

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

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INTERVIEW

WITH

*William Toffler, M.D.*

Interview conducted June 3, 2008

by

Jim Kronenberg

## SUMMARY

In this interview, Professor William L. Toffler, M.D., talks with Matt Simek about his career in private practice and his tenure as a faculty member in the Department of Family Medicine at OHSU. An outspoken opponent of Oregon's Death With Dignity Act, Toffler discusses his opinions and experiences with physician-assisted suicide.

Toffler begins with a brief look back at his early life as an "army brat" and reflects on his decision to go into medicine (the idea came to him on a date). He then moves into a short discussion of his medical school years before turning to his years as a resident in family medicine with the influential Hiram Curry at South Carolina.

Upon completion of his residency, Toffler came out West to join a practice in Sweet Home, Oregon. He spent six years in Sweet Home, and he talks about the challenges and joys of rural practice.

In 1985, Toffler joined the faculty of the Dept. of Family Medicine. He outlines Dr. Robert Taylor's efforts to advance the teaching and practice of family medicine at OHSU, touches on curricular changes in the School of Medicine, and shares his views on the positive influence that women physicians have had on medicine and medical education. He also reflects on physician manpower shortages and some of the problems plaguing the delivery of health care services in the United States.

A passionate opponent of physician-assisted suicide, Toffler then talks at length about his role in the debates surrounding Oregon's Death With Dignity Act and his experiences with physicians and colleagues on both sides of the fence.

In conclusion, Toffler looks ahead to the future of family medicine and OHSU, and muses on the possibility of universal healthcare coverage in America.

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Interview with William Toffler, M.D.  
Interviewed by Jim Kronenberg  
June 3, 2008  
Site: Oregon Medical Association headquarters

KRONENBERG: This interview with William L. Toffler was conducted on June 3, 2008, at the Oregon Medical Association in Portland, Oregon. This interview was made possible by the Oregon Health & Science University Oral History Program. The interviewer is Jim Kronenberg. This is tape one.

Dr. Toffler, it's nice to see you again. It's been a while. I'm glad to see that we're both aging gracefully.

TOFFLER: We are, indeed, Jim; it's great to see you again. It's been many, many moons.

KRONENBERG: Thanks. Thanks very much.

TOFFLER: So it's great to have a chance to visit.

KRONENBERG: We'll start out with a brief summary of your earlier life and sort of segue into medical affairs, if that's okay with you.

TOFFLER: Sure.

KRONENBERG: Where were you born and raised?

TOFFLER: Well, I was born at Fort Knox, Kentucky. And did not benefit from any of the gold largesse there. My dad was actually in the military, so he was stationed at Fort Knox at the time. And so we moved frequently, because he was a career Army officer. He actually fought in World War II and had gone across the Remagan Bridge as a forward observer several times, actually; as they were fighting over the bridge. And stayed in, ultimately retiring as a brigadier general in Germany thirty-one years after he started in the service. He also fought in Korea and Vietnam.

So I had a military upbringing in the sense that every two or three years we'd be in a different location. The longest I ever lived anywhere before coming to Oregon was going to school at University of Notre Dame in Indiana for four years. So that was the lengthiest place in one spot. I remember a psychiatrist, as I was in residency doing group work. And we'd been asked or tasked to do drawings—and the tree I drew, because we were all supposed to draw trees, didn't have any roots. And immediately the psychiatrist tied it to my upbringing, having not been tied to one location long enough to develop “roots.”

But it gave me a great opportunity to see many different aspects, not only of the country but of the world. For example, we lived in Rome, Italy, during the Rome Olympics in 1960. I remember as a Boy Scout trying to help tourists find their way around downtown Rome on the Via Veneto and across from the American embassy, and benefiting because they would give us tickets that they couldn't use to go to major events that you know, in retrospect, are kind of like once-in-a-lifetime opportunities.

KRONENBERG: How sad. How sad for you. Well then, it sounds like with your father's occupation that you're probably not only bilingual, but maybe tri- or quadrilingual.

TOFFLER: Well, I wish I were. I'm actually conversant to a degree to get by. But never in the sense that I would ever put it down as a second language.

KRONENBERG: I see. And did you go to elementary and high school here in the United States?

TOFFLER: Largely in the United States. I went to grade school and high school in Arlington, Virginia, up until my freshman year. And then went up to Carlisle Senior High School in Carlisle, Pennsylvania, while my father was at the Army War College for two years. And then came back to Arlington, Virginia, for my senior year in high school. And then traipsed off to Notre Dame for four years.

KRONENBERG: And when you graduated from Notre Dame, at that point had you decided you wanted to be a doctor?

TOFFLER: I actually had. I had had a notion of being a doctor when I was younger. But one other person in my family, a cousin, had not done well in premed. And somehow I internalized his difficulty as being a very hard thing to do so I better not do it—even though I clearly had an interest and desire to go into medicine.

I actually had an uncle who practiced in a small coal mining town of Southwestern Virginia, Keoki. And he had been the town doctor, the company doctor, if you will, because it was mostly a company town. So I had some family history in medicine, although it was somewhat remote, in the sense that we didn't live near that uncle.

KRONENBERG: Can you think of, at some point in your life, a precipitating event, or what made you sort of say yeah, I want to be a physician?

TOFFLER: Well, I'm embarrassed to say it was out on a date.

KRONENBERG: That's good.

TOFFLER: And I was actually in aerospace engineering at University of Notre Dame because I'd taken one of those crazy aptitude tests that tell you what you want to

do, or what you're good at, and I was good at engineering. So of the different schools of engineering at Notre Dame, I was most intrigued by these wind tunnels, and all the smoke, and different kind of gimmicks that you could do in testing air flow and wind dynamics, pressure, statics and things like that. So I chose to matriculate in that area.

And within a few years, I think actually right north of us in Seattle, Boeing was laying off about 50,000 people related to budget and contract changes with the feds, who often funded many of their projects. And it started causing me to do inventory of, What am I doing? Am I going to be, at that time, pushing slide rules and designing airplane wings in an industry so dependent on government contracts?

And I was, I guess thinking about this out loud with a friend sitting at a counter of a campus bar in my junior year. And I don't know if this was really legal, but we were there, at a place where we were just talking. And I said, "You know, if I had it to do over again, I'd go into medicine."

And she said, "Well, why don't you?"

And of course, I didn't have a very good answer. So the next day I went to my curriculum advisor and asked, What do I have to do to change my major in the mid portion of my junior year with a year and a half to go.

And he said, "Well, you'll need to take another year." In reality, I only needed two courses. You had math and sciences in spades as an aerospace engineer major. And all I really needed was biology and organic chemistry. But at the time, traditional schools were pretty inflexible. Notre Dame was no exception. And we couldn't find a way to let me graduate with my own class. And the idea of staying on after all my classmates went on was not something I relished.

So I finished out in aerospace engineering. And then following graduation, took the courses I needed in summer school at Georgetown University and at Prince George's Community College. I had to kind of patch together my schedule. Still, I was able to get three of the four done in ten weeks. And that actually was the hardest matriculation of my entire career, was trying to take two laboratory courses in summer in only five weeks or four weeks, whatever it was. It was the most condensed amount of material. In addition, to me it was a bit like learning a new foreign language as I was not a pre-med major in the sense of having had any biology or organic chemistry. And so that was a challenging time.

When I dropped, when I was able to only take just one course in summer school, and I could start doing things to earn income, like driving a taxi cab in Washington, DC, and working for a moving company, it was like a piece of cake to have half a my load gone. Then I was able to actually get my Army obligation (I had been in ROTC at Notre Dame) out of the way as well. Because as you recall, at that time, they were winding down in Vietnam, and they were not interested in having so many second lieutenants running around. And so it was really symbiotic. It was really helpful to me because I wanted to move on and begin to matriculate in medicine, and not spend four years in the Army. So they offered me three months of active duty for training, and seven and a half

years in the Reserves. And I leapt at the chance to do that. That was a great way that clearly allowed me to move forward with my plans.

So I got my course work out of the way. I got my Army obligation out of the way. I signed up with a Reserve unit right away because they said if you don't do that, they're going to place you somewhere, it could be up to a hundred miles away. So I went to the local people. "I'm yours. I'm ready." And I never heard from them. They kept sending me verification of address forms every three months or so, six months. And I'd fill them out dutifully, and about a year later, I'd get promoted. [laughs] It was, in retrospect, it was humorous. But at any rate, I finished out as a captain, having never served more than the three months. Because there was such a pressure, I guess, to reduce the size of the Armed Services at that time. I think at the Vietnam War peak, there were about a million and a half of us were in the Armed Services.

KRONENBERG: Interesting. So now we're ready to apply for medical school. Where did you consider going, and where did you end up?

TOFFLER: Well, I applied to about eight schools, as I recall. I had put seven on the list. And then the person that I was dating at that time, who would subsequently become my wife, suggested that I apply to her school, which was Virginia Commonwealth University. And it's a good thing I started listening to my wife even before we got married, because of those eight schools, that one's the only one that I got accepted in. [laughs] And as an alternate, no less.

Now there was a little bit of a story to that, too, because when I put in my MCAT application—I think that's the correct name for it, it still is. And it was One Dupont Circle, in Washington DC, as I recall. This group of individuals had incorrectly listed me as a home economics major. So it was corrected, ultimately. But my initial application to all these schools was that I was a Home-Ec major, not an aerospace engineering major. I don't know that that enhanced my application. But at least Virginia Commonwealth University must have read the correction, the errata sheet, whatever, that clarified what my major was. And gratefully, I was accepted as an alternate, probably about this time of the year. And the rest is history.

But you think about how your life decisions hinge on little things. Comments people make. And you're either acting on them or not acting on them. How often the course of your life takes a whole different direction.

KRONENBERG: So you were graduated in what year?

TOFFLER: I finished medical school, well, I finished college in 1971.

KRONENBERG: Right.

TOFFLER: And then I entered medical school in 1972, finishing in 1976. We were class of '76. And moved on to residency in family medicine at the Medical University of South Carolina in Charleston, South Carolina.

KRONENBERG: Was that your first choice?

TOFFLER: It was. It was, indeed. In fact, I'd gone, I'd looked at, I'd applied to sixteen residency programs. I'd looked at programs that were in small communities with no hospital, like Blackstone, Virginia, where the closest hospital was sixty miles away, and there was a residency program. And I put it down as my second choice at the same time I put the Medical University of South Carolina, which was a university program, as my first choice—so essentially, “apples” and “kiwi fruit”, if you will. It was very different, the two. But I ranked them not on the basis of whether they were university or small practice-based program, but, rather, where was the best teaching going on in the residencies. And at the time, Charleston was one of the elite programs.

