

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

Joseph Bloom, M.D.

Interview conducted April 3, 2001

by

Charles Morrissey

SUMMARY

The interview opens with Dr. Joseph Bloom discussing his transition from private practice in Anchorage, Alaska, to an academic position at the University of Oregon Health Sciences Center. Bloom had moved to Alaska from the East Coast in 1966 to become chief of the mental health unit of the Alaska Native Health Service, and was determined to stay in the Pacific Northwest. When his friend Dr. Jim Shore was appointed chair of the Department of Psychiatry at UOHSC, Bloom applied for the then vacant position of director of the Community Psychiatry Training Program. When Shore vacated the department chair, Bloom was appointed to that position as well, and he jokes that he has been following Shore in positions “he had, or should have had” ever since.

After a discussion about the development of psychiatry in Oregon and its unique characteristics, the interview turns to focus on Bloom’s administrative roles at OHSU. Asked whether administrative work particularly appeals to him, Bloom notes that fifteen past deans of the School of Medicine have been psychiatrists, and speculates that some element of psychiatric training may prepare individuals for administrative careers. He goes on to share his views on the qualities that make a good leader.

Bloom then addresses the question of organizational culture at OHSU and whether the university is overly “corporate.” He shares his impressions of university presidents Dr. Leonard Laster and Dr. Peter Kohler and of past deans of the School of Medicine, notably Dr. John Kendall. He then goes on to describe his own relationship with President Kohler, drawing in the process an analogy between deans and field generals. Bloom also discusses some of the activities of the dean’s office and of the president’s office, including search committees, recruitment, and media relations.

Turning back to psychiatry, Bloom talks at length about the elements of a good psychiatric training program, emphasizing the need for excellent clinical facilities, a diversity of patients, and a large and diverse faculty. He also notes the importance of making trainees truly responsible for patients, by having fully licensed trainees. Bloom sees this last element coming under fire from managed care programs and medical insurers, and he segues into a discussion of the current state of American medicine.

Bloom moves on to consider university finances, and discusses the impact of Measure 5 and the erosion of state funding for the university. He also talks about the resurgence in outreach to private donors through the alumni offices and the OHSU Foundation.

After a short discussion of the recent effort to reform the medical school curriculum and ongoing committee work in that area, Bloom moves on to a lengthy reflection on the relationship between the school and the hospital. Noting that the Oregon political process is almost invariably polite, Bloom nevertheless describes a fundamental tension between school and hospital that arises from conflicting interests. Bloom draws another analogy: that of the university as a constitutional monarchy, with a ruler (the president) who is nevertheless subject to various checks and balances.

The theme of tension is continued in a discussion about the Department of Medical Psychology at OHSU, which was born out of a disagreement between the psychiatry chair and the psychology division chief. Tension is also seen in town-gown relationships, which Bloom attributes mainly to the influence of managed care programs in other local hospitals. He sees a segmentation of physicians along medical plan lines, and notes a decline in support from volunteer faculty at the university.

When asked what has given him the greatest satisfaction in his term as dean, Bloom points to the launching of a group practice plan for OHSU physicians, but tempers his enthusiasm with a reflection on the difficulties that he encountered along the way. He describes his disappointment at having to consult five lawyers before making most decisions, and notes that the “legalization” of medicine has been a factor in his decision to retire.

After a short discussion of the accreditation process at the university, Bloom wraps up the interview by recounting his decision to embark on a career in psychiatry. Asked whether he has ever encountered anti-Semitism in his work, he describes a single episode at OHSU that may have been related to the debate over physician-assisted suicide. In closing, he notes that he was a history major in college, and that he very much appreciates and supports the efforts of those involved in the OHSU Oral History Project.

TABLE OF CONTENTS

Alaska and the Pacific Northwest	1
Psychiatry in Oregon	4
Life in Administration	6
Corporate Culture at OHSU	8
Presidents Laster and Kohler	9
Dean John Kendall	10
Relationship with President Kohler	11
Search Committees and Recruitment at OHSU	11
OHSU Image	12
The Transition from Chair to Dean	13
Psychiatric Training	13
Delivery of Health Care in America	15
State and Private Funding at OHSU	16
Curriculum Reform	18
School-Hospital Relations	19
Department of Medical Psychology	21
Managed Care and Town-Gown Relationships	22
Life as Dean	24
Legal Affairs	25
Accreditation	26
Choosing a Career in Psychiatry	27
Anti-Semitism	28
Index	30

Interview with Joseph Bloom, M.D.
Interviewed by Charles Morrissey
April 3, 2001
Site: Dr. Bloom's office
Begin Tape 1, Side 1

MORRISSEY: This is Charles Morrissey, on Tuesday April 3 in the year 2001. In a moment I will begin an oral history interview with Dr. Joseph Bloom. This interview is for the Oral History Project of the Oregon Health Sciences University.

Why don't I start by asking you, how did you make the transition from Alaska to Oregon?

BLOOM: Well, it wasn't all that difficult. You know, it was twenty-two years ago, and I'd been in practice—I'd been in Alaska a total of ten years—and I was looking for an academic job. It was kind of at the end of a time where I thought I could probably get one. I was basically in practice in Anchorage, and the only criteria that my wife and I put on looking for the job was that we would stay in the Northwest; and that left us two departments of psychiatry: one in Washington and one in Oregon. I had been on the clinical faculty of the UW psychiatry department for a number of years, which we can get into if you want.

So I looked at a job there, and then a friend of mine was just made chairman of psychiatry here two years before I got this job, and his job became vacant in the department, which was the head of a community psychiatry training program, which I had good credentials for. We really wanted to go to Seattle because we were familiar with Seattle and not very familiar with Portland at all; but the job was better here, it was a better psychiatry job, so we came here. And really, there are a lot of ties between Northwestern places and Alaska; there's a lot of family overlap. And, you know, twenty-two, twenty-three years ago Oregon was not what it is today. So it was just a step up in terms of size, and certainly the city, but it wasn't so radically different that it was a major transition.

MORRISSEY: Why did you want to stay with academic psychiatry?

BLOOM: Well, it wasn't staying. You see, I started in New York City, and I went to Columbia College, and I went to Albert Einstein for my medical school; and I decided I wanted to go into psychiatry. I ended up in one of the more, at that time, academic residencies in the country at the Massachusetts Mental Health Center, which was a part of the Harvard training programs. It was actually the central place for Harvard training in psychiatry.

Many of the people who were in my peer group and people ahead of me, behind me, they all ended up in academics—a lot of them did. A lot of leaders, actually, in academic psychiatry came from that training program. I ended up on a different pathway. I owed the Public Health Service time because they let me do my residency. Of course, no money at that time, but they gave me a deferment through what was called the CORD plan, and I owed them two years. I specifically did not want to go to NIMH, where a lot of my friends went—and I could get into that, if you wanted to, also—so I was looking for a different kind of job than just going to NIMH and then just going back to Boston, which most of my friends did also.

They told me about a job in the Indian Health Service in Alaska, which was to be one of the first psychiatrists—or, actually, in the group of the first psychiatrists ever in the Indian Health Service. I told them that it sounded like an interesting job, and then I got a letter saying, “Congratulations, you’ve got your first choice.” Actually, my first choice was one of the Harvard professors—I was going to end up as Peace Corps psychiatrist to South America, but I messed it up when I told them this job sounded interesting. So they shipped me off to Alaska.

Then, we liked it so much—I was in two years, ran into problems with them, basically on the way they organized their services, so I didn’t stay longer—I owed them two years; I stayed two years. Then I went back to Boston and took a fellowship back at what was called the Laboratory of Community Psychiatry in those days, which was another Harvard program with very well known people in community psychiatry.

I went looking for jobs at that point, and I looked at a few academic jobs. I went and looked at Dartmouth. I wanted to go in the country, and I liked Alaska. So I looked at a job at Dartmouth and I looked at a job at Vermont, and both were nice, small departments. Then I got offered a really good job in Boston, and that kind of put us into a tailspin because I actually had to make a decision; and we ended up deciding we wanted to go back to Alaska in private practice. So we left all the good jobs on the East Coast and went back in private practice, and I was in private practice for eight years. I was reaching the famous midlife crisis age of forty, and I had kept some academic credentials by writing some things from a private practice base, a paper or so every year or two; and it just seemed like it was either going to be then, or I was going to be in private practice in Alaska, which wasn’t all that bad of a thing. I applied to these two departments, in Seattle. Kind of from my residency on, it was an expectation for a lot of young people in that group that they’d end up in academic psychiatry. So that’s how it happened.

MORRISSEY: You mentioned someone you knew created a vacancy here in Portland. Who was that?

BLOOM: Jim Shore. Jim Shore was a guy who was in the second round of psychiatrists who went into the Indian Health Service. He then, when he finished with the Indian Health Service in 1973, came to work here as the first director of this community psychiatry program. It was a unique program; it was set up in a very unique way. It’s still in existence today, and it’s well known nationally.

