

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

Karen Whitaker Knapp

Interview conducted April 18, 2006

by

R. Sam Connell, M.D.

SUMMARY

In this interview, Karen Whitaker Knapp, former director of the OHSU Center for Rural Health and Vice Provost for Rural Health, looks back on her career as an advocate for rural health services.

Beginning with her unlikely entrance into the healthcare field, Whitaker Knapp discusses her early work in government affairs at the Oregon Medical Association, and shows how this experience allowed her to become familiar with rural practitioners and the unique challenges they face. She talks about early the grassroots efforts of Dr. Lowell Euhus and others, which led to the enactment of a package of medical legislation addressing some of the problems in rural health services. She also reminisces about the Gang of Seven, a group of seven healthcare advocates who came together to create the first draft of what would eventually become the Oregon Health Plan.

Whitaker Knapp delineates the history of the OHSU Office of Rural Health and its relationship to the Area Health Education Centers, and talks about the enormous amount of physician workforce data that has been collected over the years by the OMA. She outlines trends in rural health care and health manpower, but offers no easy solutions for how future challenges can be met.

Finally, Whitaker Knapp recognizes some of the outstanding colleagues with which she has worked, including anesthesiologist Dr. Genevieve Burk, public health pioneer Dr. Harold T. Osterud, and medical education leader Dr. J.S. “Dutch” Reinschmidt. She winds up the interview with a look back on her achievements and her plans for a long and productive retirement.

TABLE OF CONTENTS

Biographical Information	1
Getting into Health Care	2
Work with the Oregon Medical Association	3
Joseph Conference, 1988	4
Physician Assistants	6
OHSU and Rural Health	7
Office of Rural Health	8
Challenges of Rural Health Care	10
Oregon Rural Practice-Based Research Network	12
Gang of Seven	13
Federal Health Legislation	16
Ginny Burk	17
Harold Osterud	19
Dutch Reinschmidt	21
Health Manpower	23
Rural Health Services	26
Area Health Education Centers	27
Future Manpower Trends	28
Women in Health Care	29
Looking Back on a Career	31
Index	33

Interview with Karen Whitaker Knapp
Interviewed by R. Sam Connell, M.D.
April 18, 2006
Site: OMA Headquarters, Portland, Oregon
Begin Tape 1, Side 1

CONNELL: Today is April eighteenth, 2006. We are at the Oregon Medical Association Building in Portland, Oregon. I am conducting an interview with Karen Whitaker Knapp, who has recently retired from the Oregon Health & Science University, where she was Vice Provost for Rural Health, and director of the Oregon Health & Science University Center for Rural Health. This interview has been made possible by a grant from the Oregon Health & Science University. This is tape one, and I am the interviewer, R. Sam Connell.

Karen, it's delightful to have this interview with you today. I know that you had a very distinguished career with great many successes, and lots of stories to tell. But first, I would like to know a little bit about where you were born, and where you were raised. If you would give us some of that information, please.

KNAPP: Thanks, Sam. I got very lucky. I've been a very fortunate person. I was born here in Portland. But at about eighteen months, we immigrated to Southern Oregon, where my father taught at Southern Oregon College. It was Southern Oregon College then. It's now Southern Oregon University. So I grew up in Ashland, which was an ideal, lovely place to grow up. Very safe and small and friendly. And so I just feel very fortunate to have grown up there.

CONNELL: Well you've had a very interesting career, dealing with medical issues and so on. Were there any members of your family that were involved in medicine? How did you come about to be involved in medicine?

KNAPP: Well, no. Absolutely none of them were involved in medicine. My father said to me, when I entered college—everyone in the family was a teacher. My mother, my sister, who preceded me. She was six years older. She became a teacher. She married a teacher. And my father said to me, "Why don't you do something different? So that we'll have something else to talk about on holidays around the dinner table." You know. "Go do something different than teaching." And although I always enjoyed teaching, and have had some opportunity to do that, because I think I did have some inherited sort of genetic aptitude for it, I decided to do something different.

And I started out majoring in English. And that was primarily, I think, the influence of the Oregon Shakespeare Festival. You know, as a child, I used to wander downtown, wander into the festival grounds, and go in and just sit down and watch them rehearse. You could do that then. You could just wander in and watch them rehearse. And it was a wonderful influence for me. It never occurred to me that Shakespeare was supposed to be difficult. It just seemed friendly to me. And I'd close my eyes and try to

picture what it was going to look like when they were all in beautiful costume. Because they would have on their leotards and their sweatshirts, and not—Romeo and Juliet didn't look much like Romeo and Juliet when they were rehearsing. So it was fun to imagine what they would look like when I actually got to see the play.

CONNELL: So an education in English in Southern Oregon and Ashland. How does that relate to health?

KNAPP: Well, things sort of, things sort of evolved as time went by. I got married young, and I went with my husband to Corvallis. He was an engineering student. And then, of course, this was during the Vietnam War. So he had to get term by term deferments. And he finished before I did. And then my education was interrupted for a while. Because once again I got very fortunate, and we went off to England for three years. And since I had somehow fantasized that I would one day be a Shakespeare scholar, there couldn't have been a better place for me than England. I really enjoyed living there.

But when I returned to school, after he got out of the Air Force, it was clear to me that I wasn't really likely to get paid very much as a Shakespeare scholar. There wasn't much of a demand for Shakespeare scholars. So when I returned to school, and by that time, I had two children, I decided to do something that would be more useful. And so, I don't know why I thought this would be useful, [laughs] but I changed my major to psychology. Which is a ubiquitous sort of major that really isn't worth very much. But then I backed it up with a certificate, which was all they offered at the time, at PSU, in public health. So I thought I might enjoy being active in community mental health issues about the time that I graduated.

CONNELL: So when you graduated, then, with this experience in English, and in public health, and in psychology, certainly subjects which have helped you through your career, where did you go from there, then, after graduation?

KNAPP: Well, as it turns out, no one wanted to hire someone like that, either. [Laughs] So it's a real sort of serendipitous series of events. When I was taking a public health administration class, we were required to do a project that took the whole term. And so we separated into groups. And you know me well, so you can imagine that when I'm in a group of people, I tend to want to sort of assume control of the group. It just kind of naturally happens. [Laughs] But in this case, I was vying for control with another fellow. His name was Richard Pope. And he wanted to do a project on immunization, and I wanted to do a project on domestic violence. And he won. So I was a little grudging of that, but we went ahead, and we did this long project. And I got to know the people at the State Health Division, who were in charge of the immunization programs.

So after I had graduated, I got a job with Multnomah County doing an immunization project on surveying all the two-year-olds in Multnomah County for their immunization status. I wouldn't have gotten that job if I hadn't had that immunization project. Because I got to know those people by way of the project.

Then, when I got the job at the OMA two years later, it was also to run an immunization project. So I just look back and I thank Richard Pope for leading me in that direction. He never knew what a favor he was doing me.

So then that led into some political work with the OMA, and obviously getting hired at OHSU. So, it was just pure serendipity.

CONNELL: Well, probably having that English background, and the psychology, helped you deal with a great number of people. Tell me, what kinds of responsibilities did you have with the OMA?

KNAPP: I started out running a one-year program on immunization issues. I went from doctor's office to doctor's office promoting an immunization tracking program. Which was a very simple little card file index at the time. None of these records, of course, were automated. And so I joked a lot that I followed the detail man all over the state. We would see each other in the same offices and say hello. We got to know each other quite well. And I was selling this program that was being subsidized by the State Health Division, and encouraging doctors to do tracking on their pediatric immunization patients.

I also had an opportunity to do some advocacy work, because we were lobbying at the time for a state immunization bill that would require up-to-date immunization status as you entered school. And I just seemed to have a nice aptitude for that. So when the grant was over, Bob Dervedde came to me and said, "We really like you. We'd like to have you stay. Why don't you work in government affairs?" And so I did. It just turned out to be a nice niche for me.

CONNELL: You bet. I want to go back, with those early years with the OMA when you were going out. You were doing not only city surveys, but you were going out into the rural areas.

KNAPP: Absolutely. Yes.

CONNELL: How was it in the rural areas in those years in medicine? What was happening?

KNAPP: Well, most doctors were in solo practice. It was a little—there were fewer physicians, of course, then. The interesting thing is that I met doctors in that year that I still know very well, that I got to know better when I became involved with rural healthcare at OHSU. So I have some very old friends. One of them, L.J. Fagnan, who was practicing in Reedsport at the time. And I was able to sell him on a pediatric tracking program. [Laughs] So he and I go back a long way.

CONNELL: So back in those years, did the rural healthcare physicians feel that they were overwhelmed? Did they need more resources? What was the situation there?

KNAPP: Oh, I think the differential was more stark than it is now. A lot of them, however, just sort of accepted their lot in life. They were overworked. They were underpaid. There was still some tradition of the old-fashioned country doctor, I think, that was hanging over at that time. But certainly, there weren't very many of them, and they worked very hard. They didn't complain a lot about it, though.

CONNELL: Were there any of those individuals that were really kind of movers and shakers that helped initiate, bring about change?

