those days—now, you know, the population at the state hospital is very small, and they closed the one at Wilsonville, and they opened one up here over in Holladay Park. But they didn't close Wilsonville until after I came up here.

Anyway, I was very interested in that. I worked in it for about—well, I was in Eugene for six years, and one summer day Dr. Weinzirl came down. His daughter lived in Eugene. And he called me on the phone, and he said, "I'd like to talk with you. Can you come over to my daughter's house?" She only lived less than a quarter of a mile from where we lived. So I said, "Sure." And so he came over, and he says, "I've been told

what your answer is probably going to be, but I'd like to offer you an academic position. It's totally on a grant."

Dr. Weinzirl, along with the internal medicine, cardiology, and several others received a relatively good-sized grant to do some special research work. It was over a five-and-a-half million dollar grant, one of the biggest this place had ever gotten.

And so I told him sure, I'd do it. My wife wasn't happy about it [laughter]. She loved Eugene. But I came up here. That was in—I came up on November 18, 1961.

WEIMER: Nineteen sixty-one?

OSTERUD: Yes, the last part of 1961. I remember the day very well.

I was on that grant for a long time. The grant lasted for several years. But I also began to do some of the teaching, as well as working on the grant.

WEIMER: Do you remember what the grant was for, in particular?

OSTERUD: Well, the part I worked on I certainly do remember. We published quite a few articles. The person I worked very closely with was Dr. Vic Menashe, and it was at the CCD, Crippled Children's Division in those days, that's what we called it then. I worked predominantly in congenital malformations and congenital heart disease. I went to every single hospital in this state to get the details on children that they saw and children that had died.

Vic and I discovered a new cause of death that doctors weren't even looking for. It was called hypoplastic left heart syndrome, in which they really only have the right side of the heart, and the left side of the heart is—they can live okay in utero, but when they come out—there's an opening between the right and left ventricles. Well, that's supposed to close. If it closes, they die immediately, because they have—the only thing that's pumping blood around their body is their right heart. Well, there are no murmurs, and most of them were fully developed and looked good at birth.

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

WEIMER: We're on side two of tape one of our interview with Dr. Harold Osterud.

You were just telling me about the research you did with Vic Menashe.

OSTERUD: Yeah. Well, Vic and I—in those days there were no such things as computers. We used cards and a big IBM sorter. If you've ever seen one of those...

WEIMER: Like the key sort, cards with the holes.

OSTERUD: A key-sort kind of thing, yes, with the holes, yes. And we used those—I still have a lot of the old raw data right this minute. I haven't thrown all of it away [laughter]. But we worked in that for quite a while. The hypoplastic left heart syndrome, they never got to pediatricians or cardiologists. They frequently died at home. Some were posted and some were not, so the data we had I know was an underestimate. But it was the leading cause of death in the first month of life for these children, and it was an unrecognized syndrome.

WEIMER: That's quite an important discovery.

OSTERUD: Yes. So Vic wrote that one up, and I wrote with him also. And Vic really is a very fine pediatric cardiologist, no question about that.

So actually, I worked for CCD. Dr. Sleeter, who I really loved, was the pediatrician head of CCD, Crippled Children's Division, and he's the one who built the old building, the first—it was one story to begin with, and then they expanded it to two floors. And so I spent a lot of time working—before I became chairman, working at CCD.

In fact, when the grant started to expire, Dr. Sleeter hired me half-time, and I worked around with all the counties, because CCD, at that time, held regular clinics for all the health departments in the counties, seeing the crippled children that physicians would refer in—and those clinics would be staffed by an orthopedist, sometimes a neurologist, sometimes a cardiologist. It depends on what the clinic was. Dr. Sleeter didn't particularly like that arrangement, because they only held them once a year, and kids who were in trouble had to wait too long. Even when I was in Coos he came down and he said, "We want to change it so that you can send the people up here immediately and not have this delay." Well, I think it was something that was badly needed.

When it first started out we were dealing almost predominantly with nothing but orthopedic defects. Congenital heart disease and all the rest of it weren't even looked at. Dr. Starr came, and he was the first cardiovascular surgeon we'd had. He came about the same time—he started nearly the same I did. We used to work—and Dr. Griswold was another. He was the head of cardiology in the hospital, in internal medicine.

I worked in the clinics, saw a lot of the kids, and it was clinically exciting. I never thought I was a good cardiologist because I have a hearing loss. I've had it all my life, and it's low tones, and I couldn't hear the real soft diastolic murmurs, and those are the ones that are the most pathogenic. I could hear the high systolic murmurs without any trouble, but I sure didn't hear the diastolic ones very well, so I never thought I—I wouldn't trust my exams [laughter]. But it was a fun time.

I did that for a long time—I don't know, I think we published at least over half a dozen articles. The first article I ever published—when I got here Dr. Weinzirl said, "Well, you've got to write." "I do?" "Yes, you've got to start publishing." I says, "Huh. What in the world am I going to write on?" He says, "Pick something you know

something about that's worth writing about." And he says, "Since you were the first medical examiner, why don't you write about what that program is?" Because it was just getting started in the state. So I said, "All right."

My study took in everything in the entire state, not just Lane County but the whole state. All of the departments—and the pathologists were at the state health division, so that's where I got my data. I used the old IBM machine to do it.

The first—I wrote it and I gave it to Dr. Weinzirl—you know he was chairman of the department—and he looked at it, and it came back absolutely solid red. So I rewrote it and gave it back to him, and he gave it back to me. It was still almost as red. The third time I wrote it and I took it in to him, he looked at me and he says, "I want you to understand one thing." He said, "Writing is not easy." And he says, "I hope you understand that my criticisms are only directed to try to make you a better writer." So okay. So I rewrote it, and finally, on the seventh one, he said, "I think this is good enough." He says, "Where are you going to send it?" I said, "Well, it's really just Oregon, so why don't we send it to *Northwest Medicine*," which was then published in Seattle. I sent that article to the editor of *Northwest Medicine*, I got a letter back—I still have it—and he said to me, "Congratulations. We accept your article just as written without any corrections."

WEIMER: Oh, how wonderful.

OSTERUD: Now, I never had that ever happen again [laughter]. All the other things, including the ones Vic and I wrote, and including my manpower studies that I've done since 1970, all of those I've always had to make many corrections.

