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Moore, M.D., Gerald (Jay)

University of Nebraska Medical Center

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Transcribed by: Benjamin Simon
Oral History: Gerald Moore

Robert Wigton: Hi. I'm Bob Wigton and we're here today to interview Jay Moore, who is the associate Dean for Academic Affairs and has had a very distinguished career at the College of Medicine. And also we were good friends as medical students, residents, and so forth. Jay was a member of the class of '71. And I guess we could start off with some of your thoughts—reminisces about your class and your career, and how you got into academic medicine.

Gerald Moore: Okay. Sounds good.

Robert Wigton: Just in a word. Yeah. [Laughter]

Gerald Moore: Just in a word. Yeah. Well, I joined the class of '71, as you said, and I was fortunate enough to be one of a select group of people. There were ninety of us in the class, of which nine were women. And the other eighty-one, obviously, were men. That's changed quite a bit recently. We're about 50/50 with men and women in the class at the present time. We started out—Wittson Hall was not here, of course. It was just the North lab and the South lab. And we had our Anatomy in the sixth floor of the North laboratory. I remember that because it was a semester-and-a-half long and it was very cold because we had all the windows open for ventilation. So, it was always exciting to try to figure out what to do to keep warm. One of my classmates wanted to make some money, so he was bringing up a cooler with ice to sell pop. And he was pretty much told: "That's not going to happen." So, we lost that. But we had great fun. It was a lot of interactions with the faculty members. A lot of one-on-one, because of the smaller size of both the class and the... and the faculty at that point in time. So, there's some very dedicated teachers, as there continue to be at the present time. So, first two years were standard, I

think. Mostly lecture and laboratory. No small groups at all. It was very... interesting to learn physical diagnosis on the wards. When I first started, there were still wards of thirty-to-fifty beds. The men's ward and the women's ward. And they were... We had one... one examining room. So, we brought the patients into that examining room and had four or five of us examine the patient at the same time. It's rather different than what we do now at the present time. But it was... back in the old hospital. Of course, when I was in medical school, they started building Wittson Hall. And so, the class, I think, after me—one or two years—were the first people starting in that class—for classes. The junior year, I had the standard rotations. And I remember, at that time, I was in Douglas County Hospital for surgery. We used to stay overnight and run the emergency room, because there were no full-time physicians available. So, that was quite an experience. I remember one time I was called to see a patient out in the emergency room about five in the morning. And the patient... I said: "What's wrong?" And they said: "Well, the police are bringing him in, but he said he was walking downtown and saw a flashlight and said: 'turn the flashlight out.' And then the... the train hit him."

Robert Wigton: [Laughter]

Gerald Moore: [Laughter] Amazingly enough, he didn't have very many significant findings on his physical exam. He must have just got brushed by the train. So, it's funny. Back then, on medicine, I was at the VA [Veterans Affairs]. And I remember distinctly that our senior resident was only interested in studying for boards. And so, he didn't make rounds with us on a regular basis. The students were pretty much in charge. That certainly has changed as well, for the present time. During the senior year, I didn't really know what I wanted to go into. So, I went through the process of applying to different places. And, back in those days, I didn't have very

good advice. So, I didn't go interview any place. And—but I still got my first choice, so I was happy with that. Spent the year at Bronson Hospital in Kalamazoo, Michigan doing a rotating internship. Had probably a hundred twenty-five deliveries under my belt. Seventy-five of those I was the primary physician. So, it was pretty good experience. Emergency Department, Pediatrics... All the standard rotations. And then, I didn't know what I was going to do, because I was—back then, there was the draft. And I was eligible for the draft. I was classified 1A. So, I went for a physical. And they said: "Unfortunately, you... if you hadn't been a physician, you wouldn't be eligible." I said: "Why?" And he said: "Well, you've got a hernia." I thought: "Damn. I just went to medical school for the wrong reason." No, I'm kidding. Anyway, I didn't know what to do. So, I called back here. And I don't... I talked to the Chief Resident before you. Who was that?

Robert Wigton: It... it might have been... Oh, let's see... Right before me... Oh, Hassing.

Gerald Moore: Yeah, John Hassing.

Robert Wigton: Hassing, yeah.

Gerald Moore: Anyway, I talked to him. And I said: "Do you have a place for me—or have a suggestion?" And he said: "Oh, come in as a second year of medicine resident." So, I... I came in and... Since medicine is three years long, I ended up doing the Chief Residency after you.