KNAPP: Well, I think I could probably point to one physician more than anyone else. And I did meet him when I was doing my immunization project. His name is Lowell Euhus. He's up in Enterprise, in Wallowa County. He, I don't think he ever intended to be a mover and a shaker. It's pretty antithetical to his very quiet personality. But the doctors in Enterprise in 1987 were feeling very discouraged. They were working very long hours. They didn't feel very appreciated. And I was working for the OMA at that time. And we had sent out a postcard to all of the doctors in the state saying, "The legislative session has just ended. Is anyone interested in having some members of the government affairs staff come and talk with you about what happened during the legislative session?"

So the Wallowa County Medical Society that had three doctors—and the hospital administrator was also like an honorary member of the medical society—wrote to us and said, "Yes, we very much would like to have you come and talk with us." So Jim Carlson, who was working with me at the OMA, and who is now head of the Oregon Health Care Association, and I drove out to Wallowa County, sat down with the three doctors, and heard what was troubling them. And we were going through one of those malpractice crises at the time, too. So their insurance was very high. They all did obstetrics, of course, because there wasn't anyone else to do it in Wallowa County. So they were paying very high premiums. They didn't feel like they had a lot of community support. They were working very, very long hours. And they were just generally discouraged.

So we suggested to them that they contact Mike Thorne, who at the time was their state senator. And he was a very powerful state senator. He was the head of the Joint Ways and Means Committee. So they did. And Lowell sort of led the charge on this. I don't know if you've ever met Lowell, but he is like a Gary Cooper of rural medicine. He even looks like Gary Cooper, and he even talks like him. He has that quiet, just self-deprecating way of conducting himself. And so they talked to Mike Thorne, and Mike Thorne said, "Well, you have to tell me what it is that's really troubling you. It can't just be the three of you. It's got to be other rural physicians, as well."

So this is one of my favorite stories of grassroots policy development. So all on their own, they sent out a survey to other doctors in eastern Oregon. They paid for it themselves, and analyzed it themselves. So then they went back to Mike again, and they said, "Here's what we found out." And he said, "Well, now you have to tell me what to do about it." And so at that point, they contacted the Office of Rural Health, which at that

time was being run by my predecessor, Marsha Kilgore. And the best approach seemed to be to put together a group of people to talk about these things. So there was a meeting held in Joseph, Oregon, in the spring of 1988, where about sixty, seventy people came together. And we had hospital administrators, nurses, doctors, lawmakers and local government officials, and also, a very sizable contingent from OHSU, including Dutch Reinschmidt.

And so we met for a day. We had a wonderful lunch that the women's auxiliary served to us. There is a nice little city meeting space in Joseph. And they came up with a lot of good information. And Dutch Reinschmidt really led the coalescing of that information following the meeting, got that information to Mike Thorne. And by that time, Gene Timms, who was a state senator from Burns, who also attended the meeting.

And they introduced Senate Bill 438 in the 89th session that was an omnibus rural health bill. And created the Area Health Education Centers Program, created a number of benefits for rural physicians, including a state income tax credit that no one, no other state had ever done, and still hasn't done, to the extent that we do it. A loan repayment program. Moved the Office of Rural Health to OHSU. That was actually a separate bill. But that happened at the same time. And gave the Office of Rural Health some additional funds and tools to do recruitment and retention programs, and technical assistance. And not only asked us to do some things, but gave us the tools with which to do those things. So it was a huge step forward for rural health in Oregon. And it really was started by Lowell Euhus. And I think he's very modest about taking credit for that now. But unquestionably, he's the one who started it.

CONNELL: Oh, that's neat.

[short disruption]

CONNELL: Karen, that's a very interesting story. What other major changes during your tenure occurred in rural medicine in Oregon?

KNAPP: Well, I think certainly more resources, more organized resources on behalf of the state. And more than anything, a recognition that the State should have, as a policy, that people who live in rural Oregon should have reasonable access to healthcare. That people who choose to live outside the metropolitan areas—in many cases so that they can harvest the timber that we use in our houses and grow the food that we eat in the urban areas—deserve a right to adequate healthcare.

CONNELL: That's important. In addition to Lowell Euhus as an important mover and shaker in rural medicine, are there other people who ought to be acknowledged as people who also facilitated and improved rural health?

KNAPP: Oh, we have many heroes in rural healthcare. [Laughs]

CONNELL: Would you like to comment on a few?

KNAPP: I think that Bruce Carlson, who is a physician in Umatilla, Oregon, is someone who deserves mention, certainly. A couple of years ago, he was the Family Physician of the Year at the National Rural Health Association. But what he has done in terms of rural healthcare delivery is very significant. Because he started the first clinic in Oregon that employed physician assistants in rural Oregon. And that was back in the seventies. And those PAs, David Jones and Dennis Bruneau, in Condon, are still there. They have been there the whole time.

CONNELL: And they were trained in the military—

KNAPP: They were.

CONNELL: —as paramedics and physician assistants in the medical army. Is that correct?

KNAPP: That's right. And they were Vietnam vets. And of course, you probably know the story of how Duke University started the first PA program, deciding that these fellows who had been medics were very experienced, and it was a shame to let that technical expertise go to waste. And so David and Dennis were, I think, in the second class at Duke University of training of PAs.

CONNELL: When did the Oregon Health Sciences University begin its program as a mandate from the legislature to initiate a physician assistant program? Was that back in about 1993? '92 or '93?

KNAPP: Yes. It was the 1991 legislative session that explored the possibility. And really, the impetus for that exploration came from our Rural Health Coordinating Council. That is the advisory body to the Office of Rural Health. The representative from the PA society on the council at the time was David Jones, the PA up in Condon. And so there was a lot of discussion, and became a well developed idea to present to OHSU and to the legislature that we really needed a PA training program. So the 1991 legislature asked the Office of Rural Health to do a feasibility study: to, first of all, determine if we had a shortage of primary care providers in the state, and second, to make a determination as to whether or not PAs could help meet and fulfill that shortage, if, indeed, there was one.

So that fell to us at the Office of Rural Health. At the time, there were two-and-a-half people in the Office of Rural Health, doing all these projects that the legislature had mandated. [Laughs] So I brought in a working group, an advisory group, to help me do a survey, look at the environment, and then write this report. And of course Dave was part of that group. But also, a number of other PAs were a part of that group, and physicians, and educators. So I think we produced a pretty credible report. And of course it concluded that yes, we do have a shortage of primary care practitioners, and certainly, PAs could be used to help address that shortage. So that was presented, actually, to the

emergency board in '92. And then the '93 legislature appropriated some funds for a PA program.

CONNELL: Well the first class of PA students at the Oregon Health Sciences University began in 1995. Have you any idea as to how many physician assistants are out in the rural area practicing with physicians today?

KNAPP: There are—I'd have to make a guess at this, but I would guess around 450 in Oregon. And many of them are practicing all alone in very remote rural communities, having remote supervision from a physician. And Bruce is one of those physicians. He lives in Umatilla; he supervises the clinic in Condon; and he also supervises a clinic in Christmas Valley. And he has to visit them every two weeks. So he makes that loop. And he's probably got more miles on his car from driving around rural Oregon than anybody I know.

CONNELL: Well, it's a fascinating story. And certainly the PAs have contributed greatly to rural health.

KNAPP: Oh, they have.

CONNELL: Well, I would like to move on and ask, how was OHSU involved in rural medicine? How did that all come about?

KNAPP: Well, it came about primarily when the administration changed at OHSU. But certainly Dutch Reinschmidt made a contribution prior to that by attending this conference in Joseph, and making sure that there was adequate follow-up. And I know that Dutch always had a deep desire to start an AHEC program. And so when a new search was launched for a new OHSU president, Dutch was on the search committee. And that was the big question he wanted to ask of everyone: How interested are you in Area Health Education Center programs? And how interested are you in outreach activities? Because I know that OHSU was certainly an important contributor to medical education and research before Peter Kohler came along. But there wasn't a great deal of interest in activities at the time.

CONNELL: So what did OHSU do? And how did it work?

KNAPP: Well, one of the first things Peter Kohler did was declare the state of Oregon a 96,000 square mile campus for OHSU. And he meant it. And he still means it. You know, one of the things about Pete Kohler is he's another one of those people that says what he means, and stands by it. When he decided—and I'm sure he wasn't all alone in that decision—but when he began to steer OHSU in that direction, everything changed in rural Oregon. And new resources became available to the Office of Rural Health, being part of OHSU that just grew and grew and grew until the office became a very integral part of OHSU. And more and more resources became available statewide.

CONNELL: And that has just grown stronger, has it not?

KNAPP: It absolutely has. Yes.

CONNELL: What were some of the stumbling blocks to that growth?

KNAPP: Well, I certainly tripped over a few of those blocks. [Laughs] When I started at OHSU, I had no academic background at all. And very little understanding of how academic politics work. And I suppose I should have been able to intuitively know that.

CONNELL: A steep learning curve.

KNAPP: It was a very steep curve. And I can remember when I made the decision to leave the OMA, and it was a difficult decision, because I really enjoyed working for the OMA, and I made many, many good friends. I was talking to Bob Dervedde, who was the executive director. And he said, “Karen, if you think the politics in Salem are difficult, wait until you get up there on that hill.” And he was right. I’ve had to tell him that a few times. He was almost always right, as a matter of fact.