WEIMER: Tell me about Dr. Weinzirl. He was the head of the public health department here?

OSTERUD: Well, Dr. Weinzirl was a very interesting man, and he—by the way, when the Allen D. Hill Teaching Award was created for the best two teachers in the school in basic science and in clinical science, he was the first one to win it.

WEIMER: A very nice award.

OSTERUD: The first one to win it. He was a very popular teacher. He was a fine teacher.

Dr. Weinzirl was born in 1900. He was born in New Mexico, and his father was head of the laboratory at New Mexico, for the territory's health department. He had also had tuberculosis, and he recovered from the disease there.

Well, his father finally ended up heading up the laboratory at the University of Washington. The University of Washington at that time did not have a school of medicine, and so he was primarily involved with teaching Ph.Ds. Dr. Weinzirl went to

the University of Washington for a while and then transferred to the University of Oregon in Eugene, graduated from the University of Oregon, and then immediately came to this medical school. So he was a graduate of this school.

After he graduated from this school he went back up to Seattle to do his internship at what was then, I think, called King County. It's part of the university now. Anyway, he did his internship there, and when he completed his internship he had some very frightening things. Actually, he developed meningitis, and his father treated him with some of the sera, the antibody that he developed from people who survived meningitis, and cured him, believe it or not.

But he worked there in Seattle, primarily in a hospital, and then he decided that, since his father was so interested in the public health side—his father was beginning to write a book, and so he said, “Well, I'll help you with the book.” And he said, “But I need some education first.” So Dr. Weinzirl went back to Johns Hopkins in Baltimore, and he got his master's degree in public health at Johns Hopkins. He then became assistant health officer for the city of Baltimore, did some very interesting work—diphtheria was a tremendous problem back in those days. One out of every six deaths in kids was from diphtheria. Anyway, he was there for quite a while, two years, I think, or maybe three, married; and then he was offered a position as city health officer for the city of Portland, and so he came back to Portland to be health officer.

Well, the state health officer—I can't think of his name right this minute. I have it at home in my study. The state health officer had been working with University of Oregon Medical School—most people don't realize that our department [Department of Public Health and Preventive Medicine] is not the first public health department in this school's history. Public health was taught from the very start of this school.

WEIMER: So at the very beginning there was public health?

OSTERUD: Yes. And I have that written about, and I've got the courses that were given. They had two people who started it. One was a judge, who did it from a legal standpoint, and the other was a physician, and it was called hygiene. Well, in those days hygiene, coming from Greek *hygieia*, for healthy, stressed what people should do on a personal standpoint to be healthy. And then gradually in the late 1870s, the Oregon Medical Society's first resolution was to form; the second was to create a state health division. Well, that was in 1876. They didn't get it done until 1903.

WEIMER: A long time.

OSTERUD: It took a long time to convince the government to have a health division.

But anyway, this subject was taught by faculty for many years. Then, it gradually went to Dr. Sears, who was professor of bacteriology; and so Dr. Sears took over the teaching of the hygiene in 1919, and his interests were broader than just individual health.

It was also in the community and so they had two forms of hygiene. One was the personal hygiene, and the other was the community, or public, hygiene. And so he did that, and he created bacteriology and hygiene. Well, after several years—I don't remember just how many right at this moment—he created a new term, and it became bacteriology and public health.

Dr. Weinzirl, when he arrived in town, became the city health officer. Dr. Sears recognized that the subject was not a basic science subject, it was a clinical subject, because they were dealing with tuberculosis and they were dealing with all the infectious diseases, they were dealing with problems of food and water and all of these things, and it really is—some of it certainly uses basic science. We cover both basic science and clinical. And so he invited the city health officer and the state health officer to come and teach.

Well, when Dr. Weinzirl came, they were still teaching under the Department of Bacteriology courses, and so he started also to teach with clinicians—and then the state health officer retired, and Dr. Weinzirl took it all over. At the same time, he still was the health officer at Portland. In 1933 there was the last smallpox epidemic in the city of Portland, and Dr. Weinzirl had that one, too.

He also was the medical director for a large hospital that took all of the children and others who had serious communicable diseases, like whooping cough and diphtheria and smallpox and all of those. He did not think that was an appropriate hospital at all. It was over, I believe, on Powell Boulevard. The building is still there, you can still see it. It's a nursing home now. The hospitals would not accept those children, because they were afraid they would infect everybody in the hospital. Well, finally they began to develop it so Good Sam and some of the others began to accept these cases. Well, Dr. Weinzirl was busy teaching here for several years, through the thirties, and then—and I don't remember the exact year now; I think it was about in the early 1940s—an ophthalmologist died. You know about him.

WEIMER: An ophthalmologist?

OSTERUD: Died, yes, and left his entire fortune.

WEIMER: Dr. E.C. Brown?

OSTERUD: Yes. And left his entire fortune to create the E.C. Brown Trust Fund. So Dr. Weinzirl created the department, under his name, and decided to come up here full time to teach and also to conduct the health education clinics on sexually transmitted diseases all over the city. And that's when—the head of the program was the president of the University of Oregon, because the Medical School was a part of the University of Oregon. But he hired Dr. Weinzirl on the grant money, and so Dr. Weinzirl started the first clinical department. All the others had been in the basic sciences, and it became clinical.

It was about 1949 when Dr. Weinzirl was able to create enough state funding to pay his salary, a secretary's salary, and a salary for Dr. Carl Hopkins, who was to teach the biostatistics, because they hadn't been teaching the biostat in the class. Dr. Weinzirl did some of it, but he wanted a full-time one.

Then he created the department of public health and preventive medicine as a clinical department, I think in about 1949, even though he had been here for quite a few years before that teaching the subject, and immediately expanded from one course to three courses plus a lot of electives. Believe it or not, my father knew his father at the University of Washington.

WEIMER: Oh, no.

OSTERUD: Yes, because my father took bacteriology from his father [laughter].

WEIMER: There's a family tradition in that.

OSTERUD: Yes. And we didn't know this until many years later. I didn't know it at all until I talked with my mother, because I didn't know who my father had been with at U of W. I didn't know hardly anything about it.

But anyway, Dr. Weinzirl came down to Eugene and asked me to come up, just on a grant, and I decided to do so.

