HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

John Kitzhaber

Interview conducted November 21, 2006

by

Scott Gallant

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[Begin Track One.]

GALLANT: –with former Governor John Kitzhaber took place on November 21, 2006, at the Oregon Medical Association in Portland, Oregon. This interview is made possible by a grant from the Oregon Medical Education Foundation. Scott Gallant, alumni association executive director, is the interviewer. Tape one of two. Do you want me to do it again?

SIMEK: No, that was perfect. You've got it.

GALLANT: Okay, John, this is for the purpose of having a permanent record on Oregon citizens' positions, specifically who have had great influence on medicine. And you obviously are one who's done that, both as a practicing physician, and as a former legislator and governor and gadfly in public policy. But we'd like to start with, pretty much at the beginning, and really have you talk a little bit about why you got into medicine, who might have influenced you in that process, and what your expectations were on your adventure into becoming a practicing physician.

KITZHABER: Well, my medical career, not dissimilar to my political career was, to some extent, an accident of history. When I was in high school, I was very interested in biology. And there was an emeritus professor of the biology department at the University of Oregon named Ralph Hustus who befriended me while I was in high school. And I used to spend time up in his lab. And I became very interested, actually, in artificial organs. And artificial sight, in particular.

So when I decided to go to medical school, it was basically during, it was while I was in college. And I wanted to go and get a medical degree to pursue my research ambitions. I never really had the desire to actually practice medicine.

And my last term in medical school, I discovered, I did a rotation in the emergency room. I guess it was when they had the old Multnomah County Hospital up there. And just fell in love with it. It was fast moving, you know. You had to make decisions. You were accountable pretty quickly for the quality of the decisions you made.

So when I went off to my internship, I took, I think, one of the last rotating internships probably offered in the country, and took all my electives in the emergency room. And decided sort of in the course of that senior year that I actually wanted to practice, and I wanted to practice emergency medicine.

GALLANT: Was emergency medicine a specialty at that point?

KITZHABER: It became a specialty, I think the year I got out, or the year before I got out. So I was actually in that class that could have been grandfathered in if you wanted to spend the time to take the exam. And of course, then I got involved in politics and never really had the time to do that. So I never did become board certified.

GALLANT: In the process of going into emergency medicine, was there a particular professor or a role model–

KITZHABER: You know, there really wasn't. I had a number of people who had a significant influence on me when I was going to medical school. Dr. Lewis, Howard Lewis, was one of them. And Bob Bacon, of course, was another. Harold Osterud. You know, just real, I mean, to me, what doctors were supposed to be all about. But I don't think I knew anybody, actually, that was involved in emergency medicine. I don't think it was a specialty when I was going through med school. It was just sort of, you know–

GALLANT: Yeah, I think John Morehead was the first head of that department, actually, so that's kind of interesting that your paths just missed at that point. You chose to practice in Roseburg. Was that because of opportunity existed because of your desire to fish? Or outdoors? Or family?

KITZHABER: It was because of my desire to fish. I went to Roseburg because of the North Umpqua River, and the million acres of forest down there. I just love that part of the state. It had nothing to do with really anything else. As luck would have it, one of my classmates, Paul Norris, had the contract at Douglas Community Hospital down there, although that's not where I started out. I started out at the old nursing hospital, and ended up working there with Paul for most of the time I practiced emergency medicine. But it was a geography choice.

GALLANT: You know, in that era, county medical societies were very active, and, I think, provided physicians and families quite a network of support and that sort of thing. Was that your experience in that period?

KITZHABER: You know, I was twenty-seven years old. I was single. I spent most of my free time up wandering around the forest and fishing in the river. So I didn't actually get involved in organized medicine till actually after I was elected. As you may recall. [laughs]

GALLANT: I do recall. [laughs]

KITZHABER: But I knew some great people who actually were very active and went on to leadership positions. Roy Skoglund is an obvious example of someone who I had a great respect for and a wonderful friendship with while I was in the ED.

GALLANT: And we'll talk about him later. You began practice in Roseburg–

KITZHABER: '74. October of '74.

GALLANT: And you actually, then, decided to run for office shortly after that. You must have run for office in 1978?

KITZHABER: '78, yeah.

GALLANT: For the first time. What motivated you to do that? You hadn't been in practice very long.

KITZHABER: Well this actually, my desire to get involved in politics preceded my desire to become a physician. I was a junior at Dartmouth College in 1968, when the civil rights movement was going on. And we were in the height of the war in Vietnam. We could get drafted at eighteen, but we couldn't vote till we were twenty-one. And I was just sort of caught up in all of that. And actually, it was the assassination of Martin Luther King, and later of Bobby Kennedy that actually, I think a lot of people of my generation suddenly just realized we wanted to get more engaged civically. So I can just remember the moment in time when I decided that I wanted to run for public office. I never really thought of making a career of it. So I carried that desire throughout my training.

Actually I ran, I had two unsuccessful elections. I ran, actually, as a delegate to the Democratic National Convention in 1972. I was going to support John Lindsay, who was running as an independent. [laughter] I think maybe I got three votes. I don't remember. And then I ran against Dave Grube as class president of my medical school class. And I remember giving a speech about civic engagement and the war in Vietnam and all this stuff. And Dave got up and promised a keg every Friday, and he just swept the slate. [laughter]

So then when I went to Roseburg, obviously I was going to run in 1976, and I got to thinking that I couldn't possibly get elected down there, given my sort of bent, philosophic bent. And I actually considered moving. And then I came to the realization that if you really want to make an impact, you need to try to convince people to your point of view rather than just go to a safe (seat?). So I actually ran in '78 and just barely got elected.

GALLANT: I know that one of the early political action committees happens to be the Oregon Medical Political Action Committee. What was organized medicine's reaction to your–

KITZHABER: Well, they sort of held me at arm's length. I remember coming up here for my job interview, and afterwards walking out and Barney Speight putting an arm around me and saying, "Well, I just don't think you quite got over the top, John." And the OMA did endorse my opponent, who was a land developer, who I just barely beat. That was my first experience with OMPAC, if you will.

GALLANT: Well, sometimes we get smarter as we get older. What were the themes during that campaign? What do you think?

KITZHABER: You know, healthcare wasn't one of them. That was the year that Prop 13 passed in California. And Jarvis and Gann, the measure's proponents, were actually were up. And we had one on the ballot. I can't remember what the ballot, I think it was ballot measure one, I can't remember. But there was, it was essentially a property tax limitation measure. So that was a huge issue.

There was also an issue, measure to repeal (?) planning program. And I was actually on the wrong side of both of those from the standpoint of Douglas County politics.

And soon enough, there was a huge issue about septic tanks and sand filters. It was very interesting. Rural Oregon, a lot of people wanted to develop out in the farmlands. Very poor soil, so that was a huge issue. I don't know why I remember that. And the chronic issue of school funding.

When I got elected, we were still at the height of the sort of the timber boom. So those, I mean there were natural resource issues, but medicine really wasn't, we had some rural health issues, but it wasn't a prominent part of the campaign in '78.

GALLANT: Did you have a fairly large campaign team? I would suspect first run, you might have done it out of your house or car.

KITZHABER: Pretty much. I mean, I had a house that I remember talking to Gratin Kearns, who was the majority leader at the time, I think, and he told me that this race was going to cost me as much as twenty-nine thousand dollars. And I'm thinking, my god, my house cost 26.5, you know. But I basically did it myself. I called up the Democratic Party, which is pretty much on life support down in Douglas County. I said, "I'm running. Are you guys going to help me?"

And they said, "No. We don't actually do that kind of thing."

So I just recruited people in all the precincts. And it was pretty much knocking on doors. We did a little radio. It cost about twenty-nine thousand dollars. And so it was very much a grassroots campaign. And I think Al Shaw probably would have beat me if he saw me coming. But I was twenty-nine years old and an ER doc. Although that actually helped, because I treated probably 90 percent of the wood products workers at one time or another in the emergency room, so that actually helped a lot.

GALLANT: Was it a large class that year for Democrats in the state legislature?

KITZHABER: As I recall, both chambers were pretty solidly in Democratic control. And we elected Hardy Myers speaker. Jason Boe was finishing up his fourth term, I think, as senate president, also from Douglas County. So there were a lot of

freshmen that came in that year. Like Tom Mason and a lot of folks you probably remember.

GALLANT: From the past. Yeah, who went on to other things.

KITZHABER: The big issue in that year was organizing the House. Hardy had twenty-one votes, and then you had Jeff Gilmore and this group that called itself the Hornets, sort of the conservative Democrats. And then you had a group from the coast, Bill Grinnell, and it took forever. It took, I think, three weeks after the session opened to actually get the House organized.

GALLANT: It's an art and a science, as you found out later, when you became senate president, as I recall. A lot of phone calls, etcetera.

KITZHABER: Indeed.

GALLANT: One of, 1979, your first session, was actually before my time. But I remember Barney Spate, who used to be the lobbyist for the medical association, always saying that they actually won the issue on, scope of practice issue, which appeared to be a really big deal then, nurse practitioners had their scope of practice expanded, to the chagrin of organized medicine. Do you recall any of that?

KITZHABER: Oh, yeah. I think I was the sponsor of the bill. I think that was, I believe that was one of the issues that came up during my interview with the OMA. And I came at it from a really a rural health perspective. We had parts like Powers in, over in Coos County and (Coquille?) County where you just didn't have any primary healthcare. So the idea was to give them a very limited formulary. And that was the sort of the first, and, I think, one of the few times I actually had a direct conflict with the OMA position. And it was a fascinating bill. I mean, we'd got caught up in a bill that Jason Boe wanted to amend our fill and removal law to fill in part of Coos Bay to put, I think, a grocery store or something out there. And it became involved in sort of an issue. I ended up on a conference committee on this fill and removal bill, the outcome of which was going to determine whether the nurse practitioner bill got to the floor, and it finally did, and actually got, I think, thirty votes in the senate. And I think it's turned out reasonably well since then.

GALLANT: Well that kind of brings up, I think, a broader theme that I think we should get into maybe early on. Rural health has been a problem in Oregon for years. And it's true in other areas of the country as well. I know that you've had a particular interest in that area. And your view of it might have been different twenty-some odd years ago versus how it's progressed over the years. From your view, do you think it's improved significantly? Or are we still kind of struggling to figure out how to deliver?

KITZHABER: I think we're still struggling. We tried all sorts of things. One time there were loan programs and subsidy programs to try to get physicians to move out. And you know, in very many cases, it wasn't really the money as much as it was the lack of a

backup, like a specialty backup, just sort of lifestyle issues. And I think we still have a huge challenge delivering rural healthcare. I mean, I think one of the things that Peter Kohler did with the AHEC, the Area Health Education Centers, was brilliant. I mean, it basically sort of extended OHSU. Politically very smart in terms of getting support from the institution from rural legislators. But also served, I think, a real need. And I still think that that's going to be an issue we really struggle with. I mean, you talk about changing the healthcare system, you have to specifically carve out rural medicine, because it's a different animal. And how you reorganize it for an urban setting is completely different than the challenges that I think you face in rural parts of the country.

GALLANT: Well one of the things we're hearing now is that, for example, Medicaid patients in Ontario, if they need surgical services, even though it would be closer to go to Boise, they're not being accepted because of reimbursement.