But I didn’t understand the hierarchies. I didn’t understand the working relationships among schools. So I sometimes just stepped on a landmine from time to time. I didn’t understand, for example, why the School of Nursing would not be wildly enthusiastic about a PA training program. [Laughs] So I just made the assumption that since it seemed to be the right thing to do, that everyone would support it. And not understanding the history, the competition for resources and recognition. I’ve learned some of it since then, but I still think, probably, upon retirement, there was a lot I didn’t know.

CONNELL: It’s hard to overcome culture, isn’t it?

KNAPP: It’s very hard to overcome culture. And the first step is in appreciating the culture. So that’s what I had to learn first. And find out how things really get done. And what the relationship of the Office of Rural Health was to the University. Not understanding that there would be people who would immediately assume, wrongly, that the Office was there to promote OHSU hospital services. And Pete Kohler was very clear on that. He and I talked about it and made sure that the integrity of the office would never be compromised. That our credibility would always remain strong. So I kept a very arm’s-length relationship to the clinical programs the entire time, and I still do. But not everyone understood that. A lot of people just assumed the worst, of course, which is what people generally do, naturally do sometimes. So I had to find my way through all of those sort of—

CONNELL: And you did it in spades.

KNAPP: [Laughs] Oh, thank you.

CONNELL: Very, very nice. Were there any stumbling blocks in the rural community?

KNAPP: Oh, I think that people, any time you say, particularly in rural Oregon, "I'm from the government, and I'm here to help you," you have to prove yourself. You have to prove that you are sincere. So it took some time to establish the Office of Rural Health as a credible source. One of the things that we set out to do from the very beginning was to be as non-bureaucratic as we possibly could. So when I finally got the chance to begin really hiring some people, and we had, you know, some more resources to deal with, that was what I stressed to them. "If you've already worked in state government, I want you to abandon all the ideas that you have about what state government is like. Because we are not bureaucrats here. We don't talk about programs; we talk about services." So making sure that everyone was very service-oriented.

And also understood the entire time that these were the people who were paying our salaries. That the taxpayers of Oregon were supporting us. So we really had an obligation to make sure that that money was spent in a conservative and useful way. And to get the most for their money that they possibly could.

I knew some people in rural Oregon. I knew some of the doctors, because I'd had the opportunity to meet them when I was working for the OMA. And that was very helpful. It was an entrée for us. And of course, our alumni responded well, because they already had a relationship with OHSU. When the Office of Rural Health was part of the State Department of Human Resources, it was much more difficult, because the Department of Human Resources was regulating with the one hand, and providing advocacy and services with the other, which is sort of a schizophrenic situation that doesn't work very well. So moving the Office of Rural Health to the university was a very positive sort of thing.

And among my colleagues nationally, there are about fifteen offices of rural health that are in universities. And about, well, about thirty that are part of state government. And the rest of them are either private nonprofits, or affiliated, maybe, with the state hospital association. And I think the ones that really perform are the university-affiliated offices of rural health. They have less restriction on what they can do. In Oregon state law, our office is told to be a legislative advocate. And most of the offices that have to be in a state government department of human services, or department of health, are prohibited from lobbying. So they can't be advocates. And I think one of our greatest strengths is to be an advocate for changes in the law, changes in regulation. And if you can't do that, then it takes a lot of your potential worth away from the office.

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

CONNELL: Were there other stumbling blocks going from government, or State of Oregon regulating these rural health issues, and moving rural health to OHSU?

KNAPP: I think it went very smoothly. Resources were one of the issues. And the previous—the Office of Rural Health and state government had a contract with the Federal Bureau of Primary Care to do designations for underserved areas. They refused to transfer that contract to the university. It was a bias on the part of the federal agency. So we were unable to continue doing that. And that really goes hand in hand with getting resources for those areas.

Fortunately, we did the next best thing: we formed a really good relationship with the people at the State Health Division that were doing that work. And we began to meet together monthly and make sure that we kept each other informed and updated on what the other was doing. So it actually turned out okay. But it looked at the beginning like it might be difficult.

CONNELL: Well, what problems still exist in rural healthcare? Or have they all been solved?

KNAPP: Oh, gosh, I wish they were. I remember once testifying in front of a senate committee in Salem. And Bill McCoy, bless his heart, who has now passed on, said to me, “Now, Karen, you come here every session and you keep asking us for things. Have we finally fixed it now?”

And I said, “Gosh, I wish I could say yes.” But it’s just like another piece to the puzzle. And it’s a complicated puzzle. And there’s just not one way you can fix it. And it’s a lot like running as fast as you can up an escalator that is going down. [Laughs] And if you stop running, you’re going to sink. And you have to run very hard just to stay level. And then it takes a fairly Herculean effort to gain any, to make any gains.

I think there will always be problems with getting doctors, particularly, to go to rural communities. And in some ways, those problems are more difficult than they used to be. There are fewer people choosing primary care than used to. And often, that’s the only practitioner in a rural community, is a family physician. Even general internal medicine, if there’s only going to be one or two doctors in a community, then generally family physician is the one that you really need. Because they’re more likely to do obstetrics. And to see the whole range of pediatric patients to geriatric patients.

I think that the remoteness is something you can’t do anything about. We thought for a while that telemedicine might overcome that problem. But I think that was a hoped-for panacea that hasn’t quite come to fruition. People don’t feel comfortable always talking to cameras instead of real people. And although there are certainly some things that you can do, you can read X-rays dandy—I mean, it’s a dandy thing to do, to read an X-ray in Portland that’s being transmitted to you from Burns. But talking to the patient, reassuring the patient, delivering a baby, doing surgery—although that has been tried—I think there’s just no substitute for a real person. So I think that’s always going to be a problem.

The health of rural hospitals is always going to be a problem. Because there just simply aren't enough patients, sometimes to even pay the overhead. So they run in a continual deficit sort of situation. So it's always going to be a challenge. We can convince more physicians to be interested in rural healthcare. And things like the rural rotation at OHSU are a huge incentive for physicians to go practice in rural areas.

CONNELL: We're going to come back to that topic in a little bit. But I think what you're pointing out is that there are solutions to some of the problems that the rural health providers are experiencing. That's neat. Well, could you think of any non-medical practitioners who have stood out in the medical community in the rural health areas that you can think of?

KNAPP: Well, I think the one that comes—there are certainly some legislators that need to be mentioned. And the number one person who needs to be mentioned is Mark Hatfield, who knows more about rural healthcare than most lobbyists who lobby for rural healthcare. It was always a wonderful experience to go visit with him on Capitol Hill because he was absolutely up-to-date on everything that was happening. And I haven't seen him in about a year or so, but I understand that he still is. So all of the work that he did passing laws on the federal level, and of course assisting OHSU to locate more resources, have had a wonderful impact on rural healthcare.

We've had some heroes on the state level. Gene Timms from Burns, Oregon, is certainly a hero. Mike Thorne, who helped get our first bill passed. Len Hannon, from Ashland. And then, of course, John Kitzhaber. You can't not mention John Kitzhaber as well, who was always very approachable on rural health issues, and very supportive.

But even more so—and of course, I don't have names for all of these people, but people on a community level. In a very small community, you don't have very many leaders to go around. To be on the school board, to be on the local water board, to be on the health district board. But those are the people that really make it happen. A woman named Ramona Bishop in Burns is someone who comes to mind, who serves continually in a leadership position.

Ted and Fran Molinari, who are from Fossil, Oregon, who are willing to travel to anywhere in the state to attend a meeting of the Rural Health Coordinating Council. They get thirty-one dollars a day to do this. Work that doesn't even pay for their gas. But Fran has served on our Rural Health Coordinating Council. And her term ran out. And the governor's office said, "We've reappointed her too many times. We're not going to reappoint her again." And so Ted, her husband, stood up, and said, "Okay, I'll do it now." And so now he's on the Rural Health Coordinating Council.

And these are people who have a sense of responsibility to their communities. They feel like they have the ability to make it better, and they do. And they don't shirk from that. In Portland, it's so easy to let somebody else do it. It's so easy to just be anonymous and say, "Well, I know that we need people for the school board, and the library board, and all these various commissions." But in a rural community, you can't

duck those responsibilities very comfortably. You can do it, but then you have to assume responsibilities for why things aren't working, if you do that. So there are some very tireless people who work on behalf of their own communities in rural Oregon. And those are the people I really have been privileged to know, and have a lot of admiration for.

CONNELL: Oh, that's neat. Well, what do you think has been your greatest accomplishment? Or what has the greatest accomplishment of the Office of Rural Health been during your tenure?

KNAPP: You know, I thought about that, Sam. And I think being an advocate for rural communities, having some visibility, getting to the point where people would call us when they had a problem. An example would be the doctors in Burns were ready to give up on seeing Medicaid patients because the reimbursement rate was so low. And yet, they felt a responsibility to continue serving the people in their community.