He did very well—I came up in '61, and about 1966, '67, he began to have some problems, and in 1967, early in the year, he had a stroke that just affected one eye, and he couldn't close or open his eye. He continued to teach, even though he had it. It didn't do anything intellectually at all.

It was a Friday morning, and he taught a class, and he said, "I'm kind of tired. I'm going to go home and rest for a while." Doctor—the dean of the school...

WEIMER: Oh, Dean Baird?

OSTERUD: Yeah. Dean Baird had asked me to take over as acting chairman because he was worried about Dr. Weinzirl's health, and he wanted him—Dr. Weinzirl was sixty-seven, and he was going to extend his teaching. He went home that Friday morning, after he had class, and laid down on the couch—he lived right up the Hill, right here—and his wife called me, and I went up, and he died immediately, very quickly, when he just laid down. Joe Trainer was his physician, and I know you know who Joe Trainer was.

WEIMER: Yes.

OSTERUD: So Joe Trainer also came. We didn't do a post, but we figured that he just had a large hemorrhage.

WEIMER: Well, it was an end to a wonderful, long career that he had.

OSTERUD: Oh, yes, he had a marvelous career. He didn't write as much as he thought I should, but he did edit his father's book, and I'm using it right now in the history of the department. He did write a lot of articles, and he was very active all over the country in the field. More active than I was. He had some travel funds, but those travel funds totally disappeared. We didn't have any travel funds for many years.

WEIMER: So you became chairman after his death?

OSTERUD: Yes, and—well, yes. Dr. Baird just called me up—I never will forget, when I came up to have my interview, Dr. Weinzirl sent me over to talk to Dr. Baird, and Dr. Baird said, “What are you doing right now in the way of study?” I said, “I'm looking at these children who are dying for no apparent reason.” It was part of my medical examiner stuff. And these are now called sudden infant death syndromes. I'd had seven of them, and I was studying them, and I was telling him I couldn't find out what in the heck had happened. I had the pathologist, Dr. Furr, and Dr. Starr and the group down at Eugene, at Sacred Heart Hospital—I paid them to do the autopsies from vital statistic funds, and we did all of the cultures and looked for bacteria. We couldn't find anything wrong. So I told him about that interest, and I kept that interest for a long time. I'm still very interested. We still don't know.

Anyway, he interviewed me, and then he finished the interview, so I left him. He called Dr. Weinzirl before I even got down, and he says, “Hire the little squirt” [laughter]. Because Dr. Weinzirl was, oh, probably six-two, six-three, six-four. He was very large, and, of course, I'm just a little fellow [laughter]. I never will forget that.

I liked Dean Baird a lot, and I was really very fond of Dr. Holman too. That's when the school—we were so close to each other. Today there are so many, many people here, I haven't got the vaguest idea who some are anymore. We're so large. In those days we were small. We didn't even have a parking lot.

WEIMER: Oh, that is small, then.

OSTERUD: Yes. We didn't have a parking lot. We parked wherever we wanted to.

WEIMER: I'd like to go back to those times.

OSTERUD: Yes. Well, the school has certainly grown, and so did the department that we have.

I'll have to admit that we've never been very well financed, and we're still not. We have to find money wherever we can, and that's what we did. Maybe I shouldn't say this, but I didn't have a state salary for eighteen years.

WEIMER: That's a long time.

OSTERUD: Yes. We were, for a long time, very successful in getting federal grants for teaching and for the residency training program. I didn't lose those funds until I was about sixty-four, sixty-five, and, finally—we still were approved—but they didn't have enough money to fund all of those they approved, and so they let some of those go that had been getting the money. I got it for, oh, goodness gracious, from about 1970 until 1985, '86.

WEIMER: I didn't realize that so much was dependent even then on federal grants.

OSTERUD: Oh, yes. Our department—we had three grants. We had a teaching grant, we had a grant for training residents, and we also had a grant for training—Dr. Morton had a grant for training medical students. And we had those medical students. They were under Dr. Morton and under Chris Williams at CCD. Do you know Chris?

WEIMER: I've heard his name, but, no, I don't know him.

OSTERUD: Oh, you ought to talk to him. He's a wonderful person. They started the migrant health clinics for the children, and they grew—they started the first one in the basement of a church in Stayton, and that one finally became the one which moved to Woodburn. And so they started the first one. The second clinic to start was Dr. Kessel's, who, by the way, is going to lecture this next Thursday to our class. Dr. Kessel was one of our residents, oh, goodness gracious, in the late 1960s. We worked with the state health division that had the residency. I'll tell you about that change.

But anyway, Chris Williams and Bill Morton started that using federal funds; and that started and led to the development of our current community health clinics, and we have them now in many communities. A few are in health departments; most of them are independent, like the one in Washington County in Cornelius. The one in Hood River is independent. So we've had many of them.

Of course, I worked a lot—as I've already told you, in my first six years I worked a great deal with the Crippled Children's Division. Chris Williams came in a little bit later. Chris and I—I think one of the most exciting things that happened in this school, and one of the very, very important things, was in the late 1960s, Dr. Holman and others said we have got to look at our old curriculum. The old curriculum, I had classes from the freshman year for biostatistics, the sophomore year for the public health side, and the junior year was the preventive medicine, community medicine, and the clinical side. We had very little chance of doing anything but just talking to the students. And so Dr. Holman said we should look at our new curriculum and change that curriculum and make it better—more reality.

So they formed a committee to actually look at and plan a new curriculum. We frequently went over—Dr. Bill Krippaehne, the surgeon—he was, I think, one of the most magnificent people we've had here. He's brilliant. He chaired it. I ended up being the secretary. That way they could make me keep my mouth shut [laughter]. We met all the time to see what we would do, and we had had a theory to have each department teach its own thing and pay no attention to anything when medicine crosses both clinical and basic science barriers.

We decided that physics and the biostatistics and many things need to be taught together, and so we were going to create courses, and some of them would actually be stronger and better courses and would be more coordinated. Departments still kept their own teaching time, that is true, and so did we, but through the committee we tried to make sure that we did a more integrated job.

One of the things that I have always been very pleased with was with the Department of Pediatrics and the Crippled Children's Division. Our department, the child psychiatry and the psychology department and the pharmacy department, we decided to create a new child-health block. That block is no longer here. I think that's wrong. It was a strong block, and for the first time—I chaired that block for eight years, for the first eight years, and did all the planning for each of all the students' rotations. And every student, of course, rotated through the child health block. We had three weeks, our own. We had a clinical rotation of three weeks, and we did it jointly with Chris Williams and CCD, and so we had both the clinical and the public health side of it, because CCD is public health.