If you think back, Jim, they had computers in every single exam room. They had cameras in every exam room. They had two-way mirrors in every exam room. So that they could really teach the art of biopsychosocial medical practice. The chairman of the program was actually a visionary man—a neurologist by training. A man by the name of Hiram Curry, who'd tried a practice, general practice, having had a strong internal medicine residency background. His efforts at practice frustrated him—it just gave him migraines, because he'd been so poorly equipped. He was very well trained for hospital work, but so poorly equipped to deal with the undifferentiated patient who comes in the door of a primary care practice. He lacked the training and skills to provide optimal care of them over time. He had training and skills that were excellent for hospital work, but not so good for managing a patient or a patient and that patient's family in the outpatient setting over extended periods of time. Yet it was out of this experience that he developed his conviction and insight that there needed to be a different model.

And, coincidentally, somewhere along the late '60s and the early '70s, other forebears in the field of family medicine, many of whom were in general practice before that, recognized that there was this vacuum in our residency education programs. There was a need for excellence in education in residency training that would be on a par with any other more established residency training. Primary care could no longer exist on a model where you did a rotating internship and then hung out your shingle. Because that was a recipe for disaster. You just were ill-equipped, just as my chairman's training didn't allow him to be effective, be happy, be fulfilled, in his practice. And your patients would either benefit or not, based on that background and training.

KRONENBERG: Bill, I'm interested, at that point, family practice as an emerging specialty, I think you'll agree with that definition—

TOFFLER: Right.

KRONENBERG: –was a relatively new departure, although the old general practice establishment, through the American Academy of Family Physicians, had been talking about and planning this for a long time.

TOFFLER: Right.

KRONENBERG: But it was relatively new. What made you as an individual, Bill Toffler, at the completion of medical school, decide that you wanted to be a family physician?

TOFFLER: That's a great question. It was a bit of a leap of faith, because I wasn't one of the first persons, among the first people in residency programs in family medicine, but I was in the first wave of five or six years. I was entering probably the sixth year of this particular program in Charleston, which had started about the same time as the residency program here in Oregon in 1970. And the concept of being a person that specializes, or a doctor who specializes in the person, not just the part, the eyeball, the system, was appealing.

And I think in my second year, in spite of the lack of exposure to role models like I hope I've become, and I kind of sensed were there, there was a wonderful doctor who was ultimately to be, as it turned out, the vice chair of the program where I would ultimately match—at the Medical University of South Carolina. Dr. Lewis Barnett came and gave a talk, one talk, at the Egyptian Building of the Medical College of Virginia. And I still remember the talk. I still remember him talking about the warmth, the love he had for his patients, the satisfaction he got. And I said, “That's the kind of doctor I want to be.”

I was sitting next to my roommate at the time. And he ultimately turned out to be an OB/Gyn. And he didn't resonate with the talk at all. So it was clearly just, I guess, the romance in the sense of what was appealing to me, and what drew me. The passion of wanting to be of service in this way, in this older model, that embraced the technology of today, and at the same time maybe had that Norman Rockwell relationship, if you will, of the doctor at the bedside who really knew his patients and his family in a way that seemed to be disappearing. And I think that there was a resurgence, or a renaissance, if you will, that recognized that medicine was missing something, and I needed to try to be part of that movement, to join with others to recapture that.

And that was not at all rejecting the wonderful technology that I depend on every day, and that I believe in fully. But I think we managed to actually bring to fruition, in a large part, the vision that our forebears of the 1960's had sought.

KRONENBERG: This should come at the end of the interview, I think, but I have to ask you this question. Has the specialty of family practice, in your own experience, in your own life, lived up to its billing?

TOFFLER: Well, very much so, in terms of what I wanted from family medicine and what I saw in family medicine. I think that there's no question that my lived experience that I envisioned (and that far-sighted people before me envisioned), is something I see in patients' eyes as they want to glomp on to me as a doctor. Not because I as an individual represent something that's dramatically different—rather they are drawn to the ideas, the concepts, the systematic approach to the person as a whole—a holistic unit, and their family. That's something that many, many people are hungry for. Perhaps not to all people; thus, when I do encounter people who really want to hear from the “left eyeball” doctor, of course I help them get to that person. If that's what they need to have to reduce their anxiety, I try to help to get them the care they want.

Over time what I find is that people start to recognize I'm not a barrier, I'm a facilitator for that reassurance that they want. So I take care of full professors and chairmen of departments at the same time I take care of people who are on the margin and on subsidies for their housing and their healthcare. And I can do that right here in the heart of Portland. Just like I did in full-time practice after I left residency. I was in practice, in full spectrum medicine in Sweet Home, two hours south of here. Sweet Home is a community fourteen miles from the nearest hospital, and the last bastion of medical care for ninety miles on the way over the mountain pass to Bend. So we were kind of a full service practice that was as often as much of an ER as it was a family practice. And so a logger might come in with a little “splinter” that kind of went through this side of the leg and out the other side-- they'd call that a splinter.

KRONENBERG: A splinter.

TOFFLER: And you'd be taking them to the OR in the hospital. I recall two of us operating on that leg for hours, trying to get the debris that had shed itself from the original piece of wood.

KRONENBERG: How long did you practice in Sweet Home?

TOFFLER: Six years.

KRONENBERG: Six years.

TOFFLER: It was actually a Public Health Corps site founded, started by my two partners who recruited me. They were actually graduates of my same program at the Medical University of South Carolina who were transplants to Oregon (neither of them being Oregon natives) but both wanted to go “out west.” And they did. Originally they had actually wanted to practice in Philomath, which was recruiting and had established all the paperwork in place and everything. But their timing was bad, as there two or three other doctors—I think two at the time, David Grube and Dave Cutsforth.

KRONENBERG: Grube beat you to it.

TOFFLER: Well, they beat my associates to it. And they (Grube and Cutsforth) were hometown boys. Ultimately I think Philomath made the right choice, because they're still in practice there. And the three of us (who were in Sweet Home) have gone on to other activities. All good fruit, but at the same time, Philomath got the long term settling of having their hometown, homegrown product come back and be a tremendous, a giant part of the medical health of that community.

On the other hand, the practice that we founded is still there in Sweet Home. It's gone through several generations of doctors. But for the most part, there's been a fair amount of stability there as well with the average stay, I would guess, of a doctor coming to the Sweet Home practice of perhaps being in the same neighborhood for at least five to nine years, just as we were there for about that length of time.

KRONENBERG: At my age, my memory is beginning to fail me a little bit. I should know who your partners were.

TOFFLER: Well, I'm impressed you can remember all the names you do with several thousand plus active members of the Oregon Medical Association. But Larry Davis and Jim Gulick were the founding partners. And then we had some other ones that were there for shorter periods of time. But Larry was there for nine years, and Jim was there for a couple of years before he changed fields and went into Anesthesiology. Actually I think he came to OHSU to earn his credentials to practice anesthesiology.

KRONENBERG: So you're by this time settled into practice that you obviously like. You have—by this time, I suspect, you're married.

TOFFLER: In fact, I got married in residency. Or no, I'm sorry, let me get this straight. [laughs] I got married in medical school, in my second year in medical school, to my wife Marlene, who was the one who helped me link up with a medical school. And Marlene and I went for about three to four years before we had our first child. We had our first child in my first year of residency, our oldest daughter, Emily, who now has three children of her own and lives in Indiana.

But I was the one that drug my feet in terms of being open to children. I think my wife would have been glad to have us get pregnant the day we wed. And I was the one that said dumb things; Jim, I'm embarrassed to think back on my mentality. Honestly, I said, "Well, you know, we don't have a perfect relationship yet, we shouldn't have kids." Well, of course, if you waited for that criteria, the world would be childless. I then was saying things like, "I'm too busy. I'm still in medical school, I'm in residency, I don't want to have children, I can't devote time to them."

Marlene, by this time, had gotten better at answering my lame excuses and had said something along the lines of, "Well, I'm not too busy."

KRONENBERG: It's interesting how wives can do that.

TOFFLER: It's a good thing. Because sometimes the left brain part of the relationship, as husbands can often be, is not the best place to be. And I think women have a little better command of both sides, and a little better balance.

So I had to learn a lot of my parenting and openness to children from Marlene. I was the youngest of two; she was the oldest of four. And so a lot of my parenting skills, I might say all my parenting skills, came from my wife, not from my residency or medical school training. And it's a good thing, too, because we ultimately had seven children. And despite my hesitation, once we got started, we seemed to be on a roll.

KRONENBERG: So to speak.

TOFFLER: Exactly. So to speak.

KRONENBERG: So at this point, you've been in practice in a rural community, which sounds like, to a great degree, the expectation that you had from practice. You have a family who are reasonably well settled. How do we leap from Sweet Home, Oregon, to OHSU?

TOFFLER: Well, I always had a vision of going into academics. And actually was asked to stay on in the residency program in Charleston, and did actually for two months because they were so short of faculty. That was the time where they were growing their own faculty, and I was essentially, behaviorally, the chief resident, even though I wasn't titularly the chief resident. And I was asked to stay on permanently. And I didn't want to do that, because I'd seen some (bad) examples. This is, again, how I project or internalize sometimes what I see. I'd seen some examples where that was not good, where people didn't respect that person. And I couldn't separate out the fact that that individual might be the problem, not that the specific tack or that approach.

At any rate, I stayed on, and I really wanted to go do the practice, and I did. And I had three opportunities. I could have practiced in North Carolina or Virginia or here in Oregon. Oregon was the least lucrative option. It was the lowest paying of the three jobs. But it was the most wide ranging practice. And I knew when we only had one child at the time, and practicing in a small town, it would be a total leap for me. I'd never lived in a community smaller than twenty thousand. Probably Carlisle was the smallest town I'd been in previously. I thought now would be a good time, because we're less encumbered. And that was, in retrospect, good logic.

And we ended up choosing to join the practice in Sweet Home, which had been a Public Health Corps site. And they were successful, and had converted it to a private practice at the same time I was coming. So I was able to join them, really, as a partner, which was very generous on their part because I'd not been there doing the ground work. But they didn't have the same sense that they had to put their own money up, because they'd gone through the Public Health Corps system to get the initial support. And the community was fully behind it. There was a health hospital district, I think, that was able to raise revenues to support the ambulance system as well as the healthcare needs of the

community. And the practice and my future partners were the beneficiaries of some of that revenue.

KRONENBERG: And your hospital was Lebanon.

TOFFLER: It was. And at the time, it was before cell phones. We had these two-way radios that would patch us in through a tower up on the mountain to a telephone. And you'd have to tell the patient, when you're done talking, say "over." And hear "over" and "over," and you'd go back and forth with the conversation.