KITZHABER: Reimbursement, yeah.

GALLANT: And are either being driven or flown to Bend or Portland because that's the only place they can go. Do you think that this is such an intractable problem? I mean, it's really no different, it seems to me in my experience for today, than it was then.

KITZHABER: No, I don't think it's changed very much at all. And I think the issue, and I know that all of your viewers will agree with this, I don't think the problem with our healthcare system is lack of money generally, but I do think that is part of the problem with rural healthcare. You basically have to invest in some infrastructure. And that's true not just of healthcare. If you go to rural Oregon, we, those of us on this side of the mountain subsidize the roads over here. Because essentially just more gas taxes are raised over here. The same thing with schools.

And part of having a rural part of your state, and there's a lot of reasons that we should value and honor rural sections of our state and country, is you have to spend more to provide those services over there. So I think it's going to take a significant capital investment to provide the infrastructure necessary for quality care to be delivered. I mean, not that there aren't quality providers, but I mean, it's very fragmented.

GALLANT: So an intractable problem that still needs a solution somehow.

KITZHABER: Yeah, I think we've not solved that one. I think telemedicine has and will continue to help, to a certain extent. I think St. Charles has done a pretty good job developing a network of hospitals, related hospitals over there, but we still have a lot to do.

GALLANT: Being in the House of Representatives is a different experience than being in the Senate. And obviously being governor, a key person for policy for the state, I'd like you to take a moment to reflect, maybe, on kind of what it was like to be in the House in that era. There were some fairly significant players who come to my mind. Obviously Vic Atiyeh was governor, as I recall. Very moderate Republican. Mike Thorn.

Democrat was Ways and Means chairman Jeff Gilmore. A very different kind of personality as the other co-chair. And so that was kind of one perspective. And there's a different role, really, when you're in the Senate. Can you reflect about what it was like to kind of go–

KITZHABER: Well, the House is much more chaotic, I guess, in a way. You have sixty people. But what I do remember about those days is that the legislature, I think, was very functional. Jason Boe really created the legislature as a co-equal branch of government. I mean, he really strengthened the legislature. Vic couldn't cough without basically checking with Jason Boe. And the Ways and Means committee, you had guys like Mike Thorn, but you had guys like L. B. Day, and Jack Ripper, and Debbs Potts

And it worked. It was a good old boys operation, to some extent, but we fought about all sorts of things during the election. But then they got the job done. They didn't have these long sessions of inaction. Decisions were made and it actually worked. And we had debates. When a bill was brought to the fore, he didn't always know how it was going to turn out. People actually had debates and minds were changed, actually, on the floor. And I think you saw that more clearly in the Senate, because it's a smaller body, and an individual had more influence than in the House. So the House, I was only there one term. I went right over to the Senate when Jason ran for treasurer. But I guess it was much more, it felt more democratic in a way. It was more freewheeling, and the Senate, he had kept a pretty strong hand on the till.

And actually, I learned a lot from Jason. So go to the Senate, the pace seemed slower. It seemed more organized.

GALLANT: One of the characters who was in the House of Representatives, I think, when you were first elected, was Howard Cherry.

KITZHABER: Howard Cherry, yeah.

GALLANT: I don't know if you interacted with him very much, but if you did, do you want to reflect on that?

KITZHABER: Well, what I remember about Howard, he was a genuinely decent person. He was just a very nice person. And as I recall, he was an orthopedist.

GALLANT: Yeah, I believe he was an orthopedic surgeon.

KITZHABER: And he'd do rounds before he came down. I think he was on the Portland School Board, too. The guy was sort of like Bates in that he had all sorts of, and he was tired. I remember him dozing off during debates on the floor. And I remember his real passion was public education. I mean, I remember him more for his advocacy of schools than medical issues. And again, I don't think there were any huge medical issues like we have today back in 1979. But he was just a great guy. And a real role model in

terms of demonstrating you can maintain a medical practice. I mean, his was a lot more challenging than mine, because I could actually get some time off. Great contributor.

GALLANT: Being in the Senate, of course, you have a great deal of opportunities to influence policies. I think you were the only physician in the legislature other than, I think Dr. Cherry retired shortly after that.

KITZHABER: Right.

GALLANT: But there are a couple of issues that come to mind. One, for example, when you were still practicing as an ER physician, was the medical staff bylaw issue. Would you like to talk about that a little bit? Your experience?

KITZHABER: Well, I remember, and again, I'm reaching way back here. But I do remember that the hospital I worked at was actually purchased by HCA. And the suits from Nashville came in and they asked me to be on the board. Not that I knew anything about governance, hospital governance, but I was Senate president at the time, and I think that was the reason. And they made all sorts, they were going to remodel the hospital. They were going to hire local workers, the whole ball of wax. And the first meeting, these guys told me that my primary obligation was actually to make a whole lot of money for HCA. So I ended up resigning from the board.

And as I recall, they adopted a set of bylaws without even consulting the physicians. And I'm not even sure the doctors would have objected so much if they'd had a say in it. But it was just that they utterly took them for granted. And there was a major revolt down there. And of course, it was a time when Roy Skogland was very active in the OMA. So they'd sort of stepped on the wrong tail. And the result was the legislation that came out of that.

GALLANT: Well that kind of brings up again a broader topic. Medicine has really changed since you first practiced and through your political career as well from, again, a very small network of physicians and hospitals to more of a corporate sort of system of practice where the hospital system may have particular priorities that may or may not be the same as physicians who are in private practice versus those who are employed by hospitals. You also went through the era of managed care, as well. From a policy perspective, what do you think worked during the earlier years before managed care and very major hospital systems, versus were we are today? What's working better, if anything? What do you see down the road for how medicine might be provided in the future?

KITZHABER: Well, I will say that, I think one of the results of sort of the corporatization of medicine, I remember Art Rillman having all sorts of articles on this when he was still with the *New England Journal of Medicine* about how we're not a business. We're not a corporation. Sort of warning. And I think we got kind of pulled into that by necessity. I think that the movement toward hospital systems has not been an entirely positive one because you have system needs which often trump the needs of

actually the local community hospital. And it sort of creates a real tension. But it has made hospitals much more significant players.

And I would say that when I got to the legislature, the OMA was a much more significant player than the hospital association. I mean, it wasn't that you could write them off, but there was no question about the relative influence. And I think over the years as the systems have developed, it's now the Oregon Association of Hospitals and Health Systems, not just hospitals, and I think the fact that physicians' practices were purchased during that sort of move to managed care in the '90s has really fractured, I think, our political effectiveness in the legislature. And we saw that, I think, during part of the rollout of the health plan with the (Hen?) Report that demonstrated that the capitation rate for the Oregon Health Plan was being disproportionately going to the hospitals and less to physicians. And part of that is the fact that they had more lawyers, they had more corporate power, and more influence in the legislature. So I think we've suffered to some extent.

But I will say, and I'm certainly not just saying it because you're interviewing me, I think the Oregon Medical Association has, through the time that I was in the legislature, really kept a sense of its mission. And medicine's mission. And has been actually consistent in the positions that you've taken. The large policy positions you've taken throughout this whole kind of tumultuous time. Whereas I think some of the other players in the healthcare arena have begun to look more narrowly at their role.

GALLANT: Well, I think it brings up a good point. I think nationally and at the state level, medicine has been very good at splitting off and having subgroups. The Academy of Family Practice Physicians has a lobbyist now. ER Physicians has a lobbyist. And you can go through the list, and I think it's inevitable. And it's happened at the federal level as well. What kind of impact do you think that's had? And what would be your observations of what medicine needs to do to either strengthen or improve its ability to provide good healthcare to patients and influence policy?

KITZHABER: Well, I think the sub specialization and the political action representatives who represent not medicine but family practice or ER or ophthalmologists has weakened medicine's voice. I mean, I don't think if you're an average legislator, I'm not sure you could say who actually speaks for medicine in Oregon. It ought to be the Oregon Medical Association. But I mean, there are conflicting messages. And I remember the perennial fight between optometrists and ophthalmologists that would come down there. And to the average legislators, these were just a bunch of guys who were making too much money. And you didn't know who was who. It's very confusing if you don't have a medical background. I mean, I think it's really important for medicine to identify a subset of issues that reach across primary care, specialty care, that really have to do with quality and access. The kinds of issues that really drove the development of the health plan. And own those. And have the Oregon Medical Association sort of be the repository of those large issues that speak to policies that affect everybody who practices medicine. And I think that's really important that we get back to that kind of focus.

GALLANT: You know, there always seem to be certain touchstone issues. And we'll get to those, some of them, in a minute. Overall healthcare reform, which you've been involved with. But let's talk about some pretty controversial ones first. One, obviously, is liability reform. You were Senate president in 1987 when a bill passed to actually put a limit on non-economic damages. And you've had a great interest in that issue over your career. We're into round three or round four on that issue. It's having a great impact on physicians and patient access to care. Another one of those issues that never seems to go away.

Why don't you reflect on your involvement, first of all, when the legislature had the authority and the ability to make some choices in that arena, and what impact do you think it's having today, and may have in the future?

KITZHABER: Well, the bill we passed in 1987 as my second term as Senate president, we had a heavily Democratic caucus. And the chairman of my judiciary committee was Bill Frye, who was an attorney from Eugene who was bitterly opposed to this bill. It was a real struggle to get this thing to the floor. We actually squeezed out enough Democratic votes. So it wasn't just Republican votes that passed it. But it was very difficult. And what a lot of people didn't know at the time was that Bill Frye was dying of melanoma. And he'd come up off of the floor after just hiding me, and then I'd come and change his dressings up in his office. So there was this sort of, and I loved the guy. I mean, we were very close personally, but we were just miles apart on this issue. And I remember there was this sort of subsurface strain involved because I knew, basically, what was going to happen to him. He didn't survive the interim.

But we passed the bill. I think it was a good bill. I still think it was a good bill. It didn't solve the problem, but it did alleviate the premium increases. I think the record clearly shows that. I don't think there were any adverse consequences in terms of patients. And you know, the problem, of course, is that it was actually thrown out based on the interpretation of the constitution that denied the right to trial by jury. And that's made the job of dealing with the tort issue much more–

[End Track One. Begin Track Two.]

KITZHABER: –difficult, and I've come to the belief that as long as the issue is framed in a political context as sort of greedy physicians taking advantage of poor, injured consumers, it's just really hard to address it that way. So I think that in the work that I'm doing now on healthcare reform, it's real clear to me that you can't solve some of the big issues in the healthcare system, particularly on the delivery side, unless you have some significant changes in the tort law. But if you can demonstrate that you can't solve the larger healthcare system without doing that, it puts it into a larger context. I mean, we all know that in certain parts of the state you can't get primary obstetric care right now because of the tort issue. So it's a real problem. I think it's just going to be difficult to solve, though, narrowly. It has to be put into a larger context.

GALLANT: Was some of it put in the context of patient safety issues.

KITZHABER: Right.

GALLANT: The medical association, actually, the hospital association opposed a patient safety commission, which did pass and was signed by Governor Kulongoski. And one of the thoughts at that time was that it might create a mechanism for a broader, for broader consideration of some kind of tort reform if you could do a systems change. It's not worked out that way. But I think the public is very concerned about the level of and quality of care delivered, which is another reason why that legislation, in my view, and in the association's view, is very poor. It's also important nationally, and pops up periodically.

