Interviewee: **Reeves, Robert**
Interviewer: **Karen Thomas**
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Thomas: Dr. Reeves, can you tell me a little bit about your background, your educational and professional background as a scientist?

Reeves: I can start at undergraduate. I was an undergraduate student at the University of California at Berkeley; I majored in biochemistry. I think since I was young I wanted to be a research biochemist, so that was my career goal I went on to New York University and in 1963 and received my Ph.D. from NYU in 1969 in biochemistry. I was at the medical school, I took a number of medical school classes; I became interested in medical school education. I even taught a little bit while I was there. That was, I think, my first introduction to medical school as a graduate student and in the Department of Biochemistry at New York University. After that, I went back to Berkeley. There was a person there that I arranged to do a post-doctoral with and I worked in bacterial genetics for two years at University of California. It was a bad time for academic positions in 1969 when I first applied for a position. I applied here — in fact, I think I only got two interviews, one at the University of Missouri, St. Louis, and one at FSU. So I came to FSU originally in 1971. It was my first job here.

Interesting history, because I was here at FSU for six years, and because of — and I did very well, I had several publications, I had two major grants, Career Development Award, but it was kind of a strange time in the Chemistry Department and tenure was kind of hard to come by. I decided t leave FSU and went to the University of Tennessee Center for the Health Sciences, another medical school job and taught in microbiology there for two years. Rose to associate professor there. And at that point, I was asked by Gib DeBusk, originally, and by Robley Light, to interview for the position in Program in Medical Sciences. And I interviewed here and really enjoyed the interview; I interviewed with the people here at FSU, at Florida State, and also flew down to the University of Florida College of Medicine at Gainesville and interviewed with the administration and with several department chairs and so forth at the University of Florida. I guess they liked me because they offered me the position, and I came in 1979 at that time as the new director of the Program in Medical Sciences.

I was also in the Department of Biology. I think one of the things that struck me right at the beginning was administratively it was very difficult to manage such a program. I answered to two different deans. The College of Medicine dean, I guess for the direction of the program and the medical education aspects of the program, but all budgetary aspects and my career and so forth I answered to the dean of Arts and Sciences here at Florida State University.

Thomas: So not only was it two different deans, but two different institutions.

Reeves: That's correct. And so I was an assistant dean at the University of Florida College of Medicine, I went to deans' meetings once a month. PIMS was looked at sort of at that time as — it had been going since 1971, so '71 to '79, Paul Elliott and before me Robley Light were directors, and when I came on, the funding for medical education was on a decline. I think one of the things I faced right away was a thing called the GMENAC[1] Report, which was a federal report that said we had too many physicians and we were going to have a greater abundance of physicians by the year 2000, and that actually we should be cutting back on medical education. And I think with a year, we lost our federal funding, which came through the University of Florida but was funding for the Program in Medical Sciences. And so we existed on state funds through the College of Arts and Sciences almost entirely for that whole — for the time I was program director. And so for budgetary reasons and other reasons, I answered to the dean here; for directing and running the program as far as their medical education of thirty medical students, I answered to the dean of the College of Medicine. So it was a little strange. I was also — I didn't even have the power of a department chair, because in terms of my career and my tenure and position and so forth, that was decided by the chair of Biology. So it was kind of a strange position in terms of directing a medical program and educating thirty medical students.

Thomas: Were you continuing to teach and do research in biology while at the same time you were directing the program?

Reeves: Yes. The program was almost considered a half position when I came in. I was director half time and I ran a research laboratory and taught in the Biology Department. Actually, most of my teaching was with PIMS. I taught an infectious disease course which included bacteriology and virology and those aspects of the medical school. Our curriculum had to match the curriculum in the first year at the University of Florida; I mean, you couldn't leave things out. So in their first year they had virology and microbiology, and that's what I ended up teaching when I came. So I had a reasonable teaching load, was administrator of this program, and also had some duties within the Department of Biological Science as well. So it was a full job.

The job before me, when Paul Elliott was director, I think was primarily an administrative job. So when I came on board, it became sort of a — almost like I said, a half time administrative job between the PIMS program and then my own duties in biological science.

Thomas: Let me back up a bit to ask you — you were a student at Berkeley in the '60s.

Reeves: Yes, I was.

Thomas: And you were not a Southerner, and you came to FSU in '71 and then you went Memphis. So since '71, your professional career has been in the South. Can you talk about

[1]Graduate Medical Education National Advisory Committee

some of the, I guess, social context of some of what you were doing. There's a lot of reform in health care, in education. Did any of that seem to affect you or did you feel kind of outside that?

Reeves: Actually, you know, I was delighted when I came to Florida State University. Maybe it was — I think I was really impressed, because when I first came, I came in the Department of Chemistry here and the Department of Biology and the Department of Chemistry were both excellent departments. I mean, they were not — you know, I expected a somewhat — I don't know exactly what my expectations were, but I thought that there might be inbred departments and so forth and so on, but that was definitely not the case. I mean, the Chemistry Department here was an international department, and I was really pleased to see the balance of the faculty. It was a research-oriented department, as was biology. And so in terms of my career as a biochemist and biologist, I was extremely pleased. In medical education, I had heard a lot about — NYU Medical School — that was my first association with medical school — and then when I was at Memphis — Memphis was not — University of Tennessee was not a very strong medical school in the basic science departments, but it was quite strong in clinical _____ [??] was a strong department. And the hospitals in Memphis were very good and so forth. The academic departments were not as good, and I think I gladly returned to Tallahassee, I think, because I think the quality of education and the academic structure were better here. And in a sense I was a little bit disappointed with the University of Tennessee Center for the Health Sciences, not because of their clinical teaching – that was excellent, but their basic sciences were not very good.

Now, what I was to do as the director of the Program of Medical Sciences was to teach the basic medical sciences to thirty students. So I was involved in teaching anatomy and physiology and biochemistry and so forth and directing that program. The other aspect of the program that I've always — you know, I've considered myself lucky and I think I fit with the program fairly well – it's a student-oriented program. It's a program to recruit students primarily from rural north Florida – that was the whole mission of the program – and get them interested in primary care and to return to primary care. And my forte is, I think, my interaction with students. Currently I'm the associate chairman for undergraduate studies in my own department, and I fit very well in that and I think I do a good job with handling student problems and students in general. And I think students like me; I deal with them on almost an equal basis and I think students like that. Anyway, so I felt that this was almost made for me in a sense that it was a student-oriented program. I didn't have to worry about faculty positions and faculty appointments. We did have a small faculty, but the person that was their administrator was the department chair that they were in, that particular department. So I didn't have faculty problems to deal with, which I consider myself lucky; those are some of the tougher problems with an administrator at the university. But I was involved with a student-oriented program, teaching thirty students the first year of medical school and running that program and making sure that the students got a quality education and would move on into the second year of medical school at the University of Florida.

