

Oral Memoirs
of
F. Daniel Duffy, MD

An Interview
Conducted by
Clinton M. Thompson
February 11, 2016

Development of the Tulsa Medical College:
An Oral History Project

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Interview History

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The Development of the Tulsa Medical College Project was conducted by the Schusterman Library at the University of Oklahoma-Tulsa from January 2016 to June 2018. The project focused on the history development of the Tulsa Medical College, which later became the OU-TU School of Community Medicine. The project consisted of 28 interviews with former and current employees of the University of Oklahoma-Tulsa.

F. Daniel Duffy was the first Chair of the Department of Internal Medicine.

Clinton M. Thompson was the first Director of the Tulsa Medical College Library and went on to become the Director of the Robert M. Bird Health Sciences Library at the University of Oklahoma Health Sciences Center.

Alyssa Peterson was a Medical Librarian at the Schusterman Library.

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Hope Harder was a Library Tech at the Schusterman Library.

F. Daniel Duffy, MD
Oral History Memoir
Interview Number 1

Interviewed by Clinton M. Thompson
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THOMPSON: February 11, 2016. Would you like to introduce yourself?

DUFFY: I'm Dan Duffy. I'm a general internist, Professor of Internal Medical at the University of Oklahoma, College of Medicine, School of Community Medicine, in Tulsa—originally the Tulsa Medical College.

THOMPSON: What—your education? You want to take that?

DUFFY: Start from the beginning?

THOMPSON: Yeah, that's fine.

DUFFY: So, I graduated from St. Patrick's Grade School (laughs) in Johnstown, Pennsylvania. I went to the University of Pittsburgh for my undergraduate training in zoology. And then I went on to Temple University Medical School in Philadelphia. I drove into Philadelphia the night of the big race riot in 1964. So, I thought I was in for a real treat coming to Philadelphia. Then I left medical school and came to Oklahoma because in the middle of medical school, between the second and third year, I married Kay Frawley from Tulsa, Oklahoma. And I've learned that if you marry an Oklahoma woman, you have a good chance of spending a substantial amount of your time in Oklahoma. So, we met at the University of Pittsburgh, and after medical school I decided I wanted to be a general practitioner, a family doctor, working in a community, and I found a really good hospital in Tulsa, Oklahoma, where Kay was from—St. John's Hospital—and I came here to do an internship. The internship was kind of interesting because that was the year that they eliminated general practice, and, therefore, there was no rotating internship anymore. So, I did a mixed-medicine internship: six months of medicine and six months of other things.

After completing my internship, we had some family issues that we needed to stay closer to Oklahoma, and I went to the University of Oklahoma to do my internship there—completed my

residency in internal medicine. I had received the Berry Plan, which meant I had a deferment to complete my residency training and would go into the Navy as an internist. So, I spent three years in Oklahoma City completing residency and one year of fellowship. Jim Hammarsten, a chair, asked me to stay on as a chief resident in Internal Medicine, which I really enjoyed. And [I] completed my training in Oklahoma City in 1973, when I went off to the military to fulfill my military service with the Navy. So, I spent three years with the Navy—which we'll come back to how that influenced my experience in Tulsa. I had an opportunity to work for the Physician's Assistant Program, was on the faculty there [and] helped develop the Navy Physician's Assistant Program.

I left the Navy in '76 and returned to Tulsa; and at that point Tulsa had established the two-year branch campus, the Tulsa Medical College. And I thought while I'm waiting to see what to do with my life, I'll join the faculty of the Tulsa Medical College. Martin Fitzpatrick was dean then, and I was, I think, the third faculty member or fourth faculty member to join this new school. Dan Plunket and Bob Block were already here. So, one year moved to the next and moved to the next and before long I was asked to be chairman of the Department of Internal Medicine. They were having a really hard time recruiting a chair for the department. Sol [Solomon] Papper in Oklahoma City, who was on the search committee, told Dean Thurman at the time that the only thing I had going against me to be chair was I was too young, and he was sure that was the only thing that would change. It has.

So I did that job for about seventeen, eighteen years, until 1976—I'm sorry 1996—I came here in '76. In 1996, I took a job at the American Board of Internal Medicine, returning to Philadelphia. So, Philadelphia to Oklahoma to Philadelphia. And [I] spent ten years in Philadelphia as the Executive Vice President of the American Board of Internal Medicine—really an exciting time that shaped an enormous amount of what I'm doing right now. Everything in my career has nicely grown into something else, not by plan, just by agreeing to do it. So, I stayed in Philadelphia for ten years; and then in 2006, Kay decided she was returning to Tulsa with or without me. And so I said okay, we've done this gig. Let's go back to Tulsa. I expected to come back and retire quite frankly. It was sort of a nice career.