So even though he was a young guy—there was a lot of trouble in the psychiatry department. They had appointed a chairman—the chairman who was there for many years had reached retirement age, which they had in those days, and he had to step down. They appointed a guy from the East Coast via England, who came and hit smack dab into Oregon psychiatry, which is a little bit different. He ended up staying here two years, then went to Hopkins—Paul McHugh—where he was a spectacular success. He's just retiring now.

Jim, after all the turmoil in the department, at age thirty-eight he was appointed chairman. He's a very talented administrator. So when he was appointed chairman here, his job in community psychiatry was vacant, and that's the one I applied for. I subsequently—when he left in '83 to become chairman in Denver, Colorado—I've kind of followed all of his jobs around over the years. He was a person who everyone knew was a talented administrative person, very good. He's now the chancellor at Colorado. He was the one that everyone thought for sure would be dean here had he stayed here, but he went to Colorado. He became chairman over the years from '83 on. He was just appointed chancellor last year, but he had had every acting job they had: dean, hospital director, chancellor of the University. Now he has a permanent job.

So he left here in '83; I ended up being appointed in '84 as chairman, and then this job started in '93. So I've kind of been following along in jobs that he's had or should have had, and I told him that this is the last one. I'm not doing any more of these. But that's who it is.

MORRISSEY: What is the appeal of the Pacific Northwest to you?

BLOOM: Well, that's a good question. I think that one of the things that I've found in the West Coast, and certainly starting in Alaska, is I had an opportunity at a very young age to do things in Alaska that I never would have done had I gone to NIMH and gone back to Boston. I mean, it probably would have taken ten more years in Boston, there were so many people—and talented people—and Alaska has a very small number of people. To a degree, it's the same thing here.

I think the first thing to me is they're overwhelmingly beautiful places. Alaska is breathtaking. Oregon is very, very nice. I always had the idea that I didn't want to go to a place just for the job; I wanted to live there. We've had very good times there and here and raised our family in both places.

So I think it was that; I think it was the opportunity. I think the universities were unique. This is a pretty unique place in that it's not that bureaucratic, although I don't know that everyone would agree, and it certainly is changing as it has gotten to be more of a university. I came here in '77. Prior to '73, this wasn't a university—it was the University of Oregon Medical School, with the dental school and the nursing school kind of pasted on somewhere in the administrative structure. So it's a young university, with

lots of opportunity; it's pretty entrepreneurial, and if people work hard or can figure out ways to do things, you can pretty much do it. So those are some of them.

I like smaller cities—I think they work better—although this is now no longer a small city. And I think they're friendlier and they're better places to live, and things like that.

MORRISSEY: At any point since 1977 have you considered leaving here?

BLOOM: Well, I've only applied for one other job in my time here. I always had what I would consider pretty good luck, in that I got jobs here. I didn't have to leave to become a chairman, I didn't have to leave; although I never planned to be a chairman or a dean, I didn't have to go anywhere to get those opportunities. So that's been good for me. Had I been in a situation where that wasn't the case—and of course, a lot of it is luck, because it depends on faculty members, a lot of it is timing and this and that. So I never was in that sort of a situation.

At one point in my dean's job, I looked at a senior mental health services research job at UCLA; that was about three or four years ago. I have a big interest in that research area. This was a very, very good program, and I just thought it would be good to get back into a research career, at least to try it. It combined a lot of the things I had been interested in in my own research career. And so I did apply for the job. I didn't get it. So that was the only time I did.

I've tried pretty hard not to, unless I was really serious about it, not to get on the job circuit thing. Lots of people do that, and there are a lot of people that it becomes pretty well known pretty quickly that all they're doing is boosting their egos, maybe, or boosting their internal deal. There's just a lot of energy involved in it, so I never did it. That's the only job I ever looked at in the time I've been here.

MORRISSEY: Did I hear you say a moment ago that Oregon psychiatry has distinctive characteristics?

BLOOM: Yes, you did hear me say that. Oregon psychiatry, certainly in distinction to some of the more traditional Eastern psychiatric centers, developed a rather unique model in relation to psychiatric practice. We never had a strong psychoanalytic community in Oregon. I mean, if you contrasted Boston psychiatry to Portland psychiatry, that would be one of the features. And the chairman, the man I mentioned before who retired at age sixty-five, was a fellow named George Saslow. Actually, you ought to interview George at some point. He's now ninety-three, comes to work two days a week. A very vigorous guy, a very good guy.

Well, George trained in New York City, first as an experimental psychologist—he got a Ph.D. in psychology—and then he became a psychiatrist. He approached psychiatric practice from a much more empirical base than the traditional psychoanalytic practice. So George was the first, really the first permanent chairman here. He came here

in '57. Prior to that, there were chairs who were community-based physicians, psychiatrists. And George really put the stamp on the department and its training program, and it was a very different stamp than many of the programs in the country.

In addition to that, the only other training program in the whole state was at one of the state hospitals, the Oregon State Hospital, which is located in Salem, about forty miles from here, in the state capital. That program was also very unique. They had a training program. It was headed by a psychiatrist named Dean Brooks. Dean Brooks was the chief psychiatrist in the movie, *One Flew Over the Cuckoo's Nest*. He got an acting job in that movie. That movie was filmed at Oregon State Hospital. And some of the psychiatrists from the department had acting roles in that, including Jim Shore, who we just mentioned.

Anyway, Dean, as a state hospital psychiatrist, and very innovative, invited people to the hospital and to the training program who were very accomplished. For example, they had in England a very famous guy named Maxwell Jones, who had started a therapeutic community type model for ward government in inpatient units in psychiatric hospitals, and he spent a couple of years here.

And the program was unique, but not psychoanalytically unique, and they turned out, not a large number, but a certain number of residents a year. Both programs did. They weren't huge programs; they weren't large at all.

And these were people who were different than the typical, you know, Massachusetts Mental Health Center product, who were really long-term psychotherapy, psychoanalytically-oriented psychotherapy-type psychiatrists. These people were much more pragmatic and not ideology-driven in any sense, and they produced a different type of psychiatrist here. And actually, given the environment in Oregon and pretty much around the country, the managed care environment, these people are very highly effective psychiatrists. They take care of problems efficiently and pretty quickly, and they're interested in psychotherapy but they're not in love with psychotherapy as the only modality in psychiatry. So, yeah, it was quite a difference.

The closest institutes, psychoanalytic institutes, were in San Francisco and Seattle. There's now an institute in Portland, over the last five or six years, but things have changed dramatically in psychiatry nationally at this point.

So, yes, it did produce a different type of psychiatrist, I think. One of the things I've thought of doing when I stop doing this job is maybe write a little history of Oregon psychiatry. I may or may not do it, you know. I tend to write things that no one reads, so this might be another one, another such episode.

MORRISSEY: [Laughing] Well, that's the consequence of a long academic career.

Is there a correlation between the emphasis you're putting on community psychiatry in Oregon and the fact that the Oregon Health Sciences University emphasizes family medicine?

BLOOM: There may be a correlation, but it has nothing to do with me. It's really kind of interesting that Dr. Kohler, who's the president of this institution, has a background that is completely not in community work. He was an NIH research guy and a geneticist and internist, with a solid academic career going way back. I've said to him a few times it's like we switched roles. I used to be all over Oregon; now I never leave the place. He's now all over Oregon.

Family medicine has its own history here that predates both of us in significant administrative roles here. Dr. Kohler came in '87. The family medicine department was organized, I would guess in the seventies some time—I don't know exactly—and so it's got a tradition. It's now on its third chairman, and very successful in its own right. But what Dr. Kohler did, along with Dr. Reinschmidt, who was an associate dean here and head of our continuing medical education program, was to tie primary care, rural medicine, the AHEC programs all together, and that strengthened all of them.

And I can safely tell you that I can take no credit for that, although, you know, if you want, I will, [laughter] but I didn't do very much. I've supported it, but that doesn't have to do with me.

MORRISSEY: I noticed, preparing for this interview, that you served as acting chair of psychiatry, two stints, '79-'80 and '85-'86, and you were vice-chair from 1980 to '85 before you became chair in '86. Was there an appeal to you of becoming an administrator?

BLOOM: You know, I can honestly tell you that I never thought of things that way. I think administratively, I think. But these people asked me, "Would you do this?" and I said yes; but I never had a plan that I would do this. When I came here in '77, there were things that really were deficits in my education and background—like, I'd never had a strong research background—and I had to learn things. I can remember the first grants I wrote for NIH, NIMH. It was very, very difficult to learn all of that, but I never had to learn any administration.

I think one of the things that we may want to talk about, you may want to talk about, is there are now fifteen deans who were psychiatrists, and I think there's a certain amount of administrative training in psychiatry that's part of psychiatric training; and I just thought that's what you do. Now, in these jobs, I was asked to do these jobs, and of course I did them, but I never could say that I wanted to be an administrator or that I was aspiring to be one.

MORRISSEY: Can one safely deduce that you have enjoyed the administrative function?

BLOOM: Can you deduce that?