Now, the students – the whole idea was to recruit students from rural north Florida, and some of these students were not very sophisticated, but it was very pleasing to me to see some of them do extremely well. I can remember — before I was director, I had one of the students —

I'm blanking on his name — who was a student from rural north Florida, really rural north Florida, just north of Pensacola is where he lived — Cletious David Smith is his name. And I always imagined him as sort of the epitome of the Program in Medical Science. We brought him in; he worked in my laboratory as an undergraduate, so he went through the PIMS program before I was director. But by the time I knew him, he was committed to medical school, he worked in my laboratory; I think I even taught him biochemistry. Now this was before I was director, so this was back in the mid-'70s. But he was the type of student we were looking for. And lo and behold, he went to the medical school; he did very well in PIMS, he did very well at the University of Florida. He only did one year of residency, but then he returned to his town in rural north Florida and became sort of the clinical director of the hospital, and PIMS has sort of highlighted him several times, and so has the College of Medicine now. C. David Smith. And so that was the type of student we were after. And I did very well with C. David Smith. He and I became friends, essentially. I invited him back to speak to one of our medical classes at their — we called it convocation; when they left the Program in Medical Sciences we always had an ending ceremony, and C. David Smith spoke at one of those and he did a fantastic job. Very inspirational, from just telling about his life, you know, what he did and how he came out of rural north Florida in a very small town and went to medical school, did a very good job and went back to that town to provide services. That was sort of like — I held him up sort of as the example of the type of student we were looking for.

Thomas: When you began as director of PIMS, can you give me an idea of what the composition of the applicant pool was and who the students were who actually enrolled?

Reeves: I forget the exact time line, but when the program was started, it was started as a joint program between Florida State University and Florida A and M University to recruit students within that student population to take the first year of medical school. In fact, when it was first set up, you could actually join the medical program as early as your sophomore year. The original goal was to move students from their undergraduate education into medical school and almost combine them in a sense.

Thomas: It was an accelerated —

Reeves: Yes. Well, it wasn't exactly accelerated, because you could start medical education even as — and take some of the classes as early as, let me say, the junior year. And so you could blend the first year of medical school in with the end of your undergraduate education, and that was the whole idea. So the selection process was fairly complex because in the beginning they could even interview people who were sophomores essentially and accept them early. It wasn't exactly guaranteeing them a seat, but they were guaranteed to go on to the first year of medical school as long they performed satisfactorily. So they could start taking medical school classes usually in the junior-senior year and blend them in with their undergraduate education.

Thomas: And this was at a time when it was very competitive to get into medical school?

Reeves: At that time, yes, it was. The applicant pools were high and so forth. The whole idea was we could pick our best students and guide them into medical school, even early in their career. Well, unfortunately that plan is very hard to deal with. It means that you have to keep track of students at all levels and so forth and guide them into the program, and the PIMS program really didn't have the — what should I say? It didn't have the people that could watch these students and guide them; we were a small program. So it ended up, unfortunately, becoming a very traditional selection process where we were looking at seniors who were into the first year of medical school. And by the time I — and I think Paul Elliott had a horrendous time trying to manage that. When I came on board, we were already interviewing pretty much seniors for the first year of medical school. So unfortunately that model of blending the medical school program with, say, the last two years of undergraduate education and an extra year – it didn't work very well, unfortunately. It was very hard to manage. We had a few students like that when I came on board, but almost everybody that we were interviewing were seniors and/or traditionally taking their first year of medical school as the PIMS year.

So by the time I became director, it had already sort of morphed into that type of program, unfortunately a more traditional type medical program. But we were non-traditional because we were taking a pool of students just from FSU and FAMU. We then added West Florida.

Thomas: In 1985, I believe?

Reeves: Yes, I believe so. And the reason for that was the pool was just not big enough. We always had difficulties with — ideally what you want to do is interview three students for every student you pick. Something like that. You want to be able to — and for medical school, you want have — we couldn't pick students who were inferior to the student population at the University of Florida. If we did, we'd get in all sorts of trouble. And we did in some situations. So we added West Florida to increase the size of the pool, and I thought that was a necessity. In fact, what I really wanted to do was open up the pool eventually to any resident of the state of Florida. Which did happen after I left the program, and I thought that was coming because we just didn't have a large enough pool to select thirty students of the type of students we wanted. For instance, even though we were after students from north Florida, well, they don't all go to FSU. And so the population of students that we had to select from would be maybe only ten or fifteen percent or twenty percent that were from rural north Florida. Anyway, so it was very difficult to even satisfy the mission of the program with this set pool of students that we had.

Thomas: So the main strategy for getting students from rural north Florida was to limit the applicants to FSU and FAM, which were geographically in north Florida.

Reeves: Yes. But that, you know, the student population of FSU and FAMU is not necessarily rural north Florida.

Thomas: That's correct.

Reeves: In fact, West Florida, I think, had more rural students than we did, on a per capita basis. So actually taking West Florida in the program was, I think, a smart move as such. We invited people from West Florida to sit on our selection committee and so forth. But the mission of the program – we always had a hard time satisfying what I considered the mission of the program, to direct students into primary care. To take students from rural areas, primarily in the panhandle of Florida — then it became — well, there was one other aspect of the program. It was also inner city; it was inner city and rural. It was trying to serve the underserved, and the underserved were the inner city and the rural. There's no doubt about that. So we also looked at inner city kids that were from anywhere in the state. But again, we were — I don't want to say we were stuck with the population, but we were limited with the population that we had at FAMU and FSU.

And we were also after minority students. That was why FAMU was included from the very beginning, and I think we were not completely successful at that. I know the students at FAMU were being advised to apply to the traditional black medical schools, for instance. And I had no problem with that. In fact, I encouraged that, too. I said, "You should apply to PIMS because it's made for you if you want to do it, but you should also obviously apply to Meharry and the traditional black medical schools in the United States, and they did. We were criticized for not taking enough minority students into the program.

Thomas: Where was that criticism from?

Reeves: Well, it was primarily from FAMU. I don't know if it came from elsewhere, but the criticism I received was that the administration at FAMU didn't think we were doing enough to get their students into the program, although my contention is, "Well, we tried to do enough," and we had advisors over at FAMU that were supposed to be directing them into our program. And that didn't work out very well, either, unfortunately. In fact, I had a very embarrassing meeting with (and I can't remember what the vice president's name was at FAMU) about I thought that we needed to get a bigger presence at FAMU, a program office, which we didn't have over there. They were part of the program, and they were one of the undergraduate schools and they had a pre-med advisor, Lynette Padmore, who I got along very well with, but she had no office essentially for PIMS. She was sort of the PIMS advisor for us. But she was also their pre-medical advisor for FAMU. So that was always a difficult — you know, we wanted more minority students, we encouraged them to apply, but many of them did not. I know for a fact not many of them were applying. So we did what we could. Actually, I visited FAMU, I went to see Lynette Padmore and we always had two people from FAMU on our selection committee.

Thomas: And Lynette was one of them?

Reeves: Lynette was one of them, and usually the chairman of Chemistry was another one. You know, there were several and then they changed, but we usually had two faculty members from FAMU. Then like I said, when West Florida joined the program we had two from there. The selection committee was about half physicians, half from academia, and the physicians, many of them were — some of them were former PIMS students who had gone through and

were practicing medicine right here in Tallahassee. Our chairman for a long time was one of the pediatricians here in town who went through the Program in Medical Sciences, and by the time I — the late '80s, we had a number of physicians practicing here in town who were from — who had gone through the PIMS program.

Thomas: Were there attempts to create relationships with the local minority physicians in Tallahassee?

Reeves: Unfortunately not. In fact, we were criticized by some of the minority physicians in Tallahassee. Was it the Gunn Society?[2] I forget. There was a society here in town made up of physicians and pharmacists and so forth who were black, and they were critical of the program, and probably for good reason. I mean, we hadn't done what we had hoped to do with recruitment of students at FAMU. And that was always a very tough problem to crack, frankly. I was certainly open to having more cooperation and more involvement with minority students from FAMU, a larger applicant pool and so forth, but we just could not seem to make it *their* program as well as — they always considered it an FSU program, unfortunately, I think. And well, it was set up at FSU, it was run at FSU, and so forth. So I can see why they thought they were sort of left out of the program in a sense.