A young man who works in the Office of Rural Health, his name is Troy Soenen, went out there and met with them. He is a guy who is very happy to work in the background, doesn't want any individual recognition. But he is individually responsible for increasing reimbursement to the physicians in frontier counties in Oregon so that women in those areas can continue to have obstetrical care. You know, he's a hero. And he doesn't even know it. He just thinks he's doing his job. But that kind of advocacy work, where he worked with the state Medicaid program, convinced them that there was a problem, came up with the solution, and persuaded them to adopt rules to make that solution happen. That's the real strength of the State Office of Rural Health.

CONNELL: Neat. Neat. There is something, and the acronym is ORPRN.

KNAPP: Right.

CONNELL: Which is the Oregon Rural Practice-based Research Network, in Oregon, which links researchers to physicians in the rural area. Can you talk a little bit about that? And your involvement in it, and what happens there?

KNAPP: Oh, I can't take much credit for ORPRN at all. I've certainly worked to try to support it. But the person who takes, who deserves the credit for that, is L.J. Fagnan. And L.J. is a person from my past, as I mentioned earlier, who was one of the family physicians in Reedsport who was part of this early immunization tracking program that I was able to do for the Oregon Medical Association.

L.J. came to OHSU about eight years ago. And he had been involved in an earlier national version of a practice-based research network. And it was his dream to make it happen in Oregon. It is so much more than a practice-based research network. But he likes to show a graph that talks about where medical clinical research is done. And of course, most of it is done in big, academic health centers. And the people who are going to be affected live out in Reedsport or Enterprise or Lakeview. So why shouldn't we do that research in those rural communities with those patients?

So he went around the state, recruited physicians, many of whom were his former colleagues that he knew well, to participate in this practice-based research network. And what has happened, he has had some luck getting funding. And certainly it was supported through the Oregon Opportunity, as one of our main rural components of the Oregon Opportunity. But he has been in a position to provide so much support assistance to rural physicians, and really make a network out of those rural physicians, who then have a real connection to OHSU. It's a powerful thing. And I'm sure it will have great results. I'm very proud to have been any part of it at all.

CONNELL: Well, I hear a great deal about it, and I think it's a significant program.

Karen, you've kind of hit upon a pivotal event that occurred in 1988 and around Joseph, Oregon, with the Enterprise group. I also—and you've talked about that a bit, but I've heard another kind of an expression of a group of people that met, and it was called the Gang of Seven.

KNAPP: Oh. [Laughs]

CONNELL: I think something that followed the 1987 Oregon legislative session. Can you tell me, what is the Gang of Seven?

KNAPP: Well, this was a group of us who were lobbyists. One of the members, well, actually there were a couple of state officials and a person who was staffed to one of the legislative committees who also participated in this group. But we got together and decided that it was time to have a different healthcare system in Oregon. Sort of a young, ambitious, arrogant way of looking at things. So we all were in some way indebted to an organization or a point of view. We agreed to take our hats off at the door, come in the door, and begin to examine, explore, what an ideal healthcare system would be composed of. And we met weekly for, I think, into the next session, so probably about a year and a half. We probably didn't make it every single week, but that was our goal. And we had some very lively debates. So for people who enjoy health policy, it was great fun to sit down with some of these people who had wonderful minds. I felt like I really didn't measure up to the caliber of the rest of them, but I was very happy to be a part of it.

So we came up with a model that we called the compression model. And we had a sort of a straight line of people who were privately insured on one side, and government-sponsored on the other side, and the uninsured people in the middle, with a gap maybe this big [demonstrates]. So the idea was that you put pressure on both sides, and you bring it together in the middle so that the little gap is only this big, instead of this big.

And recognizing that there are always going to be people that you cannot enroll, even if the resources are available. And I think, like the Canadian health system, recognizes that about five percent of the population never gets enrolled because of their

lifestyle. You know, they may be very transient; they may not have access to regular kinds of services. So you have primary care clinics, for safety net clinics, for those people.

We envisioned that not only would we grow the Medicaid program, we'd also grow the employer-sponsored programs. And so part of that would be to require employers to provide health insurance to their employees. And to provide tax credits, particularly for small businesses, to be able to make that leap into providing health coverage. And to support the safety net clinics. And also to change the state Medicaid system in some way that would make it run more efficiently.

So we were quite proud of ourselves. And we pitched this idea to John Kitzhaber and Vera Katz at the Night Deposit Café in Salem. It has since closed. But it used to be quite a hangout for legislators. And John was the Senate President, and Vera was Speaker of the House. So John liked it, and he took it. And he added some of his own elements to it, making it his own. And that was, most especially, the ordered list of services, which hadn't occurred to any of us. That was a whole new idea to us.

But when he introduced the Oregon Health Plan in the '89 session, it included all of those components, including a risk pool for people who are uninsurable, who could not get standard insurance because of preexisting conditions. And that risk pool is still in existence, by the way. It included a mandate for employers to provide health insurance and tax credits. And it raised participation in state Medicaid to 100 percent of the federal poverty level. And completely eliminated categories of coverage that were federally defined, like aid to dependent children, foster children, the elderly and the blind and the disabled. Anyone who was less than 100 percent of the federal poverty level could join the Oregon Health Plan. And they were subject to a restriction of coverage that had to do with the list of paired diagnoses and treatments that the state actually came up with during a series of statewide meetings. So there was a lot of public input to this whole process.

And it all passed. Which was astonishing. Associated Oregon Industries even supported it. And, you know, we were all euphoric. We thought that was probably the best thing that ever happened. But they did put a later implementation date on the employer-mandated insurance. And sure enough, leadership had changed by the time the next legislature came into session, and they repealed that part of it. So there could not be overwhelming success without all—you know, it's like a three-legged stool. You had to have all of the parts working together, or it just couldn't work. Because the idea was to eliminate the cost shift. And if it had actually happened, it would have done that.

CONNELL: What an accomplishment. Do you recall any of the names of the participants in your Gang of Seven?

KNAPP: Well, you know, I have come up with all the names but one. And I have been unsuccessful in conjuring up that seventh name. But Barney Speight, who was, at the time, a lobbyist for Kaiser, and certainly one of the smartest men I have ever

met in the field of healthcare. He is now part of the Department of Health in the state of Washington. Dick Grant, who at the time was head of the State Health Planning and Development Agency, and eventually became the head of the AHEC program at OHSU. Tom Lundberg, who is a healthcare economist and consultant, and he eventually went to work for Good Samaritan Hospital. Now I'm missing more than one. Bruce Bishop, who is a healthcare lobbyist and attorney. At the time, he was staff to one of the healthcare committees. And I think that's all I can remember right now.

CONNELL: Ed Patterson?

KNAPP: Ed Patterson. Of course.

CONNELL: Was Scott Gallant involved with that?

KNAPP: No. He sent me to do that. Scott's a little cynical.

CONNELL: I keep hearing his name involved with your career as well.

KNAPP: Oh, he was my boss at the OMA.

CONNELL: He was your boss.

KNAPP: Yes.

CONNELL: Oh, okay. So he's the one who directed you to be involved in this. Well, he was very smart to have done that.

KNAPP: Oh, thank you. [Laughs] Well, Scott and I worked well together. We especially did good cop/bad cop well together. I always got to be the good cop, fortunately. But every now and then, we'd just get people off balance by letting me be the bad cop. Which is not a very comfortable role for me.

CONNELL: So what was the relationship, then, between—and I know it's a close relationship—between rural health and the Area Health Education Centers, and the issues of critical access to hospitals?

KNAPP: Well, I like to describe the relationship between AHEC and the Office of Rural Health as sort of a supply and demand relationship. The Area Health Education Centers are all about training health professionals. Not just physicians, but nurses and allied health. And making sure that rural areas have the health workforce that they need. And they do this in a variety of ways, including pipeline projects in communities, and helping to host students and residents in rural communities. But they're really all about supply.

And on the other side of the equation is the Office of Rural Health, which is really about demand, and about demand for services and assistance, and particularly, technical

assistance, to support the people on the other side, and rural hospitals as well. So it's a good way of explaining it, at least in my mind. I don't know if I always convey it well.

CONNELL: You know, it seems to me that in part of your activities, you've been involved with the rural healthcare providers. You've been involved with the legislature. How does this extend to the federal government, to Washington, DC? What has been your involvement there as well?

KNAPP: Well, certainly we've always made annual or semi-annual visits to Washington to talk with our congressional delegation about what can be done on the federal level. And sometimes, it's really the role of the federal government to do some of these sweeping kinds of changes and access to resources that people need. There's much more federal money available for rural healthcare than there was when I first began. They created the Federal Office of Rural Health Policy in about 1988. And I began in 1990. And there were twelve state offices of rural health at the time. We were one of the oldest. North Carolina is the only state office that's older than the Oregon state office.

And they set about to build a network of state offices, one in every state. And they succeeded. There are now fifty state offices of rural health. And I think you can argue about whether or not New Jersey needs an office of rural health, [laughs] or Maryland. But you know, rural is a relative sort of thing. So those people feel like they are rural, and to them, you know, that is a reality. So they certainly helped to build up a powerful network of people who could contact their own state representatives and senators and explain what the situation was in their own states.