MORRISSEY: Could an outside researcher in the future, looking at the history...

BLOOM: I have enjoyed these jobs. Obviously, I didn't know as much then as I know now. I actually think of things, you know, what I do administratively, and I have certain administrative ideas that I think are important. I've got a much clearer idea of what I think leadership should do for people, what the leaders should do. So I've enjoyed it; yes, one can deduce that. As you can see, if you ask me one question, I might talk for the rest of the time [laughter].

MORRISSEY: That's fine with me.

Well, could you elaborate on what's entailed in good leadership, what leaders should do?

BLOOM: Well, as I've gone on in this job—and I think I've done this all the way through, but probably more tentatively—I believe in being very straight with people. And I think I'm a heck of a lot more blunt now that I was when I first started, but I never BS'ed people for the sake of anything, as far as I know. I didn't ask people to do things I wouldn't do. I tended, I think, to try to lead by example in a lot of ways. I also believe that people want people in positions like mine to make some decisions now and then, and tended to make decisions. You know, I've gotten, from time to time, people who were not happy with me, but I think it's important to make clean decisions and then try to tell people why, to have reasons.

So I think sort of along the lines of some clean administrative lines and procedures. And I've tried not to gunk up things, tried not to talk too much to people, or confuse the subject. Just things that I would say, probably, you learn in psychiatric training, and maybe the way I've done it for myself. I think some of these things are important in leadership. I've not sat down and organized it, but these are some thoughts that just come to mind.

MORRISSEY: What else do you know now that you wish you knew then?

BLOOM: Well, I guess what I'm trying to say is that the way I behave now, I think I had the tendencies all the way along the line. I enjoy talking to people and trying to work things out, and these kinds of things. And I think what I know now is more clearly how to deal with problems and how to deal with people. But I don't think, I was trying to say, that I'm doing things anything vastly differently. I'm just a lot more conscious of doing it. Hear it out; make a decision; try to resolve it. As a good example, right now, I'm in the middle of an issue with the basic science faculty, in that we might institute a tuition, a small tuition, for graduate students. We have, over the years, waived graduate student tuition, and we might institute a small tuition. I don't think there's one person that agrees with me, at least that said they agree with me in that, and I was thinking that it's good for me to do it. Since I'm leaving this job, it's good for me to do it

and not leave it for the new dean to figure it out and do it, if we're going to do it. So last week I was to the point, I said, "Well, I'm just going to go ahead and announce it." And then it sort of bothered me that in hearing all the reasons why people think I'm doing this, that a lot of them are not the reason I think I'm doing this. So, I didn't announce it last week. I decided over the weekend that I just have to face this thing. And I've had this many times in this job. I just have to face it. I've got to just stand up there and tell people why I'm doing it and let them say their piece, and maybe they'll come up with a better idea. So I decided to do that over the weekend. I just told pretty much everybody on the basic science side, and we'll have a special forum next week, and we'll see what happens. But I think it's partly you just have to, from time to time, just face up to these things and get up there and say your piece.

So I don't remember where I started with this, but the point for me is that from time to time you have to have, I guess, a certain amount of—at least to yourself—a certain amount of courage in these kinds of jobs and not try to shy away from those things. And there are never confrontations. People don't really want to have confrontations with me; they just want to say their piece. Again, maybe they'll have a better way.

MORRISSEY: I know you've written a lot on how cultural context affects the delivery of psychiatric services. Is there a definite corporate culture to OHSU?

BLOOM: Well, I don't know the answer to that. The people downstairs, the central administration—we call them the "people downstairs"—they tend to use words like 'corporate.' I keep telling them they shouldn't do it. But I think the influence of the way the university has been organized since we became a public corporation is along more corporate lines, and they kind of like that stuff and like the terminology. Whether it's true or not—I don't know how corporate we are or not. I've never worked in a corporation other than the one I'm in. I try to, again, do what I think is right.

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

BLOOM: I never do anything I don't agree with. I've gotten to the stage of my career where I don't really care. I do stuff that I think is right. There are a lot of things what we're doing, whether they're corporate or not, that I think are correct. And so I agree with many of the things we're doing. I do think, however, we don't at times appreciate the negative effects of words; so that if I'm telling you that I'm doing what I think is right and I'm calling myself the Corporate Compliance Office, and I tell you again I'm doing what I think is right and I call myself the University Compliance Office, I think we'd have a whole heck of a lot easier time if we called ourselves the university than we call ourselves the corporate office.

So I think we can do things that are efficient and entrepreneurial and this and that and all these things, but I think we don't pay enough attention at times to the language we choose for things. And that's a good example, because we have a Corporate Finance Office. I said, "Why don't you call yourselves the University Finance Office? You could

do a whole heck of a lot, you can do the same things, and people won't think you're doing corporate things." So I just think it's important that we pay a little more attention to what we call things. And you could still go ahead and do what you consider to be the right things to do, without casting a halo over it.

I'd also say that probably there are people, whether on the OHSU Board or some of the people who work here, who want to portray a corporate model. So, my suggesting, or other people suggesting, that you might choose different language—they might have chosen exactly the language they wanted to choose. I don't know the answer to that, but I think it can be problematic at times for us.

MORRISSEY: You've mentioned the word 'entrepreneurial' at least twice so far in this interview. Has this institution become more entrepreneurial in recent years?

BLOOM: Well, I think I mentioned it going back to why I liked being in Oregon. I think we were able to accomplish things, if you had the energy and the drive and some imagination to do it, all the way along the line. And I think I said that we were maybe less bureaucratic or less rigidified than other places. We're kind of a unique institution in that we are a freestanding medical university. There are only twenty-five or so in the country. I just did a department review for a major Midwestern university medical school that's part of a big university, and they're just a heck of a lot different type of institution.

So, yeah, I think that all the way along the line we've been able to be that way to a certain extent. With our new status as a public corporation I think we've gotten much more flexible than we were under Higher Ed, and I think that was really a great move. And I think that Dr. Kohler and company did a very good job in the way they conceptualized it, because a lot of places they tried to pull the hospital out of higher educational systems. Here, he pulled the whole place out and didn't want to separate the hospital from the rest of the place, and I think that just was very, very wise.

So, I think that's been a thread all the way through. Since we've become a public corporation, we can do things on our own. We've instituted personnel salary policies that can reward activities without a vast salary structure, et cetera; so, yeah, I think we're pretty entrepreneurial there. But I think we were always going in this direction; but we're just a lot freer since '95, since this took place.

MORRISSEY: You mentioned Dr. Peter Kohler. You've worked for two presidents here, Leonard Laster and Peter Kohler. Similarities and differences between each president's mode of operation?

BLOOM: Yes, there's a great deal of difference between both presidents in terms of their operation. Let's see: I came in '73. Dr. Bluemle was the first president of the institution, and then Laster was appointed next, with some interim people—Dick Jones, who's a very great supporter of the medical school, who was biochemistry chairman; he was interim president for a while. And then Dr. Laster came. And I didn't work for him for very long. I did the year I was acting chairman—and that was '79—although there

was a dean between me and Dr. Laster. And then he appointed me chairman, and there was a dean between me and him then. Dr. Kendall was the dean who appointed me chairman.

But through all the different meetings I've gone to over the years, I've certainly got to know him pretty well, and he was a person who you'd characterize as a micromanager, someone who was very hard on his administrators. Dr. Kohler is not a micromanager, he's about the opposite of that; but he's kind of a vision person, and he has had a consistent set of goals for the institution in all the time I've worked for him. So I'd say you probably couldn't get administrative styles that are more opposite than the two people you mentioned.

MORRISSEY: You mentioned Dr. Kendall. What was it like having him as your dean?

BLOOM: Well, if anybody ever listens to this and they want advice about administration—they actually do have aspirations to become an administrator—one of the things in medicine is that there are people who, when you ask them to do something, they say “yes”; and then there are people, when you ask them to do something, they say “no, but maybe”—they negotiate. Well, I was in the first category, so I was on a lot of committees. I actually was on the search committee that recommended Dr. Kendall, so I got to know him as a candidate. He's a long-term professor of medicine here who had been the head of research at the VA, and he's a very fine man. I mean, he's a very rational guy, and you could bring problems to him.

I think he had a tough go of it because he was functioning in the university, working with Dr. Laster, then in the transition between Dr. Laster and Kohler, and it was a time when the university was less financially stable than it is now. So in that way I think he had a rough go of it. But he certainly is an ethical, interested, fine person who has maintained his dedication to the school all the way through. And he's now an emeritus professor; he's here in the endocrinology department. And he was a distinguished professor at the VA and continues with some important assignments there. So it was really a pleasure to work for him.