Thomas: My understanding is that there was originally a component of PIMS in the FAM pharmacology department? Or had that already gone away by the time you came?

Reeves: Oh, yes, I had forgot all about that. Yes. Now what happened was pharmacology was taught in the first year at the University of Florida. But before I came, they moved it to the second year, just about the time I came or just before I came. And so it became — we were teaching pharmacy or part of the pharmacy program is in the pharmacy school at FAMU, and we had a couple teaching positions over there that were paid through PIMS. Lynette Padmore's salary was always paid through PIMS, for instance, or her half salary. I'm not sure exactly how the budgetary arrangement was made, but we paid one of the pharmacy faculty members. Now this was — the whole idea was to teach that aspect in the first year of medical school at FAMU, teach pharmacy over there. Unfortunately, because it was moved into the second year at the University of Florida – I think that came just before I joined the program – then that sort of collapsed because we no longer had to teach pharmacy. Again, we had to match, essentially, the curriculum at the first year at the University of Florida; since they were moving that to the second year, then we simply dropped pharmacy from our program, or pharmacology.

Thomas: Now when you came to PIMS, was it a one or two year program?

Reeves: It was a one year program.

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[2]The William Gunn Medical Association was a medical society for black doctors in Tallahassee.

Thomas: It was a one year program. Okay.

Reeves: But like I say, it was a one year program – the basic medical sciences were taught in one year. It was three semesters. We started in the summer; it was summer, fall, spring, and then the students had their summer, the next summer off, and would transfer out to the University of Florida. Yes, it was a one year program by the time I arrived. Now before it had been – like I said, they were trying to pick up students early and move them into the program, and so for some of the students that were – at least early in the program – they were chosen as juniors, and so they almost did three years with PIMS in a sense. But by the time I became director, we were pretty much selecting students along a traditional line, just to take their first year of medical school with us, and so we were interviewing seniors for the most part.

Thomas: Tell me about — you came to PIMS — you know, tell me about the application process. You said you interviewed with quite a lot of people both at FSU and UF. Can you tell me some of your initial impressions of when you first heard about the program and applied for the position?

Reeves: It's hard to relive those years, but I can tell you that I got different opinions depending on who I talked with. Some people felt that PIMS was on its last legs already. It had only started in '71, and here we were at '79, but because the federal funding, the loss of federal funding – and that was right around the corner by the — I think I had partial funding for one or two years when I was first here, but we knew it was going to disappear. And because of that, I kept getting asked the question, "Are we going to select again for next year's class?" People were saying, "Is this the last year of the Program in Medical Sciences?" I really didn't get that feeling from the University of Florida. I got it more from here. And so I think people felt that the program was going to collapse or it was going to disappear within a year or two, and that University of Florida was going to absorb all those students into their first year. And yes, I got a lot of that when I did my first couple of years here. But we managed to stay afloat. We tried to do everything we could do to boost the number of students that we were interviewing. I think that was one of the biggest criticisms that we got, and man, it really became a criticism in the late '80s when the applicant pool fell off. By 1987, the applicant pool was at an all time low, I think. We could not select thirty students!

Thomas: Both within PIMS and nationally in all of medical education.

Reeves: You know, I could see it coming because in the early '80s, about the time I took over, there was this big change in the delivery of medicine. I mean, everybody became aware of it. HMOs and new medical groups were forming like crazy, and most physicians were feeling that somebody else was paying the bills and they didn't have any control over their own practice and that there were third-party payers —. And so they were telling students – and I heard this over and over and over again – "Don't go into medicine; it's just — the business aspects of it are just going to be horrendous and you won't like it —" and so forth and so on. And I used to say, "Well, that's not medicine; that's the business — medicine is treating patients" and so forth. But

we got a lot of that, and that filtered down to the students and then the applicant pool through the first part of the '80s, and by 1987, I think we were at a real minimum. Students were being discouraged to go into medicine because it was just not satisfying to a lot of physicians. And I got that feedback even from our own community here.

Thomas: You talked about the importance of the ending of the federal funding. Did you ever pursue other types of external funding such as grants —?

Reeves: Yes, we did.

Thomas: Can you tell me about that?

Reeves: Well, for instance one of the grants — there was a grant that was given to satellite programs and we were considered — and I thought, "Gee, we're a perfect satellite program." Our program is after the type of student that medicine in general was after. We were trying to build primary care. The whole nation was trying to do that. And primary was thought, you know, with the new HMOs especially and all this new — that we were going to need primary care physicians – as gatekeepers, some people called them. These were the people that were going to control — they were going to be the first — the patient's physician was going to be a primary physician associated with an HMO or something like that, and the specialists were going to be — you know, these physicians were referring to the specialists. So anyway, there was a need for primary care physicians. There was certainly a need for rural physicians, which were considered primary care – in this area, anyway.

There was one other source of external funding that we investigated, and I even applied for, and that was a satellite program grant that funded programs that were satellites to medical schools. But before we got too far along with that grant, they told us that we didn't qualify. And I'm not exactly sure why to this day. I thought we fit the bill exactly, but it turned out, I think, that most of that they were after were primarily minority programs that were satellite programs to large medical schools. I think Drew[3] to UCLA was one of them, and they were supported. And I remember there were several others. But they didn't think we qualified because we were not a minority program feeding into a majority medical school such as — you know. So we didn't qualify for that. We did try — I mean, everything that came along, I looked into, but we would never fit the bill quite right. And building funds were zero, and we really did need a new office and — and that didn't come until after I left, as a matter of fact. Those kinds of things we almost impossible to get, at least from the federal government.

Yeah, funding was a real problem. So we existed on state funds that came down — there was a special funding category for PIMS that was attached to the university budget here at FSU, and that came through to us every year. And it funded — I think we had like five and a half faculty positions, thereabouts – it changed from year to year. We had expense money and we had OPS money. And we tried to use it as wisely as we could. It was not a large budget and we were running essentially a mini-medical school on a shoestring, if you want to know the truth. I

[3]Charles R. Drew University of Medicine and Science

mean, we managed, but we were not in the greatest office space. We had a makeshift anatomy lab that I tried my best to put together my first two years here because we lost our anatomy lab – it was just too small, we had to go to a larger one.

Thomas: So the lab that was here when you came into the program could no longer be used.

Reeves: It was just too small. They were teaching anatomy in two shifts; we couldn't do that any longer; it just wasn't working. So we needed an anatomy lab that would hold thirty students. I think they were teaching fifteen at a time. It just was not working very well. So we got the space and we converted a room in the Montgomery building to the anatomy lab, and we got money for that. But that was about the only renovation-type money that I think we ever received when I was here. We were always in need of money, in need of funds.