But I remember taking call while I was canoeing on the Santiam River with a friend or whoever, and getting a call from one of the lumber barons there in town who had a spouse and kids. And I remember getting a call from his spouse where her child was having abdominal pain, and I'm literally doing this back and forth on the radio telephone patch and making the diagnosis of appendicitis over the radio. And you'd learn to do that. Of having the mother have the child jump up and down and ask them where it hurts. Talk to the child, and this is about a ten year old child. And I had them meet me at the office, so I had to pull the canoe into the shore where I could get some transportation—thus we ended our sojourn a little early. But I'd call the surgeon and say, "I think we've got appendicitis here."

And he'd say, "Well, call the OR."

That was kind of the relationship between the surgeons. I didn't have to give him really any medical details. And we would both do the case.

And it was excellent care. In fact, I had, at that time, had to encourage people to not go elsewhere with a bigger name, but not necessarily the better care at the time. I remember having to argue with some of my, well, with the doctors in some of the larger institutions where people would go because they thought it was better care. And I'd be telling them well, you know this person that you did a hernia on now has a foot drop. And I think it needs to be tended to. And they would argue with you over whether or not it was related to the surgery they'd just done. This was a perfectly healthy, as I recall, single digit (about seven year old) boy. And that was the level of care, where you had pockets in small towns where there were better trained and more conscientious practices and doctors than some of the better known, I won't go into names, larger institutions (where the care was purported to be better).

And (over the years) there was a tremendous turnaround in the community's attitude toward local medical care. For example, there were people in the community when I first came, who said they wouldn't take a sick dog to Lebanon Community Hospital. And it changed in the half dozen years (when I along with other people had "flooded the zone" with this new discipline of family medicine) to a point where, indeed, they wouldn't go elsewhere without checking with us to see if that was really the right move. And that was a tremendous turnaround.

KRONENBERG: There were some, as I recall at that time, there were some really superb physicians who practiced in Lebanon. And I'm blanking on the name of the surgeon.

TOFFLER: Yes, for example, Howard Johnson was an icon—a giant of a man. He lived within two miles of the hospital, and he would be our backup for OB. He would be our backup if there was an adrenal tumor. He was the old school, where he would work on thyroids, and parathyroids, as well as many other areas of the compartmentalized field of surgery that exists today. And the higher tech tools weren't part of the landscape. Yet people got excellent care. They really did. It was astonishingly good. And it was a symbiotic relationship among the medical community. It was ideal.

When you're asking, why make the transition, there was a lot that was good there. I remember being asked by people, including my former chair, again, asking me to come back to Charleston to teach. I had just been elected president of the Linn County Medical Society; and I had found it very satisfying to be in practice. I learned to appreciate the small town and what it had to offer, as opposed to getting mad for what it doesn't have to offer. And I think it was very much of a growing experience for my wife and me, as we had challenges in our own relationship. And we started doing Marriage Encounter weekends. And that caused our marital relationship to solidify in a way that it had never been, probably even from the start. And that was a strong gift that I still look back on fondly. We continued some of that activity, even after we came to Portland.

We would have medical students come, not as often from OHSU, our closest medical school, but from all over the country. You get word of mouth from someone who had a great experience living with us, literally in our homes. They would practice with us, going back and forth daily, sometimes twice daily rounds; delivering babies, all that. And each would have such a great experience, they'd send some of their friends. So we must have had thirty-five students over the course of four or five years rotate through us, and at least a dozen residents.

And when they would come, I think both my partner Larry and I would really get jazzed up. It would really be great to have these excited young learners be part of the scene. And when they'd leave, there would be kind of like a denouement, at least, I wouldn't go so far as to saying it was depressing, but it was definitely a feeling like, "why can't we have this more often?" And that was ahead of the AHEC (Area Health Education Center), the decentralized approach to at least part of the medical school education that is true now in Oregon. And had there been an AHEC, I'm not sure I would have left. For example, I might have stayed in the area like Rick Wopat who is down in Lebanon—he is a huge part of Linn County medical care. Yet, he was the beneficiary of some of our outreach efforts that we've been able to successfully develop and (in essence) decentralize at least part of the education of all of our medical students as part of the required curriculum.

KRONENBERG: Bill, this is a fascinating conversation because you've now convinced me that being a family physician in a very small town without a hospital was

the greatest thing since sliced bread. But still, eventually, as we know, you ended up at OHSU.

TOFFLER: Well, there is a point for me and I think for most people where you've gotten an opportunity to do much of what you wanted to do. And this missing link of having decentralized medical education was still there. So I didn't have the same sense of growth on year five and six that I had on year three and four (which caused me to decline an offer to go elsewhere). So at that time, I remember meeting Bob Taylor, who had just been hired, or was in the process, I think, of being hired, actually. And my partner and I had been able to attend one of his talks that he was doing in the interview process.

At that time, we would come up once a month. This reflects how hungry we were to be part of the teaching scene, my partner and I. We would get up at five o'clock in the morning once a month, go make rounds at the hospital, tell the patients, of course, ahead of time, that we were going to be waking up to visit them the next day. We would close the office. We wouldn't even have coverage for it. And we would come, then, up here. We'd have breakfast at the Original Pancake House there on Barbur--Cherries Kijafa, I think was my favorite breakfast.

And then we'd go to morning report with the residents. We'd spend the day, the entire day, attending the clinic with people like Peter Goodwin doing the shepherding for us. Because Peter was on the faculty—he had been hired by Laurel Case at that time. He himself had been practicing, as you know, over in Camas for probably twenty, twenty-five years. I knew Peter, actually, because he'd done a sabbatical in Charleston as part of the eclectic group of visiting faculty that was part of Charleston's program. We also had people from England, we had people as strange as Peter who hailed from South Africa and Camas.

So at any rate, we would come up here to OHSU. And one of those times they were looking for a new chair to replace Laurel Case, because there was a gap there where there was an acting chair. I think it was probably Bill Fisher or Merle Pennington or a combination of the two, for about two years—which is a bad thing to happen in a department because people, residents, whoever else, want to have stability and want to know what the vision is of the leaders. So not having a chair is not a good thing.

Yet Bob had a vision, and he'd been back east on the faculty in North Carolina. And he really wanted to take the department from being a good residency program, which it was, to being a true department with a research mission, with an undergraduate education mission, which is what I've been a large part of for the last twenty years. And with outreach to practicing doctors as well as developing the residency program from good to, I think we've gotten into the top tier. We're usually mentioned in the top five. I think this year we were the second in the country among *US News & World* rankings for family medicine residency programs, or departments. So we've come a long way.

And Bob had this vision. Yet, at the time, I was also getting offers from my friends who were also going into academics, having gone through the Charleston program, which was really a premier program that had the notion that we were a “stable of thoroughbreds”, carefully selected residents, and that you would go on and do something to improve the field of medicine, particularly family medicine. And that really was true. All those folks, I mean, I’d say two-thirds of them ended up in leadership positions around the country—in residency education, medical education, whatever else.

And one of those leaders who’s now deceased was in my year, had been in Oklahoma, and he wanted me to come visit there. And I told Bob Taylor. He said, “Go ahead. Look at those things. I encourage you to do that.” And I got excited about Oklahoma, because their program was farther along than OHSU’s family medicine department at the time. And as he heard that I was excited about that program, he decided to meet me at the airport as I came back. Took my wife and my kids out to the only place you could take this relatively young couple at the time with their three or four kids, or whatever—I think we had four kids at the time. Or she was pregnant with our fourth. He took us out to Chuck E. Cheese as our interviewing trip. And that was very memorable—in fact, it always comes up in conversation as an odd place to be recruited. Yet Bob was a little nervous as he really recognized that I was at risk of going off to one of these other university options. And he was trying to build what at that time was a fledgling department with really very few credible clinicians. And you can’t do that—his vision was at risk.

So we were a small faculty at one time where we could go, and actually did, have regular dinners at one another’s homes and the like, to the faculty now that it’s hard to keep track of exactly how many of us there are.

KRONENBERG: Cast of thousands.

TOFFLER: The budget has, you know, gone up twenty-fold, and the number of people that are nominally faculty is close to fifty or sixty.

KRONENBERG: In your reference to Bob Taylor, you talked about his vision for the department. Judging by top ten polls, OHSU’s Department of Family Medicine has done pretty well. As an insider in this process, and obviously part of building it, how well do you feel that Dr. Taylor’s vision of the department has come to fruition?

TOFFLER: Oh, I think it’s completely come to fruition. He was a very careful, he still is, a very careful man. He’s a “J” personality on a Myers Briggs, where he had his five-year plan well defined. And I think he must have accomplished 85 percent of what was in his five-year plan in that first five years. And he was chair for fourteen. But I think your point about being able to be part of a program in an earlier, more embryonic stage, was exactly what made me decide to stay at OHSU. I had wanted to go into academics, as I said. I wasn’t ever thinking that I could do it here in the state, because there just didn’t seem to be that kind of a fertile ground. And it was Bob’s coming here, and his convincing me that he was going to do this—and I believed it was going to happen

whether I was there or not. So I decided to become a part of it, because I thought I'd have more influence on the program that was smaller than on one that had already formed its direction, its personality, its identity, its particular missions and sub-missions. And that turned out to be true. It has been very much true.

And I think he's been a tremendous mentor over the years. He's now not officially retired, he's still in the department. And he's very active. I think we get lots more productivity out of him than is reflected by the money paid to him or his wife, Anita. They're just a tremendously productive and influential team, and always have been.

KRONENBERG: That was and is quite a team.

TOFFLER: They are. I mean, they quip at a national level, "Bob and Anita." And that's almost a name. Kind of like you'd say Cher or you'd say Oprah, and you know what we're talking about. And she has deservedly got almost as many awards as Bob has, despite not having an MD or any terminal degree, for that matter, like a Ph.D. She's had a huge impact on medical education across disciplines, as she's, as you know, written several books on personality type and specialty choice, and is a national if not international expert on that.

KRONENBERG: Speaking of personality types, you obviously have built a reputation as an excellent educator. But what I'm struck with is how consistently over your tenure at the medical school, how you're viewed by the learners. As a teacher, as a one-on-one teacher. In this seems among many, many attributes that you have, this seems to be sort of your strong suit. Is that a fair statement?

TOFFLER: You know, it's interesting. I think I have something to contribute, but I don't see myself that way. And I don't think my vision is some false humility, either. I just came from graduation, and there are people who are giants and perennially get teaching awards and are incredibly popular teachers. I'm not sure that's what I do. I'm far more effective with smaller groups and individuals and maybe giving them a vision of a doctor that isn't for everybody. I think there are people who are irritated by the stands I take, or, my speaking just clearly what I believe. Even if it's not meant to offend anyone, I'm afraid we're in the time when sometimes people take it that way. And that's kind of sad, especially when we consider ourselves universities, where I look at the proverbial university as a place where it's enriched by differing ideas. To me it should be a boiling pot of different ideas—and the capacity to have animated dialog and respectful dialog, but have dialog about different points of view.