Actually, I tell people, with me stopping, one of the things that I think Jim Shore said to me, is that no chairman should work for one dean. So that's what I tell people now, that I'm just doing it for them [laughter] and that they shouldn't work for one dean. But, in the year I was acting chairman, I worked for Ransom Arthur, who was another psychiatrist, a very distinguished psychiatrist, who came here from San Diego, was a professor at San Diego, and was dean probably four or five years. Then I worked for Dr. Kendall, and then I worked for Dr. Benson, who was an interim appointment that Dr. Kohler made in between Dr. Kendall and myself. Dr. Benson is one of the finest guys around here. So that's three, and I guess if I go back to the psychiatry department, no more administration, I'll have worked for a fourth one, or at least I'll watch a fourth one. They've all been very, very good people, the people who were deans here.

We had an interim dean—Bob Grover. Bob Grover was an interim dean, before Dr. Kendall I think, and he was also a very, very fine guy. People I knew and worked with here have been just very good to work with.

MORRISSEY: If the future historian of OHSU wants to know what was the relationship between Joseph Bloom and Peter Kohler, what's your answer?

BLOOM: I think our relationship has been fine. I mean, we're basically the same age; we've done a lot of different things in our careers. He has let me—and I use that term on purpose—he has let me function as the dean of the medical school, and I think, as he's become confident, in his view, of my abilities to do that, he's let me do it. And I appreciate that, and I appreciate the opportunity.

The relationship has been business-oriented, not a personal friendship or anything like that, but I think in a day-to-day business way it's been good. And I think in some ways we complement each other, because I've told people at times that there's no detail that's too small for my attention. I'm a type A prime obsessional, you know, and he isn't; and you need both.

I'll say this on tape, since they've all made fun of me when I said it to them in person: I kind of view what I do as I'm like a field general. This is an army here, and I've got to make decisions in the field, and this thing has got to work. And I'm good on tactics. I probably could be okay on vision if it were my job to find one, but it isn't; he's got to have the vision. But I'm very good, in my own assessment, of getting from point A to point B. There are lots of different ways to do it, and this thing is like a big army, and I'm happy functioning in the role of a field commander. That's the way I view this job.

And he's got to make—again, this is a big reversal. I used to go to Salem all the time with the psychiatric bills and do lots of stuff. He's got to set the strategic direction for this university, and the medical school has got to fit into that; and I don't have to do that. As I said, I think I probably could if that were my job, but it isn't. So I think that we've been able to keep those roles pretty straight. That's the way I would characterize our relationship.

MORRISSEY: Search committees: any advice on how they best should function?

BLOOM: Well, before I got to the dean's office, I think they hit on the right model, and that is—we're talking about chair searches, searches that deans' offices have to do. I don't know if it was Dr. Kendall, in his last years, or Dr. Benson. They set it up in such a way that the dean's office conducted the search, staff here staffed the search, didn't farm it out to a department then.

What I've done is had associate deans chair the search, so it's pretty much the dean's office operation, and we can control it and we can make it run pretty efficiently. And Dr. Everts, who is associate dean, senior associate dean, has done a number of them;

I've farmed out one or two for various reasons. But that's been the way we've evolved, and I think it's very efficient. We got the drill down pretty well.

In the early searches that I was doing, we'd have candidates and then we'd invite the spouses on the second visit; and we'd find out they don't like the rain or something, or don't like their spouse, whatever the heck we found out, so then we started inviting them on the first visit. So, I mean, we've just done things over the years to refine that; but I think it's pretty efficient.

MORRISSEY: Was that model in place before you became dean?

BLOOM: Yes, it was in place. I think we made it more so; but yeah, it was in place.

MORRISSEY: Over the years, has it been easy or hard to attract people to this institution? Has it been easy or hard to keep some of your better people here?

BLOOM: I've tended to define the searches as, we're running a job placement service and we're helping people figure out what they want to do in life. It has not been hard to attract people here. People who haven't come here, it's because we've helped them figure out what they want to do with themselves; and that's fine. So it's been easy to attract people here because—lots of reasons, about the place and the setting. And we've been operating in a, not lush financial environment, but a better one, so that we have some resources and we can attract people. And nobody ever leaves.

MORRISSEY: Really?

BLOOM: Nobody ever leaves. Some of you are thinking of it; very few people have left. I mean, there are people, obviously, who have, but it has not been a problem. We've had some senior people—what we were talking about earlier in relation to me—we have had people who have had offers, and we've retained people, key people. That has happened from time to time, but it has not been a problem. It's been easy to get people who want to come here, given that they really want to do something, and it has not been a problem keeping people here.

MORRISSEY: When you've gone to Salem to testify on behalf of various psychiatric bills, have you sensed there is an image of this university among members of the Oregon Legislature?

BLOOM: Well, don't forget, what I said was I used to do that. Dr. Kohler has kept the major part of the lobbying efforts very well organized, in very small group, himself and his vice presidents group. And even though I serve as a vice president, I haven't gotten into that. And I think they've done a very good job. It's extremely easy to get off track there. So they control what they do, and I think they're right.

Now, when I was a psychiatry chairman and I was testifying on psychiatric bills, it really was less to do with OHSU and more to do with the practice of the mental health care system and the practice of psychiatry, and the institution was not that relevant. I keep up with the Oregon Psychiatric Association and its legislative committee, but I don't do very much down there now. So I think they could also be commended, in addition to—I mean, if you've got a vision and you want to get from point A to point B, they've done a much better job, than anyone in the past, of trying to keep their lobbying efforts on point and trying to keep their media relations—I learned a lot from them on media relations. Not that I'm interested in it, but they do a very good job. And I think it's just gotten more vicious over time; the media—you have to try to manage them, and they've done a good job. They have good people in the vice president's role for public affairs, Lois Davis, and they've got an excellent media services office, and they really work hard. And they work very hard to try to manage the news in such a way, or manage the relations in such a way, that there's a positive relationship. And, again, as I said, I'm not that interested in it personally, and I'm glad I don't have to do it [laughter], but I think they do a great job; and I think it's very important.

MORRISSEY: How did you make the transition from chair of psychiatry to being dean of the School of Medicine?

BLOOM: Well, I had a year where I was doing both. I was acting dean, and I continued in my job as chair. And you know, I don't know how I made the transition. I just came to work every day and tried to deal with it. So I think that's how I did it.

I had a certain amount of transition to do with people who were my peers, chairmen. Obviously, they had some say with Dr. Kohler in him asking me to do it as acting dean; and I had worked with them. And then, over the years, people in my age group, many of them in the last few years are reaching retirement age or stepping down as chairmen, and I've recruited a whole bunch of the chairmen now in this institution; and it's a different relationship. I think I have a good relationship with all of them, but it's not like we're the same age or we started at the same place and all of a sudden I'm the dean and they're not, and they're the chairs.

So I think it worked, in the beginning—actually, they supported me very heavily in doing a couple of things that we had to do to straighten the finances out, and I got very good support from them. I believe I've had good support all the way along the line, but I never—again, like we were talking about before: I wasn't consciously thinking of how I'm going to figure out this transition. It's basically, go to work and try to deal with the problems.

MORRISSEY: With respect to training young physicians to become psychiatrists, could you speak about what constitutes good training? Let me rephrase it. Could you speak about what you have learned constitutes good training?

BLOOM: There are several keys to training in general, and I think in psychiatry in particular; maybe they're the same thing.

You have to have patients. This is not something you can learn from a book. All of our clinical training depends on having facilities that have adequate numbers of patients and diversity of patients and different cultural groups and different problems and a range of problems. So that is a key in psychiatry and everything else, and we've had that here. We have good facilities. Just a general statistic for you that kind of illustrates this: we had, last year, a half a million outpatient visits here. It's a big operation—the whole place, not just psychiatry.

And we have the VA, and the VA is a tremendous facility. It's beautiful; one of the last new ones built. It's very convenient. Many places have excellent VAs, but you have to travel back and forth. That's okay, but here the faculty can be involved either side of the bridge very easily. So, clinical facilities. And we have good facilities here.

Our biggest problems here at our facilities are the overall health care environment, which is a problem across the country. I'm very unhappy about having to train people in an immoral environment. That's American medicine. And it's worse in psychiatry; we're more immoral there than we are anywhere else. But that's no different in Oregon. As a matter of fact, the people, the governor, have tried to do things better here, and have succeeded in a lot of ways.

So, you've got to have your clinical facilities, and then you've got to have a faculty that, in psychiatry—and again it's probably everything else—but in psychiatry, that's big enough and diverse enough, because psychiatry is a complicated field. It's got a lot of different facets to it, and you have to have a decent size faculty, and we do. We're probably in the medium size toward the little bit between medium and larger size departments.

I always describe psychiatry departments around the country that there are—at least, there were; things have all changed now with managed care. But there were three—Cornell, UCLA, and Pittsburgh—that were bigger than Luxembourg in terms of countries, and then there were the rest of us that were just regular size departments. But this place, between the university faculty, the university side faculty, and the integrated VA faculty, was big enough, diverse enough, had enough spread from junior to senior faculty, enough professors and senior faculty, and good cooperation from the clinical—the volunteers in town—that you could offer a good training program.

And this one had particular strengths in cross-cultural, trans-cultural psychiatry, as you mentioned before, and community work and public psychiatry and PTSD at the VA—post traumatic stress disorder with veterans—a number of very good foci, where there were people who were intellectual leaders in the country. So those are the ingredients.