You finished after two years?

Robert Wigton: Mhmm.

Gerald Moore: Doing that. So, I took over there and had a Chief Resident at the VA. Merle MacLevy. Had a good time from that standpoint. And I stayed here on General Medicine staff. So, I did General Medicine for some time. And then, about... late '70s or early '80s, the only

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rheumatologist in town left. So, we had a Rheumatology clinic that was once a month. An Orthopedics clinic. And the Chairman of Medicine at that time said: “Well, you’re Chief Resident. You don’t have anything better to do. Why don’t you run the Rheumatology clinic?” So, I ended up doing the Rheumatology clinic with the Vice Chairman of the department, who was an infectious disease doctor. So, a generalist and an infectious disease doctor did rheumatology with orthopedics for a couple years. Ended up, when Jim O’Dell and Lyn Klassen joined the faculty as the first rheumatologists, they eventually suggested that I might want to get training in Rheumatology. So, I spent a year at the NIH [National Institutes of Health] doing some clinical research, then came back here. And I’ve been here ever since.

Robert Wigton: That’s interesting. Now, what was the name of the rheumatologist that left? I can’t remember it.

Gerald Moore: Yasichu. Hissan Yasichu.

Robert Wigton: Oh, sure! Sure.

Gerald Moore: He was from Turkey.

Robert Wigton: Yes. And he was the guy that... that’s famous for his articles in... one of those diseases that’s prevalent in the--

Gerald Moore: The shets.

Robert Wigton: Yeah. The shets. Right. It was—he became an expert on that.

Gerald Moore: Mhmm. We’ve had—we actually had his son come here for his visiting professor a few years back. So...

Robert Wigton: Interesting.

Gerald Moore: Very interesting.

Robert Wigton: So, when... when did you get into the Dean's office? And why?

Gerald Moore: Yeah. Why? That's—there's an involved story there. Unfortunately, I was volunteered to—or I—fortunately, I volunteered to be on the curriculum committee. And this was back in... about, oh, '80s, '78—'80. Something like that. I was on the curriculum committee and we decided we were going to look at the curriculum in the second year. And analyze and see whether it could be improved. And at that time, there were a lot of little courses. Two hours here, three hours there, one hour... And I said: "Hmm. Why don't we consolidate that into one course called Introduction to Clinical Medicine?" And they said: "Well, fine. Why don't you run it?" So, I ended up running this course.

Robert Wigton: Oops.

Gerald Moore: Yeah. "Oops" is the exact correct answer. So, I ran the course for several years. And then, I went to the NIH, as I said, for—1985 for a year. And when I came back... Bob Waldman, sorry. Bob Waldman was here as Dean. And he asked me if I would be interested in becoming Assistant Dean for curriculum. So, that's how that happened. And then, I've been in that position, or something like that, ever since that point in time. So, I've been involved in a lot of the changes that have occurred in the curriculum over the years.

Robert Wigton: Now, say something about evolution of the curriculum.

Gerald Moore: Well... Actually, we have some pictures of the curriculum in 1900. I think you created some of those and... Especially the one with the stagecoach and the bones... they're... they're standing outside. And the scrum for the... the football team that we used to have. Wasn't quite that bad when I was here. But we had classes... standard classes in Biochemistry, Physiology, Anatomy, et cetera. I remember the Histology class was in the amphitheater in the

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North laboratory. There was a chalkboard there, of course, and the histologist came in with his colored chalk every morning for fifteen minutes, putting the scheme on the board. So, some of us—not me, but some of the people in the class ended up going to fifteen minutes early so that they all the colored pencils out, and they copied all that. Little different from what happens now. But, as I said before, it was mostly lecture and small group—or and *not* small group. And laboratory experience was very important. Physiology laboratory, where you did experiments with gastric acid. And... and Cardiology for exercise-induced disease, et cetera, et cetera. So, it was a good experience. I didn't know any different at that point in time. And, as I said, things... things evolved into many small little courses. And the... But they were still basically discipline-based. So, Anatomy, Physiology, plus the Clinical Medicine course that I taught, which is the physical diagnosis primarily.

Robert Wigton: And they often followed a book.

Gerald Moore: Right.

Robert Wigton: Like... like they'd have a particular book, as college courses did.

Gerald Moore: Right.

Robert Wigton: And you'd have chapter one for a certain amount of time.

Gerald Moore: Exactly right.