WEIMER: I hadn't thought of that, but I think you're right.

OSTERUD: It is. In almost all states it's in the state health division. A few states have it in welfare. There are only two or three states in which it is independent. And here its funds come from the state health division right now. The Medical School doesn't fund it; it's funded from federal funds that come to the state health division.

Anyway, it was a very popular rotation. I'm proud of the fact that I created the first off-the-Hill clinic in the pediatric block in Multnomah County.

WEIMER: Oh, very good.

OSTERUD: That one still goes right now. They didn't cancel that one. The current pediatric block canceled the three-week block that we had, primarily because they were cut from twelve weeks to either nine or ten weeks in the new curriculum.

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

WEIMER: This is Tape 2, Side 1, of our interview with Dr. Harold Osterud. I'm just going to let you go on.

OSTERUD: Well, I was talking about the new curriculum, the one that is currently in place. In the late 1980s and early 1990s there was a feeling, and many of us backed that idea, that departments should not just teach as departments, that we should actually integrate the courses so that the courses would be taught together, and this was accomplished. Today, departments do not control our teaching curriculum. That's controlled by another group. Of course, they all have departments they come from, and all departments. We're teaching our biostatistics along with many other subjects in one course. Some ways it's good, some ways it's not, because I have to admit we've lost some time in our teaching.

One of the things that really disappointed me was that—I taught in the child-health block, even for over a year after I retired, before the block actually was canceled. Again, they decided that pediatrics had more time than it should have, and they cut pediatrics' time down. They didn't cut internal medicine down or surgery, the surgical specialties, but they did cut peds.

And they have created new ideas. One of the things that we've done for many, many years, is that we've created a whole series of electives, and we've had these now since the 1970 change in the curriculum. One of those that I think was more important was the international medicine, when we sent medical students overseas. Not every medical student, but anywhere from three to six a year. We're still sending—our department isn't sending as many now as we used to. We used to get very good funding from the RDIFMAP program. Reader's Digest International Fellowships and Medical Assistants Program. It's still going. It's located in Georgia, just outside of Atlanta. And anyway, students who want to go overseas—and it takes at least two to three months.

Well, the new curriculum provided much more time for independent electives, and so our department still has these. We've had one at Clackamas County for quite some time, and we've had them both in the basic science side of it as well as the clinical. More in the clinical, though, than in the basic science. These are going to continue. We're planning to have one that's going to take a lot of students, and it will be at the health department in Clackamas County, where I was health officer after I retired. Alan Melnik is now there.

We have a new residency program jointly with Family Medicine. Why? Because most public health departments do have physicians, but not often full-time, and they need to have a very broad-based education. And so that's why. We did this with pediatrics too. People don't realize that, but we had a pediatric public health residency in which they came out with both, although they had to go for the MPH somewhere else. So that is a new program.

For many years we recognized that we were deficient in our department in that we did not have the MPH, the master's degree program, that all physicians have to have in order to have this specialty. We had to send all of our residents somewhere else for it. In the early 1980s we worked with the University of Washington and with Portland State to develop a new regional school for the master's degree so that our residents would be able

to get much of that education here, some of it at U of W directly. And U of W was going to send teachers down here, and we would also go up there. We were given an award, but the federal government cut it in half, and I didn't think we could afford it.

Unfortunately, Governor McCall called out that there will be no new programs in government that are not totally self-supporting. In other words, we would not be allowed to take our teaching time and teach in a brand new program. It was a decision that—frankly, he shouldn't have made it go everywhere. So I gave all of the money to the University of Washington, and so our program has been joint with the University of Washington from the early 1980s until Dr. Greenlick came and created a new master's degree program here.

WEIMER: So you now have one here?

OSTERUD: Yes. Well, we had one, you see, but we had a joint residency. The joint residency was attacked by—the boards come under the same one that surgery comes under, and they seriously questioned whether our program jointly with the U of W was a good program. They said, "You can continue the field, but you can't send them up and have them working at the University of Washington at the same time they're in the field. They're going to have to get their MPH totally separately." So they cut us from a training program that lasted nearly three years down to a one-year field experience, and that hurt us a good deal. That happened just—Dr. Morton was chair of the residency program when that happened. I was pretty much already retired.

Mitch Greenlick could see the problem, and when they threatened Dr. Morton—and he was in charge of the program when they said, "You're only going to get one year." Dr. Greenlick was just joining the department, and I know for many years—he's been on our faculty ever since he's been in Portland—and anyway, Mitch said, "We're going to have an MPH degree," and so he said, "We can't do it alone." So he went to the University of Oregon, Oregon State, Portland State, and the Med School and began to develop a program. Unfortunately, the University of Oregon had a pretty good program, but they canceled the whole darn thing, and so that left us with three.

And so the MPH degree in Oregon and its program is back—has three universities. Students can go and get their degree from any of the three, but they can take classes at any of the three. We've had students from Oregon State, we've had many students from Portland State, and they have many of our students. So it's a unique master's degree program. It's the only one that I know of in the country that has three universities in it. I don't know of any other.

You wanted to know some of the major things. That was a very major one. Our department—Dr. Kendall seriously questioned whether we needed to have a preventive medicine public health department separate from others, and he was thinking of combining it with a different department, just like he combined medical psychology with psychiatry. I'm not saying it would not have worked, because we've already taken a step with both—we did it with pediatrics, jointly with pediatrics, for a long time, many years,

and then we also have developed a program with family medicine now in which they get both the public health and the preventive medicine.

Kendall says every physician practices preventive medicine, and that's true. It's becoming very, very important. All physicians today, we're going to have to—we have a lot of disease. We can't afford to treat all of it and cure it, and so it's important that both medicine and pediatrics practice prevention—pediatrics has always been strong on that point. But Dr. Kendall doesn't realize that you have two types of preventive medicine. You have the type that goes in a physician's office, and he certainly understands that one; but he does not understand very well the one that is in the state health division and all the health departments and DEQ and all the rest of them. That part is preventive medicine aimed at absolutely everybody. And they used to call it public health. And he was—I think it would have weakened the program.