I remember bringing up an issue once, and the topic's not as important as the fact that one of my colleagues thought there's no point in talking about that, everybody's already made up their mind. Well think about that, Jim. If everyone's made up their mind, you're essentially saying they've closed their minds. And this is a university. So it's a sad reflection on the state of affairs.

So in the course that I was able to lead for fifteen years, up until this past summer, I introduced some sessions called Controversies in Medicine, where people who had different points of view, sometimes polar opposites, could speak in their own voice about their points of view. And the point of that was not to have a propaganda session that either point of view was going to be for everybody. It was to allow a dialog, a respectful dialog, to be role-modeled by faculty. So part of the session was to let people speak in their own voice about whatever the issue, that they might have their view shared—but also to show how to do that respectfully. You could still work with people, as I have for my twenty-plus years at OHSU and disagree with them about some issues—life issues, ethical issues—yet still respect the person at the same time that we obviously don't share the same worldview.

And I think that's important. Because obviously we live in a very eclectic country with people from all different perspectives: emotionally, ethnically, spiritually. We're just lived experiences. And I don't think you can come to a common viewpoint. Nor should I or anyone else impose a viewpoint on another. That's not what we're about.

On the other hand, one of the current issues is, Can you allow a doctor to keep his or her integrity, or are they going to have to fit as a vending machine to be involved directly or indirectly in whatever issue might be legal? And that's still a ball that's up in the air. We haven't settled that one as a society. It's very clear to me that I think we're poor as a profession if we don't respect individual integrity.

And you can get away from the highly charged issues that you might think of as I'm talking, but as we talk about these concepts—I won't mention names, but he's a very prominent faculty member—happens to have an emergency department background. But he would be uncomfortable referring someone with a strained torn ligament of the neck to a chiropractor. And I respect that. I actually wouldn't be feeling as strong about that, because I know chiropractors who are actually very appropriate with their history taking and all that. And I would try to share with a patient my perspective that it might not be the best thing at this moment, give it a little time to heal, but I wouldn't try to not be a part of even the referral process. So you see, we all have different points of view, is the point. And I would respect this person's right to, as a doctor, to not be involved—not be involved because they weighed the risk as being too great.

You know, it goes back to my medical school. I remember my wife and I at that time wanting to get a contraceptive device, an IUD. And she'd gone to a doctor in Richmond, Virginia, which is where we were living. And because we hadn't had children at that time, the doctor was not willing to put the IUD in this person (my wife) who'd never had a baby. He was worried about her future fertility.

Now at the time, Jim, I was a little tweaked, because I was the husband. I wasn't actually in the exam room, but I understood as a medical student, even, there are risks and benefits. You just tell us the risks, and we choose. That's what I was kind of being given as a message, the systematic approach to how doctors and patients should interact.

And I was tweaked. But I wasn't tweaked enough to encourage or push my wife to go get an IUD.

Now think of this. I was in Richmond, Virginia, which is the home of the Dalkon Shield. That was an IUD that literally cost many women their wombs, and some women their lives. And the doctor had the integrity to say, "I don't want to do this"—because he was worried, not about moral issues, but about just simply the balance of risk/benefit. And I look back on it, I'm really grateful to that doctor for having exercised his integrity. And I'm glad I had not enough passion to go fighting against it or seeking a different solution, because I think he was right, in retrospect. And again, I'm not talking about the medical issues that have changed over time. But I think that it's an important lesson that we're a profession. And we're supposed to be exercising professional judgment about what's the best. And when we turn away from this traditional ethic and say "Whatever's legal we'll do on request," we're just vending machines. And we either do it or one lever's the referral to expedite that particular option. And that's very dangerous.

And that's a national discussion now. We know it's evolved, or devolved, depending on your point of view in terms of the intensity and passions on different sides. But it is clearly, I think, one that ultimately should be decided so that we keep our integrity and we don't compromise that. We don't just become automatons in terms of what we do or don't do.

KRONENBERG: Let's talk, not to get away from this, because I want to get back to it.

TOFFLER: Sure.

KRONENBERG: But let's talk about a couple of things that you as a professional medical educator have seen happen. And your, sort of your impression, your take on what all this means. Obviously if we think of the demographics, the most spectacular thing that has happened probably in American medicine in the last 120 years from a demographic standpoint is the huge influx of female medical students and female physicians. And you certainly experienced that.

TOFFLER: Sure.

KRONENBERG: I suspect that when you started work, things were really changing then. When you started in academic medicine, maybe 15 percent of students were female. And now I don't know what it is this year, but it's somewhere around 50 percent of each class is female. What's your take on all this? Not just from an educator's standpoint, but someone who, in terms of being a medical educator, you have larger responsibility to be sort of a part of the establishment that plans for workforce in the future, and so on.

TOFFLER: Sure.

KRONENBERG: These are kind of the issues that you've been talking about.

TOFFLER: And the issues aren't necessarily aligned.

KRONENBERG: Right.

TOFFLER: No, and I think it might have been better, because my school, the Medical College of Virginia, now the Virginia Commonwealth University, was perhaps ahead of its time. It took older students. Perhaps that's why with my aerospace engineering background, I got accepted. We took black students. We had probably at least 30, if not 35 percent of the class being female. We had students as old as forty years old. At OHSU now, we've actually had a grandmother of three enter the class, who's now in practice here in town.

So I think that that's been enriching. I've said actually twice in the last week, this is for real, I was at an NIH grant meeting of the principal investigators of grants given to nine medical schools, OHSU being one of them, and I'm the P.I. for OHSU. I said to one of the leaders of the grant distribution folks, back at the National Institutes of Health, that I think that part of the reason why there's more openness to the concepts of behavioral science and change was the increased number of women in medicine. It's a great gift to the field of medicine, which had heretofore been dominated by the viewpoint that is largely masculine (when you exclude females). And you either do that behaviorally, or actually specifically, as it was at one time—for example, with questions that admissions interviewers were asking women about their plans with respect to pregnancy.

I mean, in my lifetime in medicine, women used to go through childbirth not just with poodle preps and enemas, but they were strapped down in leather restraints as part of the childbirth exercise. I mean, this is in my lifetime. I'm not an ancient guy yet. And it's astonishing the good that's come out of the transition so that it's actually the majority of women, the majority of medical school applicants in my school and many schools, I think it's across the country now, is actually female. Now some of those females are emerging in leadership positions now in schools. For example, the person I was talking to (who heads the behavioral and social science section for the National Institutes of Health) is a female. And her subordinates are all glad for her leadership, for example, the male who is her subordinate introduced her by saying, "We're all glad she's here," as he reflected on the fact that, "she's actually done great things with that section." So that was one conversation.

Then today, at graduation, the two faculty members I spent the most time conversing with, before and after the graduation, were both pediatricians, both of whom were females. One's an MD/PhD, and the other one is a leader of the course that I used to direct for fifteen years. I was kind of glad, when I stepped aside from the course they replaced me with four people. And they started paying those people, which is a good thing. Because the medical education, often the teachers aren't directly compensated for their teaching, in the sense of monetary. So they're often distracted by clinical care, research, or grants. So (another) one of the good things that I tried to add my voice to the

effort was to get teachers paid. And that was also one of the conversations. Because we're not there yet. They're going to ratchet it in over four years. And every time you get a blip that comes along, like the tort ruling, adverse decision with respect to tort coverage for the school, causes the tuition to get bumped up, and causes a hesitation, if not a halt, to appropriate shifting of dollars in the direction for the people actually doing the work of teaching. And that, in my mind, is a great social injustice when that happens.

I mean, think of it. What do tort reform and the increased cost of doing business in clinical care have to do with your tuition? I grant you, some of these pots of money get mixed. But the point is that it seems to me often the decision gets made on the backs of the people with the least political voice. That is the medical student. And that's why the ratcheting up of the annual cost, is exactly 180 degrees from the Mayo Clinic. The Mayo Clinic, I think, just recently announced that it was doing away with tuition. And I think that's a tremendous boon as well. Just like opening classes to females was a wonderful change in medicine, the idea of opening classes—to people who are economically disadvantaged—wholesale, would do a huge service to the redistribution of doctors. Because if you only take doctors who don't blink when there's a forty thousand dollar-a-year tuition, you've excluded a huge portion of Oregon's demography/demographics. And that's true nationally as well.

And such people who often grew up in small towns, where 25 percent of the United States population lives, towns less than 25,000, are more likely to go back (just like Grube and Cutsforth did, to Philomath) and stay there, and be of service, than someone who didn't grow up in that environment. And that's been shown over and over again. And that's been linked.

Now there's another aspect that's linked when you talk about women—I think that most of the data shows that they have better balance in their lives. And they have families. And they should. I just encouraged one of my faculty members, who's having her fourth baby. As she threw in a couple of words like “this might be our last,” kind of thing. I said, “Well, don't. I can't imagine life without our last three kids”—because we have seven. And you know, she listened to me. Not that I can tell her and her husband what to do. But the idea of closing off your life for something else was not a good idea.

And when I think back in the '70s, when I finished medical school, one of my closest friends, we used to go on canoe trips on the Shenandoah River and the like, entered a surgery residency at the University of Washington. I remember them priding themselves, or at least it was one of those “factoids” that leaped out, it was almost like they were proud of it. They all had such severe call schedules, being on every second or third night or whatever, that by the third year, fourth year of the residency, all the couples were divorced. And that's not something we should be proud of. I mean, thankfully, with some important decisions like the eighty-hour work week and the like, we've had a benefit. But I think women in medicine have had a huge impact on the whole way we go about training—appropriately giving accommodations for people who need accommodation. And not just for some disability like reading and dyslexia, but for the temporary change in one's status as you become pregnant, and that I can be very proud of

our institution, OHSU has been a leader in providing such accommodation. In fact, I often have to encourage students to exercise their right to be accommodated, and I think that's a good thing.

Now, is there a down side down the stream from that, in terms of healthcare planners? Well, yes, I think that we've been a little sluggish in opening the doors to more medical students. Because if you have doctors that aren't burning themselves out, and who are having families (and they appropriately should spend more time with their families), you need to have more people—which would be good. And I think there was an effort in that direction by our current leadership. Certainly, OHSU's president, Dr. Robertson, is expert on the manpower issues, and has spoken about these regionally and nationally. Unfortunately, at least recently, the Oregon legislature balked when it got up to the plate to deliver some of the funding for that. Subsequently, there's been a back and forth on this issue.