Robert Wigton: So, the organization was fairly standard, just because it followed the different books.

Gerald Moore: The textbook, yes.

Robert Wigton: Textbooks, yeah.

Gerald Moore: And most of the instructors were not clinicians. In fact, I would say a very

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minority of the instructors in the first few years were clinicians. We didn't notice any difference, because we didn't know that clinical medicine really existed until our third year. Then, third year we had a—probably the thing I remember most about that is the family medicine rotation I did out in Aurora, Nebraska. We stayed in the hospital wing that was a nursing home. And one of my classmates and I were there in January.

Robert Wigton: Oh.

Gerald Moore: [Laughter] And two things happen. One is one night I got awakened about three AM with screams from my compatriot's bed. And it turns out one of the patients from the nursing home had wandered around and was climbing into bed with him. And so...

Robert Wigton: [Laughter]

Gerald Moore: So, that was exciting. But the other thing that happened... We had a snowstorm on a Friday afternoon. A blizzard. And it was so bad that a rescue squad came in with a patient with chest pain. And then, they closed the road. Nobody could get there. I was the only physician, like, person there. And the guy arrested in the emergency department. So, I ran this cardiac arrest in the Emergency Department. Well, it wasn't really Emergency Department. It was just sort of a room off of--

Robert Wigton: A room.

Gerald Moore: Yeah [Laughter]. I did the... the code. Unfortunately, the patient didn't make it. But afterwards, the nurses said: "That was really exciting!" And I said: "What—why, you know, why is that exciting?" "That's the first time we've ever done a resuscitation." [Laughter] I'm not pretty much the right person to be doing that, I guess. Anyway, I took electives during the Senior year. And... So, it was pretty standard from that format. Then we made the change that I alluded

to before to consolidate some of the courses. That was the next step that I think we noticed as much as anything. And then, mid-'80s, with Bob Waldman—said: “We need to start looking at our curriculum.” When I started becoming Assistant Dean for Curriculum. So, we looked at our curriculum at that point in time and said: “What can we do differently than what we’re doing now?” And so, a lot of the issues that we’re facing today are—we were facing then, is how to get the students more involved. Get rid of the passive learning. Get more active learning. And we decided to try to consolidate things a little bit better and separate it out. So, we ended up with a curriculum that the first year was, quote, “Normal Anatomy,” “Normal Physiology,” “Normal Biochemistry,” taught in that manner. And then the second year was Primary Pathology. And they were separated out grossly that we. We started using problem-based learning, which was very popular at that point in time. It was one of the—we weren’t the first schools to do it, but we were one of the early adopters of that. And that was the beginning of using small groups as an educational tool at this institution.

Robert Wigton: Mhmm. I remember that.

Gerald Moore: Yeah. That was—it was good. It was interesting. A lot of the faculty reacted to this: “Why are we making this change?” And, basically, “How do you prove that it’s good and you’re successful?” et cetera. And we had a hard time answering that. Basically, the bottom line was... Well, it got us to thinking about the curriculum. That’s probably the most important thing we did. We applied for a grant from the Robert Wood Johnson Foundation. Got a relatively small grant, but it was nice because it gave us a deadline of a year-and-a-half that we had to get the curriculum done and online. So, that worked out pretty well. So, we continued with that curriculum over the next twenty-or-so years.

Robert Wigton: This is... This curriculum started in the '90s?

Gerald Moore: '92.

Robert Wigton: '92.

Gerald Moore: Started in '92. And it stayed pretty much—the format stayed pretty much the same. But a lot of things have added in those ten years. A lot of things have made a difference. I mentioned the small groups already. Using problem-based learning. Now we're doing something called team-based learning, in which the whole class has groups in a classroom; and they go over some questions, pre-questions, and pro-questions. And the instructor helps them with that kind of stuff. We're doing virtual Histology and virtual Pathology, which is taking online, electronic slides of the tissues. And the instructor can control the computer and draw the circle around the cell that they think is the most important. That's—We don't use microscopes anymore. So, I don't think our students know how to use them, from that standpoint. The Anatomy laboratory has become computerized. That's been major thing, so that they can also control the screens at each table. Each... each table of four to six people will have their own computer and projector. So, that works out pretty well.

Robert Wigton: This is where the... the synthesized body is lying as a... electronic in the--?

Gerald Moore: Well, we don't use that as much in the medical school. They use that more in Allied Health right now in teaching.

