

The Doctor is In:

OHSU's new president, Joseph Robertson, M.D., discusses Pill Hill's role in the region and in the state

by Merilee Karr, M.D.

This writer conducted a wide-ranging interview with Joseph Robertson, M.D., on his new job, the healthcare workforce, who gets in to his school, and state support. This interview has been edited for length.



Courtesy of OHSU

Expectations

Merilee Karr: *So this is your first six months. How's it feel?*

Joseph Robertson: I entered this office on September 15, 2006. The first six months is just completed, yes. It feels great. I absolutely love the job. The best thing is that I'm thoroughly immersed in OHSU. I've spent my entire professional life here, so I'm a staunch and ardent believer in the institution.

MK: *Have there been any surprises?*

JR: The biggest surprise about this job, to someone who spent most of their professional life as a surgeon, is how much talking there is. (Laughter)

MK: *Right. Here the patient talks back.*

JR: That's the biggest surprise. I have spent much of my professional life actually doing things, rather than—I mean, I hope that I'm still doing things—in a manner other than talking. There is more talking in this job than any that I have previously encountered.

MK: *Did different kinds of talking surprise you? Like, the way the School of Nursing talks, the way Pendleton talks?*

JR: No. I really haven't been surprised by the manner or content. You do need to say things several times and in different ways for the message to really penetrate.

MK: *Have you yet seen any of your talking pay off in action? Or is that a much longer-term expectation?*

JR: I think, generally speaking, it's a longer frame of reference. I think I have seen the talking pay off in that the public is more aware of the workforce issues that we face in healthcare, than they were six or twelve months ago. I think my talking is one of many factors that have contributed to that change.

The Healthcare Worker Shortage

MK: *How bad are Oregon's workforce problems?*

JR: Extremely severe. Nationally, the American Association of Medical Colleges recently called for a 30% increase in enrollment to meet healthcare needs—and the number of physicians trained per capita in Oregon is half the national average. If that's the situation nationally, and we're only producing at half the national rate, then you can see the future for Oregon.

The numbers are just as striking in nursing—and across the board, in all of the healthcare professions. In 2004 there was a prediction that over the next two years, 1200 Oregon physicians would leave the workforce, while we graduated 200 students.

Support of OHSU—Another Shortage

MK: *When I ask my patients, 'What's the best thing in your life?' I also ask them, 'What's the worst thing in your life?'*

JR: There's too much to do. Even though I've been at OHSU for 27 years, there is still more about the institution that I don't know.

MK: *Anything that you despair of getting to, on your list of things to do?*

JR: I think the task that I dread more than any other is limiting or removing resources from a given program. Or being in a situation where there aren't sufficient resources to fund an important program. I've been at OHSU as a faculty member, division chief, department chair, dean—I know what it feels like to receive 'No' as an answer, when you're asking for critical resources. There is a visceral identification.

MK: *Speaking of resources, since OHSU became a public corporation, how have its sources of revenue changed? Research grants, clinic revenue, public money from the Oregon Legislature—what else?*

JR: The percentage of support that we receive from the state of Oregon has markedly diminished as we have continued to grow.

MK: *How bad?*

JR: I think the percentage of our budget that is provided by the state, of our operating budget, has dropped to roughly 2.9%. However, that amount of funding is still critical, because it is fundamental support to the academic mission. No matter how efficient you are, there will always be operational gaps in education and research that have to be filled. The funding that we receive from the Legislature is not intended for the clinics, despite the fact that we continue, and will continue, to take care of a disproportionate share of the underserved and underprivileged.

MK: *So, research grants pay for research, clinic income pays for some of the patient care, but not all. There's a gap. Who pays for education—teaching doctors and nurses and dentists? That's the Oregon Legislature's slice?*

JR: Yes. But there are two slices that are larger.

Both the contribution from the faculty, called the MEIF, the Medical Education Improvement Fund—that is, euphemistically called the MEIF, it's called by the faculty The Dean's Tax—and the contribution from student tuition. Each of those slices of the pie is larger than the Legislature's.

Health and Rural Economic Development

MK: *Now, why should the rest of Oregon care? OHSU is obviously good for economic development right in Portland in so many ways. But does OHSU matter to Pendleton's economic development?*

JR: Absolutely. I'm more convinced of that than ever, especially after the trips that I've made around the state this past fall and winter. OHSU is about health. It's about the health of all Oregonians and Oregon communities, and it has a major presence in all the counties. As I journeyed across the state, the number one health concern that the citizens, the physicians, the healthcare administrators, all voiced to me was that of a healthcare worker shortage. In all the disciplines. It's not exactly the same in each town, city, or setting, but the theme is the same. It only takes an absence of one member of the team, it doesn't matter which—and none of the other members can function.