But the concept of expanding the pool of people going into nursing and into medicine as physicians is absolutely clear. I think people are appropriately trying to have more balanced lives, which is good for everybody. And that's very different from the message that I got from the dean when I entered medical school in my first week of medical school. Essentially he said, "You're going to be married to medicine." And I remember at the time having my hackles up in reaction to that statement. I certainly didn't not see my role in medicine that way—even though, now, at least if you asked my kids, they would say I spent too much time with work.

For example, when we would take vacations as a family, it was always tied into some meeting or whatever else. I mean, I remember going to Orlando because I was speaking there. And I'd gotten a fairly good stipend to do that—it allowed us to buy airline tickets for our entire brood. And that's the way I creatively put together things. But on the other hand, I think kids would like you to have time with them that's not distracted by other commitments. Even though I spent three days there at Disney World, and didn't, I don't think, go to any meeting except for the one I had to talk at, they noticed. It sends a behavioral message. Am I balancing my life appropriately? In short, I wouldn't deny the charge that sometimes I put medicine ahead. Thankfully I've had a spouse that's been able to complement that tendency as she is without the same pull that I have—not having an outside career of her own. Because her "inside career" is the most important career in the family.

[tape change]

**KRONENBERG:** This interview with Dr. William L. Toffler was conducted on June 3, 2008, at the Oregon Medical Association in Portland, Oregon. This interview was made possible by the Oregon Health & Science University Oral History Program. The interviewer is Jim Kronenberg. This is tape two.

Bill, let's talk a bit about, to continue on this general subject of the needs in the future for an adequate number of physicians to serve the population.

TOFFLER: Sure.

KRONENBERG: We heard earlier today from one of your esteemed senior colleagues who practices in a specialty, that there are probably an adequate number of his particular specialty, at least here in Oregon. But he's not so sure about other parts of the country. And my experience with physicians in policy-making positions, academics and so on, there seems to be a kind of unspoken but growing unease with whether we're really training enough physicians in this country to meet an increasing population's need in view of the fact that the physicians whose generation you represent and those that preceded you had a different viewpoint about medicine. And I'm not saying that they worked harder, but they worked a lot more than in general they do now. And there are great exceptions to that.

TOFFLER: Sure.

KRONENBERG: As an educator of physicians, how do you accommodate the changing lifestyles of not just young physicians, but a whole generation with meeting the legitimate needs for healthcare in this country?

TOFFLER: Sure. And we've done some good in that direction, but it's been incremental. I mean, we've gone from, I think, 126 allopathic schools to 129, as we sit here today. But there have been very few additional medical schools. There have been expanding class sizes, including our own. When I first came to OHSU, the class size was closer to 95, 96 in a given year. And the class size now is 115. So that's good. But it doesn't match the demographics that you described, or the aging of those demographics that you haven't described. And as I get older, I will need some of these doctors to be very good at taking care of me as a geriatric patient. And I hope that they'll reflect some of the innovations that we've managed to move into medicine and medical education.

I embrace the demographic change in more females. I think it's been a tremendous boon to medicine. In particular, I remember back in practice in Sweet Home, and our practice all being male doctors, would have a female resident come stay with us for a month, and people would "come out of the woodwork" to get their specific exams done that would allow them to not have to go through that barrier cross-gender, that otherwise is inherently there if your only option is a male provider. So it was a good thing for the people of Sweet Home—including our staff often—who were even more embarrassed to have the very doctor they're working with be their physician. Not all of them, but for some of them, clearly that was an issue.

And yet it wasn't necessarily the best for that individual's training, because she needed to learn about more than pap smears and pelvic exams as a family physician. But that was literally a reality. And it still is, to some extent. We have to work to get enough experiences for some of our male residents, because the gravitation, often, like it or not, is toward a same-sex provider. So the idea that we have balance there is good. And it

keeps females from being overwrought with too many of one type of medical practice when they want to learn the whole broad field.

By the same token, across disciplines, we've had an imbalance as long as I've been in medicine, beginning back with general practitioners who were a dying breed after World War II. And the huge influx of dollars into technology, antibiotics, the NIH, all of these demographic realities incentivized people to essentially practice in areas where they knew more and more about less and less. And that's good in one sense. If I'm going to have somebody do something intricate, I'd like to have a person exactly like that. On the other hand, for most of what are society's healthcare needs, it isn't to have that compartmentalized, increasingly fragmented type of care provider. Rather, it's to have someone who specializes in you—for example, you, Jim, as a whole person. And it could help—essentially, grease the skids, pave the way, to helping you access the healthcare system.

And I'll give you an example of that. I mean, one of the people I care for who is a former chair of a department, and he is off on a trip, and I find his results, because I'm the primary care doctor. The pathology lab results are adverse in the sense of the outcome you want—essentially abnormal cells that are the kind that need to be tended to. There may be early cancerous changes present. I'm able to “run interference” with the specialist; as there, tone and tenor that is invisible (even to a sophisticated patient like this one) because I'm the one that actually talked to the pathologist about what he saw and why they decided to do DNA fingerprinting on this specimen. And it's not that they “screwed up” in the lab, it's because it was so different from what they expected to find in the individual that they actually went to that length of technology to be sure that they hadn't screwed up in the lab in terms of who was the specimen from.

That kind of a tenacity of purpose to be sure the person gets the right care is something that I can do. In fact, I enjoy doing, and I'm good at it. Now, are there enough of the equivalents of such doctors playing this role? Sadly, the reality is no. In fact, I think that there's been an entropy away from it, because in this country, the “brass rings” are set up where the folks who do procedural work in a very limited area are rewarded more, the compensation is better. Medical school debts have gone up. And you see people who are bright people making appropriate choices—in part because of the lifestyle issues, in part because of their monetary exigencies. And I think that's a reality. And I think increasingly this is documented by the exit interviews for medical schools, people (our graduates) are saying that.

And (sometimes) you'll have a faculty member add fuel to that phenomenon. One of the things we offered in a course once was to have two chairs, the chair of Medicine and the chair of Family Medicine present in front of 120 student at a time, and the twenty faculty members who were the small group leaders, and talk about their view of the future of medicine. We tried to tape it, and unfortunately the sound didn't come out. I wish I'd had it, because it was so interesting to see these two iconic figures, in terms of our medical school, have such different world views about what the future of medicine would be like. They both can't be right. One sees a view that is all with mid-levels, and

that everybody is into these reductionistic (specialty and subspecialty) roles. And the other one sees essentially a better balance, like most of the “First World” nations that have about 50 percent primary care doctors and 50 percent who are limited specialists. And that seems to be a balance that’s also associated with better healthcare outcomes.

And so which of these views is going to be our new reality? The answer may not just be based on which ones best for the patient, but may simply reflect the politics of our country. It may well reflect our collective willingness to look at the facts, reacting to the facts in a dispassionate way, and not necessarily just following what we’ve always done—which I don’t think is the best, and I don’t think many people would argue is the best for the healthcare of the nation.

**KRONENBERG:** After twenty years as an educator of family physicians, and a much longer, obviously, a much longer engaged career in this specialty, my sense is you’ve seen huge changes in not so much how family practice as a specialty discipline has changed and grown, but how family practice and family practitioners are viewed by the other guys, the specialists. Can you talk a little bit about that?

**TOFFLER:** Sure. You know, I benefited from being in the Northwest and specifically Oregon, where family medicine was not a place that I had to fight an uphill battle to establish who I was in the same way I might have if I’d gone to some places in the Northeast at the time I entered medicine in the late ‘70s (in terms of finishing my residency). So family medicine was actually the dominant specialty in Lebanon. It was the only specialty in Sweet Home. I had surgeons who would essentially offer to take me out on raft trips in the Deschutes River (or off on his fishing boat that he had a little interest in) because they depended on us for their livelihood. So it was a balanced system. We had probably seventy or eighty doctors on the staff. But most of those doctors of the Lebanon Hospital at that time were itinerant. They were not living there in the community, at least half of them. And about half were. But the dominant specialty was family medicine. There were perhaps two or three internists. There was one pediatrician. There was an OB/GYN and three surgeons.

And it really worked very well. And what I experienced was this almost ideal worldview in that setting. And you can contrast that to places where people had trained in the Northeast—almost none of the students at a given medical school in that region, *none*, would go into family medicine. If you were a medical student interested in family medicine, and you might be seen as a bright person—which many of the students who came from Harvard or whatever (similar institution) were. Indeed, some were very bright, and they’d chosen to go into family medicine. For example, in my residency program we had the person who was number one in his class in Harvard choose family medicine. But you can imagine what his professors said to him. “What’s a smart person like you doing going into family medicine?” Because the dominant worldview of academic centers was that family medicine wasn’t a part of the scenery. It was not academic. It was people just practicing, or treating colds. I mean, that was the majority viewpoint.

So I didn't have to fight that battle like you might have in some locales or states. And I think that's still present; there's still some of that around. At the same time, we've grown as a specialty from a concept to, I think there are eighty thousand family physicians, that's about a tenth of the doctors in the country. My family medicine colleagues have been in leadership roles whether they're in healthcare systems, the Oregon Medical Association, or the Society of Teachers of Family Medicine, which now has four or five thousand doctors (as active members) in it. And Family Medicine has changed. There is a research arm. We've actually got endowed chairs with people from different disciplines serving our discipline. We're living out a little of what my former chairman, Hiram Curry, might have envisioned. Hiram was a neurologist who recognized the strength of pulling together experts from different disciplines—psychiatrists, psychologists, anthropologists—who could each contribute to the new specialty of Family Medicine. He had visiting professors on grants from England, recognizing we needed all these people to work together to produce a curriculum and training program that had a different product.

And now having lived through thirty years of that, we are into another generation where you're seeing concepts like having a "medical home", and trying to socialize the very notions, the very philosophy that I'm describing, in a more substantive ways—this then is the order of the day. Because everyone recognizes you've got to have some change. It's not sustainable to continue in the direction we're going. You can't have fewer and fewer students choosing careers that would otherwise balance the system. And whether or not we're able to put in incentives both at the federal level, at a state level, that allow people to see this (family medicine) is not only a good choice, it's a vibrant choice. It's good for them as individuals, it's good for the healthcare of the community, the outcomes of healthcare in America. If we can't achieve those goals, then I think we're poorer for that outcome.

**KRONENBERG:** It's a very interesting perspective in a lot of different areas. We've talked about your ability to look into the past and bring us up to the future. What do you see in the future itself? Not just for your specialty, but for medicine in this country, and healthcare in this country?