Well, Mitch came up here, and do you realize he came up here for nothing?

WEIMER: No.

OSTERUD: He did. He didn't get paid a damn dime. He came up here to save the department, and he did. Now the department, with our master's program, is a much stronger department, because now Kendall—well, Kendall is no longer dean. Kendall and I are actually very close. He was my daughter's physician. But anyway, today I think that Mitch has altered their minds with the—I'll have to admit I worked very hard to get the family medicine, preventive medicine, one in.

One of the things we did—most people don't know, and maybe I shouldn't tell this in the history, but I'm going to anyway. When I began to do the physician manpower studies in the early 1970s, it was very, very clear that we had physicians that—we needed them desperately in many of the smaller towns in rural areas. They were very short. And so, working with the Oregon Medical Association, we created a new program to try to recruit physicians to come to Oregon to help, and believe it or not, in the 1970s we increased the number of physicians by over 75 percent in less than eight years.

WEIMER: That's an amazing growth period.

OSTERUD: It was an amazing growth period. The school also increased up to 120 students, and then we were forced—because we didn't have enough teachers for that many students, they had to go back to a smaller class. I think you're well aware of that.

Well, that program—I recognized immediately that we had no program for training family physicians, and family physicians would be predominantly the ones who will practice in these small, rural areas where there's not room enough for a full-time pediatrician and an internist and a cardiologist and all of that. So I got together, through Multnomah County and through the Oregon Medical Association, with two family practitioners, Laurel Case and Merle Pennington, and we met frequently at the Multnomah County Medical Society, now the Metropolitan Medical Society. We met

there frequently and worked with them and created—and I think Merle Pennington perhaps was the most influential one, but Laurel Case was the first director. We created a new department at the Legislature when Internal Medicine and a bunch of departments here didn't approve of it and didn't want it.

WEIMER: Oh, so you took a runaround and went to the Legislature.

OSTERUD: We ran around and created it at the State Legislature, and they had to accept it [laughter]. And Laurel Case became the first chairman.

WEIMER: And this was—officially, what was the name of the department?

OSTERUD: Family Medicine.

WEIMER: Family Medicine. Rather than Family Practice, Family Medicine.

OSTERUD: We called it Family Practice in the beginning, but it became known as Family Medicine.

WEIMER: Well, very good.

OSTERUD: We did that and I went down with the proof of the need to the State Legislature, and Merle and Laurel Case went down with why they're needed and what they're going to do. And it's a three-year program. That changed the university to some degree. Now the primary care programs have more power than specialties, because in practice people have to go to their primary care physician before they go to the specialist.

This has some good points and it has some bad points, and this is what we're going to be studying this summer. We've already just completed the study of the 7,331 physicians by—just by their distribution, where they're practicing, but many physicians have more than one place they practice now. They have one place they identify themselves with on their license, and the Board of Medical Examiners don't know how many places they practice in. Well, the study we're going to be doing this summer is not just going to look at distribution, it will look at productivity. We want to find out what is really going on in the way of productivity. It's going to undoubtedly address some of the problems that we are now seeing physicians have with managed care.

And managed care is not going to go away, it's here to stay, and I don't think there's any question about that, but there are some things that are going to need to be changed. It is not fair for managed care to tell doctors what they can do and what they can't do and what a patient needs and what that patient isn't going to get. I don't know whether any of the others who have come up have talked to you about this or not.

WEIMER: They have briefly mentioned it, but not talked about at length.

OSTERUD: The purpose of the study—Dr. Kohler has already approved it; the Oregon Medical Association has not only approved it, they will actually publish the final data at no cost to us; the Board of Medical Examiners has approved it, and the questionnaire will be going out from the Board of Medical Examiners this summer.

Karen Whitaker in the office of Rural Health, I, and Tim Ennis, we will actually do the analysis. This is an attempt—if you take a look at the School, the School has changed so much. When I came here in 1961, Multnomah County Hospital and our clinic were paid for by Multnomah County, believe it or not, through the public health department, and that payment had existed for seventy-five years.

WEIMER: I didn't realize it, and I don't think other people realized that.

OSTERUD: The County. And all of the people who were hospitalized there, they didn't pay anything.

WEIMER: Well, I knew that we had indigent patients up here, but I did not know it was public health that was paying for it.

OSTERUD: All right. Then, Don Clark—he was the head Multnomah County commissioner—in 1972 he came to Dr. Holman's office, and he says, "Dr. Holman, our county cannot continue to pay for all of this service."

They had just put three-and-a-half million dollars into the new surgical wing of the hospital. The city health department built the emergency room. Did you know that?

WEIMER: No, I didn't.

OSTERUD: Tom Meador did, yes.

And so this place has had influences that most people don't even know existed. The city of Portland started public health well before the state ever did, and the head of it was the sheriff [laughter]. That's going to be in my history.

WEIMER: Oh, I'm anxious to read your history when you get it done.

OSTERUD: It's still mostly the Medical School, but the Medical School was involved, even back then, even before they were up on the Hill here.

And so Don Clark was meeting with Dr. Holman, and he said, "I will not stop it immediately, but I'm going to phase it out in three years. We'll pay all of it this year, next year two-thirds, and then one-third, and then we are out." Dr. Holman says, [sound effect] "What will happen?" And he looked at Commissioner Clark, and Commissioner Clark says, "I'm going to achieve this by selling you the hospital and our clinic for one dollar."

The story goes, and I'm sure it's true—I've heard it; I wasn't present, but the story is told, and Don Clark told me this.

WEIMER: Oh, he did?

OSTERUD: Yes. He said Dr. Holman gave him the dollar, and he said to Don Clark, "This is the worst buy I ever made in my life" [laughter].

And it completely changed the way we had to finance things. No longer were we truly an indigent service. The state hospital part wasn't an indigent service at that time; they were charging. But the School was—much of it was not in much competition with the practice of medicine. Today, this school is in competition with every single physician in practice. It has no choice. If it didn't do that, we wouldn't have a School. Why are things like our library in trouble? Because we don't know how to get money to support it. Should we charge people a fee when they take out the books?

WEIMER: Some would say that would go against library tradition.

OSTERUD: Well, it would. My gosh, our librarian here, she was magnificent.

WEIMER: And you're speaking of Bertha Hallam?

OSTERUD: Yes. I knew her well.