MK: *How does whether or not they have doctors and nurses in Pendleton affect economic development?*

JR: There are some very interesting figures. The direct economic benefit of placing a physician in a community probably easily exceeds a million dollars because of the services that are rendered both in the office and in the hospital. A substantial number of jobs are created. But in a global sense, if you want a rural community to not only survive but thrive, you need jobs, education, and healthcare. That's the three-legged stool that the community is built upon. Without any one of those legs, it's not sustainable.



The aerial tram on its way to "pill hill".

MK: *Indirectly, does rural health care determine who moves to small towns? And whether employers set up shop there?*

JR: I think it does. There are places in Oregon that if you live there for retirement, and you have a stroke, there is no way you would ever be a candidate for thrombolytic therapy because you will not be able to enter the protocol within the time window. So I think the educated consumer is going to look at the healthcare of a community before they move there.

Can Oregonians Afford an Oregonian Education?

MK: *Can smart kids from Pendleton afford to go to OHSU? Resident tuition is twenty-five thousand a year for the School of Medicine, ten to fourteen thousand a year for the School of Nursing. Where do Portland State University, University of Oregon and Oregon State University rank among OHSU's feeder schools?*

JR: It changes year to year. They are very high. I don't know what school has been number one in the past year.

MK: *I've heard that Stanford and University of California run generally one and two, and U of O and OSU run fourth and fifth. [PSU was the top in state feeder schools in 2006. —ed.]*

JR: That was probably true for one year. Both of those schools have been near the top, or at the top at some point in the past. But historically, and currently, I don't believe that's the case. For a brief period of time following one of our legislative cuts, we were forced to accept more nonresidents to balance the budget and to keep the school at its current enrollment.

MK: *When was that?*

JR: That was from about 2001 through 2003. Then as we adjusted to that cut we began to reverse the trend.

MK: *How many more nonresident students did you have to accept?*

JR: For one year, I think we reached 50% of our class. But even then, if you look at the numbers, the additional revenue raised never equaled the revenue that was lost. The situation we faced

was, do we cut the size of the class? Or do we increase the number of nonresidents? And if you look downstream, and evaluate the benefit to the state, we maintain that the capture rate from our medical school is the same for nonresidents as it is for residents. So the state was much better served by maximizing the enrollment, even with nonresidents, as a way of adjusting to that cut, rather than reducing the class size.

MK: *Let me make sure I understood that. That our capture rate—probably meaning how many stay in Oregon—was the same for Oregon residents and nonresidents.*

JR: Right. And it's significantly higher than most medical schools across the country.

MK: *Is that capture rate—*

JR: Maybe I shouldn't call it capture rate. (Laughter) Retention rate, maybe.

MK: *The Mount Hood effect. And are we really capturing them for their career in practice, or just as of the month after graduation in their residencies?*

JR: I can't tell you exactly what year, but it was not looked at in residency. It's significantly beyond residency.

MK: *Are nonresidents equally likely to become doctors in Pendleton? Does it really matter if we have in-state or out-of-state students?*

JR: The greatest factor determining whether or not you will practice in rural Oregon, or rural America in general, is whether or not you have a rural heritage. If you're from a rural heritage, your likelihood of practicing in a rural setting is six times greater than if you are from an urban setting. There's nothing else that compares, for predicting that.

MK: *How many rural nonresidents are we attracting?*

JR: I don't know the breakdown. We actually are one of the few schools that considers rural heritage in the diversity profile when we evaluate the diversity of a candidate. So in many respects, someone from a rural heritage would have, relatively speaking, a greater chance of being admitted to this school than another school.



A view of Portland from OHSU's west hills campus.

MK: *Do you have any feeling for whether the in-state or out-of-state students are more likely to have that rural heritage?*

JR: I haven't looked at that piece of data. I would be reluctant to speculate.

MK: *Because the bottom line for that question is: Maybe it doesn't matter if the Oregon Legislature supports OHSU. Maybe we can welcome nonresidents and give them diversity points for rural heritage, and take care of Oregonians that way.*

JR: I think that perhaps we could take care of Oregonians in that manner, but I think it would be unfortunate, and it would be unfair to the Oregon students. From a public health policy perspective, it might not matter. But with regard to equal opportunity for all Oregonians, it seems unfair and unwise.