How does patient safety and quality issues, transparency, kind of fit in your thinking of what it was like when you practiced to what it's like today?

KITZHABER: Well, I don't think people even raised those issues. You know, patient safety, medical errors, transparency, those were issues that really weren't even discussed. Liability issues were certainly discussed. I remember when I got elected, I probably couldn't have told you the difference between Medicare and Medicaid. Because I had a contract with the, my group had a contract with the hospital that gave them, I can't remember what, but some percent of our gross billings. And they paid them malpractice insurance and they did all the collections. So we basically got whatever we made, so we didn't have to deal with that issue. Which is also nice because you didn't have to be concerned when someone came in about where the reimbursements were going to come from.

So it was much more pure medicine, I think. And I think that a lot of people, particularly in primary care, would tell you the same thing. Back in those days, you really were practicing medicine. You were practicing the art and the science of medicine. It was much less complicated than it is now.

And now, I mean, I think it's clear that in many cases we do over treat. We do over test. Some of that's due to liability issues. Some of that's just due to how the system's evolved. And I think there really are some serious questions there.

I remember coming up to your executive board back in the late '80s, talking about, with a proposal to develop some practice parameters back when this was (cookbook?) medicine, and nobody wanted to hear. But actually, there was some real interest in looking at that, because it was my belief then, and I still hold it, that if you could practice some practice guidelines, I think you're in a much stronger position to use that as an affirmative defense in medical malpractice cases. So you need to fix the tort system, but I also think we have an opportunity to step up and do some of it ourselves.

GALLANT: Well one of the issues that I think will become even more important, not in the broader context, but at least on quality measures, is that there's a high probability that you could have twelve, twenty-four hundred different sets of quality measures depending on how many insurers there are.

KITZHABER: Right.

GALLANT: And there is no mechanism in the state or nationally, we'd probably object to it being national, but at least at the state level to have an agreed upon, uniform set of measures that physicians are involved in and agree would have some real positive impact. Do you see a role for some kind of process, maybe along the lines of what you were thinking–

KITZHABER: Way back then? Yeah. I mean, I do think, and I think physicians have to be directly engaged in it. They're the critical factor. But you do have to set some standard that people have some confidence in, the physicians have confidence in. And you can't be expected to dance to six different tunes. I think that's one of the problems with the insurance industry today. Everyone does it differently. They reimburse differently. They calculate differently. It's a morass, it's a maze. Not just for physicians, but for individuals as well.

GALLANT: When you said that in the '80s, and in the early, well, not so much in the '90s, but certainly in the '80s, physicians had more of an opportunity to actually practice medicine. To actually worry about their patient, not worry about reimbursement. How did that change? Why did that change, from your perspective? How is it impacting the ability of physicians to apply appropriate care without providing too much or not enough?

KITZHABER: Well, I think there's been a rather relentless reimbursement erosion from the public side. Certainly when we did the health plan, I mean, up until that point, I mean, one of the two tools that legislature used to balance the budget was just to arbitrarily whack provider reimbursements. And you're seeing that in Medicare, I think. So as the federal budget deficit, federal fiscal picture's gotten tighter, the place they go is they'll cut back on Medicare reimbursements. And if you just have to look at Oregon's Medicare reimbursement based on the national average, we're way significantly below it. So I think there's been, it's not even reimbursement policy. It's basically balancing the budget by shoving more cost onto providers that has created considerable strain. And I think the strain has been particularly acute on primary care, non-procedural physicians. Because our system is skewed for better reimbursement for, especially procedural care, that's just how it's been set up. So that's created a real problem.

Then I think a lot of your primary care docs are getting older. Fewer people are going into primary care for some of these exact reasons, and they're just getting burnt out. I mean, the number of people you have to see during a day to actually make a living is pretty significant. And I went into medicine, I actually spent a year and a half in Roseburg with a couple of general practitioners. And my real draw was being able to

actually have a relationship with that individual and spend that time with them. And it's very hard to do that today.

And I just think you're seeing, and also I think the regulations, the paperwork, the number of different forms you have to fill out to get paid for what you do, it's choking the practice of medicine.

GALLANT: There are some estimates that the overhead cost for insurance premiums is like 30 percent. I assume that's rolling in physician's costs to fill out everything, etcetera. But it has to be a huge amount of money.

KITZHABER: Yeah. Yeah, it's huge.

GALLANT: And not being used for any particularly effective purposes. In your experience, has there ever been a really good mechanism to try to address that? Or is it just so esoteric?

KITZHABER: I'm trying to think back, whether we really tried to do that. I think the number of insurers has sort of increased. Now you have not just insurance companies, but you've got a whole host of different health plans out there. So the field has gotten much more complicated. And when you think back on the health plan, really what we did is we didn't really look at the delivery side at all. We looked at how you more rationally develop a benefit, how do you, at least theoretically try to prevent cuts in reimbursement as a budget balancing tool. But we pretty much, the only requirement is you had to be a fully capitated health plan. But you didn't go much beyond that. So, I'm not sure we ever really tried.

The interesting, fascinating thing, if you had five people walking down the road, and they all stepped off a curb and they got exactly the same ankle break and were treated exactly the same, you'd get paid one thing if they were on Medicare, one if they're on Medicaid, one if on worker's comp, one if they're on Blue Cross, and one if they didn't have any insurance. And it makes absolutely no sense. And I think we need to basically step back and start saying, "What's that about? Why does that have to be?"

GALLANT: Well, that kind of gets to the health plan, which obviously is very near and dear to you, and, I think, to the state. In that era, in the '80s and '90s, obviously very controversial. But I think, first of all, I think there was an assumption that states actually could, on their own, with some help from the feds, reform healthcare. And there are other issues that we'll get into. Is that true? Was that your assumption at that period, even though I think as you've told me in the past, it's illegal. We all knew it was illegal when we passed it, at least according to federal law. That's one kind of point of entry. And the other is do you think that a state can really reform healthcare anymore?

KITZHABER: Well, we certainly believe that in the '80s. I mean, the system was much smaller, and the political process was not nearly as polarized as it was today. It was much more collegial. I remember the minority leader at the time was Cub Houck when

we passed it. Very conservative Republican from Salem who actually ended up voting for the employer mandate in that bill. You had AOI, the largest business lobby in the state actually supporting the employer mandate because they recognized they were picking up the burden for their brethren who weren't offering health insurance. I mean, it was a different era. And I think we really did, we were caught by the sense of the possible. Really believed we could do this. And we were the focal point of the national health policy debate for three or four years. We had less than three million people in this state. And it really was because people had the courage to stand up and say, "This system doesn't make any sense. We're going to do it differently."

And again, I mean, I've told you this before. We couldn't have done that without the Oregon Medical Association. I remember speaking to medical societies all over Oregon. It was a big idea, it was a controversial idea. But the quality of leadership we had out of this organization at that particular point in time was absolutely essential. And I think it also dramatically improved people's perception of the OMA. I mean, there were doctor issues, but this was a big social issue that we were engaged in.

I still believe we can do that, obviously. I think it's more difficult because the process itself has become more polarized, and Congress has become just utterly paralyzed. But I still think that we have the capacity in Oregon, particularly within the medical community, to grab a really big idea again and run with it.

Again, I don't think this is going to emerge in the legislature as much as trying to build some consensus around what it ought to look like going in. But I still believe it can make a huge difference.

GALLANT: Can we take a break for a minute?

SIMEK: Let's stop tape.

GALLANT: Let me just check. [pause]

SIMEK: Okay. Continue on with where you left off.

GALLANT: One of the key controversies at the time was a transplant patient who was on Medicaid, a boy, a young man, Cody–

KITZHABER: Coby. Coby Howard.

GALLANT: Coby Howard.

KITZHABER: Coby Howard.

GALLANT: Very, very controversial. And it was aided, as I recall, out of special appropriation, I think, in a Ways and Means subcommittee. I'm trying to think of the Democratic–

KITZHABER: Tom Mason was the major antagonist in that.

GALLANT: Right. You want to talk about that?

KITZHABER: Yeah. Well, what happened is in 1987, during the general session, we were still sort of recovering from the big recession, sort of on the way out of it. But we had a deficit in the DHS, Department of Human Services, budget. And so Frank Roberts, who was the chairman at that time, essentially prioritized needs, I mean, it was a very open process, and applied the money that we had available. And one of the things that dropped out was Medicaid funding for transplants, which was an optional service.

And the other reason that we dropped that service is HHS had passed a ruling the year before that said if you have a transplant program, you've got to transplant anyone who applies. And what we'd actually been doing was checking to see if the transplant was going to work, whether they had a match. So we were afraid we were going to lose control of the program.

GALLANT: Well wasn't there, sorry for interrupting, but wasn't there a committee of physicians who actually reviewed–

KITZHABER: Yeah, there was. They reviewed, they reviewed the applicants.

GALLANT: I remember one of them saying that he would never do it ever again.

KITZHABER: Yeah. It wasn't pleasant work. So then, so we passed the bill. It was totally uncontroversial, almost unreported. No effort to hide it. But probably the reason is there was nobody who needed a transplant at the time.

So we went home and in the late summer, this little boy, seven years old, Coby Howard, who was on Medicaid, he had acute lymphoblastic leukemia. And his pediatrician recommended a bone marrow transplant. And of course, we no longer covered those services. So then they went to the press. And there was this highly, very emotional, and you'd watch every day this cute little boy going to kind of this little bald waif. It was very tragic. And he died in, over at Emmanuel, late that year. December, I think.

So what happened is we were in the interim. So Tom Mason put in a motion to fund transplants for the people who had applied. We were going to turn them down because we didn't cover it anymore, so we wanted to pay just for them. And that's when I first actually got involved in the debate. And to me, the question wasn't whether or not transplants had merit, or whether we had the two hundred thousand dollars. The question was, if we were going to spend more money on healthcare in Oregon, where should the next dollar go? And what was the policy that would lead us to fund transplants for eight people as opposed to twenty? And we had I don't know how many kids with no coverage

whatsoever. We had a huge uninsured population. So you know, where was the rationale for that?

And it was the most amazing debate. It was a two-day debate, first at the emergency room, the subcommittee, and then at the full E Board. I was co-chair of the E Board with Vera Katz. And the vote was nine to seven in support of this blocking the transplant. And you never could have had that debate in front of the full legislature. I mean, everyone there had fiscal experience, and it was clear we had limited resources. There was no way out of that. And I think the defeat of that motion is what, was the impetus for the Oregon Health Plan. So now what? So that's what brought this whole idea of trying to set some priorities in making a transparent project. So Coby, I think, really, I mean, it's that case that I think really led to the enactment of the health plan.

GALLANT: Well as I recall, Tom Mason was pretty bitter about how he approached that. Or "bitter" is not the right word. He was very aggressive in his comments, which was kind of unusual for him. Did that bleed into the federal level after the health plan?

KITZHABER: I don't know if Tom, I mean, he was very emotionally engaged in this. And he argued the other side of this. "This is this little person who needs our help. We need to help him." And my argument was, we had thirty kids that died every year in neonatal intensive care units for low birth weight. It's just a classic debate. But he did a good job on his side of it.