**TOFFLER:** Well, I think there are a lot of very optimistic signs. I mean, one is that we've labored with these conversations about the current system being unsustainable and that we need to have change for long enough that I think most people believe that. I certainly do. On the other hand, I think that we're also a very creative country that has the capacity to incentivize appropriate goals. And if we need more primary care doctors, you won't have to make people do that, but you certainly make it easier for them to do that. And you may make it harder for people to do other things—that is if you don't need another left retinal specialist because you've saturated the system's capacity, then we ought to do that. You don't necessarily need to restrict people from doing it. Yet, there's only so much need in a country, and allocating resources in one direction when you've lacked, have a scarcity "over there" makes no sense. I mean, we have to have some control. But it isn't necessarily "run from Moscow", if you will. It's recognizing that people ought to have the free choice to choose the thing they're passionate about. That

could be bench research. I just came from the NIH and I realize that research and the NIH are also important.

On the other hand, the little money, the small amount that they put into behavioral and social science in the last few years, this is the third year of our five-year grant, is a tiny, almost immeasurable fraction of the billions put into the bench research. So I don't want to take away from that good fruit. But I think that it's clear that we've been out of balance, where we think technology's the answer to everything. And it is the answer to some things; it is not the answer to everything. Yet, unless we have people who can articulate that reality at a legislative level, that can pass the appropriate incentives, legislatively, we will remain unbalanced. And I emphasize the word "incentives."

And it's amazing how people change. I mean look what happened back in managed care, where it looked like the only way you were going to get your referral was through a "gatekeeper." Well, that's a failed philosophical principle. I'm not trying to restrict anybody from anything. I'm a facilitator. I'm an orchestra conductor. I'm trying to make beautiful music, not trying to restrict oboe players and violinists. So it's, it was a failed idea in that regard.

But then on the other hand, the idea did cause change, people do react to changes, incremental or not—they certainly do. Look at our own institution when we take away tort claims coverage as an umbrella, at least for a certain dollar amount, we certainly caused an upheaval. And we haven't established what the next dollar amount is. So it's a crazy place to be right now.

But we do know that when you do implement those systematic protections, then medicine can thrive. I'm told there are people migrating to Texas because the tort claims is favorable at this point in time. That's amazing! Can you imagine that? The doctors are deciding where to go to practice related to tort laws.

KRONENBERG: Yes. Yes, I can.

TOFFLER: It's hard for me to visualize that, Jim. Remember when I said I chose my residency program, it was the quality of education. It wasn't the tort claim coverage in the locale. But this is remarkable that we have such imbalance in the way we go about giving people appropriate opportunity for compensation for a perceived injury, that we've actually caused the demographics of where people practice to change. This is crazy.

And until we have leaders who can say, "This is the best way," and believe it in their heart, they don't just say it testing the wind, then we're in trouble. And we, I think we're closer to that. I think we're also closer as I listen to people who are offering innovative solutions. For example, Ezekiel Emanuel came here a few months ago, articulating a way that we could actually have vouchers for healthcare insurance. Very similar to the way the government employees are able to have coverage.

So there are existing models of systems that are not broken that allow maximal choice—kind of an American concept—and at the same time, don't take away the appropriate incentives and disincentives for people to be innovative and productive and manifest all the genius that causes people from foreign lands to come here for their specialized treatment. At the same time, while we've managed to have the best in some technological interventions, we have the worst in terms of our being able to have access to care, or continuity of care. We can take care of an emergency, but we don't take care of your hypertension over time. We just take care of your stroke, and then give you a POLST (Physician Order for Life Sustaining Treatment) form so you don't have interventions, because that will cost society too much. I mean, these are the crazy things. I may be being "hyperbolic" here, a little bit, of course. But it's unfortunately too close to reality.

KRONENBERG: Okay. Let's do a right turn.

TOFFLER: Sure.

KRONENBERG: I think perhaps, perhaps the most interesting and exciting thing that happened in my long career with the Oregon Medical Association was something that you were very much involved in, and very concerned about—along with a lot of other physicians. As a matter of fact, physicians on both sides. But for me as an employee of an organization that essentially took a policy of neutrality on this social and medical issue, I had the luxury of being able to look at both sides. Not only on physicians, but also the larger society. Because whether physician-assisted suicide, a la Oregon, was or is a good idea or not, it's quite clear this was probably the most compelling thing that had anything to do remotely with medicine as far as the public was concerned, certainly in my lifetime. And I'd like to just sort of talk with you a little bit about how you look at it, although I know, I'd like to have you share that with the camera, if you will.

TOFFLER: Sure.

KRONENBERG: And also, to sort of look at this as you have so well in other issues, retrospectively, based on what's happened, where we are now, what you might see in the future. And I'll shut up now.

TOFFLER: Okay. Sure. Well, it's interesting that you frame it in how do I look at it now, and how would I look at it when I entered medicine. It was unthinkable when I entered medicine. I actually took the Hippocratic Oath. It was the untouched version. In 1993, an article by Edmund Pellegrino, there was only one medical school left in the country that still took the Hippocratic Oath.

Now the Hippocratic Oath, of course, got very specific. It named certain things that you would or wouldn't do. You'd pay respect to the teachers, which the oath still has today with its modified version. But it also would say things like I'd give no deadly drug, even if asked. Now that was something that every single doctor in training took as they

were walking across stages across the country. That's where this was unthinkable. It was absolutely contrary to the oath.

Now the oath wasn't a religious construct, Jim. It was crafted in a pagan era by people who recognized the inherent conflict of interests for doctors who on the one hand were presenting themselves as advocates for the health and wellbeing of their patients, and on the other hand, giving deadly toxins, poisons, plant chemicals, that could kill you. Kind of like the death of Socrates, who took an overdose of hemlock. So it was a great clarification that came out of a Greek pagan era. And it, I think, served the house of medicine for two millennia.

So the concept of getting doctors to have a different viewpoint about this wasn't one that happened in the OMA. It wasn't one that even happened in Oregon. It happened with people who were promoters of assisted suicide. And Derek Humphry in his book, not *Final Exit*, but *Lawful Exit*, wrote that it's important to get the doctors out of the way—because people tend to follow their direction. So he, a British writer, an enthusiast for assisted suicide, was the one who came up with the concept that you experienced and I first heard about in the early months of 1994. It was before I read his book—and I knew what it (really) meant when somebody presented a resolution to essentially contradict 2400 years of medical history. It was, indeed, a historic moment.

I called up the leadership of the OMA at the time, because I had, in that Eugene meeting in 1994, an obligation had already been made—I'd had at least four talks accepted that I was presenting at the same time as our OMA meeting on the East Coast. And I couldn't be at the meeting. I couldn't "bi-locate"; I still haven't mastered that. So I called up people like George Waldmann and others, I think Dr Schroeder in Eugene. And I recall specifically, I was being reassured by the leadership of the OMA who told me that it (the resolution) would never go anywhere. Yet, I was still worried—because I had seen how the House of Delegates can be pushed in one direction or another by people who are very passionate and articulate at the microphone. And there's a tendency to want to get along in this body, of trying to reach consensus and compromise.

And unfortunately, I was prescient. I was not in attendance at that meeting although I presume you were. When it became clear that the house was deeply divided on this issue, the reference committee—thinking it was going to be wise, I believe, in retrospect—decided to take "no position", that was not technically neutral. It was simply taking no position. But in essence, behaviorally, it was I think correctly read by the press as they've changed their position, because they used to be opposed to it. Now they're taking no position. So that sends a tremendous message to the populace of Oregon. That doctors, with whom we have confidence, and in whom we have faith, don't have a strong feeling about this. It's kind of up to them. Essentially, if you will, I don't decide, you decide.

And that's what, indeed, played out as the very close 51-49 vote in November of that year—when the doctors had essentially neutralized themselves. Now it wasn't just the OMA. I don't think we can be so egocentric. There was also a mandate that every

state agency was to be silent on this. This is, by what would turn out to be a very pro-assisted suicide government at the time. So the mandate was we're (state agencies and/or employees) not supposed to take a position on this.

Now think about how specious that is as you look at someone who might be the president of the University of Oregon or OSU having a debate about a policy that gets to be a ballot measure and they're certainly expressing their viewpoints about the future and welfare of their institutions and the public life. I've seen—and I kept—one of my 35 mm slides (in the days before PowerPoint) was showing the former president of the University of Oregon articulating his position, above the fold on the *Oregonian*— with his counterpoint, I think it was Barbara Roberts, but a different point of view about this. And the two of them, state officials, taking an official position on a ballot measure, but on assisted suicide we were gagged.

And now think of what this means. The only institution in the state, the only medical school in the state that has the expertise and insights about the background philosophy, the medical-ethical implications, the historical perspective, the implications to the practice of medicine, is essentially gagged from being able to express its viewpoint. I could speak as Bill Toffler, 1010 SW Cheltenham, but I could not speak as Bill Toffler, associate professor or professor (or whatever I was at the time) of family medicine with a clear, titular perspective that ought to play into the debate and the thinking of the population of Oregon. That's sad. Because you're essentially asking people to make a decision about a very complex issue over “sound bites” and “drive by debate”.

And you're not allowing the people, who have expertise, a voice. I remember Susan Tolle, the head of OHSU's Center for Ethics, I think at one time, publicly or privately told me that she was in my camp. She told me this. And I encouraged her to speak out. I told her that if she did that I would support her and the like. And she says, “I can't; I've been told I can't.”

Now in retrospect, I think our so-called Center for Ethics has no ethic. And that's not my opinion. In their ten-year glossy production of the accomplishments of the Center for Ethics at OHSU, they prided themselves within the first two pages on being neutral on assisted suicide. And it's my contention, Jim, you can't be neutral about some things. You can't be neutral about child abuse. You can't be neutral about wife abuse. You can't be neutral about slavery or flying airplanes into skyscrapers in New York to make your political point. There is no neutrality. If you say you're neutral, you're essentially saying, “I understand this in some situations. It makes sense to me.”

And I think I really learned that most graphically when I was invited to speak to a group of psychiatrists as the person who was opposed to assisted suicide. And they invited one of my protagonist colleagues who was for it. And they invited a person who was neutral. And as we started talking, it became clear, obviously, the person who's for it is doing a wonderful job of saying why this is a great new tool in empowering physicians to do this under whatever circumstances. I'm saying that I'm not really keen on this idea. And the person in the middle is saying, “Well, you know, sometimes I don't think it's

such a good idea, and other times I do. It's kind of good." And I realized it's not a one against one debate. It's a one and a half against one debate. Because the person who's claiming to be neutral is really not neutral at all—she's just less enthusiastic about it than the person who was cast as a proponent.