Portland State and OHSU

MK: *OHSU and PSU collaborate on some programs, such as public health. [the Oregon Master of Public Health Program also includes Oregon State University. —ed.] There's been talk about OHSU and PSU merging. Do you have any interest in that?*

JR: I think that that discussion was fueled by noble intentions. I would be the first to say that we should optimize opportunities for collaboration and look for synergies. I have enjoyed doing that in the past. I was one—certainly not the only—but one of the principal architects of our regional medical education plan that works through collaboration with other institutions and other health care systems. If you look at our institution, we face the workforce crisis, finding a way to build out the Schnitzer campus, and the daily challenge of coming up with the operating budget to support programs that have expanded over the past ten years as our state funding has been shrinking.

So while there might be many advantages of the merger, on a very practical sense I don't see where either institution has either the financial capital or the human capital to really do the due diligence and to craft and fund that at the current time. We are also highly dependent on our clinical enterprise, for the subsidy of our academic enterprise. Diverting any of our focus and energy away from that could threaten the underpinnings of the institution itself. I think to sustain what we have takes

laser-like focus. Any merger between OHSU and PSU would require a major, underscore, underline, bold print, italics, major investment by the state. And realistically I can't believe that that's going to happen at a time that the state appears not to be able to even fund a limited number of policy option packages that we think are absolutely critical to the workforce.

MK: *So you've got a full plate right now, and it's not clear what PSU brings to the table.*

JR: Well, I think that anytime that you enlarge a scientific community, the sheer numbers, the combinations and permutations are such that synergy and collaboration increases. If you're all in one system that collaboration is probably easier. I think both institutions would bring that to the table. So there are those potential advantages, but I think they have to be carefully weighed against the practical realities.

MK: *It sounds like you're very open to collaboration and de facto merger.*

JR: In fact, as we plan our Schnitzer campus, we will plan it in a manner that easily interfaces with PSU at its northern border. I think we will try and build those activities that would most likely be done jointly with PSU at the northern end of the campus. I see PSU expanding south, and OHSU expanding north, so it's only reasonable for us to facilitate that interaction, almost an interdigitiation.

New Ways of Teaching and Learning

MK: *Will South Waterfront be the new campus? What's going to move down there? The medical, dental, and nursing schools?*

JR: Over time, the vast majority of our pre-clinical education will occur on the Schnitzer campus.

MK: *There was an interesting word in the Oregonian's article on the \$40 million anonymous gift for a new South Waterfront medical school campus. The word was "interdisciplinary." As in "a new interdisciplinary medical school complex on the waterfront." Which disciplines might that include? Medicine and nursing? Social science? Engineering?*

JR: It includes all five of our schools. That is medicine, dentistry, nursing, OGI School of Science and Engineering, and the College of Pharmacy



that is a joint program with OSU. All of those will have a major presence on the Schnitzer campus. There will be venues for all of those students to interact.

MK: *Social venues?*

JR: Educational venues.

MK: *How do you envision that?*

JR: We think if you're going to run a simulation in the ICU, shouldn't you have people from every discipline that would be involved actually taking part? If you're going to study ethics, shouldn't you simulate the practice environment that you will be in? In some of the pre-clinical sciences, there is an overlap in the curriculum. Couldn't that be taught in a shared manner? It adds to the sense of community.

All of the outcome data suggest that the key elements of quality are teamwork and communication. It doesn't happen—the quality outcomes—if people don't communicate and work as a team. If that's true, why should we train people in silos, and then on the day of graduation tell them to go work together?

It's a unique opportunity. Academic health centers have almost always been in large urban areas. Twenty acres doesn't become available in a large urban area very often, where you have a chance to redesign the way an academic health center is laid out. You have a chance here to build a campus that would actually embody your educational ideals. This would be a unique opportunity, for an academic health center to be able to do this.

MK: *You're pretty excited about that.*

JR: (Laughter.) I am.

MK: *Have any other medical schools considered blending the educational streams? Opening the silos?*

JR: There have been other places that have built new campuses, and there have been other places that have considered blending the streams. But there's been no place that's really doing both.

MK: *As a medical writer, I've discovered that nursing culture and ethics just don't seem to have some problems that burden medical culture. My education might have been*

better if I'd seen another way of thinking about certain things.