Thomas: What were your relationships with the administration here at FSU and then also in the College of Medicine at UF? Who specifically did you report to and —

Reeves: Okay. In terms of raises, my salary, things like that, I reported to the chairman of Biological Science. At that time when I first came it was Gib DeBusk. And we were on very good terms. In fact, he was the one, from one what I understand, one of the people that recommended that I be interviewed for the position. So we were on very good terms, and I got along with Gib quite well. In fact, I got along always quite well with the biological science people. In terms of budget and in terms of running the program, it was the dean of Arts and Sciences, and that was Werner Baum when I first came. And Werner, I don't think liked the Program in Medical Science at all. In fact, he made comments that he was not – didn't think that medical education belonged in Arts and Sciences, essentially. And so he tolerated the PIMS program, but I don't think he actually was — he certainly didn't go to bat for us. And when I would take problems to him, and funding problems to him, he would listen and sometimes he would just frankly say, "What do you think I can do?" So that was really tough. I got along with him, and we talked well together, but I don't think he ever was a — he certainly didn't support the Program in Medical Sciences.

Now at Florida, University of Florida College of Medicine, it was Dean Deal and Associate Dean Dockery. Those were the two that I dealt with, and I guess I dealt with Dockery more than Deal, although Deal was pretty open. He invited me once a month to deans' meetings, and frankly, of all the administration that I dealt with at the University of Florida, I thought they were the most straightforward and easiest to deal with. The new dean that came on, I knew personally because he was a chairman of Microbiology at the University of Florida. He was a virologist and I knew him – Ken Burns was his name, and I knew him pretty well. And I thought that I would have a pretty good reception after he became the new dean. He was an MD-Ph.D.; he knew the program. I could talk with him fairly well, at least earlier, but I think after he became dean I don't think I ever talked to him once. I dealt with associate deans and assistant deans that were assigned to deal with the Program in Medical Sciences. The dean of Education was the one that mainly dealt with Program in Medical Sciences, and he was not very – what

should I say? – supportive of the program. In fact, I remember one meeting, and I think it was '91, that I went to – that I was invited to the University of Florida – that I thought was just horrible. They asked me to come down and talk because it was going to be a meeting about PIMS, sort of, but they didn't tell me what the agenda was. And I asked, you know, "What are we going to talk about? What's on the agenda?" When I got down there, it was a larger group of people, and not only the administration but a chairman — there were other people there, too, that I didn't even know who they were – and all they did was criticize the Program in Medical Sciences for about an hour. It was very tense and I was furious after I left, if you want to know the truth.

Thomas: Criticize it on what grounds?

Reeves: That we were taking inferior students, that they weren't performing well when they transferred to the University of Florida and things like that. Well, in a sense — well, when I looked at the data, on occasion our board scores and so forth and our performance was good then bad then good and – there was no real trend except until we got to the late '80s. And remember, I said that that's the time when the pool sizes were really down and we had a terrible time picking a class that was what you might call a high quality medical class in terms of numbers and so forth. The people we picked, some of them we liked very well, but some of them — in fact, the ones that we had the most difficulty with were actually sent to us by the selection at Gainesville, and we interviewed them because our pool was low. And some of our most difficult students were from that pool, it turned out. But we were responsible for them, and some of them didn't perform well, unfortunately, when they transferred to the University of Florida. So we got heavily criticized for that.

I think there was a movement again to sort of do something about the Program in Medical Sciences, and I think I was targeted to some extent. So I said, "Well, the way they're treating me and the way they're treating the program, I can't deal with this." And unfortunately, I left on kind of a bad note.

Thomas: _____[??].

Reeves: In '92. Now Myra Hurt was my associate director, and Myra and I always got along very well. I don't know if you know, if she told you in her interview, but I was on Myra Hurt's Ph.D. committee at the University of Tennessee when I was there. And so I had known Myra for a long time. In fact, I was the one that sort of moved her into the associate directorship position. And I told her, you know, she saw – she knew the PIMS program quite well and she saw what was going on, and she knew that she was going to have to deal with a some criticism. But we had a meeting that was here in Tallahassee with a number of the administrators from the University of Florida, and Myra and I and the other associate directors of the program were there, and we all talked about the direction of the Program in Medical Sciences. And I think at that meeting we decided to open up the pool and do a number of things that would make the program better. And I thought, well, good, if that does happen, then the Program in Medical Sciences will improve and I think the quality of students will be better as well. So I think that

solved the program.

Now the one worry was, if we did something like that, would we lose this – you know, the rural north Florida tradition that we had in the program? Actually we had sort of lost that anyway when the pool shriveled up, because it was difficult to choose and we had people that we really wanted. I think we still did quite well in picking primary care students that chose primary care when they left the medical school. In fact, we did do well – we always performed well in that capacity. But you know, the lack of federal funding, the drop in the pool size and so forth – the PIMS program suffered a number of problems. I think the pool size problem was the biggest problem that we had. And unfortunately, I couldn't resolve that as long as we had FAMU, FSU, and West Florida as our only pool of students. And so opening up the pool really improved – it improved the quality of the students. And the other thing is that you had a larger pool to pick from and you could pick rural students from other parts of the state and other parts of the country. And the reason we were interested in picking rural students – and I think there's a good reason for that – if you looked at who went where after medical school, people from cities and suburbs were just not going to go into rural practice. You needed somebody who understood what was going on in small towns, and those were the students that were likely to return to those towns, so that's what we were after.

Thomas: So you say that two of the successes of PIMS are that they did a good job in choosing students who did eventually go into primary care, and they also did a fairly good job of bringing rural students in, especially after the applicant pool increased. Can you talk about the admissions process and especially how it might have been different from say a traditional medical school admissions process.

Reeves: Well, for one thing – when I was director, anyway – the one big difference was that we knew the students before they even applied, for the most part. I mean, we were their pre-professional advisors as well. That was one other aspect of PIMS that nobody brings up much. The office was also involved in all the pre-professional advising for the whole university. So we advised for dentistry, medicine, pharmacy, everything except for nursing. So we knew all the pre-medical student before they applied. So the people who ran the program – myself, the associate directors, and the people that worked within the program – we knew the students because we talked with them. Even the students from FAMU; they would come over and talk with us; the students from West Florida. We would either know them or the people on the selection committee would know them. We had a better – I think because we had this limited pool, we knew our applicants quite well before they even applied. So it was — and we also — I know Myra Hurt – in fact, she's one that always said that we were looking for missionary types in the Program in Medical Sciences. In a sense, that's true. We were looking for people who were outgoing, who wanted to help other people, who were likely to become primary care physicians and hopefully return to a rural area to practice. So we had that goal. Now, admissions policy, how did we influence that? Well, we directly asked questions about that on the essays that we would write, we would see — we knew where they were from. We would have them write — have a student letter sent for them, so we tried to get all aspects. In other words, were they good with their peers? We tried to assess whether they were going to be good

with their own patients. Whether they were going to survive in a primary care rural setting. So we would look at that.

Thomas: So you asked for a peer recommendation from other students?

Reeves: We asked for a peer recommendation as well. I don't think there was anything too unusual about the application process. It was like a traditional application, but we did look at – we did ask questions about where they wanted to practice and how they pictured themselves in ten years and things like that. We wanted to get an idea where they were going and hopefully pick those that were interested in primary care. I guess if we had had a larger pool, we would have done better – let's put it that way. But because we had the limited pool size, we certainly _ _____[??] — okay, in terms of picking those students — that may be where we got in some trouble with the University of Florida. They sat on our selection committee – the dean would come to our selection committee meetings, the dean of students, Smiley Hill, and usually the chairman of our selection committee would also come to all of our meetings. And they were critical of the way we would try to select those who were from rural areas and so forth, even though they weren't as competitive in terms of GPA and CAT scores and so forth. But I know if we found a student that we thought was really dedicated, from a rural area, definitely interested in people– and demonstrated that in their application – we would give them the benefit of the doubt _____[??]. Some of our best students were along that line. I remember dealing with a student named Les Wilson, who didn't make it into medical school his first time, and I kept encouraging him and so forth. I would meet with him — in fact, I met with all the students —

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Reeves: — after they were rejected and talked to them and told them what to do. And Les Wilson was one that I met with that I told him, you know, that he really should try again and so forth. Anyway, he succeeded.