So since then, we have seen rural health outreach grants that are available to individual communities, or coalitions of providers. Network grants, rural health research centers, and—probably the one that we have been most active with was the Medicare Rural Hospital Flexibility Act. And that created a special class of rural hospital that would be supported by cost-based Medicare and Medicaid reimbursement. So that made a huge difference for the rural hospitals in our state, and provided a lot of resources for our Office of Rural Health to continue to work with rural communities. And there are now, I think, 21 or 22 what they call critical access hospitals in Oregon. Certainly maybe half of those hospitals would not be open, they would have failed, if there weren't that additional amount of assistance available to them. So I love to say to people, this is a government program that really works.

CONNELL: That really works. Well you know as a kind of overseer and dealing with a lot of governmental departments, and so on, you actually had to be kind of a lobbyist in Salem, and certainly further east. How has it been? How has your experience been with dealing with the legislature and trying to convince them of the issues in rural health and what your goals are?

KNAPP: Well it's been, overall, a very positive experience. One of the best things about lobbying for rural healthcare is that it is a completely bipartisan issue. And I don't know how that ever happened, that we resisted politicizing it. Because so many

issues that on the face of it seem very reasonable and don't seem to support any particular political position, nevertheless become allied with one party or the other. So we were able to work with equal access to Republicans and Democrats, with our governors. We've always had good relationships with the governor's office and with our congressional delegation, and often found our congressional delegation crossing party lines in order to work with each other on rural health issues. So by and large, it's been a very positive experience.

And for me, who am certainly more to the left side of the aisle than the right side of the aisle, personally, it educated me on the good intentions of people with whom I sometimes don't agree politically. And I made some very deep friendships with Republicans that surprised me. [Laughs] So it kind of restored my faith in human nature.

CONNELL: Well, your ability to interact with people is outstanding. So it doesn't surprise me that you were able to accomplish all this.

KNAPP: Oh, thank you, Sam.

CONNELL: I would like to move on to another area, and to bring up a couple of names. And first of all, I'd just like to ask you if there are certain medical practitioners that were most unforgettable in your career.

KNAPP: [Laughs] Well, the person that comes to mind first, who was a personal mentor to me, is Ginny Burk. Ginny was an anesthesiologist out in Clackamas County. She was on a committee with me back in 1984 that addressed the informed consent issues surrounding breast cancer. So she chaired this committee. And the OMA set about to put together a publication to distribute to physicians about how to do proper informed consent. And it included a brochure that would go to their patients that would explain to them all of the various treatment options, and give them some resources to turn to, and help them to make good decisions about their treatment. So we worked on this for about a year.

You've heard about Ginny before, and she was a bit irascible. And she was sometimes not very diplomatic. But she was generous of spirit, and she was absolutely committed to whatever she undertook. And she and I just formed a very fast friendship.

At the end of that year, after we had published the brochure, I found a lump in my breast. And so I talked to Ginny about it. I went to the doctor, who said, "Well, this doesn't really show up on the mammogram. I think you ought to just stop drinking coffee for six months, and come back." And I heard Ginny saying, in my head, something that I can't say on the camera. But, you know, "Horse feathers. That's not what we're going to do."

And I talked to her about it, and she encouraged me to demand a biopsy, which I did. And it turned out to be malignant. And she was my best mentor and friend during that time. I said to her about ten years later, "You know, I think you saved my life."

And she said, “Yes. I did.” [Laughs]

But she was just an amazing woman to me, both professionally and personally. Being the president of the OMA, having the forceful personality that she had. And she grew up in rural Oregon. She grew up mostly in Baker City. And when she went to take her anesthesia boards, it was the first time she ever wore a skirt.

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

KNAPP: [Laughs] So, she had wonderful stories to tell. She had her husband, from whom she was divorced, was an undertaker in John Day. And she told wonderful stories about the funerals, and how all the cowboys would ride up the hill, and there would be an open grave there, and they’d all fall in. They’d all ride up the hill and fall in. Because they were all drinking. And she had great stories to tell. She was a wonderful friend, to me and to my children, both. So I really value her.

Having said that, there are many, many others with whom I was so privileged to work. Harold Osterud.

[brief disruption]

CONNELL: Karen, we were just talking about some of the most unforgettable individuals. Characters, if you will.

KNAPP: Right.

CONNELL: In your career experience. And you had mentioned your involvement with Dr. Ginny Burk, an anesthesiologist, with regard to having a malignancy, breast cancer. So the question comes to mind that as an individual who is helping to form healthcare issues and what’s happening in healthcare, and then stepping over to the other side as a user of healthcare, what did that experience bring to mind to you?

KNAPP: Well, I have to say I’ve never been a big fan of consuming healthcare. I consumed all the healthcare I really wanted to that year. But I think I had a distinct advantage, working here at the OMA. I had a lot of advocates. And the doctors that I went to see were people that I already knew and had confidence in. And they took very, very good care of me. So it could have certainly been a worse experience.

Chemotherapy at that time was a little more brutal than it is now. And they were really shooting a gnat with a shotgun at the time. So that was a very unpleasant experience. But I had a lot of support from the doctors I was seeing, and from the colleagues at the OMA. It has been more than twenty years.

CONNELL: Wonderful.

KNAPP: So I have been very fortunate.

CONNELL: A very exciting success story.

KNAPP: That's right, I feel very—thank you, Sam. I feel very lucky.

CONNELL: And you were connected with the right people at the right time.

KNAPP: I was.

CONNELL: And did get some good advice. Who else in your career have you met in the medical field who are unforgettable characters?

KNAPP: Well, I have to talk about Harold Osterud.

CONNELL: All right.

KNAPP: Who was just the dearest, most lovable man I think I've ever met. Maybe I should exclude my husband.

CONNELL: Jerry is a neat person.

KNAPP: Yes.

CONNELL: What was Dr. Osterud? What was his position? Who was he?

KNAPP: He was the chair of the community health department at OHSU. He was very interested in what we called, at the time, manpower. We now call it workforce. But he had been working on this for a long time. And the person that he worked with at the OMA was someone called Lee Lewis, who subsequently left the OMA to go to work at OHSU. And I think that I sort of naturally assumed her place there to work with Harold, because I was staffing the public health and safety committee.

And my first introduction to Harold was he would show up at the OMA, without notice, usually. With his white clinician's coat flapping. He never buttoned it. He never took the time to button it. But he'd come in with it flapping, and he was just one of the most endearing and committed people I've ever known. And we became very fast friends, he and his wife, also.

CONNELL: What were some of his accomplishments?

KNAPP: Well, I think Harold had—he knew where all the physicians in Oregon were. They ran around in his head all the time. And I tried to explain his sort of reputed absentmindedness by telling people that. You know, if you've got all the physicians in

Oregon running around in your head, then you're not always going to remember all of the mundane details of life. But he was very concerned, not only that we have enough physicians, but also that we're training the right kinds of physicians. So he was alarmed by the growth in specialties and the decline in primary care, and the decline in general surgery.

And I don't think that any other state had the kind of data that Oregon has to really track, way back into the mid-1970s, the changes in our physician workforce. And looking at the trending, and the increase, for example, in women physicians, which is very significant, and the changes in ages of physicians as the workforce gets older. So it's important to know those things, so that you can make sound policy decisions. And I don't believe we'd have ever passed our rural health bill back in '89, if it hadn't been for the data on declining numbers of physicians in rural areas. So it's a very important adjunct to policymaking.

And Harold didn't limit himself to that. He had a serious motive to pursue social justice. And he never met a windmill he didn't like to tilt at. So he went off in many directions. And I think that one of Harold's finest hours was at the OMA House of Delegates. The public health and safety committee was embarking upon a project—and this would have been in the mid 1980s, probably—to examine the effect of the fears of nuclear war on children's development and their learning processes. And the fear was—and there was quite a national movement in this direction, maybe international movement. The fear was that children felt that nuclear war was inevitable, so they were not feeling encouraged to really make substantive plans for their lives. And it was kind of a general depression sort of thing. And we were concerned about how this was affecting their development. And the Physicians for Social Responsibility were very involved in this, and Harold was part of that.

Well, the OMA was, and remains, a very conservative organization. So we took this to the OMA House of Delegates, because that's the way policy is developed at the medical association. It's all kind of a legislative model. So you have to take the committee recommendations to the House of Delegates and get them approved. And we knew this was going to be controversial. But a doctor stood up at the reference committee meeting, or the hearing on the proposal. He was from Washington County, and he was very, very conservative. And he started talking about how ridiculous this was. And he called Harold a "Jane Fonda doctor." [Laughs]

And I think it was really one of his finest hours. He was not a man who was large in stature. He was small. He stood up, and he just kind of shook for a few minutes. And he turned very red. And then he wheeled around, and just let this doctor have it about letting politics interfere with his concerns for his patients and for the children in the community. And he got applause for that. It was really—I was so proud of him.

But he always was very concerned about, very committed to public service. Very concerned that the Oregon Medical Association would move in that direction. So I think that it was really his influence that led the OMA into a lot of public service and

community service types of projects that they probably wouldn't have pursued without him.

CONNELL: So he was really a mover and shaker then, with regard to the OMA.

KNAPP: Oh, well, he was, yes.