Robert Wigton: Ah.

Gerald Moore: But that's one of the newer things that are occurring. We could talk about technology for a long time.

Robert Wigton: Sure.

Gerald Moore: There's a lot of new things with that. We also are one of the early adopters of the OSCE, the Objective Structured Clinical Examination, in which we said earlier clinical exposure, either through the standardized patients or using... mannequins, or something like that, would give people an opportunity to practice on a non-human, so to speak. But it's relatively life-like. And then, be able to go onto the wards and have a little bit more feeling for what's happening and how they should be con—treating the patients. We spent a lot of time talking about history and physical examination. How do you deal with a difficult patient? If the patient with—needs a translator... Under privileged individuals and how do we handle that? Those that don't have fin—financial support. Things like that. So, that's been good, from that standpoint.

Robert Wigton: If we could—could we go back a ways and say a little about the three-year curriculum.

Gerald Moore: Yeah. Okay. Good thing.

Robert Wigton: Were you involved in that at all?

Gerald Moore: No, I was not involved in that. That was—that stated about 1972 and went through 1980, or so. So, what happened was—The idea was to consolidate medical school down from four years to three. Basically, all that happens is we eliminated all vacations. Sort of made it a little bit more intense. The first year we did it, we had a four-year class and a three-year class. So, we had to double-up the amount of education we were doing for that. And then, in reality, we got a lot of extra physicians out that year, because we doubled up.

Robert Wigton: Yeah.

Gerald Moore: But after that, it was just the same as... Just came a year later—earlier than before. I think it was fairly successful. I've talked to people that have been through that

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curriculum. They were happy with it. They didn't know anything different. They felt that they were well-trained. But it got to be the point where it was too intense for people. And that's why we went back to the four-year curriculum. And the doctor shortage was resolved a little bit.

Robert Wigton: A part of the stimulus was that the federal government was offering a stipend for extra person you got out...

Gerald Moore: Right. Yeah. Exactly.

Robert Wigton: From the baseline and seventy-two, or whatever it was.

Gerald Moore: Right.

Robert Wigton: And that was disappearing too. And I... I think that led to maybe part of the... the.... I... I thought one of the big issues was that the Senior students had to—the third-year students had to apply for residencies without as many clinical rotations.

Gerald Moore: Right.

Robert Wigton: And I think they felt like they were at a disadvantage because of that.

Gerald Moore: Right.

Robert Wigton: But otherwise, I—I felt the same way, that they got the same training basically.

Gerald Moore: Right.

Robert Wigton: It was just a little less vacation.

Gerald Moore: Yeah. No summers off. And...

Robert Wigton: How do you feel about these changes in the curriculum? Especially the one... the big one in '92, where we went to a different re—reorganization with the cores and this sort of thing?

Gerald Moore: Right.

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Robert Wigton: What's the advantages—I mean, what have proved to be the advantages or disadvantages?

Gerald Moore: Probably the biggest advantage is what I alluded to earlier. And that was that we stimulated some of the faculty to things in a different way.

Robert Wigton: Different way.

Gerald Moore: To think about it again. Unfortunately, some of our faculty liked to use—and they—those days, a two-by-two slide set—and showed the same slide set for twenty years in a row and—not updated. So, remodeling--

Robert Wigton: When I was... When I was in, there were just a couple of people actually used what's called lantern slides.

Gerald Moore: Oh, yeah.

Robert Wigton: Big ones with a—you could type on them.

Gerald Moore: Oh, yeah.

Robert Wigton: Type inside. They were two pieces, as well. You--

Gerald Moore: Do you remember the overhead projectors and--?

Robert Wigton: Oh, yeah.

Gerald Moore: ... the rolls of acetate that people used and had to clean it off every time before their next lecture.

Robert Wigton: It was ubiquitous, especially for certain... certain courses. Certain disciplines would use a lot more.

Gerald Moore: Right.

Robert Wigton: And...

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Gerald Moore: For younger people listening to us talk about this, they probably don't know what we're talking about.

Robert Wigton: Oh. That's right. [Laughter]

Gerald Moore: It's a little bit different than it was.

Robert Wigton: Well, in fact, I caught the tail end of using these big carbon arc projectors...

Gerald Moore: Oh, yeah.

Robert Wigton: ...in the room. Say, there were two pieces of carbon and then you got them—you send an electric current through them. We got them at the right distance from each other.