Thomas: Was he rejected for PIMS or rejected —

Reeves: Rejected for PIMS. He had tried again, and I don't know if it was the second or third time of his application that he was finally admitted to the program. He went through the program. He wasn't the greatest student, but after medical school he married a young lady that he met at the University of Florida and they were fantastic. They returned to his area of the state, he practiced rural medicine for a number of years. They now have a primary care office here in Tallahassee — again, they practice in Tallahassee but they're great primary care physicians. So we were looking for students like that. Now Les Wilson – and he'll tell you this himself – that he wasn't the greatest student, he didn't have the high scores and so forth, but we thought there was something there in terms of primary care, that he would be a great primary care physician. I remember he was selected for that.

Thomas: And I've heard about the — that Manny Suter and Paul Elliott did a great deal to develop new admissions criteria and procedures that would identify students with promise who were not maybe competitive in the more traditional terms. And when you said you saw promise in this student, what did you see that triggered —?

Reeves: Yeah. When I look at a student's application, I look for things like, you know, what have they done? I think all medical schools do this, but we emphasized it more. And I think Paul – okay, number one, you know, from a rural area is a good bet – okay, they're likely to go into primary care; that was number one. So we looked at that very seriously. And I think Paul knew that. Number two, we would look at what they did. I mean, so all the applicants — now, this is true for any application to medical school. They want to know, you know, what you've done in terms of health care, what you've done in terms of community service, and what you've done in terms of outreach programs, what you've done in terms of helping other students – your own peers – and so forth. And yes, we looked at that very carefully. Those were all predictors of somebody who's going to go on in primary care. And so, yes, that was part of the applicant and it was definitely part of the interviewing process. I'm not so sure that we were doing anything all that different, frankly, by the time I came on as director, because I went to the national meetings of the AAMC and I would always go to the selection process meetings to see what other people were doing and so forth. And we weren't doing anything that much different, but I think what we were doing is emphasizing those things — I mean, some medical schools got – should I name medical schools? Anyway, got the — well, got tagged with being — they only looked at MCAT scores or they only looked at GPA. Anybody that had a 6 on the MCAT was automatically excluded and so forth. We didn't exclude anybody. I remember we always had somebody with a GPA below 3.0 in our class almost every year. And people say, "You did? How in the heck do you do that?" Well, we had what we called "retread" students that had done very poorly and then had come back, and with help, with guidance that came from our program, they did very well in school and improved themselves dramatically. They had such poor grades in the early years, they were never going to have a high GPA, but we would take them anyway. Now that's also done —

Thomas: So if they'd shown improvement —

Reeves: They'd shown improvement. I mean, we can't take students who were 2.8-type students were just straight — they're not going to compete in medical school. I don't think there's any doubt about that, in fact. But we would take 2.8 students who had shown improvement. I remember one student that we selected who was an older student, had a 1.9 GPA in his first two years, and he dropped out of school and so forth. But then he came back and did all the sciences and finished his bachelor's degree; essentially he had a 4.0 in his last two years. And again, his GPA would be terrible in terms of, you know, you wouldn't even want to report it in terms of your admissions data. But we would take students like that. They would also have to show some promise of, again, is this the type of student we really want to take, we really want to have in the program. And I think that was the final _____[??]. There is a faculty member here in our medical school now, at FSU, who I met down at the University

of Florida – Gene Ryerson. And he was the chairman of the selection committee down there and I served on that selection down there for a while. And he and I really saw eye to eye. I think – in fact several times either he or I would say, the ultimate thing you want us to do when you selected a student at medical school is to find a student who is empathetic, who you would want to have as your own physician, somebody that would deal well with other people and so forth. And so that's what you try to assess. And it's hard to do that on a written application, so that's why the interviews are so important for medical school.

And we had three interviews – that's one more than most medical schools; most medical schools had two. One of them was usually by a student. We got criticized for that as well. But we had students on our selection committee the whole time I was director. And so students would interview. Well, we got criticized by that, and I think sometimes in the later years I think the students got dropped off the committee, which I thought was not a good thing. Anyway, so the selection process, yes, we looked for students who we thought would be good primary care physician students who could interact with people. And we would select a student, even though they didn't have the numbers, who sort of fit that description, that category.

Thomas: You mentioned the AAMC – can you talk about any interaction you had with either that organization or other medical education groups?

Reeves: Well, as a satellite program of the University of Florida College of Medicine, I was invited to the AAMC meetings, and I always went, went every year. And again, I usually would attend the selection process meetings and so forth, because that's — our biggest role was selecting thirty students. Our curriculum wasn't all that different from other medical schools, although we did emphasize medical education – or not medical education but medical —

Thomas: Clinical?

Reeves: Clinical aspects right in the first year. We started the Neighborhood Health Clinic, which is now the Neighborhood Health Services here in Tallahassee. It was a free clinic for the — well, anyway, getting back to the AAMC, we didn't have a whole lot of interaction with them directly. We were accredited; I went through two accreditation processes as part of the University of Florida, so we would have that interaction. But except for going to national meetings, bringing home information from those meetings back to the program, we didn't have a whole lot of interaction with AAMC. When the program was first started, I remember Paul Elliott gave a couple of national talks; they were very interested in this new program that was a satellite program and so forth, that was going to select primary care physicians from a rural pool and all this thing. And so there was some popular press for the Program in Medical Sciences at that time. But by the time I became director, that sort of all died down because the program was in its eighth year or so and we were — but we were still trying to accomplish that mission of selecting rural students, selecting them for primary care. I mean, that was the main goal of the program. In fact, that was the — you know, the fact that they added geriatrics and so forth to the new medical school sort of came out of that, to provide primary care for a needy population — and geriatrics is just not well represented here in Florida. So primary care in geriatrics became

sort of a theme for the new medical school. And I think some of that came out of Program in Medical Sciences, or that tradition, anyway.

Thomas: Can you tell me more about the establishment of this neighborhood clinic?

Reeves: It was before my time, so I don't know exactly — I served on the board for a couple of years and I got very involved with it. I would even go over and made visits to — they only operated one night a week, I believe, or maybe two nights a week. So it was like Tuesday and Thursday evenings. They were in the basement of the Presbyterian Church here just off campus, where they had exam rooms set up and so forth. They only saw elderly patients – well, I shouldn't say that – patients who couldn't afford to pay, who had problems with high blood pressure and diabetes. So in that sense it was a fairly limited clinic. But it did serve a number of people who had no place else to go. They could get a physical exam. If they were diabetic or had high blood pressure, then drugs could be given. There was always a physician and usually a nurse practitioner was involved with the Neighborhood Health Clinic. David White was instrumental in setting that up. But again, I don't know exactly how it really got going because it happened before I — they wanted a place for the medical students to do physical exams and to do some clinical medicine. So we had a clinical medical program in the first year that was fairly unusual for medical schools, because that usually doesn't come till the second or third year. And so we tried to get our students involved in contact with patients right from the very beginning, and the Neighborhood Health Clinic was the vehicle that we used. So it certainly wasn't my idea; that happened before – Paul Elliott and Dave White set that up as a clinical part of the Program in Medical Sciences.