What happened, though, is that it got, you know who grabbed onto it was Al Gore, who was a US senator at the time. And I remember exactly how that happened. I had been invited back to Nashville to some conference on organ transplants, and I basically told the Oregon story, and I got into this shouting match with a guy named, I can't think of his name now, I'll come to it. But he was Al's health policy person. And I offended him greatly. So he went back and worked on Gore.

So Gore was the major opponent of the Oregon Health Plan when we were trying to get our waiver. His statements were amazingly outrageous. They compared us to the Third Reich. I mean, it was human experimentation. It was just amazing. And that's what really, what turned it for us, actually, was two things. One, we got on *60 Minutes.* And I remember running up and down the Oregon coast the day before that, practicing my answers to make sure that no matter what they asked me, I wouldn't say something they could take out of context. But it was actually a very good interview.

And then what happened is Bill Clinton, a guy named Bill Clinton showed up in my office. And it never occurred to me that he was going to run for president. He was governor of Arkansas, but he was head of the Democratic Leadership Conference. Just sort of wandering around. Barber was governor. So I gave him that little slideshow I used to take around to the county medical societies. He listened to the whole thing. So he knew about the health plan. And his wife at the time, Hillary, was head of the Children's Defense Fund, which was another vehement opponent of the health plan.

So during the, actually during the first presidential debate in 1992, Clinton and Perot and President Bush, they asked, Sander Vanocur asked a question about the Oregon Health Plan waiver. And Clinton said, "Well, if I was elected president, I'd give them the waiver. They deserve the waiver."

And we'll never know if that was just something he needed to fill a political moment or whether he really meant it. But it's just a fascinating, you know what that taught me is you can be a little state. But if you have a big idea and you can get your own troops together around it, you really can drive the national debate. And I think it's even more true today because there's such a sucking vacuum out there in terms of what to do about this situation that there's a huge opportunity for us here in Oregon.

GALLANT: I mean, that's not the only controversial Oregon, issue Oregon has been involved in. The Oregon Death with Dignity initiative, one that was controversial and still is controversial today. I believe you were also involved in talking to members of Congress regarding that as well. What was your experience?

KITZHABER: This was the most democratic process that you can imagine that brought that to the law. It was a voter initiative. I had some concerns about it the first time it was on the ballot, because I didn't know, hadn't had any kind of sort of thoughtful review. Came into the legislature. Actually I was elected governor at the time. And the legislature simply referred it back and said, "You folks really didn't know what you were doing." And I think it passed like 60 percent the second time around.

So I went back and actually testified in front of Henry Hyde's committee. And I mean, it was not, it was not pretty. And it stirred up all sorts of, it was very similar in a way to the transplant debate. But I think this one was even more emotional. And of course no one, I mean, to me, the real issue was should individuals have the ability to have some say over their last few months. And the administration response, as you recall, was essentially say if physicians gave medication with the intent of bringing about death versus just curing pain, they could be subject to criminal laws. And of course, who's going to make that decision? Someone in the bowels of the Department of Justice. And it would have really, I think, had a huge dampening effect on the willingness of physicians to provide legitimate palliative care. And that went to the highest court in the land.

And I'll tell you, when I was traveling around the country, people go, "Oregon. Let's see. Oregon. You constitutionally can't pay a sales tax. You can't pump your own gas. But you can kill yourself."

GALLANT: What a deal. [laughs] Remarkable state. The health plan had a lot of successes. I think it also had some failures. It may have been failures of policy or implementation or any number of things. Clearly, one of the key issues was the employer mandate. You were not in office at the time when, I believe Gordon Smith, who actually moderated some of what was going on at that time, was Senate president. I've forgotten who was speaker of the House.

KITZHABER: He was actually, actually what happened, it was Bill Bradbury was Senate president.

GALLANT: President, okay. Yeah.

KITZHABER: Gordon was minority leader. And in order to fund the plan, after we'd gotten the waiver, so we funded it in '91. The waiver was turned down. They funded it in '93, after Clinton had granted the waiver. But in order to give them the funding, they had to put a provision in the law, they didn't repeal the mandate outright, they said if Oregon doesn't get an Orissa waiver by, I think, January of 2005 or 2006, it automatically goes away. Which was a brilliant move. Because they could continue to advocate for the mandate here while they quietly snuffed it back in Congress. And this is exactly what happened. So it quietly went away. That was a key element, was to try to create a system of more comprehensive reform, rather than just a unique Medicaid program.

GALLANT: Were some of the key players in that as I recall, and I think I talked to you a little bit about it. I'm sure that Bradbury probably did as well. But some of the key players were NFIB, the restaurant association, the hospital association, and AOI. All, well, at least two out of four of those groups actually had supported the health plan, including the employer mandate. What do you think–

KITZHABER: What happened?

GALLANT: Yeah.

KITZHABER: Well, I think what happened is in '89, they had some fairly enlightened leadership down there, name of Carl Frederick who was, I don't know if you remember Carl. He was a real big picture thinker. And AOI, at the time, represented predominantly businesses that offered health insurance coverage. So they understood the cost shift issue. And they actually advocated for it and supported the mandate. NFIB did not support the mandate, understandably, because of their membership.

And then what I think happened to AOI is they became more of a trade association and they began to compete with NFIB for members. And their membership shifted. So they had more people on their board. So they became sort of internally fractured on the mandate. And I think they were significant players then, the next session, in setting up this repeal.

GALLANT: What do you think has changed today versus then? I mean, I would suspect that either an employer mandate or some other mechanism, employee mandate like Massachusetts to some degree, employer mandate, in order to do any kind of major reform, is still an issue that should be addressed, has to be addressed.

KITZHABER: Yes. It has to be addressed. And my idea is to try to capture the public resources and reallocate those. You know, Medicare, Medicaid, I'm not saying it's politically easy, but they're straightforward. Those are publicly financed programs. Whereas the public subsidy for employer sponsored coverage is basically a tax benefit. I mean, you get to deduct the cost of that care.

So I think the first conversation has to take place with those employers who basically offer workplace-based coverage. About 57 percent of Oregon still get their health insurance through the workplace. And the question is, can you allocate that tax benefit in a different way. So what employers are going to want to know, there's a lot of ways you can do it. You can capture the value of it, which is going to essentially amount to a tax increase for those employers. And the question is, are you taking enough of the healthcare benefit off and refinancing so their costs go down? But that doesn't address the equity issue. Because you've got two employers: one offers health insurance and one doesn't. This person's going to be paying for a benefit for everyone, and this one isn't. and I think probably the most equitable way is some kind of a payroll tax employer and employee where the tax benefit is used to offset what you pay. That's another way to do this. There's a series of ways to do it.

It's interesting. What's changed is those employers who offer health insurance coverage are really ready to look at a completely different way to do it. They want out from under this in a big way. So that's one of the key groups.

GALLANT: Have you thought about a defined contribution approach to healthcare? I know that that's been at least an AMA issue. I'm not sure I'm a big fan of it. But my point, as a mechanism to take the burden off of employers to some degree. But I'm not sure without saying that you have to provide a certain minimum contribution from the employer that increases with medical inflation so that you're not simply allowing employers to eventually totally come out of that process.

KITZHABER: Yeah. That's another way to do it. The issue is, I think, I personally believe that you have to have some basic package of care. We're going to argue about what's in that, but some defined package of care that's not tied to the workplace. I mean, it made sense in the '50s and '60s when people had the same job, but it just makes no sense right now. And it's an unfair burden for the employers. Then with the ability of employees to buy up beyond that secondary insurance package. I think the challenge, of course, and you put your finger on it, is if you separate a component of the benefit from the workplace, what's the incentive for employers to provide any. And I think that's a real question, which you could get at with some kind of defined contribution.

But the bottom line for the business community, and really for all of us, is you've got to mitigate the cost increase. If you can't control cost, you haven't really solved anything. That's what's really driving the problem. And that's where, I think, the real, to me, the real political challenge isn't in financing. That's just a way to pay for something. I'm not saying that there aren't issues there. It's redefining what we mean by a benefit

and looking at this poorly performing system through which we delivered. And that's provider politics. And that's, that's what I think, those are real politics.

But I think physicians, I just came from a meeting at grand rounds at St. Vincent's this morning where I was trying to engage doctors and saying now if you could step back and redesign the delivery system, what would it look like? Physicians can't tell you that. We're in a real world of hurt.

GALLANT: How did they do?

KITZHABER: Well, they'd never really thought about it. I mean, they're so caught up in, you know, actually, (?) they started talking about how you should reorganize chronic care management. I mean, they know it. They were talking about a system where in order to adequately get reimbursed, you've got to see thirty people a day and don't have thirty minutes to actually sit and have a relationship with someone who's got a terminal illness and giving them good advice and counsel. So I think engaging them in that kind of conversation. That's the place where no one else can provide the information.

GALLANT: Have you ever been with a group of physicians who haven't whined about the delivery of healthcare?

KITZHABER: Oh, never. That's part of the genetic makeup of physicians.

GALLANT: [laughs] You know, one of the things, I mean, getting a waiver for the Oregon Health Plan was tough. But that was one exception to one program.

KITZHABER: Right.

GALLANT: And maybe I'm missing this, but let's say that your concept moves through the state legislature in this coming session. By my calculation, you'd probably have to change federal tax law, Orissa, Medicare, probably some exceptions to Medicaid–

KITZHABER: Yeah, you'd need an active Congress. You couldn't do this through the lawyer process. You'd need statutory changes. So we basically recognized that if we were to do this, essentially we'd be asking our delegation to enact, you know, part of what I think is very important is that right now there's–

[End Track Two. Begin Track Three.]

KITZHABER: No one is running for president who's willing to take on the underlying structure of the Medicare program, for example. Notwithstanding a 65 trillion dollar unfunded entitlement. I mean, they're not willing to talk about the issues that have to be addressed. So the real value, I think, of Oregon sending back this grenade with the pin pulled out that basically challenges (?), there's a more rational way to do it. It creates

that tension. You either have to embrace the status quo, or you have to take on the real issues that have to be addressed. And I think how that debate is framed, you know, what are the real issues. Clearly we know it's the entitlement programs. But I think there's some fundamental issues about how we practice medicine and how we're inhibited from practicing medicine that need to be put up there as the right issue. So to the extent that the medical community can help frame what needs to be addressed, I think it's enormously, will have a huge impact.

And you know, the other states are very interested in what we're doing. I had a long conversation two weeks ago with Chris (Bellshay?), who's the director of the Department of Health and Human Services for California, and the governor's chief health policy advisor and deputy chief of staff. I mean, they're looking for something to grab onto. So there's interest there, in Colorado, with the new governor out there, Bill Ritter, and up in Washington state.

GALLANT: Yes, we could have the United States of the Pacific.

KITZHABER: Well, this is the first step, and then we'll secede from the Union.

GALLANT: [laughs] A detail. We'll work on that later.

SIMEK: Gentlemen, I'm going to stop you here and change the tape.

KITZHABER: What we'll do is we'll take that fence, and instead of running it across the Mexican border–

[End Track Three. Begin Track Four.]