CONNELL: Now I understand that he had also, prior to his demise, that he had written, or has written, material regarding the history of public health in the state of Oregon.

KNAPP: He has, yes. He did. He became involved in a sense of history as he became ill. And he was ill for quite a long time. He started out with a brain tumor that was successfully resected. And then it grew back, and then it finally became malignant. So this went on over a period of about five years. And he and I worked together all of those years. He would write things, always in longhand, in pencil. I would transcribe them and edit them and give them back to him. And that's where his attention went toward the end of his life.

He did write a history of medicine in Oregon. And he started with—I'm trying to think of this man's name. He, this man, was on a galleon, a Spanish galleon, but he was English. And he landed on the Oregon coast as the result of a shipwreck. And sort of became part of the native population there, and didn't leave. And so he was really the first practicing doctor in Oregon. And he has a lot of very interesting little facts like that in his manuscript. I've turned that over to the history department at OHSU. But I have to confess, I kept a copy of it for myself. And I still have a few pages that I've found that he wrote in longhand that I'm not sure ever got transcribed. So that will be one of my retirement projects, to make sure that all of that information is in one place.

CONNELL: Fantastic. It will be fascinating to read all of that information. Are there other individuals that you would like to cite as unforgettable?

KNAPP: Well I have to mention Dutch Reinschmidt, who was my mentor both here at the OMA and at OHSU. Dutch was—in a world of very remarkable people, lots of them, and lots of people that I felt very privileged to work with, I don't know that there was anyone I admired more than Dutch Reinschmidt, who was a humble man. But he was very active at the Oregon Medical Association. And of course, he was an associate dean in the School of Medicine. And he provided a very effective bridge between the two institutions. And I knew from very early on in my tenure at the OMA that if I wanted the truth about something, I would go ask Dutch. Because he was simply incapable of being devious or manipulative. If he knew it, he told you what it was. So if I was trying to make a decision about something, I counted on his counsel to show me the right way to go. And he never failed me.

He and I then worked closer together when I went to the university. And he was the one who actually approached me about the job in the Office of Rural Health. He said,

“There’s a job at the university that’s absolutely perfect for you, Karen.” And I was quite happy at the OMA, because I was so fond of the people that I worked with, and the doctors that I worked with. I was reluctant to leave.

And when I was going through my files before I left my office, I came across the file that related to my hiring. That must have been there from my predecessor. And I’d never found it or looked at it. And I realized that the filing date for this position was the twenty-ninth of December, 1989. And I submitted my letter of interest and resume on the twenty-ninth of December, 1989. So I had a real difficult time coming to the decision whether or not I should apply for the job. And I’m really glad that I did. Dutch was absolutely right. It was a perfect place for me to land.

CONNELL: Well, we’re certainly glad that he had the foresight to bring you to OHSU.

KNAPP: Thank you, Sam.

CONNELL: All right. Can you think of any other individuals that you would like to comment on?

KNAPP: Well, I think that Dave Jones, the PA in Condon, has made an enormous contribution to healthcare in Oregon. And his business partner, Dennis Bruneau, the same. I think that there are a number of rural doctors. Bob Bomengen in Lakeview. George Waldmann, who practiced in Madras. Chuck Hofmann, who practiced in Baker City, still does, has been the mayor of Baker City. Some very, very strong personalities who have made just a huge contribution to healthcare. And of course the people that stand out at OHSU that have been so patient with me as I learn my way, and so supportive of the work that we do: Pete Kohler, Lesley Hallick.

When they asked me to become a vice provost, I was really just stunned. And I said to Dr. Kohler, “I don’t have the credentials to do this job. You can’t, you can’t give me this job, because I don’t have the credentials.” I have a bachelor’s degree from Portland State University, and I’m in this heady academic atmosphere.

And he said a very kind thing. He said, “Your experience and your reputation are your credentials.” Which I think speaks so well for him. And made him such a wonderful person to work for, and with.

And certainly, Lesley Hallick and I became very, very close from the very beginning. We just communicated really well. And she has also been so supportive of what we’ve done. And almost never—I don’t believe she ever, in the sixteen years that I worked for her, ever said, “Karen, do this.” She never gave me any direct orders on what to do. We met together often. We talked about some options. And sometimes some pretty dicey, delicate political decisions. And she always helped me make decisions. I never felt that she was telling me what to do. And she always respected my point of

view. Very few people have that kind of advantage in their jobs. I always knew that I was just very fortunate to be where I was.

CONNELL: Well I believe that Lesley Hallick had the greatest confidence in your leadership and your decision making, and that's why your tenure has been so very, very successful.

KNAPP: Oh, well, thank you, Sam. I think her leadership had a lot to do with that.

CONNELL: You were certainly a valued member of the vice provost group. And we are going to miss you. I wanted to go back to something, if I could, just for a minute, Karen, something that we were mentioning when we talked about Ginny Burk, and the number of women that were practicing medicine. There's kind of been a change in the number of women physicians within the state. What do you think has brought all this about? Why are we seeing increased numbers of women going into the profession?

KNAPP: I'm not sure I can answer that for you. I think we've had some general societal changes. The profession itself is changing. In that I don't believe the men, or the women, who are going into medicine are content to work eighty-hour work weeks, ninety-hour work weeks anymore. I think that they've become more aware of their role in raising a family. Both parents' roles, and the importance of dedicating time to their family. And I think most of the young medical school graduates that we talk to about recruitment and so on, they want a better quality of life. And that sometimes really helps them to choose rural practice. But not if they're going to be the only doctor in town, so they're never going to have a day off. And they may be on call all the time, and can't leave town, because they can't find anyone to do a *locum tenens* for them.

So I think we're just seeing the reflection of some changes in our culture and our society that more women feel that they can choose that opportunity. Certainly when I was growing up, almost no women—if they were interested in medicine, they became a nurse. And, you know, women were nurses. And they were teachers. And then they became social workers. And they were in the helping fields. And that was traditionally what women did. And I was fortunate to grow up in an environment where my parents encouraged me to do whatever I wanted to do.

CONNELL: It's very important. Tell me about something of your accomplishments. And I know that you're well known for collecting data on the numbers of physicians. Their ages, the kind of practice they're involved in. Could you tell us a little about how you collected this information and what did the data that you collected show? And how are we going to, if there are any problems, how are we going to resolve them?

KNAPP: Well, I think first of all, it wasn't my job solely. I had a partner. You know, Harold was my partner in doing this. And then when he was no longer there, I just carried on. And it's very interesting. The trends are fascinating in Oregon. And what

we're seeing now is something we have never really seen before. The shortages—particularly in the metropolitan areas—are not in primary care. We did a very good job of directing physicians, particularly here in Oregon, into primary care specialties. They're occurring more in the high-risk specialties and sub-specialties.

And if you should try in Portland, for example, to make an appointment with a gastroenterologist for a colonoscopy, you may—I mean, no one really wants to do this, but sometimes we have to [laughter]—it might take you three or four months to get an appointment because there is such a shortage of gastroenterologists. There's a shortage of neurosurgeons. There's a shortage of orthopedic surgeons and plastic surgeons, and all kinds of, particularly in surgical, but also in some internal medicine subspecialties.

Which may reflect maybe a number of things happening: the aging of our population. So the demand goes up. And we didn't plan for that very well. We knew this was going to happen. We hoped it was going to happen, particularly those of us in our age group, but we didn't plan for it very well. And I think that the malpractice environment has something to do with it. Neurosurgeons are shying away from very complex and high risk cases. Family physicians, and even obstetricians, are giving up delivering babies because their premium goes up just exponentially if they're doing deliveries.

There was a situation down on the southern coast, it was Reedsport, where the surgeon left, and the three remaining family physicians didn't feel comfortable doing C-sections. But they were willing to do it. And their insurers wouldn't let them, wouldn't indemnify them to do C-sections. So they managed to recruit another surgeon. And he said, "Sure, I'd be happy to be a referral source for you for C-sections." He took that to his insurer. And it took his—I'm trying to think of the exact numbers. It took his malpractice premium from \$27,000 to \$67,000, if he did one C-section a year. Well, you're not going to get, you're never going to make your money back on that one. So he could not afford to continue. It wasn't that he didn't want to, or that he wanted to make a lot of money. He simply couldn't afford to do it. And so the women in Reedsport now have to go to Coos Bay for all of their obstetrical care. And this just doesn't encourage people to go into obstetrics, particularly in rural areas.

But for the first time, we're seeing shortages in the metro area, that we've certainly kept track of all these years, because the comparison is a worthy undertaking. You know, to compare urban and rural. But it's a whole new type of situation now. And I'll be very interested to see how it plays out. I know that our School of Medicine, Joe Robertson is very interested in working with these numbers, and making sure we train the kinds of physicians that we really need.

CONNELL: You bet. You know, one of the other problems that—when you say that there is a shortage of physicians throughout the state, when we talk about that shortage, do we know that the shortage is due to physicians that are choosing to practice only two to three days per week because of a lifestyle? And/or have some of those

physicians moved into hospital administrative positions, and/or are doing other kinds of consulting and maybe computer programming in the medical field?

KNAPP: All of those things.

CONNELL: How do we find out who is actually seeing patients?