And then you have to have good trainees. Psychiatry went through a period of time, which seems to have been resolved now. When I was a resident, there were large percentages of the class that were going into psychiatry. Then it fell to about four percent

of medical school classes, which is where it stayed—although, in the last few years it seems like it's creeping back up again, and it probably is doing that because psychiatry, even though it may not be as financially rewarding as some disciplines of medicine, is very varied. And I think students who were kind of revolting against some of the managed care practices and the regimentation in medicine could look at psychiatry and not quite see that there. It was a little more fluid and flexible. So our trainees have always held up here, and in the last years, in just this last match last week or the week before, we did very well in psychiatry. So I think those are the ingredients.

And you have to offer, you know, a chance for people—this is a thing also generally in graduate medical education—for progressive responsibility and taking on cases and being responsible, actually being responsible. These were all licensed doctors. And these are areas that, a lot of them, the last for example, that are under threat from insurance companies and managed care companies and this and that. But they're critical to development, and we've been able to kind of keep it together in these areas.

MORRISSEY: Has the current condition of American medicine had an impact on your decision to retire from this job?

BLOOM: Well, you have to be a little more introspective than I am generally, but I think in some ways it has, because I'm kind of sick of it. I had predicted that we were going to fix American medicine by 2002 about ten years ago. I mean, everybody who predicted anything ten years ago was wrong; why not me? But I thought what would happen is that we'd have to get out of the deficit, the budget deficit, and then for sure we'd fix it. And what are we talking about fixing? We ought to say that. We have, basically, a system with forty million people uncovered. And I think we're projecting that to our students. And hospitals like ours receive ever increasingly less subsidies, and they're ever increasingly faced with bottom-line pressures. And so those are the faces of medicine that we show to our students.

Well, anyway, I thought we'd have a chance of fixing some of this stuff. I think we're probably as far away today as we've been in the last decade.

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

BLOOM: It's caused, partially—it figures into what I'm doing. I don't see any global fixes coming along here, and I'm interested in more private things. So I think it's had some influence. I wouldn't say it's had the major influence. But you know, we're managing better. I think we're coming out of the managed care revolution, which was probably doomed from the beginning, although a lot of people made a lot of money in it. So maybe some things will be a little bit better; but we've basically not decided, as a nation, to fix a problem that we should fix, and probably tagged it in the wrong place to begin with by putting all of our health insurance based on employers and not on the tax system, or not on the public system.

So, what I'm saying it, maybe things are a little bit better, but my timeline is running out here in this stuff, and I don't think it's going to be vastly different in the next four to eight years.

MORRISSEY: You've also had to deal with the impact of Measure 5.

BLOOM: Yeah, we dealt with the impact of Measure 5. And when I said people helped immensely when I started, I mean Dr. Kendall and Dr. Benson had to implement Measure 5; and what they did was cut some budgets. And when I started, we were operating in a deficit position in the medical school, and it was a great economic position. We were giving away more money than we had. And that has to do with a lot of factors, Measure 5 being one of them, because we lost \$5 million in Measure 5.

As a matter of fact, today the amount of state money in the medical school budget is, dollar for dollar, the same as it was in 1991. We're sixty-seventh out of seventy, yet we've had immense growth. And that relates to what we were calling 'entrepreneurial' and to leveraging. We've done very well.

We had to deal with Measure 5, but we also had to deal with our own administrative processes; and I think we did. I never believed in legacies, but my legacy is having raised the tuition beyond all deans put together in the history of Oregon medicine. So that's one legacy; I socked it to the students, which is nothing you want to be proud of. We did a number of things financially, budget-wise, that, without being facetious about it, allowed the medical school to grow.

And my own view of it is, they were worth it, because we're not—I mean, we could have had years and years and years up to the present time of kind of being in a low morale, deficit, no raises, no this, no that situation. That's intolerable. It's intolerable for me. So we fixed the budget problems, but it was made very difficult. We wouldn't have had anywhere near the extent of the problem without Measure 5, and we certainly could use a little more state money. But we were able to weather the Measure 5 budget cuts, and then to move on from there; and we did that by some fiscal measures, one of which was tuition.

So I think Measure 5 had its dire effects, but I think we have gotten through it.

MORRISSEY: Maybe the subject of private philanthropy lies outside your purview as dean but...

BLOOM: Absolutely not. I'm very interested in it.

MORRISSEY: ...the question is how have you dealt with the opportunities provided, particularly in the economic context of the last eight years or so, to benefit the school?

BLOOM: Well, if you take state money, and that's been a constant: we haven't lost any, we have gained very little. Actually, we've gained some from the central administration, but the result is that we're now back to where we were in '91. We were lower than that.

So, how have we grown here? Well, we had a lot of help from people downstairs in recruitment. Initially, when I started, we didn't have any money, and we got help in recruitment, and we were able to bring in people, and they got grants. I mean, we did things initially that were for the future, and we continue to do that. We're just, in the medical school, much more able to participate as equal partners. So the grant dollars have gone up.

The indirect cost dollars have gone way up. The clinical faculty practice revenues have gone up, and we get a fixed percentage of those dollars. And philanthropy has been a very big interest and very good for the medical school. And I do a lot. I mean, I probably could do a lot more, but I try to be helpful. We've developed in the last three or four years a very good development office, including people who work in the dean's office directly. And prior to this time period, our Foundation was described as a bank with very little on the development side. Now, we recruited a man named David Mitchell, who for personal reasons didn't stay all that long; but his lasting contribution is he vastly increased the number of development people, including the medical school which had had its own funded development person prior to David Mitchell. But when David came we got a very senior person here, a guy named Randy Petty, who we worked with them to recruit. We transferred the alumni office back from the Foundation to here. They're all on this floor. And I'm very happy with them. We increased the giving by a lot. For example, this year, within the last six months we've had two gifts. One is just about completed; one is a planned gift, the other was cash. It was \$11 million.

And our alumni organization is better; we're relating to our alumni better. I told Randy, when he first started, that one of the innovations of our program is we never did anything twice, and so we were always disappointing people: "Oh yeah, we're having this cocktail party every year to thank you for giving money to the medical school." Well, we did it once. We were doing everything once, and I told him the goal was to do everything twice. But, in reality, they've organized the alumni relations in a way that we're doing things consistently and relating to people and developing donors. If you looked at my schedule, you'd see in the next few months a number of events. So I participate in it a lot.

The thing that is important to the medical school—I mean, there are all the development efforts going on in the university, and many of them benefit the medical school, and I'm supportive of all of them: the cancer center, the heart center. Most of those things will directly or indirectly benefit the medical school or its faculty. The targets for this office are our alumni and our graduates of our training programs and our faculty. That's what we're systematically trying to do, and I think we're doing much better at that.

MORRISSEY: Do I recall correctly there's a major Robert Wood Johnson Foundation grant you received?

BLOOM: Yes, you do recall correctly. We finished that. That was a major curricular revision effort which was undertaken initially by Dr. Kendall and finished up by Dr. Benson. I really, just in the time I've been here, kind of put some finishing touches on it. Ed Keenan is our head of medical student education, and he was here with the other deans; and give those guys all the credit for that. Walt McDonald, who's now the president of ACP in Philadelphia, he was associate dean of medical education before Ed. Ed worked for him, and Walt worked with John Benson and John Kendall. So they did it; we finished up the grant. We actually dramatically changed our curriculum, and it's very well regarded.

MORRISSEY: Have you stayed with that new model?

BLOOM: We've stayed with the new model, and we keep working on it. We have goals that relate to the clinical years that we continue to work on, with the clerkships, and we continue to refine it. The grant has been finished now I think probably three years.

MORRISSEY: Any other comment on curriculum? What is ideal, or what are the problems when you try to change it?

BLOOM: Well, the problems for Dr. Kendall and Dr. Keenan and Dr. McDonald were people like me, who were the department chairmen. I figured, well, these guys are going to run out of steam either before or after they run out of money [laughter]. Well, the problem was that they didn't; they didn't run out of steam and they didn't run out of money, and they beat us into submission. I remember actually going to one meeting—it was sort of funny, looking back on it from my current job—where Dr. Kendall got us all to sign something, that we would agree to implement the thing; and of course, some of us, as I said, thought, “Well, it'll just go away at some point.” But it didn't, and they made it work; and it's very good. So the biggest obstacles were people like me and faculty. I mean, I'm like faculty too. There were a lot of faculty, “Why do we have to change our course? We love our course.” “Well, your chairman signed here. You better change the course.” [laughter] So those were the obstacles.

Our curricular activities—I think we have a very good process now. We have good committees. We have three main committees in medical student education: the admission committee; the missions committee, which is a labor of love—I mean it's a huge amount of work; curriculum committee, which is active, and they actually do things, and they review curricula and changes, et cetera. And our student progress board.