Thomas: Was there not also a clinic that was in the black neighborhood of Tallahassee?

Reeves: Not through the program. This one was right off campus. There's the Bond Clinic, but that was not through us. The Neighborhood Health Clinic was the only one that we were connected with, and it was right here just on the east side of campus. But we got people mainly from the poor and minority community to come to that clinic, and it was well received. They would see twenty patients in an evening. That's about all it could handle. But they had returning patients. But again, it was limited primarily to chronic disorders, mainly high blood pressure and diabetes.

Thomas: We're right at an hour – are you doing okay?

Reeves: I'm okay.

Thomas: What do you remember as the most satisfying aspects directing PIMS?

Reeves: This comes back to my own strengths as a faculty member and professor, and that's I think I deal well with students and get along well with students. So what I always enjoyed about the Program in Medical Sciences is that I taught with the program; I got to know

all thirty students, usually pretty well. And my satisfaction from the program was primarily dealing with the students and watching then mature and going on through the first year of medical school and on to a profession. One of the students – this was really heartwarming to me here just recently – named Kevin Broyles – he worked through the program back in the early '80s. But unfortunately he and another student go involved, strangely enough, with church activities, almost cult-like activities, that occupied all their time. And we actually dropped them out of the program and told them that they could rejoin the program in one year if they wished to if they would make sure that — because this church activity was telling them they couldn't have friends except within the church and so forth and so on. So they were almost ostracized within their own class in the Program in Medical Sciences. It was kind of a strange situation. But anyway, Kevin was very religious, and his friend were both dropped out of the program. Well, Kevin came back to visit me here just about two weeks ago and said that — he thanked me, he said that what I did was say, "Okay, I want you to sit out for a year but then you can come back into the program and you'll repeat the whole first year of medical school and you can go on," and he did. And he won several awards as a primary care physician, he is practicing at Duke University as a primary care physician, he has outreach programs there the Raleigh community, in that area, around the university. He's also involved with programs in Kenya and parts of Africa, especially with AIDS individuals. So he has — I mean, he's the type of student that, again, that we were very pleased with because went on into primary care, he's developed several – these are clinics for people who can't afford access to medical care. And then he's gone on several missions to Africa working mainly with AIDS individuals.

Thomas: He finished from Florida but now he's at Duke?

Reeves: Yes. And so the reason I bring that up is that's, you know, I get I think the most satisfaction out of just seeing the students do well, and many of them have done very well. And he overcame obstacles and still did well, which I thought was fantastic.

Thomas: Was he a rural student?

Reeves: Yes, he's from north Florida; he's from the Panhandle. I can't think where he grew up. He is from the Panhandle, but I can't remember what — I was thinking Chipley, but I don't think that's correct. Maybe Marianna. Anyway, he was a success story. And he almost failed. We stopped and said, "Okay, look, you need to do something to make sure that your outside activities don't prevent you from succeeding as a physician." That's essentially what we were telling him. We couldn't tell him to drop his church or whatever, but we needed to make sure that he knew what he was doing, because he was – they were spending forty hours a week in other than – other activities, and they didn't do a good job in the medical program. But when he came back, he did a good job, he went on. Like I said, in his senior year he won several awards in primary care in family medicine, and his career's been great. So again, my greatest satisfaction that I got out of the program was just watching some of those students do very, very well.

Thomas: One of the things that seems to have come out is the identity of PIMS changed over time. It started out to increase the class size of UF; some viewed it as a way to have a medical education program at FSU but not a four-year medical school, because there was rivalry between UF and FSU.

Reeves: We weren't considered a health university, for one thing. Well, I'm not even sure how we got nursing, because I even saw documents saying that Florida State University is not considered a health university and should not be developing a medical school or a pharmacy school or anything else.

Thomas: Do you remember what the source was?

Reeves: This was from the State University System or the Board of Regents – I'm not sure where this came from. But I remember seeing that, and said, "That's interesting." So that's why South Florida has been used – and South Florida is designated a health university and they have public health and they had a medical school well before we did, obviously. And University of Florida obviously was a designated health university. But FSU was not. So every time we talked about expanding the PIMS program – you know, in fact I did when I was director, I approached several people about, you know, "What do you think about developing the Program in Medical Sciences into a four-year medical program?" And I did that with a number of people, and even took a trip to Macon, Georgia, to visit Mercer medical school. Because they were designed very much like the Program in Medical Sciences – small class, thirty students. I think they've grown now, but they were thirty students when I visited them. For primary care in rural south Georgia; that was their mission. So their mission was very much like ours. So we visited them to see, okay, could we develop a program like theirs and so forth. We were even talking to Bud Harrison, who was the chief of staff at Tallahassee Memorial, what did he think about it, you know, growing into a medical program. And I think he was sort of shocked in a way, said, "Well, do you really want to do that?" I said, "Yeah, I think we could do that. I think we – you know, we successfully have done the first year of medical school, we have the ability to expand that, we think, if we had, you know, the clinical side of medicine," which we didn't have. But he was negative; other people were. Then I realized that in order to do this, it was going to take a political decision of some sort, which it did eventually.

Thomas: And that was what I was going to ask you. Did you have much interaction with the state legislature?

Reeves: None at all. At least I didn't. Maybe they were talking with, you know, the president of the university and so forth, and the provost, but they weren't talking with me.

Thomas: Other than Werner Baum, there's no one at FSU that you really approached in the administration or —

Reeves: I talked with Larry Abele when he was dean, yeah. And in fact, what was

surprising to me is that – this happened about 19 — in the late '90s — said, "If there was one thing you could do for the university, what would it be – in the next ten years?" And I was surprised that Larry Abele came up with establishing a four-year medical school. This was some time ago. You know, we had talked — when I was PIMS director, Larry became the chairman of Biology, so he was my direct supervisor and I had many talks with him about, you know, the problems I was having with the dean of the College of Medicine or the administration down there and so forth. And we had many talks and he always listened and so forth. But he wasn't — I didn't think he was all that interested in medical education as well, so I was kind of surprised when he came out with that. Then he went to the dean's office – chairman to the dean and then to the provost's office. And I sort of lost contact with him after I stepped down, but I was surprised to see that he thought that we should go to a four year medical program. But we had conversations about it when he was both chairman and dean.

Thomas: You said that your strengths were your teaching students, student interaction – can you talk some about faculty and did you recruit any faculty or —?

Reeves: Yeah. I was on — we always had needs in the Program in Medical Sciences, but they were always teaching needs. A couple of unique teaching positions that we had that you wouldn't see in a biological science department or other departments were the anatomy lab with cadavers. It's just not normally taught in an arts and sciences, you know, and arts and sciences college. We had several anatomists that I was involved with recruiting. Gary Gorniak was one of them that got recruited. Unfortunately, he didn't get tenure and had to leave the university. So we were constantly involved with recruiting people who taught our speciality classes like gross anatomy. I think I recruited – David Balkwill was a PIMS position at the very beginning. We were after somebody who was — I think we were after another microbiologist at that time, somebody who could kind of teach in the Program in Medical Sciences as well. Sometimes the positions within the program were not always used directly with the program. For instance, I think Dr. Randy Rill in chemistry was a PIMS hire before I was director, but he never really – he taught a little bit of biochemistry with the program, but he never really was an active member of the Program in Medical Sciences. But we felt, and the academic departments felt, that while some people that we used a great deal had no association with PIMS, so there was sort of a trade off going on, and that was before I was even director. So some of the positions – and like I said, we had about five and a half positions; there was the director and associate director and there were like three faculty positions. There had been that pharmacy position that ended when the pharmacy was moved out of the curriculum. So I think when PIMS first started, there were like seven positions, six or seven, something like that. I'd have to go back and look at the details; I don't know exactly how they were set up. But there were about six or seven faculty that were paid through the program's budget. Most of them dealt directly with the program; they taught either physiology or anatomy or my salary, the director's salary, and I taught microbiology and virology.