KNAPP: Well, this is such a good question. Because by counting licenses, we don't really know, and even though we do a superior job of counting licenses for the workforce data that we accumulate here in Oregon. We look at physicians who claim to be in active practice, and who are actually residents of the state and practice in the state. And often, when you just do a quick collection of data, you just look at how many doctors are licensed. Well, if we have about eleven, twelve thousand doctors licensed in Oregon, but only eight or nine, somewhere between eight and nine thousand of them actually practice here. There are people who maintain an Oregon license who work in Missouri. Or who are in the military. Or are missionaries and working somewhere on the other side of the world. So we try to do that the best we can.

But having said that, there are people like Pete Kohler, who's counted in there as an endocrinologist. And you know that he's not practicing forty hours a week in his specialty. And doctors who are very involved in administering insurance programs, or in hospital administration. We continue to count them, because you just can't go around, talk to every one of these people and say, "But are you really seeing patients?"

Now we know that in our tax credit database, the rural doctors—because we ask them, how many hours a week do you see patients? And the OMA has been doing a very good job of collecting that type of physician productivity data. And Harold was actually the one who started doing that, saying, "How many hours of work a week do you work? How many hours do you spend seeing patients? How much time do you spend on administrative tasks?" And occasionally, you have to collect that data. But then, making the connection between the raw numbers and that productivity data is a bit of a leap that may not always be defensible.

What we ended up assuming, on the basis of the OMA's surveys, is that about 85 percent of the licensed physicians in the state are actually seeing patients. And so we began applying that ratio to the overall numbers. And it made much more sense that way. And to just make the assumption that most researchers do: that everybody, if they have a license, that they're practicing, seeing patients.

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

CONNELL: Some of the communities actually are not covered by a physician. Are there some doctors that are kind of on a circuit?

KNAPP: There are some.

CONNELL: That are practicing in several communities today?

KNAPP: There are some. It's not a popular kind of job, as you can imagine. There used to be a doctor in Bend, who's a psychiatrist, who provided mental health coverage to six or seven different rural countries in central and eastern Oregon. He did that for about fifteen years. Until he just got tired. And he was the only psychiatrist that those counties had available to them. But what he did was train a lot of nurse practitioners to prescribe psychoactive drugs, to monitor their patients. So he created a kind of an informal specialty among nurse practitioners and PAs, so that they could enhance the kinds of services that they could provide in those communities.

But generally speaking, mental health in, oh, Pendleton, Burns, Baker City—when someone has an acute episode, they go to the jail. The only secure place. They have no secure psychiatric beds in those communities. So they put them in jail. And then they transport them in the back of the sheriff's car, whenever they can, to a place that does have a secure facility. So it's a very primitive way of treating acute schizophrenia, for example. And by virtue of the fact that they are east of the Cascades, the outlook for their recovery is not as good.

And we found that out also with breast cancer, as a matter of fact. The year after I recovered and was feeling sort of up to snuff again, and ready to take on a new project, we did a survey of breast cancer patients in Oregon. The OMA was very kind to me in giving me a sort of a free rein to do this. They understood that it was important to me personally. And Ginny Burk helped me do this. We had a committee of physicians who helped with it. We put ads in the paper in virtually every city in the state, asking them to call a toll free number to tell us: If you have had breast cancer, we want to hear from you. And we had 1200 responses.

CONNELL: Wow.

KNAPP: And then 900 of the 1200 filled out this huge questionnaire, which I later learned that you can't ask every single thing you want to ask in one survey. But it was like, oh, I can't resist this, I've got this opportunity to ask questions. So we had nine hundred and some that were returned to us. And I think that it was about eight pages long. It was a long survey. And what we found out was that women who were diagnosed in rural areas were more likely to have had their cancer spread to their lymph nodes at the time of diagnosis, and were less likely to have been diagnosed by mammogram.

This was, of course, about twenty years ago. So hopefully things have changed some since then. But there was a genuine difference in health outcomes, simply because someone lived in a rural community. It may have also had to do with social and cultural sorts of differences. People who live in rural communities are rather independent, maybe less likely to seek medical help. There are some studies that show that when they do seek medical help, they're sicker. And they have more days of disability than people in urban

areas. But fewer doctor visits. So they're sort of independent people. And they've had to be, because there may not be anyplace for them to go to, to seek medical help.

CONNELL: With regard to the shortage of healthcare providers, physicians, in the rural communities, what we tend to do in medical education is bring people from the rural areas, and the urban areas, as well, to an urban medical school, where they train and learn, and learn how to access all of the instrumentation, modern technology—

KNAPP: Sure.

CONNELL: Up-to-date technology, as well as all of the laboratory services they might need. And they have that seven days a week, 24 hours. Once people have become accustomed to having these kinds of facilities available at their fingertips, how do you convince them that they ought to go out the rural area where they don't have an MRI?

KNAPP: Well, that's where I think tele-health could play some role. And certainly, tele-radiology is important. And OHSU has a wonderful call service that we sponsor for rural physicians. They can get a curbside consult free on their patients by simply calling that OHSU consult line. And so they're not completely alone in making decisions if they don't have a peer to consult with in their own community. And I think that training physicians in such a way that they have an opportunity to experience rural practice, the way we have done with our clerkships at OHSU, is just a huge advantage.

One of my very favorite stories is, I was over in the Department of Family Medicine, involved in a meeting. And they were talking about the rural rotations. And there was a second-year resident, family medicine resident there, who was telling me that he started out as a neurophysiologist. He had a PhD in neurophysiology, and had every intention of becoming a neurologist and probably going into some sort of research. And then he did his rural rotation. And he so respected the work that was being done by the rural physicians, and he so liked the little town that he was in, that he changed his specialty to family medicine, and intended to become a rural family physician.

So those things work. They absolutely do work. And it's often the most favorite rotation of our medical students, to be able to go into rural Oregon. They all have to complete a project that involves the community in some way, whether they're working with the local health department or the local medical community. Trying to figure out why there's a high incidence of domestic violence, for example. The archives of all of those projects, that they keep in the AHEC office, are just a treasure of wonderful information about rural communities. And I think that people don't look at them very often. And that's too bad. Because a lot of important work has been done there.

CONNELL: How does the AHEC help facilitate these rural rotations?

KNAPP: Well generally, there are four AHECs in the state, roughly in a quadrant sort of design. And they take responsibility for finding housing for the students, for providing local support for them. So they play a very big role in that. They also do

something every year called MedStars, where they bring rural high school students in to the OHSU campus. And they spend a week there. And they go to the anatomy lab, which is one of the most popular activities that they have. They go to the dental school. They go up and sit in on a nursing class in the nursing school. And they learn what it might be like to be a student in some healthcare field and go to OHSU. And so that's a very successful sort of endeavor for them. You know, it's like it's fun for them.

The hardest part of this is that the poor staff that work over in the AHEC have to act as chaperones. And have to go live in the dormitories with the students, who, as you can imagine, don't sleep at all, for hardly an hour during the whole week. They're so excited. So it's very exhausting for the people who work in the AHEC. But it's very rewarding at the same time.

CONNELL: You bet. Well, Karen, using your predictive powers, what do you see in the near, and in the long term, for Oregon's medical workforce?

KNAPP: I just hate to say this. I don't think I have any predictive powers. I think until we resolve the medical liability issue, that we're going to continue to see reactions to it that may be perceived, or they may be real, but the reaction will be the same. I think that some people tend to overreact. And particularly when they go to seek a solution, may not be looking in the right direction. But it certainly has an impact on physicians. And it's a very, very high priority with them.

And the legislature, at the urging of the governor, passed a bill two years ago that would provide a subsidy for malpractice insurance for rural doctors. It pays 80 percent of your premium if you are a rural obstetrician; 60 percent if you are a rural family physician who does OB; and 40 percent for everybody else. Now, what has happened here is that the insurance premiums have risen now to the point where the discount brings them about even with what they were paying two years ago. So if that discount goes away, which it is scheduled to do next year, then it will have a cataclysmic effect on the retention of physicians in rural communities. And at the time, there were a number of people who didn't really support this proposal. I think the OMA came to it very reluctantly. I mean, they wanted to help the rural physicians, but they felt that it was giving the legislature an excuse not to deal with the root causes of the problem and simply treat the symptoms. And certainly they were right about that.

I think there's very little political will to enact the rather profound legislation that would help to change this situation. And I don't agree with all of the proposals that have been bandied about. I don't think that capping damages is really going to help. But I think we need to look very, very hard at the insurance industry, and make them more accountable for increases and premiums. There's no simplistic or simple answer to this. But it is going to have an impact on our healthcare workforce.

CONNELL: Absolutely. That is certainly a tremendous issue that needs to be resolved. Are you aware of any changes that Oregon Health & Science University is

making to increase medical manpower within the state? Such as training of medical students in other sites within the state?

KNAPP: Well, they certainly are embarking upon a plan for regional education. They're increasing the incoming medical school class. I think they're responding in a very responsible way to the perceived upcoming shortages. The problem is, the pipeline is so long. So between the time somebody hits you in the knee, and the time your foot rises, is maybe a decade. So it's just not easy to respond in any kind of a quick way. But I think the information that we have has convinced Dean Robertson and others at the university that we need to act as quickly as possible, and they're doing that. I think it's a very responsible thing for them to do. That may not have always been the case. Sometimes people like to wait until we actually have the crisis in front of us before we do anything. But they're reacting really rather expeditiously. I'm very proud of them for doing that.