When I was a chairman, we had two progress boards. We had one for the first two years and one for the second two years, and they were separate committees. I was chair for a number of years, probably three or four years, of the clinical—the second, Progress Board 2—and I worked with Dr. Kendall and Dr. Keenan as chairman of that committee. And we integrated the two. So I kind of inherited that after, and that's very good. We

have a single progress board. And we had people—I mean, you have the damndest ideas that people have from time to time—we had people who said, “Well, Progress Board 1 information is private, it shouldn’t go to Progress Board 2. So, if a student got by, that’s all you need to know. If he was getting by by the skin of his teeth, you don’t need to know that because we want to give him a fresh start.” There were people who actually believed that.

So we integrated it, and that’s our other committee. And it’s very effective. They’re experienced, and they know how to deal with problems, and they take them on. We’ve had students that have had substance abuse problems and academic problems. And it’s also integrated between intellectual development and moral and ethical development. It’s a single board. You don’t have any, you know, this person is passing but is cheating. It all goes to the same place, which is very good. So those are the key committees, and they help facilitate the program. And we’ve had a couple of students that we’ve encouraged to leave or we expelled. Over the years I’ve been here, very few; two or three come to mind. We’ve had students in trouble. Like anybody else, they can get into as much trouble as anybody, and we’ve just taken care of it.

So from the idea of the curriculum—also Dr. Reinschmidt was one of the key people with Dr. Kendall: Dr. Kendall and Dr. Reinschmidt. Dr. Kendall, as we said, was dean, and Dr. Reinschmidt was associate dean. And the two of them, together with McDonald and Keenan, put this effort together. So I have actually very few problems in that arena.

We also have a very, very good graduate medical education program, which, when Dr. McDonald was in the dean’s office as associate dean, the hospital agreed to transfer the program over here. So we have GME here also with a separate unit. Don Girard, who’s a primary care internist professor, is in charge of it now, and it’s very good. Very few problems there.

And, although we don’t pay the residents’ salaries—those are hospital-based dollars that get transferred to us and we pay the salaries—we administer the program, and it’s a joint program between the dean’s office, myself, and the hospital director.

MORRISSEY: Have you given a lot of time to hospital relationships?

BLOOM: I’d say the biggest amount of my time—a certain amount of stuff with basic science departments and space and personnel issues and recruitment, but the biggest chunk of my time has been medical school-hospital-clinical department relationships.

MORRISSEY: What are the core issues?

BLOOM: The core issues are money. It’s always money. The way I kind of look at a place like this—I mean in addition to my analogy of the school being like a field army—there are overlapping but separate kinds of areas of interest between a hospital, a

medical school, and a president's office, and they work the best when they're overlapping the most.

You can get into awful fights. I'm, by virtue of being in this job eight years, kind of a senior person in the deans' world; and not the most, by any means, because there have been people that have been there much longer than I've done it or will do it. But lots of times the problems develop just in the arena we're talking about, and they develop because of personalities; and I think they develop because people don't understand exactly what the issues are that they're dealing with. And, again, I think the issues are that there are overlapping but distinct interests.

A lot of deans complain about their relationship with chairmen. I never have complained about that. I view the dean and the chairmen as really two facets of the same part of the academic apparatus, so to speak. So, I see the interests of the faculty and the interests of the chairmen and the dean as really the same. The hospital is a much different world than we live in; they need to make a certain amount of money, and they're much more vicious with their employees than we are. And the presidents need to make this work so that he can get his vision accomplished. And it's not always the same interest.

But the Oregon political process is pretty polite. There's nobody screaming and yelling in meetings here, and nobody's insulting anybody. Very rare. There are no confrontations here in meetings. There's no yelling at people here. Of course, anything that's said in the meeting doesn't necessarily mean that's the decision, but it's very polite; and I think that's good. The Oregon Legislature is like that. You go down there, and you have five different groups testify, and they'll say, "How can you expect us to make a decision when you can't agree? Go talk about it."

So it protects people from getting too polarized, and you know, thinking the hospital administrator is too much of a something, and the hospital, all they're interested in is cardiac surgery, and they don't give a damn about this or that. So the politeness I think helps. You don't ever have these big fights, and you can talk to people. The personalities here right now in our group, there are no egomaniacs, and the people are pretty flexible, so there's no one that has to win everything. That's helped. And I think we've generally had good people in these jobs. We've had a couple of people lower down in the hospital administration that have left. But, as I said, I think they live in a different world, and you've got to respect that, because they come and go quickly, and they're more nervous. They should be.

So I think it's worked well, given those parameters. We've had a few times when we've had a lot of tension, but it tends to get resolved pretty quickly.

MORRISSEY: Any specific examples?

BLOOM: Money. It's always money. "What did you promise? Where is it? Is it being transferred? We're going to deal with the budget cut by cutting our allocation to

you.” You get into very few intellectual arguments in this arena. It’s all about promises kept, promises made, how we’re going to deal with things.

The other thing that I was starting to say about the analogy—the interests overlapping but not the same—I would say it’s sort of like a constitutional monarchy, this place, these places, in that the president, he’s the constitutional monarch. He can kick any one of us out, which is fine. His authority extends to the leaders and hiring and firing of the leaders, plus what we were talking about earlier, with the vision.

There are always the potential tensions between the medical school deans, who are always walking around, you know, “Woe is me; I’ve got no money and the hospital administrators have it all, and they won’t give it to me.” But the reality is, they can’t get anywhere without us. So the doctors make the money for them, and they can’t have any doctors without us. They can’t just go out on the street and find a doctor. Now, there have been times when they would have loved to do that, because the administrator doesn’t like the department chairman, or they’re in a big hairy fight with somebody, or they just want to do it because they want to do it, they could do it better. But they can’t. They can’t appoint anyone without us. And I’ve told chairmen from time to time that, “They can’t appoint anybody without you, so you ought to just understand what your powers are and try to work it out within that setting.”

So you’ve got these checks and balances; in this kind of a setting, we have a president up top, and you have the rest of us who have powers, and one can’t exercise them without the other. And as long as the president is pretty cool about it, that’s the way it is. It’s the truth of it, so we need each other. And when you realize that and the chairmen realize that and people sort of understand what are their limits—you know, I can’t go over there and tell them how they should run their budget. I’m sure if I went over there and spent the month, I’d understand their—maybe I wouldn’t. I mean, hospital administration is a field.

But once you realize what the competing interests are, and the fact that we really do need each other, and the extent of what you can do and what they can do, it’s not really that hard to work it out cooperatively. And you don’t get into big hairy fights, and you have a polite process; it generally can work. In a public meeting, I can count on one hand the times when I’ve seen people openly angry in Oregon. It doesn’t happen.

MORRISSEY: With respect to organizational topics, do I understand correctly there was a department of medical psychology here?

BLOOM: Yeah. There was a separate department of psychology that came about, probably in the fifties, when the psychiatry chairman and the psychology division director, so to speak—psychiatry chairman George Saslow—in the fifties, maybe even the sixties—and the person he brought with him and hired to run the psychology section, Joe Matarazzo, got into a fight. They both came from Wash U in St. Louis. They got into a fight. Matarazzo went—as he told it to me on several occasions—he went to the dean and said, “I want to be a separate department,” and the dean said, “Okay,” and made him

a department. What Joe Matarazzo told me was that the dean says, “Well, what do you want to be, a basic science department or a clinical department?” “Part of the basic science department.”

So they became, basically, a psychology department, with a small number of clinicians and a developing base of psychologists who were really basic scientists who didn’t function, didn’t care at all, weren’t interested in, and weren’t qualified clinically. It’s part of this budget crunch that we were talking about earlier when we started.

We separated the clinicians from the basic scientists and created a department of behavioral neuroscience, so they emerged into a very successful group of behavioral neuroscientists; and the clinical psychologists were placed in the psychiatry department. They included the adult clinical psychologists. There’s a group of clinical—you can never quite corral all of this stuff—but there’s a group of clinical psychologists, small group, in the CDRC, Crippled Children’s Division. From my point of view, having been around these issues for many, many years, it’s a shame that they had the spite in the fifties or sixties; because if this were a true department of psychiatry and behavioral science in a medical school and it contained some version of what’s in these two departments, it would be the most productive research department in the medical school, by far. I think both departments and both disciplines have suffered here. And nationally, psychiatry departments are ranked second to medicine departments in medical schools and NIH funding. And your place [Baylor University] is a good example, and you’re going to become the Menninger Department of Psychiatry. And I think this place suffered greatly in that over the years, and it’s irreparable because nobody in behavioral neuroscience would ever want to be under a psychiatrist, and it’s just had a terribly unfortunate history.

And many of the psychiatrists, like we were talking about with me, don’t have the research background and either they learned it to one degree or another, like I did, or they didn’t learn it; and the department suffered for it. So, yeah, that’s the brief history of it.

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

MORRISSEY: We’re here on side 2 of tape 2 of this interview with Dr. Joseph D. Bloom, on his birthday, April 3, in the year 2001.