GALLANT: –took place on November 21, 2006 at the Oregon Medical Association in Portland, Oregon. This interview was made possible by a grant from the Oregon Medical Education Foundation. Scott Gallant, OMA associate executive director is the interviewer. Tape two of two.

SIMEK: Correct.

GALLANT: Formal. One of the ideas, John, that Gordon Smith and Senator Wyden have proposed is a catastrophic proposal, essentially, to test out whether individuals on Medicaid, the uninsured or the insured could get a catastrophic plan and get some kind of basic benefit. See whether there are some cost savings in that. Have you discussed the issue?

KITZHABER: Yeah, I know their plan. Catastrophic care has got to be part of the package. I mean, there's no question about that. Although I think catastrophic care is one of the least difficult parts to do. I mean, basically it fits a traditional insurance model. You need to spread the risk broadly, and it works. So I commend them for doing it, but I don't think it solves a larger issue. And I mean, I really do believe, Scott, that we're

running out of time. Given the demographic trends and forces that we're going to get into a reactive mode very, very quickly. You know, Churchill has famously said, "You can't cross a chasm with two leaps." I think we're at a point where nibbling around the edges of this thing is going to doom us to dealing with some kind of knee jerk reaction by the United States Congress in the face of some huge budgetary issues.

GALLANT: Well, one of the controversial issues at the state level at the moment is essentially primary preventative care versus acute care. And my recollection of the Oregon Health Plan, at least originally, and I'm not saying that there isn't, shouldn't be some evolution to the process. But how do you reconcile effective acute care services where you have a particular trauma or tragedy or catastrophic illness, versus balancing preventative services for the long haul? I mean, the savings in preventative services is a very long haul.

KITZHABER: Right.

GALLANT: And there's a lot of space in between those two.

KITZHABER: Right. And just to expand on it, a lot of the stuff that really keeps people healthy doesn't have much to do with the medical system. It's other kinds of investments that keep them out of the system in the first place.

Well I think it is possible to develop a prioritization process that doesn't, I think that's a false choice. You have to have both. You cannot have a medical system that sacrifices in patient hospital acute care for preventive care. I mean, it's insane. You can't do that. So I think the challenge for us and this new project is to look at the methodology and refine the methodology. We know a lot more than we did in 1989. We're not dealing just with the Medicaid population, but a larger population. So what do you have to change in terms of the prioritization process to make that work?

And actually, I think we can envision a process to develop a base benefit. I mean, not that we want to argue about it. But we can see a process that's transparent I think people could buy into. This morning at the grand rounds, I actually read the language in Senate Bill 27 that instructed the health services commission. And it's one sentence. You know, you're going to prioritize from the most important to the least important based on the relative health benefit for the entire population. That was the direction. So we can do better than that. But I think that's a false choice, and I think we can create a system that addresses both of them.

GALLANT: Well one of, this kind of ties into something that we talked about a little bit earlier, and it's really about physician workforce and patient access. Oregon has always been dependent on importing physicians from other areas of the country.

KITZHABER: Right.

GALLANT: We only have one medical school, obviously. And the physician population in Oregon, over half of them are over the age of fifty.

KITZHABER: I'm in that half.

GALLANT: And stunningly are thinking about retirement. Have you given any thought to what the state should be thinking about in trying to increase physician workforce or attracting physicians to the state?

KITZHABER: Well, I think there's two issues. One's a short term issue, and one's a long term issue. Let's do the long term issue first. I think you need to fundamentally,(?) Oregon, is you need to fundamentally restructure medical education and the subsidies for medical education. You need to basically create more opportunities for generating the mix of providers that you're going to need, whether it be certain specialties, whether it be primary care physicians. And you have to change the reimbursement structure so there are incentives for people to actually go into those. So I mean, it's linked.

That strategy, though, is like a twenty-year strategy. I mean, we're training physicians at about the same rate we were in the late '80s, and demand is going to go up probably 50 percent by 2020, just on demographics alone. So in the interim, so I mean, I guess what I'm saying, in any long term structural revamping of the healthcare system, you have to deal with the manpower issue. And that has to do, I think, with how you structure medical education and reimbursement for providers when they get out.

In the interim, though, you have to recognize that demand is going to outstrip the providers. And this is controversial. It's not unlike what we went through in 1989, but I think on a much bigger scale. We have to ask ourselves, given the discrepancy between demand and providers, how are we going to deploy the most expensive to train and the most highly skilled resource we have, which is physicians? And what is the highest and best use for them? How do you have them practicing to the top of their license? And who else can be doing other things? How do you use physician extenders in this new system?

And I think that's a very valid question. We shouldn't view it as an economic threat. The beauty of going through this if anything were possible exercise is you can say, "This is what the reimbursement patterns ought to look like." So you want to pay docs a whole lot to do the right things and do it well. But I think there are other things that we're going to have to basically rethink just because of the reality of the manpower.

GALLANT: I have in the past kiddingly said at times that you really don't want your neurosurgeon or your orthopedic surgeon worrying about his mortgage, or her mortgage.

KITZHABER: Exactly right.

GALLANT: And I think it is a sad fact of life that physicians feel so squeezed. Not that they don't make a good income, but they're trying to do too many things and have too many chiefs.

KITZHABER: Sure. A lot of the on call issues, guys that are in their thirties and forties, it's not the money. It's the lifestyle. Or if you're a sixty year old orthopedic surgeon, you just can't stay up all night taking call and then do a full caseload the next day.

GALLANT: Or it's liability.

KITZHABER: There's liability issues. So there's a lot of issues that, you know, one of the interesting trends, I think, ought to be a wake up call to us docs is this emergence of these retail, these clinics in retail stores. Like Minute Clinics and Take Care, you know, where they're staffed by a nurse practitioner, and they treat, the average cost of your visit there is twenty-five to sixty bucks. And you don't need an appointment. And if you have to wait, they give you a beeper and you do your shopping and come back. If you need a prescription. And the reason those are there is because there's this huge unmet need in the system. And I think expecting people today to wait months for an appointment, and then wait hours in the office for a very brief encounter with a physician is a strategy of a bygone era.

So we need to step up and figure out how we're going to reshape the system, because I think the system isn't going to remain static in the face of rising costs and declining access. The solutions are going to be worse than the ones, unless we can somehow get out ahead and impact them.

GALLANT: Well, Peter Kohler, in fact, has begun talking about that very issue in the sense of how you create physician extenders that essentially do primary care, which I assume probably has the Academy of Family Practice Physicians not all that thrilled, doing what they do, essentially, for a living, so that physicians can spend more time and utilize their services better. How do you think that will be received by the medical community overall?

KITZHABER: Well, I don't know. I mean, one of the criticisms of these minute clinics is they don't foster, you lose the value of the ongoing physician/patient relationship, and they're not the appropriate setting for the evaluation, ongoing management of complicated problems. All true. But you can make exactly the same argument about urgent care clinics and the emergency room, where more and more people are having to go for their care. So I think part of it is stepping back and not saying we're devaluing physicians. We basically want them to be doing those things that nobody else can do. And they need to be paid really well for that.

And we had a fascinating conversation, you were on that first conference call we had with the docs. We had another one with, we had some primary care folks, but also some specialists. It started out with sort of the primary care doc sort of beating up on the

specialists. Then actually everybody took a deep breath and they said, "Now we all recognize there are glaring discrepancies between reimbursement between primary care and specialty procedural care, but we need them both. And what we want is a system that basically treats physicians fairly and equitably."

And then the conversation actually was very, very productive. So I think it's how you frame the debate.

GALLANT: Don't you find it ironic, though, that we pay the same reimbursement level to, say, a certified nurse practitioner, or a nurse practitioner who provides anesthesia as you do a anesthesiologist for the same service. And the educational–

KITZHABER: Yeah. Absolutely. And to me, the question is, are the cases, I mean, is the nurse practitioner competent to do that particular case? But so I mean, all I'm saying is I think you ought to take that, there's no question there's a huge difference in experience and training and investment in an anesthesiologist from an NA. The question is, let's make sure that we're taking that training and expertise and applying it where it needs to be.

For example, a trained endocrinologist shouldn't be, in my view, shouldn't be seeing uncomplicated diabetics in his or her office. It's a waste of the investment. They ought to be managing complicated cases. They ought to be overseeing the diabetic care in the community. And they ought to be paid really well for that. But the system, the financial incentives are set up so I don't think we're, I think a lot of people are practicing in the middle or the bottom of their license. But we need a system where they really are using that training and that skill.

GALLANT: It appears that you kind of anticipated that healthcare, again, would maybe reach the federal agenda level during a presidential election cycle that's going to occur in a couple of years. And you've been traveling around the country, talking about your concept. Where have you been speaking? Why do you think this has become such a national issue? Do you think it really will be the primary issue in the presidential elections?

KITZHABER: Well, I think it will be an issue. I think the question is whether the issue is designed to just get the candidates beyond November, or whether it's to actually solve it. And I would say right now, without some additional factor in the debate, it's going to be talking the talk, but not actually making any of the decisions that have to be made to address it. But I think it's a huge issue. It's a much bigger issue among employers now than it was. We have about a 4.5 percent annual erosion rate in employer-sponsored coverage just today. I mean, it's a huge issue with employers. I think the auto makers were actually just meeting with the president on this issue.

I was just invited back to Indiana by seven hospital systems that wanted to talk about what we were doing. And what's going on in Indiana is there's this medical arms

race going on. There's specialty hospitals, and people are building. And they all acknowledge that none of it has to do with patient access or quality. It's basically for protecting market share. And they know that this just isn't sustainable. And they're beginning to figure out that you've got to change something nationally. So the question is, how do you create the leverage to actually force that kind of debate.

So I think it's going to be there. I think the real question is whether it's a real debate, or whether it's just a political ploy.

GALLANT: I think you're also aware of at least four local ideas for healthcare reform. Some bigger, some smaller, or broader, than others. Kurt Schrader kind of has the pragmatist side, creating a mechanism to not only propose reform further down the road, but a mechanism for implementation. The Oregon Business Council has been playing in that arena, some of which I think you talked about. Your idea in the Senate commission. Do you think there are a lot of similarities or differences or–

KITZHABER: The only one I'm really conversant with is the Senate commission report. I read the OBC white paper, which to me looks pretty much like a consumer-driven approach, which definitely has a role. But I wouldn't call it significant structural reform. And I don't know, I haven't seen Kurt's. But I do think that, my understanding is the Oregon Health Policy Commission is going to suggest sort of a Massachusetts plan, which is already 150 million dollars in the red.

The Senate plan, I think there are a lot of similarities. They both talk about creating, they call it essential services, I call it a core benefit. But you've got to have some way to define a package. They want to create a big pool. They use a different mix of resources. It's not clear how they actually get those resources into the pool. But I think the major, probably the major difference is in, they don't include self-insureds, and they don't include Medicare.

And I personally believe that if you don't include Medicare in the debate, you haven't solved the problem. Because if you look at the relationship between Medicare and Medicaid in terms of the dual eligibles, they are the people who are about 13 percent of the Medicaid population and they drive about 45 percent of the cost. And as the population ages, Medicare's going to dump more and more of those people onto the Medicaid program, and it's going to drive our budget just right off the wall. So somehow you've got to address that. But I've got high hopes that these things can be complementary. At least, certainly the Senate commission. I mean, there are some elements, some big overlaps.