WEIMER: Why did you think she was so magnificent?

OSTERUD: She ran this library. Now, this library I think actually—she established it as a place for anybody to come. Not just people at the medical building, anybody. And she just—I think she knew where every single book in the place was. When I'd come to the library, I'd spend time with her. She was a marvelous person. I have to admit I don't know the new library nearly as well as I know the old one.

WEIMER: The new one that we're talking of is the one over in the BICC Building.

OSTERUD: Yes. Well, you see, I retired before that was built. Actually, as you know, I continue to teach some, and I continue to work. After I retired I still worked about 75 percent of the time. And I was health officer of Clackamas, and we had our medical students—and that's where we trained our public health residents. Before that, we trained them in Multnomah County and also at Washington County, and we've trained some in Lane County and even in Jackson, because the School here is not able to produce a public health site. We have to work directly with the state and local health division and with DEQ and EPA in order to achieve this. Well, the school is—we're in a much better position to achieve it now than we used to be because the school is no longer sitting right here on the Hill.

WEIMER: You have gone out to the community?

OSTERUD: Yes. Well, our department and—Pediatrics was the first department on the Hill to ever do that. But CCD has always been in the community, all over the entire state.

WEIMER: I think this would be a good time to ask about town-gown relationships, because that's one of our themes.

OSTERUD: Well, the town-gown relationship has been good and bad and good and bad.

WEIMER: Just a kind of seesaw?

OSTERUD: It seesaws, yes. And I'd have to admit I've been very active on both the state and local medical society level. In fact, I have an award from the medical society of Oregon, the medical association, OMA. I chaired its public health committee for a dozen years. I've been on it for almost thirty.

WEIMER: A long history, a long record.

OSTERUD: Yes. In fact, I'm working with them right now. They've been very important. Without them I would never have been able to do the manpower studies. They funded them for years.

It was interesting to note that Governor Hatfield, when he got interested in the physician manpower and in health, he got a federal grant, and I was appointed by the Oregon State Health Division to head up those studies, and we actually conducted the studies out of an office in Salem.

And that's when we started—we'd look not only at physicians, we looked at nursing, we looked at all of them. For example, we had no training in the state in, say, the physical education side of it at all. Now we do. And the School here is associated with other schools in the development of that, of that part of medicine. So we had worked, some of us, very closely with organized medicine. Others up here had not even belonged to organized medicine. I don't know what that is now. Oregon is much stronger than many other states because most physicians in Oregon do belong to the OMA and to a local county medical society.

I've got a luncheon at Multnomah County I've got to go to, and I'm still on a committee at OMA, and we're going to be meeting on that committee. We're going to be addressing what is going to happen. I think Tigard is going to go for the Willamette River for water. To me, it's a mistake, because certainly we can't control what gets into the Willamette, and the Willamette is one of the ten dirtiest rivers in the United States at the current time.

WEIMER: I didn't realize that. I knew it had a history of pollution, but I didn't realize it was so bad right now.

OSTERUD: Well, we cleaned it up quite a bit, but it's gotten very dirty again. I'm not going to say that they can't probably treat that water, but, let's face it, we have the largest protected water source in the United States, and we're only using fifteen percent of it.

WEIMER: You're speaking of Bull Run?

OSTERUD: That's Bull Run. We could very, very easily—now, Bull Run, the corrections are going to cost more than that plant for Tigard on the Willamette River, but that plant in Tigard—and they don't say this—will serve only a relatively small number of people compared to the fact that Bull Run will be serving probably 1.2 to 1.4 million within the next few years if they take it over.

If Tigard and Wilsonville and Sheridan and King City and Tualatin, if they all decide to go to the Willamette River, that's going to greatly reduce the opportunity of our improving the Bull Run supply. The Bull Run supply should be filtered, because at times we have—at one time we got clay into it, and we had dirty water for six weeks all over the city of Portland. Also, there's two, three, or four open reservoirs right in the city. People don't realize they could be subject to not only contamination from birds and other natural things and animals, but they could be very easily a site for someone to dump in some very highly toxic substances. I don't talk very much about that to people because I don't want people to start thinking about doing it.

WEIMER: Yes, I can understand.

OSTERUD: But the State Health Division has ordered them to put filtration in since 1960, and they've ordered them to cover the reservoirs, and, frankly, the city of Portland has not been cooperative. The lack of cooperation is why Tigard and the rest of them don't trust them.

WEIMER: I didn't realize there was such a checkered history.

OSTERUD: There's a checkered history and they don't trust them. But with Commissioner Sten I think they have somebody now they can trust.

So our department frequently gets involved in things that are statewide. The state health division provides us with teachers all the time, and they don't get a thing except a thank you.

WEIMER: It's a volunteer...

OSTERUD: It's volunteer, yes.

The State Health Division used to be the ones who did the residency training program, but they were told by state government that, “You’re not going to do this. You are not an educational training institution.” Well, our department, we were involved with them in the training and we participated in the training of residents. They asked us, “You take it over,” and so we did. That was about 1970, ’71 we took it over. We had a very large training program. It used to be much bigger than it is now. Now we have about two or three MDs in the preventive medicine public health residency. I’ve had as many as eleven. But we also went into training for positions in community medicine, not just in the straight public health one, but those clinics.

At the end of the Vietnam War we developed—with Multnomah County and Clackamas County and Washington County and the health department in Vancouver we developed treatment clinics for Vietnamese, Laotians, and so forth, because they could not get the treatment in the private sector. Nobody could talk to them. And so we created those clinics in the health departments. Some of them are still going. The ones in Clackamas and Multnomah are still going.

We created those clinics, but, goodness gracious, I started working—I’ve always done some direct medical care as well as the public health side of it with the health departments. I worked a day a week in Multnomah County for about eighteen years, maybe twenty. A long time.

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

WEIMER: This is side two of tape two with Dr. Harold Osterud. You were just telling me about physicians giving immunizations.

OSTERUD: Yes. When I came up here in 1961, nurses were not allowed to immunize.

WEIMER: I’m surprised at that.

OSTERUD: Frankly, it should never have existed, but only doctors could do it. And so Oregon had to have doctors full-time in many places in order to just do that service. So I took medical students with me. I had one to two medical students every time I went to the clinic. We taught the medical students how to do it, and all of that, of course.