We’ve touched on various aspects of town-gown relationships, but is there anything more that you’d like to say about that?

BLOOM: Town-gown relationships, I think, from the point of view of the dean’s office, have suffered in the managed care revolution. And I think it’s another one of the areas that is very unfortunate from the point of view that I discussed earlier in relation to our students, but also in relation to the practice of medicine.

The town here has two major systems and the university: Providence Catholic Health System—Providence Hospital—and the Legacy Health System, which is an

amalgamation of three or four different hospitals, some with non-Catholic denominational backgrounds, and others are community hospitals. There are no bad hospitals in these systems; they're good hospitals. A lot of our graduates work there.

But what's happened over the last decade is, as hospitals became health systems and bought into networks and tried to influence major insurers, the physicians got segmented. And so our relationships with our physician colleagues are good but not as good as they used to be, and with our physician colleagues in administrative and educational positions in these hospitals are certainly not as good as they used to be. And people say that, well, we compete in certain levels, and we cooperate in certain levels. Well, it's easier to compete than to cooperate, is the way I put it.

We have some struggles around residency education, not so much medical student, which is terrific. We've not drawn the medical students into these things. But in residency programs, we have the only residency programs in the state except for some freestanding general medicine residency positions in Legacy and in Providence Hospital, and a new family medicine program at Providence. So we're 95 percent of the residency and the specialty residency programs in the whole state. So we have tensions around that, and it's mostly, as I said, with the administrators and educators in these systems, although we have seen some erosion of general clinical faculty, volunteer faculty support as people have gotten aligned in these health systems.

We have good relationships with organized medicine through the Oregon Medical Association. We're in the process of negotiating—a number of us, including myself, have been members forever of the medical association, but not a large percentage of our physicians have belonged to the medical association. We're now working on a major increase in the number of OHSU physicians that will be members of the Oregon Medical Association.

MORRISSEY: Is there a reason for that, why so many physicians have chosen not to belong to the state medical society?

BLOOM: Well, it's not unusual nationally, where you have VA physicians, university physicians in town. The lowest percentage, probably, of all are Kaiser physicians. I didn't mention Kaiser earlier. Kaiser should be right in there as the other major health system. So Legacy, Providence, and Kaiser and us. And everything I said about Legacy and Providence applies to Kaiser. It's a major system.

We've had relationships with them for years. We probably have our best relationships with them, although, these too have been affected to some degree by the pressures of managed care, which put a lot of pressure on them. I mean, they were the original HMO in Oregon, maybe one of the original ones in the country, and they were very successful and kind of a model-builder for a lot of people nationally; and they've faced big competition pressures and have had problems. I think they've tended to be more successful here than in other parts of the country, and this place has probably

floated some of their losses, this Oregon and southwest Washington and other places in the country. But the pressures on their physicians are pretty extraordinary also.

So I generally say the town-gown relationships are good but have suffered in this decade of change that we've had. Probably close to a decade.

MORRISSEY: In the years since 1994, while you have been dean, what's given you the greatest satisfaction?

BLOOM: That's a good question. I think probably the working environment and the levels of support and trust that I perceive in relation to my colleagues. It's not been a hostile environment at all; it's been quite pleasant for me, both in the dean's office and pretty much anywhere I've worked here.

We have organized and are about to launch a group practice which will amalgamate all of our physicians into a single group. It's a major deal. I would feel better about it if some of the intervening problems that developed from the time we organized it to the present time weren't there, and I was more confident that it was exactly the right thing to do. The problem that I am referring to is that not only have we been faced by the pressures that we've talked about in organized medicine, but we've also had a tremendous amount of "legalization" of the practice of medicine—you could call it that—and in the university setting we've had lots of pressures locally and nationally on this awful word 'compliance' and billing and physician billing and Medicare fraud and abuse.

I've told people jokingly that we've become a law firm supported by a medical clinic. I personally have five lawyers; I mean, there are five different lawyers that I talk to very frequently in different aspects. It's a whole other aspect of the job that I think has had a negative effect on me. And I think what I'm getting at with the group practice is, from the time we started planning it to the present time it's gotten so damn complicated and—legalized isn't the right word, but it's been a disappointment to me that we're talking to ourselves, and we all have to have lawyers. I mean, we've now become a group hospital, a university hospital, and a medical school. That wasn't exactly the way I envisioned that it would happen.

I think part of it might have happened anyway, but the federal emphasis in the Clinton administration on Medicare fraud, abuse, compliance, all this stuff, not only has dramatically increased our overhead, which is a giant pain, but it has made these processes very, very, very difficult and less trusting.

So, I'd be a heck of a lot more proud of that if I was sure that this was exactly—it's one of those things that I'm not sure that we would have designed it exactly this way again if we knew then what we know now on this particular front. But it'll be a major accomplishment for the university and for the practice here, and I think down the road, after we get through some of this stuff—and hopefully it'll get figured out nationally and will be approached more sensibly—that the physicians here will be in a better position and will have better regard for each other and for departments other than their own. So I

think that's a major accomplishment, which I had a part in, and others have had a big part.

But I think the main thing to me is just the working relationships and the ability to get a number of things accomplished. I didn't tell you this, but having been on so many different committees and been involved in things, I knew a lot of things when I started this job. It's interesting to me that it would not have been comfortable for me to go to another medical school and try to figure out what the heck is going on; and I think it's an interesting thing administratively that there should be some people from the inside in these jobs and some people from the outside.

And I think in some ways it has sort of been ideal with Dr. Kohler coming from the outside and being responsible for the vision thing, and me coming from the inside and being responsible to fix some things that I actually understood. There are not a lot of people—it would take years to figure it out. I would feel sorry for a dean walking into it. Now, there is going to be a new dean walking into this, maybe from the outside, but we're now ten years down the line with Dr. Kohler and his people. And there are other people in senior positions, and I think the place could stand it, and maybe it would be better. But it's a tough road to try to figure this stuff out.

MORRISSEY: When you say five lawyers, are all five in house?

BLOOM: Yes.

MORRISSEY: How many in-house lawyers were here when you came in 1977?

BLOOM: None. We were part of Higher Ed, and the AG's office provided attorneys to Higher Ed; and I think that they spent very little time here. We don't get sued all that much for malpractice here, so we didn't have that many. But it's a big operation now. We have ten thousand-plus employees. We have a personnel lawyer; we have a lawyer that concentrates on research; we have a lawyer that concentrates on rules and regs who came to us from Higher Ed, and he knows all the Higher Ed rules and state stuff. We have a lawyer who only concentrates on medical group practice issues; we have a lawyer who is head of, not affirmative action, but the area that looks at sexual harassment and EEO complaints. I'm missing one. Oh, and we have a lawyer who does the malpractice cases, who's been here for a long time and he's excellent. These are all good lawyers. And we have a general counsel. So that's maybe six lawyers. The general counsel does a lot of stuff for the president and does big contracts and new ventures.

And then, we have untold numbers of lawyers who are handling cases for us. We get sued all the time now. We have whistleblowers; everybody's a whistleblower. You dismiss somebody or have a personnel action for a perfectly reasonable, sensible, logical cause, and you're getting sued for violating the rights of a whistleblower, or the person was disciplined or dismissed because they're a whistleblower. And I'm one of the few people around here with two boards in forensic medicine, so I know a lot of this stuff. But there don't seem to me to be any ethical boundaries—and that's probably the wrong

term—in what you can use as a defense or as a justification for why you’re being victimized. It seems like the extent of your imagination is the extent of the legal arguments, and it’s not pleasant.

You know, it’s not like we’re getting sued all the time, but it’s a very different regulatory environment. It’s interesting to me as a psychiatrist, because some of the situations we’ve had, it’s actually a lot easier for me to use the lawyers. If there’s an unpleasant task to occur, if the person has a lawyer and you have a lawyer, they can do it without you having to tell the person anything: “Oh, I can’t talk to you; you have a lawyer.”

And I think in some ways we brought it on ourselves. That’s what I’m trying to get at. I think we’ve brought a lot of this on ourselves because we don’t want to deal with anything unpleasant, so we now have people who will do it for you. It’s a way for administrators partially to get lazy, not confront difficult things. I’ve done it myself. I mean, heck, why not? They have a lawyer; I have a lawyer: “I don’t want to talk to that guy.” But it’s not right. I mean, it’s not exactly right. It’s legally right, because I can’t talk to that person if they have a lawyer, or I can’t do this or do that, but it’s been a big, major complication, from my point of view, and it’s disheartening in one sense. It’s also, I think, ultimately somewhat crippling.

And that’s part, again, not any major part of why I’m stopping, but it’s there. It’s disheartening to me that you need so much representation. So that’s a part of it.

MORRISSEY: Dealing with accreditation committees: has this figured significantly in your life as a dean?

BLOOM: No. We had one LCME accreditation. We set it up a little bit differently, and we breezed through it, basically. We got a full accreditation. I told Dr. Keenan, who’s head of our medical school program—I think we’re in year four, we may be finishing year four of our accreditation, and there are seven years—so I told him that I wasn’t going to be here the next time; the next dean would do that.