Thomas: And these classes were limited to enrollment by PIMS students or were they mixed —

Reeves: Some of them were.

Thomas: — basic science undergrads and PIMS, or even basic science grad students?

Reeves: Yes. Some of them were limited. The infectious disease course that I taught was almost exclusively PIMS, although I would allow a senior or graduate student to take the course if they wished to. For anatomy, we almost always had one or two non-PIMS students in anatomy. For physiology, they were mixed. Those classes were used for the Program in Medical Sciences but they were also taken by graduate students in physiology and neuro-anatomy. So it depended on the class. Now that's not unlike other medical schools. When I went to NYU medical school in biochemistry, I took the medical school biochemistry course, I took the medical school microbiology course, I took the medical school genetics course as part of my —. So that's not unusual. But it was limited. We would have maybe the thirty medical students and at most five other students in the class that were usually graduate students. And so the teaching faculty were primarily in biology. There were a couple people in psychology that taught for us. Neuro-anatomy was taught by psychology members. When I hired the anatomist, he turned out to go into biological science, but he could have gone into anthropology or human sciences or wherever he felt comfortable. We were free to put — so we hired an anatomist to teach the anatomy course, but that person could go into about three different departments when they came, and he chose biological science.

Thomas: Was there ever discussion of moving PIMS to basic sciences instead of arts and sciences? Was that not seen as an advantage?

Reeves: No. Arts and sciences was the — I mean, we used people primarily from chemistry, biology, psychology; they were all in arts and sciences. So we didn't really have anyplace to go, frankly, unless we became completely independent like a medical school, and that was unlikely the way it was set up. So we were always under the dean of Arts and Sciences. And again, our teaching faculty were in departments. We had some in human sciences at the end of the program, but when I was director I don't think there was anybody except people from arts and sciences. It was psychology, biology, and chemistry professors.

Thomas: You had mentioned a couple of national context issues, you mentioned a declining pool of medical applicants, the declining federal funding for medical education and the report that you mentioned — it seems that the '70s were this period of growth and reform —

Reeves: That's right.

Thomas: I guess what do you see as the big picture factors that affected the evolution of PIMS during the '80s and early '90s?

Reeves: Well, we've already mentioned the two major ones, I think, and that was that the GMENAC Report I referred to was used by the federal government to cut almost all funding,

especially building funds, for medical programs, and even support funds. We got capitation funds that were through the University of Florida College of Medicine, but our thirty students got – and the Program in Medical Sciences, therefore – got capitation funds from that grant. This was a federal grant that had been apparently – I don't know how long it had been in existence, but for some time – and so we derived, you know, some obvious benefit from that. We got federal money. That was ended about 1982, I believe was the last year for that, or '81-'82. We knew it was coming, like I said. We knew everybody was said, "Well, the GMENAC Report did us in, did us all in," and everybody, you know, I heard that over and over again. And "We're training too many physicians, so we shouldn't even — you know, if anything, the PIMS program should be eliminated." And that was really true. I mean, that's why I remember at the beginning of every year, were we going to be given permission to select a new class of students. Nobody ever said you can't, or we're making a decision, and nobody ever stopped us, but everybody always felt that our necks were out there and we were going to get cut off essentially. So it was not a very pleasant time, those first few years, mainly because of what was happening at the national level. We were training too many physicians, we should cut back, and so forth and so on. And that was really pervasive. At the AAMC meetings I went to, that was definitely one of the big topics; everybody was talking about it.

Then the other big thing that affected us was the change in health care. It affected everything. It affected medical education because — and I think – I don't know if this is true, but it looks like it's true, that the pool of applicants to medical school dropped because of that change and because of the dissatisfaction that physicians were showing with that change. And that the career was not what it was — you know, you were not your own boss, you had to satisfy an insurance company to get your patients reimbursed for their medical procedures and things like that. All those horror stories were coming down the line. And I don't know how many students I talked to that had talked to physicians that told them that they were crazy to go into medicine, you know. And it had an effect. So the pool dropped in the late '80s. It is now recovered; in fact, it recovered fairly rapidly. By the mid-'90s I think it had already — I wasn't following closely, but I could see it was already — we were at the point in 1987 – I think it was that year – that six people out of ten that were selected – of applicants were selected to medical school – sixty percent. I mean, everybody was suffering from the pool, from the decreased pool of applicants. We certainly were. So in those years, I mean, that definitely affected the way we ran our program, who we could recruit into the program. We didn't have a choice any more. We took all the students that were acceptable from our own pools, and then we had to interview like thirty other students that were sent to us from the selection committee at the University of Florida. So that's why, you know, I was – at that point in time said, "Unless we open up our pool, we're not going to survive. We just won't be able to pick —." When I say 'quality of students', I mean students who could go through medical school easily, but students that we want in our program. And we just couldn't do that. We were after those rural students; we really were. We were after those students and the students that we thought would go into primary care, but we didn't have a choice. So that changed the program dramatically, unfortunately. And so again, we were sort of under the gun in that we couldn't even fill our own class. So there was always this thing, should we eliminate the Program in Medical Sciences? I always felt that undercurrent all through the '80s.

Thomas: Could you talk about a change that I've heard in the way the language changes over time – in the early '70s, PIMS was founded very much as a minority recruitment program and you talked about that the early values were also to bring students from rural north Florida. So were those values equal at the beginning or — and what I'm asking is, the language changes from minority recruitment to recruiting non-traditional students who are students from underserved backgrounds, which is a broader context. Can you talk about that?

Reeves: I think by the time I became director, we were — I mean, I wasn't — what should I say? We weren't being very successful recruiting minority students from FAMU, and that was already apparent. And I think Paul Elliott was really – was deeply involved in trying to recruit minority students into medicine. And unfortunately, either because it wasn't set up correctly, there wasn't as much participation by FAMU, they felt — most of the criticism was before I became director, but we were criticized, the program was criticized by the African American community here in Tallahassee even that they weren't doing their job. Now I contend that part of that was FAMU's fault. They weren't even directing their students into the program. I remember going over there one year — we got two applicants from FAMU; I think we accepted both of them. But there were like eight or ten others that didn't even bother to apply. What are you going to do? So it was a bad situation. There has always been this rivalry between FSU and FAMU, and it just wasn't very successful the way it was set up, unfortunately. I tried my best, I think, to help FAMU out. I gave them a half position, a secretarial position; I was trying to set up a recruitment office for PIMS on the campus over there that was part of their pre-med office, but it just never happened, unfortunately. That was my goal, to do that, but I got — remember I said in the earlier part of the interview, I had this one meeting with one of the vice presidents for FAMU, and it was not a very pleasant meeting. He was telling me that I was trying to get involved in their pre-medical students and I had no – that wasn't what I was supposed to do, that that was their business and not my business and if I wanted to do anything, I could, you know, establish another position. And so I came back over and talked to — at that time it was Gus Turnbull was our vice president – provost – and I talked to him about those meetings and he was sympathetic and we did end up giving another half position to FAMU. But that position, frankly, I don't even know where it went. That was the other horrible thing: we could establish a position and send it to FAMU, but I'm not sure they even used it for what it was supposed to be used for. I mean, things just weren't set up correctly. If we want to do minority recruitment from FAMU, then I suppose it had to be like the engineering college or something like that where there was a joint FSU - FAMU presence, it wasn't on our campus and you know, it was actually separate. Well, that didn't happen. So a lot of the FAMU students didn't even bother applying to the Program in Medical Sciences. So that recruitment technique didn't work very well, unfortunately.