CONNELL: Absolutely. Well, Karen, you know, you've been involved in the healthcare issues, and rural health, for many years. And the whole field is mostly dominated, or has been dominated, by men. So as a woman in a male-dominated healthcare field, have you at times felt somewhat discriminated against? And kind of pushing against a solid block?

KNAPP: [Laughs] I don't know if I'd call it discrimination. It certainly was a challenge. When I began at the OMA, I had to work primarily with male physicians. There weren't very many women. And the way things happen at the OMA is with committees. It's a committee structure. And they have staff people that help to staff those committees. So I would have to prove myself to each new committee that I staffed, and each chairman that I worked with. And I remember one committee, I was staffing the pharmacy and drugs committee. And this was a new assignment for me. And I went to the first meeting.

And of course, all these meetings were in the evening, because that's the time when physicians can attend. And it was very impressive to me that some of these doctors were traveling across the state to attend these evening meetings with no compensation. They didn't even pay their mileage. It was totally voluntary on their part. So I felt a great deal of respect for them for wanting to improve their profession and giving their time.

But this doctor, who was a local anesthesiologist, introduced me to the committee as the committee's secretary.

CONNELL: Oh, boy. [Laughter]

KNAPP: So I tried to be as discreet and gentle as possible. And I suggested to him and the rest of the committee that I was not a secretary. That I actually had a secretary. And that I was there to be a resource to the committee. And explained why I was there, that I would do research for them, that I would do policy development for

them, that I would write position papers for them, help them carry their message to the OMA House of Delegates. And Dr. Schaff, his name was Paul Schaff, bless his heart, felt a little chastened by that. But we actually became very, very good friends. So apparently it was the right way to respond. But I needed to let them know. And I had to come up with a gentle way of doing it, without just having a knee jerk reaction. And that was pretty much the case with most of the committees I worked with. But it was a little bit of a process.

But you know, I grew up in an era where men's and women's jobs were listed separately in the newspaper. Where sexual harassment was not only tolerated, but encouraged. And so I was content making progress in small steps. I didn't feel discouraged by this. If I'd not been making any progress at all, certainly I would have. And I was raised—my mother was a professional woman. And my father, in addition to teaching classes, his main job at Southern Oregon was basketball coach, and baseball coach. He was the athletic director.

CONNELL: Terribly important there.

KNAPP: Yes. Well, he raised me. He didn't have any sons, and there was my sister and myself. So he was the more nurturing of the two parents. And so he raised us like boys. And so it never occurred to us that there would be limitations because we were women. He never conveyed that to us. And so we just proceeded forward with that in mind. So we never felt like we were prepared to be victims at all. We were self confident. And so we were very fortunate.

CONNELL: Well, you certainly have proven yourself as a capable individual.

KNAPP: Thank you, Sam.

CONNELL: Karen, you know, things all of a sudden happen quickly. And your retirement came so very, very quickly.

KNAPP: It certainly did.

CONNELL: At the height of your career, you're retiring. So what are your plans now? What are you and your husband, Jerry, going to do?

KNAPP: Well, I think I have always felt like I would like to explore my artistic endeavors. I enjoy painting. I enjoy drawing. I'm very anxious to have my husband teach me more about working with clay. Because that's what he does, primarily. He's a very accomplished artist who can call himself an artist. I've never felt quite comfortable calling myself an artist, although he calls me an artist, which is very nice. So I think initially we'll explore some of those things. And have the time to paint and draw and sculpt and do the things that we've been dreaming of doing, that you don't have time to do when you're working full time.

Having said all of that, I'm not kidding myself into thinking that I can remain distant and uninvolved in what's happening around me. Because I've always felt a need to sort of make things happen, or participate in making things happen. There will be lots and lots of opportunities for me to do that with the expatriate population in Puerto Vallarta, who get very involved in things like aid to local children and the local—they run two local animal shelters, for example. And I'm sure there's a spot for me there somewhere, where I can feel like I'm making a little bit of a difference.

My dad, whom I admired so much, I'm sure you've caught that from the way I talked about him, said, "There's really only one thing you need to do." And I suppose this sounds like a cliché. But he said, "You just need to leave the world a better place than you found it." So don't set out to change the world. Just find your own little corner, and kept it clean swept and well lighted. So I've had a wonderful little corner here in my profession. And I'm sure there's another little corner for me somewhere.

CONNELL: Oh, I know there will be. [Laughter] You're a very active individual. And there are great things yet to come. But anyway, I want to thank you for your career in rural health.

KNAPP: Thank you, Sam.

CONNELL: And at OHSU. You've been an important individual. You've had significant accomplishments. And with a tremendous amount of effort. And we wish you the very best.

KNAPP: Thank you.

CONNELL: And we want to thank you. Do you have any last comments that you would like to share with us?

KNAPP: Well, I think it's really important to give credit to all of the people, like you, that have been kind and generous to me. You know, one person never accomplishes things all alone. I've had a wonderful staff at OHSU. I've had bosses who were supportive of what I did. I just feel very fortunate, and very privileged to do the work. And when I hired people to work for me there, I said to them, "It is a privilege to do this work. And if you don't feel that way about it, then you won't be very happy here for very long. If it's just a job to you, then you probably won't stay with us for very long."

Because there's so many, many rewards to feeling like maybe you helped to do something that made people more safe. We got funds to buy ambulances and medical equipment for rural communities that we know saved some lives. So that's a privilege to be able to do that kind of work.

CONNELL: Yes.

KNAPP: And I just have been very, very lucky. And I'm very grateful for it.

CONNELL: Well, thank you.

KNAPP: Thank you, Sam.

[End of interview]

INDEX

A

AHEC (Area Health Education Centers), 5, 7, 15-16, 27-28
Ashland (Or.), 1-2

B

Bishop, Bruce, 15
Bishop, Ramona, 11
Bomengen, Robert, 22
Bruneau, Dennis, 6, 22
Burk, Genevieve, 17-18

C

Carlson, Bruce, 6, 7
Carlson, James, 4

D

Dernedde, Robert, 3, 8
Duke University School of Medicine, 6

E

Enterprise (Or.), 4
Euhus, Lowell, 4-5

F

Fagnan, Lyle J., 3, 12-13

G

Gallant, Scott, 15
Grant, Richard, 15

H

Hallick, Lesley, 22-23
Hannon, Len, 11
Hatfield, Mark O., 11
health manpower, 10, 19, 20, 23-26, 27, 28-29
history of medicine, 21
Hofmann, Charles, 22
hospitals, rural, 11, 16

I

immunizations, 2, 3
insurance, health, 13-14

J

Jones, David, 6, 22

K

Katz, Vera, 14
Kitzhaber, John A., 11, 14
Kohler, Peter, 7, 22, 25

L

legislation, medical, 4-5, 10, 13-14, 16-17, 20
Lewis, Lee, 19
Lundberg, Tom, 15

M

malpractice, 4, 24, 28
McCoy, Bill, 10
Medicaid, 13-14
Medicare, 16
mental health services, 26
Molinari, Fran, 11
Molinari, Ted, 11

O

Office of Rural Health, 5, 6, 7-9, 15-16
Oregon Health Plan, 13-14
Oregon Medical Association, 3, 20-21, 25, 26, 28, 29
Oregon Office of Rural Health, 4-5, 6, 8
Oregon Opportunity, 13
Oregon Rural Practice-based Research Network (ORPRN), 12-13
Oregon State Health Division, 2, 3, 10
Oregon State Legislature, 5, 6-7, 14, 16-17
Osterud, Harold T., 18, 19-21, 23, 25

P

Patterson, Ed, 15

INDEX

Physician Assistant Program, 6-7, 8
physician assistants, 6, 7
physicians, family, 10
Physicians for Social Responsibility (U.S.), 20
Portland State University, 2
family, 1, 30, 31
health, 17-18
women, in medicine, 23, 29-30

R

referral and consultation, 27
Reinschmidt, J. S. (Julian S.), 5, 7, 21-22
research, 12-13
Robertson, Joseph, 24, 29
Rural Health Coordinating Council, 6, 11
rural health services, 3-4, 5, 6-7, 9, 10-11, 12, 16,
25-27

S

Schaff, Paul, 29-30
School of Medicine,
curriculum, 27
students, 29
School of Nursing, 8
specialties, medical, 20, 24
Soenen, Troy, 12
Speight, Barney, 14-15

T

technology, medical, 27
telemedicine, 10, 27
Thorne, Mike, 4, 11
Timms, Eugene D., 5, 11

U

United States Health Resources and Services
Administration Bureau of Primary Health Care,
10
United States Health Resources and Services
Administration Office of Rural Health Policy, 16

W

Waldmann, George, 22
Wallowa County Medical Society, 4
Whitaker Knapp, Karen,
biographical information, 1-2
career, 2-3, 8, 15, 17, 21-22, 29, 30-31
education, 1-2