And that’s partly why I’m leaving also, because there is a timing issue here. I want the next person to have enough chance to know the medical school.

But that’s been the only major accreditation. We have monthly, probably more than—let’s say monthly—visits from residency review committees, looking at this residency or that residency. We have no programs on probation; we have no problems. We generally do fine, you know. There’s maybe a comment here or there. So that has not been a problem. And I only have to go to those if there’s something on the burner, and there really is very little of that. We have one coming up in one of our surgical subspecialties that I’ll go to, but that’s not a major issue. The university was accredited and I didn’t have to do very much—just show up. So it has not been a burden to me.

MORRISSEY: With respect to things that have changed dramatically, like the growing presence of lawyers in medical school activities, do I understand that when you first came here, shock therapy was practiced?

BLOOM: Shock therapy is still practiced.

MORRISSEY: Is it really?

BLOOM: Oh, yeah. Shock therapy—see, you sound surprised by this. The latest issue of the *American Journal of Psychiatry* has a lead article on shock therapy. Electroshock therapy was very much in vogue in the country, and it's not a major part of the clinical practice of psychiatry, but it has a place.

MORRISSEY: Still?

BLOOM: Still. Probably even at Baylor—ask them [laughter].

MORRISSEY: I will ask.

Two biographical questions: Going back earlier in your life, why choose medicine as a career path? Secondly, why choose psychiatry?

BLOOM: My mother died this year at age ninety-one. My father was a GP in Brooklyn, and my mother said I always wanted to be a doctor. Now, I have no memory of that, but that's what she said, so maybe she was right.

Psychiatry I do have a memory of. I started medical school with the idea of being an internist, and I liked internal medicine a lot in medical school. And I'm greatly disappointed—and I tell my colleagues in medicine all the time that I think they messed themselves up quite a bit from the time I was a medical student and the internists were kind of the intellectual capital of medical schools and medicine, and they got themselves into a horrendous bind by subspecialization.

So I started with that interest, and I changed during the rotation in the third year, in psychiatry. The way it was for me, the patients were very interesting; I had some very, very good teachers; and I decided after that, after the clinical rotation, that I was going to be a psychiatrist. And then, in my fourth year when I went to Albert Einstein—which at that point was a new medical school; and I was in the fourth class, and it was a great place—in my fourth year, I had a six-month externship in Cambridge in England in psychiatry, which was great. I was decided already by then, but that's where I changed, and it just provided such an intellectual challenge in that I had never seen people like that. And it was people—actually working with them and trying to understand it. And so it was a very heady time in psychiatry, actually, when I went into psychiatry. I mentioned earlier that a high percentage of classes in many medical schools were going into psychiatry. Again, it's changed since then. That's when it changed for me.

MORRISSEY: Have you at any point in your educational career or your medical career encountered anti-Semitism?

BLOOM: Well, in my medical school career—of course, I went to Columbia College, and my father graduated from New York Medical College in 1929—and he died many years ago—but he described a lot of anti-Semitism when he went to school.

MORRISSEY: I would think so, at that time.

BLOOM: When I went to college, Columbia College had a large Jewish population, and—really not in college. I was on the fencing team in college—see that plaque over there?—and I might have gotten in to Columbia or Cornell, but they didn't take that many people in. I was going to get into Cornell, and I didn't win the fencing championships; I came in fourth in the individual championships, and I don't know if that had anything to do with religion. Probably not.

Of course, I went to a medical school that was associated with a Jewish university. I never felt anything in my residency; Alaska, really not. In my time here, I never really had anything directly from anybody. There was one incident where I got a call from our campus security; it was probably a year or two after I started, and I'll tell you the circumstances in a minute. I got a call from the campus security, and they said, "We want to come over and talk to you. There's been a threat against you." So I said, "Fine, come over and talk to me." So they said they had a phone call, and the content was: "A Jew like him shouldn't be dean. We're going to fix that." And that was it. It never repeated itself.

I thought it was related—and I may be wrong—to the debate about physician-assisted suicide, which I never took a public position on. I felt like my job here was to make sure that anyone who wanted to say something, said it, and that they didn't kill each other. And basically, that's what happened here. We had very strong opinions in the faculty, and people said that we had strong opinions within the family medicine department. Probably, the leaders on each side were colleagues in the same department. And I think, in retrospect, and because of some things that happened later which ultimately involved a personnel action with a faculty member, I think it was related to that debate. And you know, Jewish people are often identified as secular humanists, although I never talk about that; and I never talk about religion or me being Jewish or not being Jewish. That's what I think it was about, and that was the only overt thing.

So I've never—I mean, who knows what, you know, social class and how these things play themselves out in the community. But I've never overtly felt anything, and that was the only incident.

MORRISSEY: We're down to the end, and we have about three minutes on this tape...

BLOOM: What do you mean? I thought we were going to go till we ran out of—
worn you out, here.

MORRISSEY: [Laughter] Is there any question I have failed to ask you that you
would like to address?

BLOOM: Well, I was a history major in college, actually...

MORRISSEY: I was warned.

BLOOM: Were you? They knew that. One of the things that...

MORRISSEY: Let me just interrupt to say you were a history major at a
wonderful time and place, Columbia in the mid-fifties.

BLOOM: Columbia was a great place. It did a lot for me. I had a wonderful time
there.

So why I said that was, I really do appreciate the fact that we've taken this on. I
know that it hasn't been well supported, but even so, some remarkable results have
happened. And what was mentioned earlier, when we started, we had a presentation, part
of our development thing to our alumni group of early history of the medical school; and
this medical school goes back to 1887. We have graduates who have contributed to the
school financially who graduated in the late thirties, who are active and vigorous still. So
I appreciate the project.

As I also said earlier, I might try to do something in the history of psychiatry here.
It would be good if we were able to take this in some direction, you know, where we
could actually write something. I know that Dr. Hallick and Dr. Kohler are interested in
that, and maybe someday we can do something with these interviews, because there's not
going to be too many people sitting down and listening to them; but I'm glad they're here
and preserved.

So that's what I would say. I don't know of one question: there are plenty of
things, plenty of details we could talk about, but they're not really that necessary.

MORRISSEY: Well, thank you very much. I think there's a good unity to this,
and it has a lot of cohesiveness. And besides, oral history in its modern guide started at
Columbia...

[End of interview]

INDEX

A

administration, university, 6-8, 11, 12, 21, 25
Albert Einstein College of Medicine, 1
anti-Semitism, 28
Arthur, Ransom, 10

B

Benson, John, 10, 18
Bloom, Joseph
 biographical information, 27, 29
 career at OHSU, 4, 6-8
 Dean, 13, 20, 24-25
 education, 1, 27-28
 private practice, 1, 2
Brooks, Dean, 5

C

Columbia College, 1
CORD Program (U.S. Public Health Service), 2

D

Davis, Lois, 13
Department of Medical Psychology, 21-22
Department of Psychiatry, 3, 21-22
 Community Psychiatry Training Program, 3

F

family medicine, 6

G

Girard, Donald, 19
Grover, M. Roberts (Bob), 11

I

Indian Health Service, 2

J

Jones, Maxwell, 5
Jones, Richard (Dick), 9

K

Kaiser Permanente, 23-24
Keenan, Edward, 18
Kendall, John, 10, 18
Kohler, Peter, 6, 9-10, 11, 12, 25

L

Laboratory of Community Psychiatry (Harvard
 Medical School), 2
Laster, Leonard, 9-10
leadership, 7
Legacy Health System, 22-23

M

managed health care, 14, 15, 23, 24
Massachusetts Mental Health Center, 1
Matarazzo, Joseph (Joe), 21-22
McDonald, Walter, 18
McHugh, Paul, 3
Measure 5 (Oregon), 16
Mitchell, David, 17

O

OHSU Foundation, 17
OHSU Oral History Project, 29
Oregon Health Sciences University, 3
 accreditation, 26
 alumni relations, 17
 budget, 16-17
 corporate culture, 8-9
 curriculum reform, 18
 funding, private, 17
 graduate medical education, 19
 group practice, 24-25
 hospital-school relations, 19-21
 image, 13
 legal affairs, 25-26
 Public Corporation, 9
 recruitment, 12
 residency programs, 23
 tuition, graduate student, 7-8
Oregon Medical Association, 23
Oregon State Hospital, 5

INDEX

P

Petty, Randy, 17
physician-assisted suicide, 28
Providence Health System, 22-23
psychiatric training, 13-15
psychiatry, academic, 1-2
psychiatry, community, 2
psychiatry in Oregon, 4-5

R

Reinschmidt, Julian (Dutch), 6, 19

S

Saslow, George, 3, 4-5, 21-22
School of Medicine
 curriculum, 18
 Student Progress Board, 18-19
search committees, 11-12
shock therapy, 27
Shore, James H., 2-3, 5

T

town-gown relationships, 22-24

U

university consolidation, 3

V

Veterans Administration Hospital, 14