And we also—both here and at the health department in Multnomah County, we ran an overseas clinic for immunization for overseas. Our department does not do that now, nor does Multnomah County, nor Clackamas County. It’s now done primarily in the private sector. Here at the School, it’s in Family Medicine and also Infectious Disease and Internal Medicine. That’s where we get them. Washington County Health Department does have one. So some health departments still have international medicine clinics for overseas shots and things of that sort, which are required before you can go.

So we've always had very close working relationships with the governmental side of it. Even though McCall said to them, "You're not in the educational business," the health division has never left that, and they do a lot of it. Without them our department certainly would not have an MPH program; we certainly would have difficulty in teaching, because in our courses we have as many as ten groups at a time, with ten different people conducting the sessions.

We don't have that faculty, so our volunteer physicians are a very important part of our department, probably more so than maybe any other department in the school. Why? Because, let's face it, our department is not in a position to charge. Now, we do get tuition, that goes to the School, of course, for those students in the MPH program and medical students, but we have to find the money for our own residents, and this is hard to do. We have three funded positions now. My goodness gracious, we used to have a lot more than that. We trained a bunch of Vietnamese physicians, four of them, and other physicians from India because we needed people who could talk to people in the clinics. Without them, we could not have conducted those clinics, not nearly as well, because, heck, I never could learn—I never learned to speak Laotian or Vietnamese.

WEIMER: Just the communication problem I think would be insurmountable if you didn't have a...

OSTERUD: The communication problem was a big one. But the person who runs the one in Multnomah County right now is a product of our residency. She was from Russia.

WEIMER: You must be very proud of that.

OSTERUD: Yes, it's good. She still runs the overseas clinic. We only have one in Oregon. All health departments, if they have people—and it's tied in, of course, with the business of people becoming citizens, as well. They will obtain their care at that clinic. And I think there may be some small charges, but certainly it's small compared to what they would have to do if they didn't have that clinic to go to. Today, the Vietnamese are almost totally integrated into our own society, and so we don't have to have all those clinics anymore.

One of the things that I really have enjoyed doing, in 1989—that was a year before I retired; I retired at the end of 1990—Mitch Greenlick was coming up to take over as chairman of the department, because I had told the Dean I was going to retire when I was sixty-seven, and we wanted some crossover between the two of us, and Mitch came up—after he was chosen unanimously by our department and also by the Dean's Office, and without any competition [laughter], because we all wanted him.

But anyway, I went out to Clackamas to be health officer, because they didn't have one, and this was just a volunteer position, frankly. And we had a clinic that was staffed by Gail Alexander, a nurse practitioner, and she was allowed to see people only three times. These were people without any insurance and no funds and no place to get

care. She was only allowed to treat acute conditions. If they had any chronic condition that needed to be seen, she had to refer it into the private sector.

And, frankly, with the development of the HMOs and managed care, it's getting very difficult to find a place to refer. So I went to Tom Troxel, and Tom Troxel went to Hammersted, who was the County Commissioner, and we decided that we would try to create a new clinic, because the Hispanic migrants had no place in Clackamas County to go. They had one in Marion and one in McMinnville and one in Washington County and one in Hood River, but none here. And so they were coming to the Department. And when I got out there, I started working in that clinic with Gail, and I began to see people more than three times, and, my goodness gracious, we had to see people with chronic illnesses, everything from hypertension to asthma to diabetes, you name it. And so we began to take care of it, and Tom Troxel, who set the standard that we wouldn't, had to change his mind, because we told him, "You have no choice. Either that, or we're not going to give any service." And he couldn't see that. So Tom Troxel went after money on the federal side and got it.

When Kitzhaber created the Oregon Health Plan, we immediately became a part of that. In fact, in the health department at Oregon City, that's where people come to join whatever Oregon health plan they want to join. It's in the health division. We don't get all of them, thank goodness. We couldn't handle it. But anyway, I know Kitzhaber's faculty appointment is in our department. But he certainly has opened up an opportunity for health departments.

Both Multnomah County and Clackamas County got together with OHSU, and we created the Oregon Health Plan that OHSU has, the one that receives funding from—this is a very important part. There was no way our clinic in Clackamas could function without hospital and more complicated diagnostic backup, and so I asked the School here, and they all agreed to go ahead. They would try to charge these people. If they get paid, they get paid, if they couldn't—or if we could pay for them, we would. And, frankly, we do pay for them, when we refer them here for diagnostic studies, out of the grants and money that we have at Clackamas.

And so that was a very important development. It was not the first, but one of the first off-the-Hill clinics that this School became intimately involved with. That one and Multnomah County, and then some of the other migrant clinics and other clinics which are there for what we term the medically indigent. These are people who are uninsured and unable to afford the fees. It's unfortunate that population is again increasing. Why? Because business is not able to afford the charges that managed care wants to make, so the businesses are trying to get people to pay more and more and more and more for their own medical care, and the people—some of them don't have it, so many people are going uncovered. And this is going to become a very critical problem.

Now, the Medical School is involved with this, but this school cannot function, either, without good sources of funding. That's why they left and became independent from Higher Education, because otherwise we would have a great deal of difficulty, and

undoubtedly we still do. I think it's miraculous that this place has been able to grow and continue as well as it has.

WEIMER: It certainly has had a long history, and it's nice that it's still surviving.

OSTERUD: Well, this place has—my goodness gracious, for seventy-five years it cared for the medically indigent in Multnomah County. But then the county hospital and the county clinic began seeing people from all over the state, and the county says, "We can't afford to pay for Washington County and Clackamas too." And so that's why I gave you the history of the school's purchase of the Multnomah County Hospital and the clinic.

It's an interesting place. I have to admit I've had opportunities of leaving, but I didn't do it. I've been offered the position of Health Officer in California and Washington and Oregon; I've been offered the deanship at the Tulane School of Public Health; I was offered a position at UCLA's School of Public Health; and also as Health Officer of Santa Monica, with no less than two hospitals, and I didn't think I'm qualified to run two hospitals. So I've just stayed here.

WEIMER: That's quite an honor to be even offered those positions.

OSTERUD: Oh, yes. Well, this happens to people.

WEIMER: We have a couple of themes. I don't know if we have talked about all of them. I do want to touch on changes in technology. You mentioned working on research with the IBM cards.