Gerald Moore: Distance, yeah.

Robert Wigton: Which, usually, only the Chief Resident knew what the distance was. And a gigantic light would project from a long ways.

Gerald Moore: Yeah.

Robert Wigton: And they had those in the North amphitheater. The other thing they had is they used a carbonate arc projector to look the wrong way through a microscopic. They'd aim it at the screen and you could see the slides.

Gerald Moore: Oh, really?

Robert Wigton: Yeah. The guy could manipulate the slides and everything.

Gerald Moore: Oh wow.

Robert Wigton: It was fascinating.

Gerald Moore: I remember my Histology laboratories and Pathology laboratories using a microscope and never have any idea what I could... what I was looking at. That's what the advantage of the virtual Histology/Pathology we do now. Because they can say: "Here's an

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arrow. Here's what—This cell's the one that you're looking at. That you should be—“

Robert Wigton: We had to draw every cell and stipple in all the...

Gerald Moore: Yeah.

Robert Wigton: Cytosomes and stuff like that.

Gerald Moore: Exactly.

Robert Wigton: How about the new curriculum? What do you think that's going to achieve? Or what's its purpose?

Gerald Moore: Well... Last two-to-three years we've been looking at this. And what we're going to do is turn the curriculum and do a little bit more integration than what we did before. So, all things cardiovascular will be taught at the same time.

Robert Wigton: I see.

Gerald Moore: So, Basic Anatomy, Physiology, Pathology, Treatment, Pharmacology...

Robert Wigton: Now, the course did some of that. Is that right?

Gerald Moore: Well, except they separated it out as the first year was all normal, without Pathology.

Robert Wigton: Oh! I see. I see.

Gerald Moore: And the second year was mostly Pathology, assuming you knew the normal. And so, you might have, for example, we always talk about acid-base balance. And learning acid-base balance. Would be taught three or four different times in this—in the old curriculum. You get first in Physiology, then you get it in again in Pulmonary, you get it again in Renal, and they each approach it a different way. So, what we're trying to do is consolidate that and say there's one big picture. And so, get better information.

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Robert Wigton: Yeah, the sym...sympathetic nervous system was another example.

Gerald Moore: Yeah, exactly.

Robert Wigton: Come at you every two months with a different teacher. That sort of thing.

Gerald Moore: Yeah, and... So, the new curriculum is trying to integrate that more. And that's been important. We're also using more simulations. We have the... the... the Sorrell Center, which opened in 2008. It's the first home for the College of Medicine, which is very important. And that's been a fantastic building for us. It has the small group rooms. There's twenty-two small group rooms that we can utilize for anywhere from eight to twelve students and a faculty member. The two large lecture halls... But we have the simulation laboratory where we have mannequins and people can go down and practice, as we talked about earlier. Practice how to do innovation or starting an IV. Whatever the case may be.

Robert Wigton: Do you think that these changes are having any effect on... on student scores on tests or on their retention. Or do we have any...?

Gerald Moore: I have to be careful about this. Student satisfaction is better. There's no question about that. Earlier clinical exposure is happening. They're more involved in their curriculum. Their more involved in... They're not just passively taking notes as much. But we want to integrate that more and stimulate them more. We're going to do more interprofessional education.

Robert Wigton: Ah, yes.

Gerald Moore: Between Nursing, Pharmacy, and et cetera.

Robert Wigton: That was always kind of a loss that we didn't take advantage of, I thought.

Gerald Moore: Right.

Robert Wigton: Because after medical school, I was in Physiology for a while, getting a Masters. And I would teach the other, like, Nursing classes

Gerald Moore: Classes, yeah.

Robert Wigton: Classes. And physical therapy. And things like that. And I thought: “Boy, there’s a kind of a wasted interaction going on there.” These were bright people who had a different—kind of a different look at this same thing.

Gerald Moore: Right, exactly.

Robert Wigton: Yeah, that’s—I’m glad that’s come up.

Gerald Moore: You know, probably the big thing that is happening is—students are smart. I mean, they’re obviously very smart. Most people say that they would not be able to get into medical school now, compared to the students that we see coming across the boards. And that’s probably true for me, as well as other people. But our students are going to succeed in spite of us. But we can certainly get them to understand a little bit better the how and why of things. Not so much the actual listing of twenty-five causes of X, Y, Z—something like that. So, making them more responsible for how they learn, how they find that information, how they ultimately take care of patients... I think that’s going to be a big thing. In the curriculum in ’92 when we did this, we had the introduction to clinical method and talked about patient interactions, as I mentioned earlier. One of the most impressive things was the faculty, on rounds, on wards, when they first got the students to come in from what was called the Integrated Clinical Experience at that time... They said: “These students are thinking outside the box more than they used to.