GALLANT: Again, an issue that's been at the top of the agenda or the bottom of the agenda over and over and over again is mental health services. The medical association spent years trying to get a bill passed. This last session bill actually passed that was broader than we managed to do increasing benefits from about four years ago. In your mind's eye, are mental health services integrated in your structure? Clearly there are not enough psychiatrists or psychologists, really, to provide all those services. Primary

care physicians and others have provided the bulk of those services forever. How do you envision that (?)

KITZHABER: I think mental health and chemical dependency services have to be integrated in, and they have to be well reimbursed. I mean, every hospital has got a cardiac center, because you make a lot of money off cardiac centers. Nobody's got a center for chemical dependency and mental health services, because we don't pay for it. But I would argue that from a population health standpoint, an investment in that area would have a huge return. I mean, almost everyone that drops out of high school, the people in the criminal justice system, there's almost a linear relationship between mental health and chemical dependency services. We know how to treat them; we just don't fund them. So I think it actually has to be a really key part of the program. You face, as you mention, the same provider shortage issues. But I do think it has to be right up there. Otherwise, you really don't have a health system.

GALLANT: Well, wouldn't you agree in the 1980s, the legislature made a choice about mental health services. One, go to an outpatient setting. Two, essentially promise that they would build an infrastructure to do that.

KITZHABER: Which they didn't do.

GALLANT: And then they also limited the benefit significantly in the process. And now we have a lot of our healthcare costs, prison costs, etcetera, all wrapped into individuals who have mental health issues. They have nowhere to go.

KITZHABER: You know, it's a huge issue, and you have to get that right back on the table. Because if I was going to place, if I had only one place I could spend money, and I wanted to really impact the overall health, other than clean air and clean water issues, that would be it. I mean, 60 percent of the kids in Oregon get to first grade not fully able to take advantage of the learning experience because of these risk factors. And most of them are mental health and chemical dependency issues. So the question is, do you want to spend some money up front and take care of them, or do you want to support them in prison the rest of their lives, or have them break into your house and steal your stereo to support their meth habit? I mean, it's not rocket science. And we know how to do it, and it's effective. And if you don't want to deal with that component, you are never going to get ahead of the cost curve.

GALLANT: Well this area is just like a lot of areas, unfortunately, in healthcare. You have constituencies that have very strong vested interests. All the way down to the local level and all the way up to the state and federal level as well. I think there has been many a person who has tried to lay out a more rational process. Especially in the metro area, where people just go across lines and they dump people from one jail jurisdiction to another, and say, "You pay for it." How do you break through that?

KITZHABER: Well, I think, first of all, I'm not minimizing the difficulty. It's really hard to do.

GALLANT: It is.

KITZHABER: The biggest challenge in this debate is somehow freeing yourself from the status quo. That is, getting yourself beyond the political obstacles to accomplish anything, and the structure of the current system to say, now what should it look like? Ideally, how would you manage chronic care? Ideally, how would you deal with mental health and chemical dependency? What would that look like? And no matter what we do with reform, we're not going to go from where we are now to where we need to be overnight. It's going to take five, ten, fifteen years.

But if you where you want to end up, if you know sort of the general parameters, you can develop a transition plan which begins to take the trapped equity in the current system and realign it over time so that you begin to shift those resources. But without knowing where you want to end up– It's just like, you know, I got on a plane the other day that said it was going to Chicago. And I assumed the pilot knew where he wanted to end up. If we don't know where we want to end up, there's no way to get there. And I think that's the real challenge. And it's amazingly difficult intellectually to free ourselves from what we know, and really think of what it ought to look like. I think that's the challenge that faces us.

GALLANT: Well, Governor, kind of in a similar way, I think you knew where you wanted to go years ago in creating, at that time, a model trauma system in Oregon. That Bill, Dr. Long, Dr. Trunkey were very influential in. And it was used as a national model. It seems to decline for lack of either attention or resources. I mean, it seems as though you have these extremes. I kind of view those with mental health and alcohol and drug problems as, at times, some of the most vulnerable individuals. To the most immediate lifesaving sorts of systems. And they both crumble over time. I mean, how do you–

KITZHABER: Well, I think what happened with the trauma system is that, first of all, none of this can remain static. The environment's changing around us for demographic reasons, for technological reasons. So you can't just take something and expect it to last forever. And I think what happened with the trauma system, I still think we have an excellent system, and the way it's been designed. But what's happened is now the ER has become sort of the provider of last resort. So now it's not just trauma you take care of in ER. You've got this huge influx of mental health patients. You've got a huge influx of people from rural areas because you don't have a general surgeon anymore. So I don't think the concept of the trauma system is flawed as much as what's happening around it.

Which is another argument for, you have to create a place somewhere in the country where you have all the moving pieces. So you can't just look at the trauma system. Because how you deal with mental health impacts the trauma system. And Medicare reimbursement affects whether physicians are going to be able to take Medicaid patients. So you have to basically get all the resources in one place and say, what should

this look like? We can still do that in Oregon. There's not many places I think you can actually bring people together and have that kind of conversation.

GALLANT: Well, one of the primary issues for Governor Kulongoski has been providing healthcare coverage for all children. It clearly is a major issue for the new majority party Congress this coming year. Some might suggest that that's playing on the margin. That it's a piece of the healthcare puzzle, but it doesn't really touch some of the fundamental issues. Maybe something that could be integrated into an overall program. Have you given any thought to that? If you were in a position to say, as governor, this is where I would go as a first priority for resources, would it be all children, would it be overall reform, would it be integrating those various pieces?

KITZHABER: Well, there's two issues, and I've talked to Ted about this, because I do think that's playing in the margin. I'm not saying it isn't important to cover kids. But there's two things you have to do, and you have to do it simultaneously. You've got a ship in the middle of the ocean that's sinking, so you've got to get people in lifeboats. But once the ship goes down, if you haven't created a new ship, they're still going to sink. So you need to do both.

And the only criticism, or not criticism, but comment I've had about that is you can't just say, "I'm going to go expand coverage for kids," and think you've solved anything. Because kids are cheap to take care of, it doesn't cost a whole lot of money. We don't actually have the money to do what he's suggesting. I don't know where it's going to come from. And they're still in the Medicaid program. Still (S chip?). So as those dual eligibles fall down, we're just going to change, either cut reimbursement levels back for providers, or we're going to drop even more kids from coverage.

It's not systemic reform. And I think we're way past the point where those kind of things can actually be viewed as significant in terms of the enormity of what's coming down the pike at us.

GALLANT: One of the controversial, one of the controversial issues, you had your last session, was a bill–

KITZHABER: Which last session? There were five in quick succession. [laughs]

GALLANT: Oh, I'm sorry. Yeah, yeah. We'll get to that, too. Was the drug review program. It was an issue that you said, "I'm going to do this. I want to do this." There were probably thirty or forty drug company lobbyists. And you ultimately won, which didn't come as a surprise to some. But nevertheless, what are your memories of that? Do you think it's still in play? Can it improve? How does it fit in kind of–

KITZHABER: Well, I still think it was a very good idea, and it was a very logical idea. Oregon is one of the few states that actually had a statutory prohibition against the formulary for Medicaid. There isn't a big company around that doesn't have a formulary. But that was in there, so we had to remove that. And the idea of the bill was

essentially to say, let's create a functional economic market for prescription drugs. I think we all pay lip service to letting the market work.

So we took different classes of drugs, like (?) anti-inflammatories, for example. And we evaluated the different drugs within that class based on their relative clinical effectiveness. We just looked at the evidence; we didn't make any judgment.

And then to be on the formulary, the drug had to be as effective as any other drug, but more cost effective. So it forced drug companies to compete on the basis of cost for two drugs that were clinically equivalent. And it's a fascinating (problem?), and they hated it. Because they don't compete, I mean, they basically compete for market share based on direct to consumer advertising, which is not the same as an outcome.

And the bill got bottled up and never had a hearing, which is unheard of in Oregon. I mean, this bill never had a hearing. It never had a hearing, even though it passed.

The last day of the session, I still have a copy of it, I circulated to the Senate president and the speaker of the House, that if they didn't get this bill out for at least a vote on the floor, I didn't ask them to guarantee that it was going to get passed, that I was going to veto the entire budget for the Department of Human Services, and I was going to call them back two weeks later to rebalance the budget. And I was going to get on the state plane and fly around explaining how the leadership was in the pockets of international drug companies. And surprise, surprise, the bill popped out. And most people voted for it. It had a very comfortable margin, because it made sense. And I think this last session, either this session or the session before–

GALLANT: Two sessions.

KITZHABER: Ted signed a bill that had a provision that sort of cut the heart out of the program. But since then, we've set up this center for evidence-based policy at OHSU that's a collaborative of fifteen states that are essentially we funded doing that evidence-based review for twenty-five classes of drugs. And we had New York and California. So we had about 40 percent of the Medicaid drug budget right there at the table. And the results of that are on the AARP website. And the consumer union has a best drug buy page off that website. So I think it's very effective. And you're going to need something like that not just for drugs, but for new medical devices as well. When you're talking about, if you want to really create consumer choice, you've got to give them the information on which to make those choices.

GALLANT: You were governor when 2001 occurred. And as you said, Oregon got hit very, very hard with the recession. Four or five special sessions, etcetera, etcetera. But a very traumatic time. And a controversial time. I've seen a few governors come and go. Not a lot, but a few come and go. But it seemed as though the press was particularly nasty in your last year or two as governor. Do you remember that period? I mean, it was

kind of, you were finishing your second term. Very traumatic for the country and the state. The legislature had to do some serious cutbacks of the health plan. What are your–

KITZHABER: Well, I remember, basically my numbers went to pieces during the special sessions. It's best to actually have the recession on the front end of your eight years and the recovery on the back end, because that's what people remember. So I got that just wrong. But I had basically one bottom line. I probably didn't do as good a job as I could have in terms of articulating it. But what I told the legislative leadership is that I thought we needed additional resources. And if they didn't want to put them in, that was okay. They could cut the budget. I wouldn't veto a bill that cut the budget, no matter what they cut. But what I wouldn't do is let them borrow.

[End Track Four. Begin Track Five.]

KITZHABER: You know, so if services were important enough to fund, we should fund them with real money that's going to be there tomorrow and five years from now. If not, we should cut them. And the Democrats didn't want to raise taxes, because they were afraid they wouldn't want to take control. And the Republicans didn't want to cut the budget because they were afraid they might lose control.

And so what they did is they sent me a series of bills that either bonded, you know, so you're going to pay for the K through 12 budget for one year, and we're going to pay it off over fifteen years. Or one particularly egregious bill moved one of the big payments for the K through 12 budget, primary and secondary budget, about 400 million dollars, from June thirtieth to July first, so it moved it out of this fiscal year into the next fiscal year. So it created a four hundred million dollar, you know. And I vetoed that stuff. And I vetoed it. And I kept vetoing it, and they kept overriding me, and it created a lot of tension.

And you know, the *Oregonian* is a great example of an editorial policy that just, on the one hand supports fiscal accountability. When it comes right up to the edge, they wanted to borrow money for schools. It doesn't matter where it comes from.