JR: Many of the great discoveries occur at the interface of disciplines. We want people to be not just comfortable with, but actually seeking that interface. We've already become a national leader in terms of regional education. We should also become a leader in trans-professional or interdisciplinary education.

Regional Education

MK: *Tell me about regional education in Oregon. I got my M.D. at the University of Washington, which has the WWAMI program.* [Interviewer's note: In the WWAMI program, first-year medical students from Wyoming, eastern Washington, Alaska, Montana, and Idaho take their first year at universities in their home states. The WWAMI program is one model for OHSU's regional education programs.]

JR: It's a true partnership with both the academic institution in the outlying education site and the health system. It really takes all three parties: OHSU, the local health system, and the academic institution to make this work.

MK: *Academic institution, such as?*

JR: Such as University of Oregon, and Oregon State. And that's to place the first-year students. The less-well-known part of regional education is the clinical program, which has much broader distribution than just Eugene or Corvallis. We place our students with other health systems around the state in individual practice settings. I am convinced that it enhances the educational experience.

We're one of the few schools that requires a primary-care rotation in a rural or underserved area. Every student has that. Not only does it enhance education, I think if the students have these diverse experiences, there is a better chance that they will seek a similar setting to practice in. Finally, I think it helps us recruit a more diverse student body. In these small communities, everyone is very much aware of whom the medical student or resident is, that's in town for six weeks, and they're really welcomed into the community. These people can serve as an inspiration, a role model for the high school student who's about ready to head off to



The new tram connects OHSU's upper and lower campuses.

college and think about what they're going to do.

MK: *Roving mentors. Where are the regional pre-clinical sites?*

JR: The pre-clinical sites are currently planned—

MK: *Planned. When do they start?*

JR: Their start date is dependent on funding from the Oregon Legislature.

MK: *So none of them have started yet.*

JR: The clinical sites have started. We have also increased the size of the class, on the Portland campus, from 96 students to 120 students.

MK: *In the medical school?*

JR: In the medical school. And we would like to take that to at least 160 students, by having 20 first-year students in Eugene, and 20 in Corvallis. We have expanded the class to 120, on the good-faith hope that we will receive sufficient funding to support that. And we have expanded the clinical sites. The most expensive step is the incremental addition of the new students at the regional campuses. So we have not committed to actually initiating that until it is funded. We do have a proposal for that before the Oregon Legislature.

MK: *Isn't the Nursing School already doing regional education through OCNE, the Oregon Consortium for Nursing Education?*

JR: Exactly right. We also have before the Oregon Legislature a proposal that will significantly increase the number of total students, OCNE students, and training sites.

MK: *Where are the clinical sites that you're already using?*

JR: There are literally scores of practices around the state that our students are in.

MK: *Maybe hundreds. I've seen the lists.*

JR: There are probably hundreds, but I don't want to be guilty of using hyperbole.

Rural Roots

MK: *You had relatives in Indiana who were doctors in small towns.*

JR: Yes, a great-uncle, and a cousin, a first cousin once removed, that were Indiana small-town docs. I was supposed to go back and become another.

MK: *What happened?*

JR: I developed an interest in neuroscience and pursued that.

MK: *How do rural doctors and nurses today practice differently than your great-uncle and your cousin did?*

JR: You know, the similarities are much greater than the differences. The key issues remain the same, and those are the providers, the technology, and the resources. There's no difference, given the relative training of the different eras, in the competency of people. It's really about resources. That's the thing that's limiting. If you needed specialty care in southern Indiana when I was growing up you went to Indianapolis or Louisville. Now, some things are closer to home, but for some things you still have to go to the big urban center. One of the changes is that there is more specialty care that's closer than there was when I was growing up in rural America. I think that's also true in Oregon.

Bottom Line

MK: *Is there anything else you'd like to tell **Metro**scape® readers?*

JR: My number one goal is to educate the public about the need for us to train more healthcare providers. Everything else hinges on that. The enlightened hospital administrator realizes the greatest strategic challenge that he or she will face over the next ten to twenty years is having a sufficient workforce. That's also part of the reason that I'm so excited about the new campus. Because we don't only have to train more people, we will have to provide care in a different way. **M**

Merilee Karr is a Portland writer and physician. She is the winner of the Creative Non-Fiction Foundation's essay contest for "Missing," a piece on malpractice suits. It will appear this fall in the collection, Silence Kills: Speaking Out and Saving Lives (SMU Press).