Robert Wigton: Ah.

Gerald Moore: ... more about ethical issues and social issues and things like that.” And that’s...

that's very satisfying to be able to say that's happening. There—But, getting back to your original questions about quest—more scores or data that suggests that there's been a marked difference. I don't think we have that. In most studies that I've seen nationally are unable to show a major change. But it depends on what you're trying to accomplish. Teaching somebody how to research something, rather than just giving them the facts is a different thing.

Robert Wigton: Yeah, after all, the students who make it into medical school already have—are very proficient in retaining and reading and this sort of thing.

Gerald Moore: Right.

Robert Wigton: Or they wouldn't have the good grades that brought them in. So, it seems like that would be a really uphill battle to improve their board scores and...

Gerald Moore: Right.

Robert Wigton: Studying the same material, and so forth and so on.

Gerald Moore: We're very proud—as you know, USMLE [United States Medical Licensing Examination] has three steps to it, basically. Step one is the basic science material. And our students do fine with that. Step two our students consistently do better than the national average with their clinical skills. We didn't see a change with the curriculum, but it didn't go down. So, that's probably the most important thing. And then we go to the curriculum. The Teaching Physicians of Tomorrow, which is the new curriculum that we're starting in the Fall of 2017. Where wherever we are now. In the fall of 2017, we will hopefully be able to integrate all these things a little bit more completely. Students will take more responsibility for their educational process. And...

Robert Wigton: So, you'll bring it in a class at a time.

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Gerald Moore: Right.

Robert Wigton: Is that what happens?

Gerald Moore: Yeah. So...

Robert Wigton: First the Freshman...

Gerald Moore: Over a four-year—So, actually, we're changing into three phases. Phase one is about a year-and-a-half long. And during that phase one, then we'll get a block of Hematology/Oncology, a block of Pathology—excuse me, Cardiology, Pulmonary, et cetera—by organ system. Then we'll have, at the end of that time, we'll have what we call synthesis—synthesis blocks. I'll get it eventually. The synthesis blocks are certainly areas where we get people for two weeks to get a case and sit down and think about issues related to what they've learned behind... before. How do they evaluate? How do they take care of the patient? So, they have to think and put everything together, hopefully, at that point in time. Second phase is a traditional clerkships, which we've already had well-developed. And they've been very successful. And then the third year's the preparation for residency. We're requiring a lot more things. We've required Basic Life Support, Advanced Cardiac Life Support... A section on quality. Training students to do ultrasound at the present time. We're doing the simulated patients, as I said. Learning how to do procedures, and hopefully using the ultrasound can do things like IVs and different possibilities from that standpoint. But, more importantly, they'll have a—what we call a capstone project, which will take some subject and put it together and develop a... almost a, I think you had to do a... a thesis, right?

Robert Wigton: A Ph... Yeah, a doctoral thesis.

Gerald Moore: Doctoral thesis.

Robert Wigton: In fact, ours was the last year that did that.

Gerald Moore: And mine was the first year that didn't have to, or something like that.

Robert Wigton: Lucky.

Gerald Moore: But we're going to do something like that again. And then, people that are going into surgery or OB or internal medicine would spend several months with a curriculum that's developed by that department as the preparation for the boards, but also preparation for the residency. So, they'll have a lot better training rather than sort of catch-as-catch-can.

Robert Wigton: Oh, that'll be interesting.

Gerald Moore: Yeah, we'll see what happens with that. It would be interesting to see how this all works out. There's a lot of details that we're still working on. So...

Robert Wigton: Looking ahead, do you see any major shifts coming up? Because there's so much change in the... in the provision of medical care. And so much argument that. Do you think... Are we going to make a big change, or is this just...?

Gerald Moore: Well, part of what we're doing is integrating that into the curriculum more or systems subject. So, how do you run an office? How do you take care of Medicare/Medicaid? How do you deal with insurance companies? Trying to—How do you improve the health of the community? Working with the College of Allied—Public Health. And putting that together is going to be something that looks at the bigger picture. The more the health of the community. So, that's going to be important. I think there's all sorts of opportunities for us to improve and stop what—You and I went through medical school—I think it was about how much knowledge can you jam in here and regurgitate back on tests? And we're going way away from that.