And I believe that you need to let people know exactly what you can buy with the resources that you have. And I think it's better to have one really bad year out of a twelve-year education where the schools fall apart, than twelve mediocre years. And I think that's really where we are.

And I would do it again, if I was in that same position. I probably would have done a better job trying to articulate the policy, the underlying policy. I got lost.

GALLANT: Do you think the states ever recovered from that recession? From what had to be done then and from a services perspective, either education or otherwise?

KITZHABER: No, I don't think we have. I don't think we really contracted, I mean, structurally contracted the state budget. I mean, what we did is we figured out ways to sort of piece our way through it.

The arguments that I made about the healthcare system sort of reflecting the realities of the middle of the twentieth century, you could make the same argument about our public school system. Every summer we shut down this huge infrastructure that we can't support so all the kids can go harvest crops. That's a nineteenth century paradigm. So I think we're continuing to fund structures that made sense when they were created forty, fifty, a hundred years ago, but don't make much sense now. Unless you want to get inside and try to change those, I think we're just playing catch up.

And I told both Ted and Ron Saxon, I gave him a presentation of what I was doing before the election, because I thought it was important that they both understood it. I mean, my perspective is that no matter who the governor is, they're going to be facing a continuous series of budget cuts. No matter how good the economy gets, because just the trending cost of both energy and healthcare going up so fast that there's going to be a hole. And what they're going to do in terms of healthcare is they're going to continue to just drop people from coverage.

GALLANT: Aren't labor costs doing the same thing, from the perspective of government employees? I mean, that's not exactly on the lower end of the CPI curve.

KITZHABER: Right. It's not a sustainable model, I don't think.

GALLANT: You've played at the federal, state level. I'm sure you did occasionally did cameos at the National Governors' Association when you felt like it. But let's talk about a couple of players, local and maybe federal as well. Mark Hatfield. You worked with Senator Hatfield very much?

KITZHABER: Yeah. I did. And actually, I went down and visited him at (Merry Woods?) and made my little healthcare presentation down there, and got to go up to his apartment up there. I think he was sort of typical of what sort of mainstream Republicans used to be like in Oregon. I mean, the best political place to be in Oregon, I've always felt, was a moderate Republican. We have a whole list of people from McCall to Vic Atiyeh to Mark Hatfield who fit that role. And I think he was great for the state of Oregon. I think he was a guy that had tremendous principles and stood by those principles. And it's hard to find people of that caliber that want to get involved in politics in this day and age.

GALLANT: Bob Packwood.

KITZHABER: You know, Bob, I think, was also a very good senator for the state of Oregon. I disagreed with him on a number of issues, and I don't condone his personal problems that he got into, but he was an effective senator. He was a champion of the

Oregon Health Plan when we tried to pass that. I think he did a good job for the state. I think he was another guy that fits into that sort of centrist mode.

GALLANT: Were there any particular governors that you particularly connected to during your term as governor that you worked with on any national issues?

KITZHABER: Well, I didn't know, I knew Bob Straub. He got voted out when I got in. I mean, I had enormous personal respect for Bob. I worked really well with Vic. I would say the best working relationship I had was probably with Neil. You know, he was a very strong leader and took on some big issues. And I had a good relationship with Barbara, but it was right after Measure 5, and things were pretty chaotic during that period of time.

GALLANT: Yeah. Needless to say. Well, it was kind of unusual. I mean, you dropped out of office for a couple of years. And obviously you'd given some thought to running for governor. What motivated you to–

KITZHABER: Well, interestingly, I hadn't. I never thought I was going to be in office most of my adult life. I got elected to the house, and then Jason Boe ran for the treasurer, and I got elected to the Senate. I wasn't going to run again in '84, but it became clear that I could actually be elected Senate president, because Jack Ripper was sort of the president elect. And then I ran again in '88, because the health plan, because the Coby Howard thing. And when I left office, I mean, I announced in '88, when I announced for my third term in the Senate, I wasn't going to seek reelection. And I felt very comfortable with that decision. And I was doing some speaking and actually developing this whole new life. And Governor Roberts was really on the ropes at that time. And it looked pretty much to me like she was going to have a tough time getting reelected.

So I got talked into, I actually remember the meeting was down at the Steamboat Inn. I can give you the list of characters who were there.

GALLANT: Oh, please do.

KITZHABER: It was, Gerry Frank was there, and Howard Sonn, he's a timber guy down in Roseburg, was one of the people. And so I basically went out and I did it. So the rest is history. So my political career, just like my medical career, hasn't been linear. It's been sort of–

GALLANT: Well, it makes it more interesting that way, don't you think? Well, maybe a couple of physician names to see if you have any thoughts or observations. Frank Baumeister?

KITZHABER: Well, he's one of my heroes. He is a real crusty, very liberal physician, and you wouldn't know that unless you get to talking to him. Frank was actually, when I actually ran against Barbara Frank, and I can't remember who else, we sent out a letter to physicians. Which was a bit pointed. It was in support of the governor,

not me. But I think Frank has been an enormous contributor to the cause of organized medicine. The work that he's done on the Citizens' Healthcare Working Group has been exemplary. And every time I've had him in a conversation about this, he's had insights that are just remarkable. We're real lucky to have Frank.

GALLANT: Roy Skoglund, somebody who was obviously a big supporter of yours, and I think may have been a big player in helping your first election for governor.

KITZHABER: Yeah, Roy's sort of in a class by himself. I knew Roy, you know when you first start out in practice, I was in the ER down there. And it's pretty terrifying that just six months before, you had a resident or somebody looking over your shoulder. So suddenly, when you send them out, no one's looking over your shoulder. And he was one of the guys that was just a delight to be with. You could call him up anytime day or night. He didn't scream at you for waking him up at two in the morning. He was a fly fisherman. Loved the North Umpqua River. His wife is just dynamite. And became real close personal friends with Roy.

And Roy, actually, after the first rocky session and my experiences with the OMA, we went round, I think he was president right around there. I can't remember. A little bit later became president.

GALLANT: '82, I think.

KITZHABER: And Roy was the reason I eventually joined. They don't make them like Roy anymore.

GALLANT: Dutch Reinschmidt. Do you remember Dutch? OHSU?

KITZHABER: Didn't know him very well.

GALLANT: No problem. Lowell Lewis, from Eastern Oregon? How about Chuck Hoffman?

KITZHABER: Well, Chuck Hoffman's another larger than life person. One time mayor, several times mayor, I think, three-time mayor of Baker City. He's another guy, he runs a practice, but he still really cares about the big picture. And I think he's doing some remarkable work, courageous work with the AMA. Not always well received.

GALLANT: So far. [laughs]

KITZHABER: But he's been a player from day one. You know, there was a series of these people that, I mean, Ginny Burk. And Mike Graham. Judge Hicks. These people who–

GALLANT: (Wavy Davies?), some of your airplane experiences?

KITZHABER: Oh, yeah, Dave Ohling almost killed me more than once. Yeah, I mean just these people who played such a huge role in my life. And they're all good physicians. But the roles they played were different. They were mentors in different ways. I mean, Dave Ohling was a mentor in basically how to change altitude without checking with flight control in Seattle and not losing your license. He's a master at that.

GALLANT: How about Bob Dernedde?

KITZHABER: Well, you know, Bob, I remember Bob when I was in medical school. I always thought Bob was sort of a fixture. I mean, I thought maybe he was an automaton that was just sort of propped up here and would never go away, like the wizard. You know the wizard? The guy behind the screen? But I remember coming down here when I was a medical student. Is there someone named Bob Hare?

GALLANT: Mm hmm. Yeah. Dr. Hare, absolutely.

KITZHABER: Dr. Hare. I was appointed to some committee on diabetes, I can't remember, I was an activist up there. And I remember coming down here, and Kronenberg was pouring very stiff drinks. Dernedde was just always there. It's hard for me to walk in this building and look around and not see Bob Dernedde.

GALLANT: Always hanging around.

KITZHABER: Yeah. Always hanging around. And making it look easy. Looking relaxed, and never a hair out of place. That's the part that I thought was amazing. Even a force five gale, never a hair out of place.

GALLANT: I know that fishing is one of your passions, and rafting, and that sort of thing. But do you have any fond experiences of playing golf?

KITZHABER: [laughs] You should ask. Well, as you know, my golf skills are somewhat embryonic. But Scott Gallant and I used to play golf once a year at Salishan at the Multnomah County Medical Society meeting down there. Usually in a raging storm. I was introduced to (ping?) clubs, is that right?

GALLANT: Mm hmm.

KITZHABER: And also, the beer cart. And as I recall, you were required to drink a beer each hole. And on one memorable occasion, Scott would hit these huge, towering drives. And they would sometimes hook or slice or not go where he wanted them to go. And he'd get a little more frustrated. And by the third or fourth hole, I was not actually as far behind him as he thought I should be. And I remember ending up actually winning the game. I still have the little card. One of my most favorite experiences. Beating Scott Gallant on the golf course.

GALLANT: [laughs] What was your best experience as governor?

KITZHABER: There was a couple of them. I think actually going down, I wasn't actually quite governor yet, but I was a candidate, I think, was the nominee. Going down when they actually implemented the Oregon Health Plan. Actually I went down and saw patients the first day in a clinic up in Portland. That was a real high point. I mean, after all that we'd gone through to actually be delivering that care.

The relationship I developed with the National Guard. I called them up five or six times for floods and fires, and really got to know these community members who provide such a significant service for the state of Oregon.

When we got the permission to implement the salmon plan was another real high point.

GALLANT: Not building new state prisons.

KITZHABER: No, that was not my favorite.

GALLANT: Might be on the lower end.

KITZHABER: Yeah, yeah.

GALLANT: Very controversial.

KITZHABER: I remember when I got elected in '94, Measure 11 had just passed, and we were citing eight prisons. And I had a group of guys with the black and white striped suits that followed me around the state for almost eight months. These were the people who didn't want the prison put in Wilsonville. Yeah.

GALLANT: Well, by the same token, Ginny Burk, former president of the OMA, was president when we were working on helmets for motorcyclists.

KITZHABER: Yeah. Oh, yeah.

GALLANT: And after she testified, she was surrounded by a bunch of good old boys on motorcycles, and it scared her to death. She fortunately was near an exit and she just kept going and pulled off. But it was a kind of similar sort of activity, I think, with that kind of thing.

KITZHABER: Well they used to, there's a group called ABATE, A Brotherhood Against Totalitarian Enactments, I think. And they're the anti-helmet guys. This issue's been going on for a long time. And when I got elected governor, there was always a helmet bill, and I always vetoed it. And these guys would always come to my office. And we actually became sort of friends for a while. They'd all show up in the ceremonial office out there. And I'd go, "Guys," I said, "when I was I was Senate president, I buried

this bill I don't know how many times, and I vetoed it this year. What is it that makes you think I'm going to change my mind?"

"Oh, come on, you can learn new tricks!" Then we'd veto the bill. Yeah. I never got, actually, the Ginny Burke experience.

GALLANT: Well, if you were vetoing or (?)

KITZHABER: Of course, I had state cops to protect me.