So it's very interesting as I think about the whole concept of neutrality, which was supposed to be the safe haven for the doctors in the Oregon Medical Association in the spring of 1994.

In my experience with the OMA, there was no way to overcome what I saw as a relatively committed (in one direction) organization when talking about some of these issues. And I remember vividly one of the people back east, a lobbyist, talking to me about the issue, because it has national implications, as you well know; he asked, "Can't we get the doctors to regroup?" And my first comment to him was, "I think I'd rather climb Mt. Everest without oxygen than try to get the Oregon Medical Association to reverse itself on the choice of being neutral." And yet as I said those words, it became clear to me that, you know, I hadn't really tried. I understood the dynamics of the House of Delegates, because I'd been involved with it for years at that point, usually on the losing side of whatever issue was there. But I also participated actively, which is something I made it a point to do, of many issues about which I had no passion, but I just lent whatever support I could to common sense and supporting good ideas of my colleagues in medicine, whether they were ophthalmologists and specialists, or they were primary care, rural, I didn't care. If it was a good idea, I was trying to be supportive, and I was on committees and did work.

And so I learned, I guess, the Roberts Rules of Order and the political process of our own largest organization of medicine in the state. And I asked colleagues who agreed with me that assisted suicide was an anathema to the profession of medicine if they would like to try to persuade their colleagues at the Oregon Medical Association. And we took it on as a charge. And in 1997, as you well know, we were able to educate our colleagues to the serious problems with assisted suicide as crafted by the so-called "model legislation" of the so-called Death with Dignity Act.

I say "so-called," Jim, because I believe in death with dignity. I believe in choice in dying. I just don't believe in empowering physicians to arbitrarily give overdoses and end the lives of patients under whatever limited circumstances you believe you can limit it to. I don't believe in empowering doctors in that way. That's a very different thing. And what we did is a matter of history now. We managed to, with trifoldts indicating the statements, dichotomous statements, that some of my colleagues made about this act—the inconsistencies, the misinformation that had been shared by proponents. We managed to succeed in convincing colleagues that not only should we oppose it, but we should "actively" oppose it because it was "seriously flawed."

Now some of those adjectives, I wasn't even hoping for. But the reference committee, hearing overwhelming testimony, that the neutral stance we had adopted in '94 was dysfunctional, had, I think, gotten their spine back and recognized that look, we

can disagree about concepts; that is, a Hollywood image of taking a pill and slipping off to sleep, that that's not what we're talking about. We're talking about assisted suicide with this act which is seriously flawed. For example, it (the measure) didn't do things like give the disabled the right to this new tool because they couldn't swallow. So it was not equal treatment under the American Disabilities Act. The mechanics were flawed; the devil's in the details. So we didn't ask everyone to agree that assisted suicide itself was inconceivable. We said, "This act is flawed."

Now as you know, the leadership had changed in those three years. And it was hard sometimes getting the leadership to follow the directions of the House of Delegates, which is what they should have done. In my opinion, there was some dragging of feet to actually be actively opposed, work collaboratively with other groups, and it was not as robust effort as I believe the organization has as its inherent capacity. And that's my opinion.

But it did give backbone to the legislature to go the only route that was available to them, because Kitzhaber, two weeks after having grabbed headlines that doctors had regained their spine with respect to an inherent conflict of interest in the medical profession, and the legislature had gotten backbone to kick it back out, couldn't go through the regular process of passing a law, because Kitzhaber had threatened to veto it. And he had gone from being, supposedly not having any strong feelings, to now being actively opposed to any effort to repeal assisted suicide. And he grabbed headlines. And he once again showed the people of Oregon that doctors don't agree about this, they have different opinions, and it's not that important. And I think that's a sad reality, but it was a brilliant political strategy.

And then the referendum to have it appealed was not talking about the issue of assisted suicide so much as this is "going against the will of the people," because we voted on this in '94. We already settled it. And it became an issue of don't let them overturn your wise judgment. Even though the doctors had the wisdom to overturn their previous, I think, misdirection of being "neutral" about this.

And you and I have different opinions about this. And I know that because I've read some of your transcripts to the House of Lords Select Committee. But people in the organization do have influence. And certainly when you're an executive director, you have tremendous influence of what gets done and doesn't get done, what tone and tenor of things that are said, how committees get formed—there's tremendous power. So I'm transparent about where I am. I think many people in the state have been less transparent about where they are. And I think that's a political reality. But it's not one that I'm mad about. It's a reality. Yet, I think that it's unfortunate. Because I think often the true agenda is hidden from people in terms of where they'd really like to go.

Currently we face a state north of us that's got ballot measure, I think it's I-1000, signatures being gathered to model itself after Oregon's, I think, misguided law. And the proponent, former governor Booth Gardner has, I think, been less effective than he could be, because he's candid about the fact that this is a first step. And that's why he's not

probably as effective as Barbara Coombs Lee was, and as some of my colleagues who even to this day claim that it's limited, when indeed there have already been many, many cases that have emerged that have shown it's not limited. People who can't swallow, somehow their lives are ended. It's very clear that injectable drugs have been used orally, we think, but we don't know, because there's no real investigation or check in place.

Even when things go awry, like they did with David Pruitt, who took the cocktail recommended by the so-called Compassion & Choices group, and he woke up sixty-seven hours later, essentially saying, I quote, "What the hell happened? I thought I was supposed to be dead?" Now thankfully, Jim, he woke up and he could articulate complete sentences. He wasn't like Karen Ann Quinlan, who, as you recall, in 1976 was a seventeen-year-old girl who took an overdose and was seriously brain damaged.

Now it's only a matter of time, in my opinion, before someone is labeled "terminal" by one of my well-intentioned colleagues in the state of Oregon, who, indeed, isn't as terminal as they thought, who takes the overdose, and who, like David Pruitt, doesn't die—but has respiratory depression, hypoxia, and injures their brain. I think that's a sad reflection on the state, of devolution, of regression to an earlier time when doctors didn't have a consistent ethic.

I remember vividly at a House of Delegates meeting John Kendall, who was a former dean of the medical school, who maybe didn't see the world like I did, totally, but he made one of the more appropriate secular points that I think needs to be expressed is, "You know, if society wants this, if you or others think this is a good thing for society, then society's a democracy, they can have it. But it shouldn't be doctors." That's a critical insight that he had that was very helpful, obviously, for the people who didn't want to look at it as an either/or phenomenon, but just should doctors be doing this.

I mean, think about this, Jim. In the state of California just within the last two years, there were two anesthesiologists who wanted to participate in an execution. They didn't because some of their anesthesiology colleagues and other colleagues in medicine said, "What are you doing? You can't do this. You're doctors."

They recognize the inherent conflict of interest for doctors to participate in the deliberate killing of another human—even when they're a convicted felon on death row! And somehow, in Oregon, we've adopted a position where I am licensed now to do just that as a part of my routine practice. It is different than the license that I held for twenty-some years in the state of California, different than the license I held in Virginia and South Carolina, and still is different than the license that I would hold in any one of forty-nine states. And I think part of why that's still true ten years after it has passed here in Oregon by a public plebiscite majority is that we've been effective at sharing some of the insights about what the reality is here—a reality which is very much diametrically opposed to what the proponents of this paradigm would share with you.

We've not only been effective at sharing it in this country, but we've been effective in sharing it in Australia and UK. The House of Lords defeated a bill by Lord

Joffe, who's Nelson Mandela's lawyer. He's a very personable fellow, and very effective, obviously, with some issues. And he worked for some years. I think he interviewed, or his select committee, interviewed you. But it was defeated 158 to 100 because there were palliative care specialists on that select committee. I don't know if you recall. And they have palliative care to a much more developed state in that country than we do here. For example, we just gave out a palliative care award to a student or to a doctor, and it was only the second one we've ever given in a medical school that's over 150 years old. We're like neophytes to giving appropriate end of life care, even though we've become almost as "advanced" as the Dutch in giving overdoses to patients at the end of life.

And I think that's a sad reality, because we have no expertise in this area (assisted suicide). We don't teach it in medical school, thankfully. And what curriculum would you take away from in order to teach doctors how to be officially "enders of life" instead of caregivers of their patients as they approach the final days of their lives? What message does it say to our patients? And I've had patients call me because they know of my public stance. And they know that I might have insight into the background of a given physician. And they call and they say, "You know, I went to this one medical oncologist and he wasn't very hopeful. He said I didn't really have much chance of doing this. I went to another one and he was more hopeful, more sanguine. Then she asked, "Is one of these doctors one of the death doctors?" I'm quoting the patient, Jim. That shift in mentality was unthinkable fifteen years ago. No one would have ever thought to ask me the question. It would have been questioning the doctor's integrity or motivation or implying a utilitarian view of the world.

And it's not just a few people. It's the people who get mad at Glenn Beck because he's got a positive point of view about the value of Terri Schiavo, and they send him hate mail. It's Governor [Richard] Lamm, who's published in the *New England Journal of Medicine*, who believes that people like you and me, as we get older, should have the good grace to get out of the way because we're using up too many resources for our level of productivity. There are all too many people who don't have the purest of intents when it comes to, essentially, ageism and discrimination.

And all of this ought to be part of the debate. But it's very hard to have that level of discussion with ballot measures. It's certainly hard enough in the House of Delegates meeting to have that level of discussion without tremendous preparation, which we experienced in 1997. On the other hand, we had very little preparation, in retrospect, in 1994 where the people who hold a different world view than I do had a great deal of preparation, had already tried to be successful in the state of California. They tried to be successful in Washington State. They had learned what they needed to, from those campaigns. Then those organizations recruited people like Peter Goodwin to be spokespersons for the opposite, polar opposite point of view.

And it's very interesting, because I talk with Peter, Peter and I who have been friends for years. I said, "Peter, you know, you're being used." He told me, "I wanted to be used." And the end that he wanted was similar enough he that it didn't matter how you got there. To him that was a good thing. "Choice" became the dominant and winning

argument. Yet, I would say I'm for choice. But I'm very much against empowering doctors to exercise that choice. Patients, they have that choice. You have a task force here in Oregon working on trying to reduce the overall rate of suicide, which, by the way, I'm in favor of. And I'm not blaming assisted suicide for it. Yet, in fact, Oregon has one of the highest rates of suicides independent of assisted suicide. But why do we care? We care because we see people taking their own life as a failing. And why would we treat people with six months to live differently than those who have six years to live?

And if you think about it—it's not, again, not my argument, it was Kevorkian's argument. It's Derek Humphry's argument—the people who favor assisted suicide. They realize it really shouldn't be limited to just end of life. They ask, "Shouldn't a person who has six years of arthritis, crippling arthritis and pain, have more right to this than the person who has six days?" What right do you have to limit it to those predicted to have six months to live?—and I asked this question of one of my colleagues who's very active, and has probably participated in twelve assisted suicides. And he told me that he declined one recently. I said, "On what basis?"