Everybody has their own smartphone and they—you can look it up on the smartphone just as

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easily as cram it in the head. But how do you think? How do you problem solve? How do you do things? So, we're going to be emphasizing that more. And I think we're going to see a big difference with people from that standpoint.

Robert Wigton: That will be very interesting. There was a... There was a Chair of Medicine at... [Pause] Oh, gosh... at one of the New York universities. I cannot—what was his name that went back and took medical school again at age 81.

Gerald Moore: Oh, yeah.

Robert Wigton: He wrote an article about his experience. And... and I think the biggest... biggest thing I remember from it was that he thought that they had given them too much detail...

Gerald Moore: Yeah.

Robert Wigton: ...and not enough thinking. And...

Gerald Moore: Yeah, exactly. The other thing is medical school is much easier the second time around when you know medicine.

Robert Wigton: I'm sure. [Laughter]

Gerald Moore: It's much easier to do. So, people have talked about having a pre-medical school

Robert Wigton: Yeah, but taking calls at that age, I don't know.

Gerald Moore: [Laughter] Yeah.

Robert Wigton: That'd be something else.

Gerald Moore: That's true.

Robert Wigton: Well... You've, gosh, been the leader here in curriculum for, what—thirty years or so? It's amazing record of that. Has that... has that been fun? Would you do something else? Or...

Gerald Moore: Oh, yeah. Absolutely.

Robert Wigton: Yeah.

Gerald Moore: I always tell people the big advantage of my job is I have multiple things to worry about. So, you know, there's always something to challenge and...

Robert Wigton: Yeah.

Gerald Moore: Sometimes people call me to say: "The lights don't work in this room. Can you fix it?" But most of it is more substantive questions about curriculum. Probably the biggest thing for me is, no doubt, working with the students. I mean, it's just so pleasant. And... and I'm just totally amazed every time I sit down with a student and not worrying about the medical aspects so much. But talking about who they are and how they've developed and what they're bringing to the—there's some very very interesting stories out there from the medical students.

Robert Wigton: Oh, wow.

Gerald Moore: And they're all—It's so much fun to see them as resident, and then as faculty when they join—some of them join. And see how they mature and develop over the period of time. And, universally, when we survey our graduates, they're very satisfied with the educational process. Since we're a state institution, one of our goals is to increase the number of primary care physicians in the state. And we're certainly trying to do that as well as we can. We're rated in the top five-to-ten nationally for that. Over fifty percent of our students enter into primary care residencies. They may not finish—all finish them, but that's been very positive.

Robert Wigton: Yeah, this has been a tremendous change. Because, when I was—When we were in school, we were just leaving an era of where half the students from here went into general practice.

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Gerald Moore: Right.

Robert Wigton: And... and the family practice residency didn't come until '72.

Gerald Moore: Right.

Robert Wigton: So, this... this was a completely different kind of training for readiness. You... you... you—After your year after medical school, you had to be ready to go out and take care of anything.

Gerald Moore: Right. Yeah.

Robert Wigton: And...

Gerald Moore: And many people did that. [Laughter]

Robert Wigton: Yeah they did.

Gerald Moore: Scares you now, but...

Robert Wigton: It's been a tremendous change in the orientation of medical school and what... what they want to prepare people for. And so forth.

Gerald Moore: Exactly. There's another area I wanted to talk about. We do something called EMET, which is Enhanced Medical Education Training. For students that want to sign up for a special—sort of a special field during—they go to all regular medical school, but they do an addition.

Robert Wigton: Ah.

Gerald Moore: So, we've got one in Geriatrics, one in Immunology, one in HIV dis—related diseases. The other one in Community Health. Things like that. Those are people who really want to put the emphasis on a special area gets a little bit of special training. It's very good.

Robert Wigton: That's great. Well, Jay, thank you very much for being our guest. For talking

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about all of this.

Gerald Moore: All right. I enjoyed it. Thank you.

Robert Wigton: I think people will find it all very interesting. Because I don't believe, in general, there's a lot of understanding of how the curriculum has evolved over this time. And it's good to have you fill it in.

Gerald Moore: All right. Thank you.

Robert Wigton: Great. Thanks a lot.

END OF INTERVIEW

Benjamin Simon 8/15/2017