OSTERUD: Oh, goodness, the changes in technology. That's true not just of our department, that's true of all departments, but it's truer of our department than any other. No one can get into our program if they're not really quite skilled. I've got a medical student and an MPH student who are working with me right now. We're going to be doing an in-depth study of parasitism in the state of Oregon, looking at—and most of them are not reportable diseases, but the State Health Division is the one that does most of the parasitology, not all of it, but most of it, and so we're going to do it from that standpoint, because we have access, and they're totally confidential records.

Well, there's no way they're going to be able to do that. All of it is now on computer. They're going to have to go to the computer, and they're going to have to write their own program to do the analysis off the computer. And I don't even have one.

I retired, but I took a job in Washington County to be acting Health Officer when their full-time Health Officer left to go to Alaska and they didn't have anybody. I did it twice. Anyway, I was the Health Officer there, and they didn't pay me directly, they paid the school for my services. I think it was Dr. Kendall at the time. I'm not sure if it was Kendall, but I think it was. No, no, it was the former head of Pediatrics. He was the Dean at that time. He let me take that \$20,000 and purchase the computers for our department.

And we had one little Apple, which wasn't worth a darn, and so we got better ones. And today, of course, in the master's degree program everyone has to use them constantly.

And so the biostatistics teaching in our department is primarily involved in large studies in epidemiology and this kind of thing. You can't do it without the computer. Our physician studies are all totally computerized, of course. I get the final report, we tell the computer what we want, and then we do the study and the analysis, because the computer can't do that. But it can give you the figures, but then you have to say, "What do they mean?"

And so, yes, that has changed our department a great deal. When I came here, the only thing we had to do that would be the big, old IBM card puncher, sorter, plus a lot of little, small calculators. And they were all mechanical.

WEIMER: Mechanical?

OSTERUD: Yes, mechanical calculators. I don't know what happened to them [laughter]. I have to admit, when I came here and we had our biostatistics in the freshman year, all the students had access to these doggone little, mechanical calculators, and they'd sit down and turn it like that. So we used those.

My goodness gracious—the Xerox machine has absolutely changed the way we do things. Before that, we had a great deal of trouble producing syllabi for medical students, and exercises.

WEIMER: Did you use the old mimeograph?

OSTERUD: We had to use the mimeograph. Now, today, goodness gracious, I'm using that thing constantly. I make all my own transparencies and stuff for teaching.

And so those two things—the availability of the Xerox and the availability of the computers—have totally changed the way our department functions.

WEIMER: I can't keep you forever today, so I would like to ask you one last question, and that is, what are you the most proud of in your career?

OSTERUD: I don't think there's any one thing that I'm most proud of. I suppose one of the things is the fact that our department—most medical schools have lost their public health departments; we haven't. Ours is stronger than ever, and I think that's what I'm most pleased with. And I will have to be honest and say that Mitch Greenlick did that.

WEIMER: Well, wasn't he working on your accomplishments?

OSTERUD: Well, some of them. But he was able to put—we did have an MPH program with the University of Washington, but it was strictly for physicians, it wasn't for others.

And today, health departments have relatively few physicians. Most of the people who work there are not physicians. They're Ph.Ds or they're epidemiologists or they're nurses or they're sanitarians or they're engineers. People don't realize that, that the physician is only one small, integral part of the function of health divisions, health departments.

I shouldn't say this, but I am very proud of one thing, that a young medical student from upstate New York came and did an elective with me. His name is David Fleming. David Fleming is now a state epidemiologist with the State Health Division, and he also is an Associate Director of the Health Division, and so he's undoubtedly one of the most successful in the nation. CDC is always trying to get him to go back to Atlanta. He won't go. On top of that, he married my daughter.

WEIMER: Oh, how nice.

OSTERUD: So I have two grandchildren.

So I have to admit that—and his department, without that department at the school we could not conduct our MPH program. We couldn't.

I have a course right now. It's brand new, first time it's ever been given in the school. It's on emerging and re-emerging infections. Seventy percent of the teaching is being done by the State Health Division's special people, because the State Health Division was one of the first four states in the nation to be funded by the Centers for Disease Control to study the emerging infections.

WEIMER: I think that's quite an accomplishment.

OSTERUD: It is an accomplishment.

And so what we're getting is for our students in the course—it's a small class. All of them are MPH students. We have some physicians in it as well as MPH students as well as medical students. We have that new program.

Another thing that I'm very proud of that Dr. Greenlick created is the five-year program in which medical students will have both their MD and their MPH when they graduate.

WEIMER: A joint degree?

OSTERUD: A joint, because the things that we teach today—because of the HMOs and the organized care and the very fact that we're looking at prevention, not from

the standpoint of just one patient, but all of the patients we have, and which of those preventive procedures. I can remember when no one would pay for an x-ray of a breast. Now almost all of them do. And searching for cervical infections and cervical cancer; the screening for early cardiovascular disease; early screening for diabetes.

All of these things now are done, not just on a one-on-one basis, but looking at the population a particular managed care program will care for. The earlier they make the diagnosis, the greater the results and the lower the cost.

And so the epidemiologic studies are now something that are going across all of medicine and now just not exclusively held by the health department for infections. And I think that perhaps has made the activities of the local divisions within medical schools part of—every single division now has to participate in that. And so that has led to many of them. It has not led to the fact that the teaching is diminished, it's led to the fact that the teaching is going across the board.

WEIMER: I need to give you fair time if there is anything else you would like to add before we conclude this morning.

OSTERUD: Oh, I could go on for a week, but I have many things that I haven't talked to you about. The fact that we went from just lectures to lectures plus the development of full-time academic rotations in the clinical years, to the development of clinics that are off the Hill. We were the first department in the school to do that. And why? Because our activity has always been more off the Hill than on the Hill. But we do now have a resident, full-time, paid for by the hospital.

WEIMER: Oh, very good.

Well, I would like to thank you, and if there are other things you need to add, we can always do a second segment.

OSTERUD: Well, I'll be coming back for more data on the history of the department that I'm writing.

WEIMER: Yes. I made a note for the interview that you have been doing research on the history of the public health department and plan to write a paper.

OSTERUD: Yes. It goes way back. People don't realize the subject has been taught here from the first day this place opened, although it was taught under the term hygiene, not public health.

WEIMER: I think it has a wonderful history. And with that, I think I'll say thank you.

[End of interview]

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