Well, he really didn't think he was "terminal" enough. He had lung problems, but they didn't seem to be "end stage." And I asked him the question: So, what right did you have to limit him access to this thing he wanted? To have his life ended? He said, "Oh, well, if you go down that road, you're going to go someplace where you don't want."

I said, "We're not talking about me. I'm pretty clear about what I want and don't want. You're saying you think you can somehow keep it straight. First, I would question what course did you have predicting that somebody has only six months to live? And second, what right do you have to impose your morality and say that he has no right, and someone else does?"

And of course, there is no answer to that question. It's all arbitrary. So I think we've got a dichotomous model of healthcare in the state of Oregon about which I (with my opinion) seem to be in the minority—and I think it's an unfortunate reality. And my work, among other doctors who share my concerns nationally, internationally, is to limit this infection, this virus, if you will, from my point of view, and immunize other states, other countries, against the spread of what I think is a dysfunctional disease in the house of medicine.

[tape interruption]

TOFFLER: You have the wisdom of whatever time on Earth you've had. And if we don't share that wisdom and be open about it, if I can't hear what it is, I can't respond to it. And so what I would say is we're poorer for that fact. And that's why I went to a group of doctors back east in Philadelphia a few weeks ago, because they'd invited me out there, wanting to know how they could be more effective working with medical societies. And part of it is the transparency.

You know, I had a person from the Center for Ethics come to me once because she had found out that a patient, no, not a patient, it was a nurse that complained that a patient had changed her mind about a tubal ligation after I'd gone in and visited with the patient postpartum. And I said, "Well, what's wrong with that?" Well, the nurse is concerned because you made her change her mind. I said, "Well, I can't make anybody change their mind." Least of all yours, Jim. "But I went in and I talked to her about options, and she chose a different option." I then asked, "Have you talked to the patient?"

She said, "Well, no, but we plan on it."

I said, "Well, good." And if you find out that the patient did choose another option, I didn't force her to do anything, which I think is impossible, you might want to talk to that nurse about what view she had about the patient's future childbearing. Was she too poor in the nurse's mind to have more kids? You might want to talk to the nurse about the objection that she had about that patient's future fertility when she was bothered that the woman had not chosen to sterilize herself.

And then she went into other details about what I limit my practice to or don't do. And I said, "You know, just being up front like I try to be with my patients, so they don't have any surprises about where I'm coming from."

She said, "Well maybe there's still a problem, because people would come to you thinking you do these things, and they're a waste of time."

I said, "Well, I tell them that the visit's no charge, if they had expectations."

She said, "But still, they have to spend the time. Maybe we could post a sign in the waiting room that says what you do and don't do."

I said, "That's really a good idea. In fact, it's such a good idea, why don't we have a sign out in the waiting room for every doctor like that?"

And she said, "Oh, I don't think we can do that."

See, I'm for transparency, Jim. And it's interesting. I shared that anecdote with a writer from the *Portland Tribune*. All he did was reduce it down to, "Toffler refused to put it (the sign) up." I actually didn't refuse. I thought it was a great idea. I encourage transparency in the house of medicine. And I encourage integrity among my colleagues for whatever they believe, so that their patients know what they stand for and what they don't stand for.

And there were some patients who wrote when they were bothered by the press hinting that perhaps I took ethical stands that were at odds with the majority view of the institution. They said, "You know, if you exclude doctors like Dr. Toffler from the institution, then I'll have no doctor that I want with the worldview and point of view that he holds. What's more, you'll have no future doctors that hold that viewpoint, because you'll only train people who see the world the way you see it." And this is a layperson, with absolutely more insight, in my opinion, than some of my colleagues who hold ethical credentials and seem to lack the insight of true diversity and true respect for different worldviews that this particular patient in Hillsboro holds. So any rate, I don't know if this is helpful to you.

KRONENBERG: Very helpful.

TOFFLER: Good.

[tape change]

SIMEK: Could we just take another maybe two minutes and ask our standard question of how do you project the future of family practice in Oregon?

KRONENBERG: That's fair enough. Let's do that. Kind of a significant segue, but I think you're up to it.

TOFFLER: Well, I think it's robust. The department's never been more vibrant, despite all the budget exigencies that have come along the way. We have a true department, not just a good residency program, which is where we started twenty-five years ago. We have a preventive medicine track within the residency program. We come a long way from when my predecessor interviewed for his job as a pre-doc director for family medicine—that's the person in charge of medical student education for our department. He went around and met other department chairs. One department chair asked him, "How can you be the pre-doc director for you department when you have no curriculum time?"

So we had no curriculum time as a department. And we ultimately moved to participating, getting a grant, participating in someone else's course, to ultimately being part of the task forces, the Culpepper curriculum revision task forces, the Robert Wood Johnson funded grant that came to the school that led to a dramatic curriculum change that allowed us to cut back, have more self directed learning, have integration of courses, have balance in primary care, have some of the primary care take place in the AHEC, the statewide program.

And it was really exciting for me. I got to be in that seat, that person who didn't have any curriculum time had just started a clerkship when he decided to move into geriatric care. And I was the person that the chair came to to fill in his role when—it was at a time when he said, again, prophetically at the time, in retrospect, "This will be a great opportunity for you. You could really build a career around this." And truer words were never spoken. I went from being a junior faculty member with virtually no curriculum time and volunteering to teach and volunteering to be on the curriculum committee, to being a full-fledged member of the curriculum committee, to being a course director for a major third-year clerkship that got crowded out of vacation time, which you can imagine how challenging that is to get, to having a second third-year clerkship, which is our rural health experience now, which had greatly helped the Oregon demographics with respect to people practicing in small towns, like Burns and John Day.

And our residency program has sent people out to practice in Lakeview and Enterprise. And we have a second residency program in Klamath Falls. We have another family medicine program here in town with Providence Milwaukie Hospital. So that many of the students who walked across the stage today were headed for Providence

Milwaukie. They wouldn't have stayed in the state of Oregon. And there's good data to show that where you do your residency is very much correlated with where you practice. Many people, I'd say almost 60 percent, practice within fifty miles of where they do their residency program.

There's another residency program in Vancouver that's affiliated with the University of Washington, but we work with them in teaching our medical students. I think if all the states were as robust as Oregon with respect to family medicine, we would not nearly have the imbalance that we currently have. We've essentially defied some of the national trends, but not all of them. And that's why I think we need to do better. We've got lots of work to do, particularly nationally, where I think we're insulated here a little bit because it's been so favorable for family medicine, and we've been so successful at being able to take the opportunities that are presented to us and run with them. Look for opportunities like the grant money that we've recently gotten for the school through the National Institutes for Health, or the training grants with Title VII for years. And we've parlayed those dollars into permanent fixtures within the institution. So that even when I step aside, as I did last summer from a role, fifteen years of leading the largest course in the medical school, 29 percent of the clock hours in the first two years are under the Principles of Clinical Medicine.

And so I had titular control of that curriculum, which allowed me to garner grants to help our school be more innovative, more successful. And it wasn't just me. It involved hundreds of people. But the opportunity was there. And the leadership in the school allowed the freedom for me and other people who were passionate about the same principles and issues to be successful.

So I think it's been a great place to be. I see no end in sight, despite the major national issues that still are before us. And in many ways, Oregon's been blessed by excellent leadership at the medical school level, albeit with, I think, mixed support sometimes legislatively—sometimes good and sometimes horrendous when you think about the bang for the buck if the legislature would be willing to shift priorities.

But we truly have come a long way. When I first thought about coming into academic medicine, I remember people in the '80s talking about closing the medical school, because we've got plenty of doctors in Oregon. Do you remember those conversations in the legislature?

KRONENBERG: I sure do.

TOFFLER: So we've come a long way as an institution, as, I think, a state, in recognizing that those are horribly regressive and dysfunctional thoughts—that you would really be throwing out the baby with the bath water. And even if the baby was having some learning difficulties in terms of its effectiveness as a medical entity here in Portland, that is, which was the head of the medical groups and which is the tail? It wasn't clear that OHSU was at the head at one time. Now I think it's emerged as clearly a

world class leader in so many ways, that that investment has, I think, had a great multiplier effect for the state. Not just in economic terms, but I think in health terms.

You have—literally, I’ve met people who’ve come into my life because they came here to use some of the miracle drugs and strategies for treatment for cancer that are unique. I mean, people come in from New England to Oregon, having looked the whole world around for therapy that was only available in Portland, Oregon, at one time. And now it’s getting more widely disseminated.

SIMEK: Universal healthcare?

TOFFLER: You know, it’s impossible to argue that universal healthcare at some level of basic services is a good idea. How do you get there?—the devil is in the details. And you cannot do it by taking key players and excluding them from the conversation. We went through that with Hillary-care in the ‘90s. You cannot do that. You have to find win/win approaches—incentivize players that otherwise would be stuck in their logic. That is, insurance companies. And take their databases. They actually have more information on people than most any other computer health system, when you think about it. But it’s now being used to exclude people from coverage. What if you turn that around to actually tracking and seeing what works? Instead of denying experimental treatment, you say “Great! This person wants experimental treatment. This is an opportunity to see if this works.” Or is it like doing pelvimetry before deliveries in the old days, which turned out to be useless; or cutting, episiotomy, turned out to be useless as a routine standard in prima gravidas.

So, what if you use this data actually positively? And there are people talking about it. What if you took the huge number of dollars in Medicare and Medicaid and gave people discretion—not to spend the money any way they want, but to buy health insurance coverage, keeping players involved. Now these aren’t my ideas; they’ve actually been documented, written, and tested, and they work. My only concern is, are there national leaders, at the presidential level, who are actually able to articulate these ideas, these innovations. Are they even willing to bring together the key people who understand them, like Ezekiel Emanuel or the person who wrote the book *The Cure*, who’s a Canadian psychiatrist who now lives in this country. And it’s very well documented chapter and verse. A solution is possible. We can get universal healthcare without compromising totally what has made American medicine great. I absolutely believe that. But I believe that there are too many people who simply want to say, “A fix at any cost is okay” without seriously looking at the problems that other countries that have universal healthcare but don’t have some of our creative passion, energy, and incentives, and they’re willing to take the other baby and the bathwater without saying, “Can we just look for the baby there?” and leave the bathwater, and keep the babies we have.

Can we do this? We’ve done this kind of thing—you know, we were behind the Russians with the Sputnik program, we’re now the world leader—

SIMEK: We're also out of time on the tape, unfortunately, so Jim, tail slate please, and then we have to wrap.

[End of Interview.]

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