GALLANT: [laughs] It would be helpful, as a matter of fact. Let's see. I would imagine when you wake up, kind of like *The Candidate,* the movie *The Candidate,* then you start thinking about well what do I do now. What was kind of your thought process after you got elected the first time for governor? Were you confident that you had a handle on the wide variety of–

KITZHABER: Well, I had a handle on some of it, and other parts I had no clue about. I had been Senate president for four consecutive terms, so I'd put together four budgets. So I really did understand the state budget, which was an advantage. And I also knew all the tricks the legislature could pull, because I'd pulled them myself. So I felt very comfortable in terms of budget management.

But I do remember being in the YMCA in Salem lifting weights during those big floods in '95. And I looked up and there's a news story and there's a big chunk of Southern Oregon real estate washing away in this river. And I remember saying to myself, you know, I think there's something I'm supposed to be doing about this. [laughter]

And I went over and called up the state police and the national guys. They said, "Oh, yeah, you're supposed to be doing something about this." And that's when I learned about calling up the National Guard and those kinds of things. So there were parts of it that I had no idea about.

But it was an amazing experience. It's the best job. The best political job I can think of in the country is being the governor of the state of Oregon. I mean, you get to stay in this great state. You don't have to deal with politics back East. You can actually do something in Oregon. You can actually make things happen.

GALLANT: I've probably been remiss in not mentioning Vera Katz, who obviously was a major player for a large part of your Senate career. I want to go back to a little story in a little bit, and you can either supplement it if you want or not. But in the liability reform session, I think it was Senate Bill 323 comes to mind.

KITZHABER: That sounds familiar. It's a painful number. It hurts when I mention that number, so that's probably the one.

GALLANT: As I recall, the bill was introduced like the first day of the session. And it was passed the last day of the session. It was a very long session, as I recall, that year. But there were a couple of pieces in the bill that the medical association didn't like. You may not know that. It had to do with the OMA having to accept non members under our insurance program, which was proposed by, I mentioned the organization. But Bob Shiprack and Mike Thorn and I had a backup, because Bill had to go through Ways and Means. So they were supposed to stuff a fix into the Ways and Means Committee.

KITZHABER: Mike was chairing that at the time, right?

GALLANT: Mm hmm. Well, Lon Gilmore, Gilmore knew, which were the rules, the chairs had to know. And Vera caught me. I got caught. So she pulled me into her office, read me the riot act, said, "Don't do that again." And I thought I'd get caught once. But we'd also planned on being caught.

KITZHABER: I may remember this. It kept showing up in various different committees, that's right.

GALLANT: It did. She caught me the second time, too, and yanked me in and told me she was going to kill the bill if I didn't back off and all that kind of stuff. So I sent her flowers, and she never said that she'd gotten them or anything. I finally walked through the chambers and looked down. And there were the flowers on the podium. I figured oh, thank God, I've finally been forgiven. But that was such a controversial thing at that time. It was contrary to Vera's normal political bent, really. I think the governor at the time was probably indifferent about it. Were there any, other than just kind of the sad human aspects we were talking about earlier, were there any humorous pieces of how you worked through kind of that puzzle as Senate (?)

KITZHABER: The tort thing?

GALLANT: Or with Vera that come to mind.

KITZHABER: Well, I don't know if they were humorous. That was really a painful process, because it was my caucus that was dragging their feet. It was real difficult to get the votes for that one. But you know, Vera was pretty remarkable. And she doesn't get nearly as much credit as she ought to for a lot of things. For that bill, that didn't have to pass the House. And the Oregon Health Plan. People forget that she was a huge advocate for that, and she actually made it possible to get the House together. So if she wasn't there, didn't provide that leadership, we wouldn't have had that bill.

I remember when Barbara went back to testify in Congress. Actually, I'm pretty sure Vera went. She wasn't speaker at the time. But Henry Waxman was having a hearing on the Oregon Health Plan waiver, and one of their arguments was this was going to hurt women and children. So we had like five women back there testifying. Very strong women testifying. So she was great. She was great to work with.

GALLANT: Do you remember the bill that Vera introduced that would have mandated physicians and attorneys to provide–

KITZHABER: A certain amount of service, yeah. I do remember that.

GALLANT: –it was like thirty hours of voluntary services.

KITZHABER: Yeah. I don't think that got anywhere.

GALLANT: No. It didn't. I remember her calling me into her office and yelling at me about that. She was just livid. And she did have a temper.

KITZHABER: Oh, she did have a temper.

GALLANT: And she was capable of expressing it. And just screaming at me about it. I said, "Ma'am, Speaker, wait a minute. You cannot be this upset about this bill. I mean, this is very simple. It's not voluntary if you mandate it."

KITZHABER: [laughs] Hello.

GALLANT: We're having a problem with this concept. But no. She had a great heart, I think.

KITZHABER: Yeah, she did. She was really good to work with. Yeah.

GALLANT: How about Joyce Cohen? Do you remember?

KITZHABER: Yeah, Joyce was great to work with, too. I mean, Joyce was a real workhorse. I had her on, she was running the Trade and Economic Development Committee. I mean, she was a, actually we flipped a coin to see who was going to run to take Ed Fadeley out. Because we were lining up the votes at that time.

And my favorite Joyce Cohen story is she had a little lipoma on her arm that was bothering her. So we brought her up to my office. She gave the chair to the vice chair. And she sits at that big oak table in there, you know, and I prep her up and put a little Novocain in, and start dissecting this little pea-sized lipoma out. And I kept a bottle of Wild Turkey in my coat closet. And Jane Cease wanders in and gets the bottle out and pours a little drink. She's sitting there watching Joyce, you know. And the thing that makes people faint is when you put a Q-tip or something down into it. She said, "We used to do that with sheep in my dad's farm."

And Joyce gets that white look and she– and we take her down on the floor, get her feet up, I finish suturing her up, we sit her up, give her a shot, and send her back down to the committee. So we actually did a lot of surgery up in my office.

GALLANT: It's probably fairly unique, again, when you're a governor, you also provided emergency services on the House and Senate floor.

KITZHABER: Well, we were just talking about that. When I was elected, we didn't have a Physician of the Day program. So I carried this beeper. And during the session, there would be three or four hundred people in the building. And I was literally getting called off the podium, you know, in the middle of committee hearings, to run down and check these folks out. So I think you were actually instrumental in that. We set up this Physician of the Day program where a physician would come down for the day, take the pager, and they'd also learn about the legislative process. And I'd meet with them in the morning and show them what bills were being heard. And they'd realize that they could actually testify. And these guys were going in and giving their two bits on labor bills, and having a great old time. And I think it served not only the medical purpose, but it helped educate the membership here about the legislative process. So it was a great program.

GALLANT: One of, and we'll wrap this up, because you're probably past your time.

KITZHABER: Bed time.

GALLANT: I think one of the key things that physicians have always done is charity, free care. And we had talked earlier about the state tort claims that were liability. Recent appellate court decision, I think, has put in question the protections for charitable services, etcetera. What do you think physicians' roles are, really, just saying "I'll take the risk." I mean, I kind of think of it as kind of a higher calling for physicians to kind of say damn the torpedoes and let's move on. Do you think the citizens really realize how difficult it is for, say, you as a physician or any other physician to just step off the street and help?

KITZHABER: No, I don't think people appreciate that at all. I mean, I don't think most people appreciate the stress that the liability system brings to a practice. I mean, you're always thinking about it. And I think it results in some bad medicine, or some redundant medicine or unnecessary medicine. And if you think about the state, you mentioned the State Tort Claims Act. If you think about it, you could have an obstetrician at OHSU who's got a cap, and you could have an obstetrician five blocks away who doesn't. I mean, it makes absolutely no sense. And I think it is a huge stress factor. I don't think the medical legal system is the biggest cost driver, but I think it has huge impacts on how we practice medicine. Not all good.

GALLANT: Well, you've transitioned from your public career in the sense of being in elective office, moved into consulting and–

KITZHABER: Agitating.

GALLANT: And agitating. Any reflections about the differences of restrictions or freedoms versus being elected as governor or state legislature versus private sector?

KITZHABER: Well, the governor was a sea change in terms of being a fishbowl. I mean, the hardest thing for me was having the security with me. I mean, they were great people, but it was really difficult. And I used to sort of slip them all the time. It was very difficult. So you really were, I lived in a house where there was a fence around it with little laser lights and a uniformed state policeman inside the grounds twenty-four hours a day. That was very difficult to get used to.

And, you know, there's real advantages to not being in office anymore, too. It's, I basically can focus on the things that I really care about. You don't have to deal with the partisan politics, which was really getting to be, it was much worse the last four or five years than when I was in the legislature. Even when Larry and the Republicans took the House, we had split chambers, we still had a really productive session that year. People still worked together and respected differences. And I think a lot of that's gone away. And you're not in the spotlight anymore, which is actually a very good thing. It's been a good ride all the way. No regrets.

SIMEK: Could you stop for a second?

GALLANT: Stop?

SIMEK: Yeah. Wait a second. Rolling.

KITZHABER: I think the Oregon Health Plan has had successes and failures. I think the problem with the Oregon Health Plan is we were too modest. We were looking at just the Medicaid program, and I think the big cost drivers in the system are bigger than that. I mean ultimately, I don't think this is a state problem or a Medicaid problem. It's a national problem and a system problem. And I think the reason the Oregon Health Plan has fallen on hard times, it's not the priority list, but I think the funding constraints really reflect the problems with the larger system.

So I don't think we're going to see the Oregon Health Plan survive like it is. I do think elements of the Oregon Health Plan are essential to a new system. And central to that is this transparent, accountable process for setting priorities and determining how you're going to design a basic benefit. But the health plan itself, I think, is going to have trouble surviving on its own.

GALLANT: Our first visit, (?) my first visit to you in your office, there was a [pause] I guess to, as a maybe last open ended question, where do you think medicine will be in five years? Where would you like it to be in five or ten years?

KITZHABER: Well, I'd like to have a system where physicians have the latitude to concern themselves with practicing the science and art of medicine. Where they're not worried and distracted by the reimbursement structure by the medical legal system, by the

bureaucratic hassles, so they can actually provide that advocacy, the support, and the care to individuals. But the only way we can get from here to there, I think, is we're going to have to become much more engaged in envisioning what that would actually look like. As I told you this morning, I was at grand rounds at St. Vincent's with a lot of physicians, and I was trying to draw them out about how would you organize the delivery of care. Let's assume that we agreed on–

[End Track Five. Begin Track Six.]

KITZHABER: –basic benefit is and what's in it. And we know it's going to get paid for, and we're going to get paid well for it. How would you organize the delivery of care? It's very difficult, because we're so used to what we have. And I think the real challenge of medicine today is to be able to sort of think beyond that. And it's challenging, because there's not a lot of time in the average day of a physician to sit back and contemplate those things. But I think it's important that we find a space to do that. And I think organized medicine is more important now than ever before. Finding those touchstones, those areas that affect all physicians, in bringing them together around some common agenda.

GALLANT: Well, Governor, thank you very much. It's been a real pleasure.

KITZHABER: Thanks.

SIMEK: Thank you. Read that piece again.

SIMEK: Say it's the end.

SIMEK: And announce the end.

GALLANT: This is the end of tape number two of two interviewing Dr. John Kitzhaber, former governor of Oregon, November twenty-first, 2006.

SIMEK: Thank you very much.

KITZHABER: You're very welcome.

[End Interview.]