I think we went into it feeling that we would do everything we could. In fact, pharmacy was involved with the program at that time, and so there was a feeling that FAMU would be a part of the program and they would be active with the program, but by the time I became director, unfortunately that had not materialized. In fact, it had gotten worse.

Thomas: But in medical education at large, you know, the AMC is putting a lot of

emphasis on minority recruitment and Paul Elliott was very involved in that —

Reeves: Yes, I know.

Thomas: But it seems that there's a move in the '80s toward a change in language to non-traditional students, both social and economic as well as strictly racial diversity.

Reeves: Well, I think you're right; I think that did happen.

Thomas: And could you see that happening in PIMS, I guess is my question.

Reeves: I think it had already happened in the '70s, if you want to know the truth, because when I got there, it was — the whole idea, or at least the major — well, there was still minority recruitment for FAMU, and we did our best and tried to recruit students. I would go over at least once a semester and meet with their pre-medical students and talk with them about PIMS. Lynette Padmore, she was very gracious, would invite me over and so forth. So we continued to do that, but you're right, I think all the writings and the emphasis on the program was on this rural primary care and inner city recruitment. Now Paul emphasized inner city I think more, because that was a way to get the minority students into the program. And yes, we looked for that as well. But I think we primarily looked for students who would go into primary care and hopefully into rural practice or inner city practice, serving those people who were under- served. So serving the under-served, I think, was sort of the way that the program became, and that meant primary care in rural and inner city areas now. Were we successful? One of the problems is that the student chooses their practice in the third year – the end of the third year of medical school. They've left us for two years by the time they're doing that. But I think we were moderately successful in doing that, just by the recruitment. And I think Paul had the right idea, that you know, recruitment is very important and when you recruit students into medicine, you look for those people that you think will conduct rural or inner city practices, who are going to be primary care people-relating positions. We weren't after surgeons and orthopedic surgeons and so forth or dermatologists; we were interested in people who were going to practice medicine, you know. I didn't really see a change. I think there were pressures on us to change, though. And unfortunately, some of the pressures were negative pressures, like the loss of funds, the loss of pool size. And there was not much we could do about that, the way we were set up.

By the time I was near retirement from the program in '92, I thought, "Gee, the only way this is going to work and PIMS is going to do its job is to expand the pool, number one." And I think — I'm not sure — you know, after I left the program I don't know exactly what happened, but I think University of Florida felt that that was a good move as well and that should be done, and that there should be a better presence of the program on the campus here, and that's why the finally moved the program offices out of Montgomery and over to that bottom floor of nursing. I think that was a positive thing for the program. So things were done in the '90s, the mid-'90s, to upgrade the program, which I thought, "That's great." And then the _____[??] political thing about, you know, establishing a four-year program, that was — well, after my time, but I think that was — I could see it coming, I guess, a little bit, but it was still a bit of a surprise.

Thomas: So you helped direct Myra Hurt into FSU to begin with and then into PIMS as well.

Reeves: She came from — well, with her husband, who was a heart transplant surgeon here – cardiovascular surgeon here and still is – and when she came, she had no position, no academic position. She got a position working with Dr. Bill Marzluff. I don't know if you've heard that name – he was a biochemist in the Chemistry Department. He was a very close friend of mine and he had a — he helped Myra get established as a research scientist in the Department of Chemistry – or biochemistry. And so she worked with Marzluff. She also got her own grant, I think, for women in the university environment, I'm not sure, so she got some of her own money. She managed, I think, to get funded. But this was mainly research money. Now she still didn't have a position and so I thought, well, gee – I knew that we needed an associate director and I thought that, you know, she would be ideal; her husband was a physician, she knew a lot about medical school and the medical program. So we — I'm not even sure exactly how it happened, but we created this position for her to get her essentially into the academic life here at FSU. I had been on her Ph.D. committee at the University of Tennessee, so I knew her from a long time back. Went to her wedding, you know, years before. And I thought she would be ideal for – you know, in terms of both her research career and to get her on the faculty if I could get her into the Program in Medical Sciences. So I think her first position was as associate director for the program. You know, I can't remember what year that was; I guess it was about 1990, early '90, something like that. And then Warren Schoenfish was my other associate director, and the three of us worked together for several years in the program.

Thomas: I think that is all my questions. Do you have anything that you want to close with? Anything that I haven't asked you that you want to say?

Reeves: I think I have very fond memories of the program. I have some other not so fond memories of the program. I think most of those were to do with the administration at the University of Florida, unfortunately, and some of those sort of disastrous meetings I had with them. But the found memories are in the classroom, frankly, and teaching some of the students in the classroom. Also a lot of fond memories with people who had been through the program who had come back and were practicing medicine here in Tallahassee, and that's been a delight for me to see, just watch people —. People — like serving on a selection committee – selection committee was also sort of a high point. Just because it was a committee of faculty, physicians, all working together and we actually selected a medical school class. I mean a lot of faculty committees are just not very satisfying, but that one was really satisfying as well. So I have fond memories about that, even though it was sort of a battle sometimes over which students should be selected and so forth. That was kind of a delight, seeing people getting selected, and I think for the right reasons for the most part. My job at that point – it was a student-oriented program. It was tough to run because of so many — the administration was set up funny — like I said, I reported to two different deans and a department chairman, and I didn't even have the power of a department chairman over many things. I couldn't discipline a faculty member, for instance, because I had no faculty members. Even though they were hired by PIMS, their administrator

and their department chairman was the one that made the decisions about their tenure and everything else. So this was purely a student program, at least in terms of what I had to do. And I liked that. It was a pleasure to select those students, to watch them go through the first year of medical school, and to watch them move on. One of the really fondest memories, and unfortunately this student just died recently – a physician named Bob Brown, who worked with the Program in Medical Sciences when Paul Elliott was director —

End side B, tape 1

Reeves: — and didn't do very well. He came back to me almost like two years later, because we had given him the option of trying again at some point in time; at least that was what the program did, because he didn't do very well. This was a minority student. And Bob came back to me and I made a deal with him that if he did a good job through the first year of the program again, we would move him on to the University of Florida. And Smiley Hill agreed to that, who was the dean of the College of Medicine down there. So we moved him through the Program in Medical Sciences, he went on down to the University of Florida, he was never a great student but he did fine. In his senior year — I always went to their awards banquet for the graduating students — and he was the only student — and I went to those award banquets for like ten years in a row — he was the only award winner – we gave him what was called the Paul Elliott Award for the best student in the graduating class from the Program in Medical Sciences. And I gave him that award and there was a standing ovation for him. Even the dean stood up and applauded him. And I know he was not the greatest student academically, but he was — and they said he had a practice in Jacksonville for many years. He was a great physician, a primary care physician. And I'll never forget that, that standing ovation for Bob Brown.

Thomas: Thank you very much for your time.

End of interview