At that point, Ron Saizow was thrilled that we were moving to a new era in Tulsa, that the dream that we had originally in 1976 of having a community-oriented medical school would actually come to fruition. And Gerry Clancy was the dean at the time, quite charismatic; I was captivated by him. Ron and I had remained friends for—throughout this period of time—and the opportunities to explore the idea of actually a four-year medical school in Tulsa came about. I did—took a position here—part-time position. Actually, it was part-time in Philadelphia part-time here, and then became senior associate dean for academic programs. That lasted for a while. [I] did some early planning with the George Kaiser Family Foundation on the four-year medical school. [I] agreed when Gerry wanted to back off of the deanship to take the dean of the Tulsa

campus a couple years and did that for a period of time; I think 2010 to 2013, at which point it became pretty clear that the four-year vision that we had was not going to come to fruition at this time, or at least it was not going to come to fruition within my life-time, and so I stepped down and then planned to retire. As my wife says, I am terrible at retirement. I've had three retirement parties; nobody will come to the next one because I flunk retirement regularly.

At that point Jim Mold, a friend, longtime friend, in Oklahoma City, was applying for an AHRQ [Agency for Healthcare Research and Quality] grant, and he asked me if I would be willing to help write it, which I did. And before long, I ended up being principal investigator for this \$15 million grant, which is aimed at transforming primary care throughout Oklahoma. It was just too good to pass up. So, in my career of medical education and then that part of the time in continuing education and maintenance of certification at the board, and then, return—attempting to actually make some changes at the medical school curriculum level, and flaming out on that one, realizing, oh my goodness, we have an opportunity actually to make changes where changes will matter, where physicians actually are in practice. So, I'm still hanging around, Marty.

THOMPSON: Still doing things. That's good! That's good!

DUFFY: So, that's probably a lot more than you wanted to know.

THOMPSON: No. No, that was perfect. That was perfect. I think with—I'll ask this question now: the various—because you did go to the board—what organizations were you involved in during your career?

DUFFY: Yeah. It was the organization—in college I was really active in stuff and had a lot of organizations, was a founding father of a surgical fraternity and things of that sort. [In] medical school I was not very active at all. I buckled down and studied in medical school. In residency, I became involved in the very first national resident organization, and that was really kind of fun. I began to see how maybe political or union organizations might form. I didn't think unionization was a good idea, but I was part of some of those discussions. And that allowed me to be to serve as the first student—or resident representative on the faculty board in Oklahoma City. I think that's been eliminated, and I think it was eliminated shortly after. (laughs) We caused some ruckus over that.

The other organizations—I was part of the medical society and so on. I remember the very first College of Physician meetings I was invited to in Oklahoma. I gave a lecture on the problem-oriented medical record—the Larry Weed System. I got a reputation as a resident for actually proposing an electronic medical record and actually—just hadn't remembered that—was kind of on the circuit around hospitals to give a talk on what this new innovation was going to be, and that was back in 1971? '70? I had never really had an opportunity to work with an electronic

medical record until I came back to Tulsa in 2006, and it was the worst experience of my life (laughs). And so, I had spent thirty years proposing that this was a great thing, and then what actually occurred was pretty awful. So, after organizations.

So, the—going to that ACP meeting got me involved in the American College of Physicians. I became governor for Oklahoma, and that got me onto the national scene. That's really enjoying that, enjoyed the people, and got to know a lot of people. It was through the American College of Physicians that I went on to the Board of Regents of that organization. Through that was reported to the Residency Review Committee [RRC] in Internal Medicine, and I served on that for two terms and then became the chair of that organization. While I was chair of the RRC, the American Board of Internal Medicine offered me a job as vice president, and the job there was to actually launch a brand new certification model called Maintenance of Certification. And the piece of that was to launch quality improvement or practice improvement as a part of physician training. And nobody had done that before, so it seemed like a really nice challenge. I like to do things that people haven't done before, and I like to swim upstream, rather than go with the flow. So, that's why, probably why, I've been in Tulsa so much of my life. There is nothing more swimming upstream than the University of Oklahoma at Tulsa, and there is nothing as rewarding as a salmon-spawning session having swum upstream. So, I came back, and then I told you the rest of the story of organizations. So, I've been in a lot of organizations, but the big ones that relate to here—I've been involved in the TMEF [Tulsa Medical Education Foundation], which we'll talk about I imagine, and the state medical association, the county medical—you know, those kinds of things.

THOMPSON: Very good. Let's go back to the early years, when you were hired. Do you remember who hired you? You said Dr. Papper was on the search committee. Do you remember that involvement and how you got back into the medical college?

DUFFY: Yeah, so. Yeah, I do. Marty Fitzpatrick was the dean, and I think he and Gabrielle Thompson [ed. note: later Gabrielle Thurman] were the only two people at the Ranch Acres office where I interviewed. There was a young guy, really a very spit and polished young guy, called Leeland Alexander, who was also there. He had been hired a couple months before, so I think there were three people when I came for my interview with Marty Fitzpatrick. I had known Marty as a professor when I was a resident in Oklahoma City, about eight years prior to that, and I liked him and we got along very well. And so he urged me to come back and be a faculty member in the Department of Medicine and take over the internal medicine residency. And a couple students who were here—by that time there were students here—I think seventeen were actually the first class. The person—so, he interviewed me and recruited me and I think Bill Thurman was acting dean at the time—or provost, and Marty Fitzpatrick was dean—that's how it worked. So, and, since I did my internship here, I kind of knew the community; I knew the other people who were here. I got mixed reviews. Many of my mentors said don't come back

here, it's a dead end, you will not have any career at all, this is a half-baked branch campus of a third-rate medical school. Why would you want to do this? And having been a graduate of the residency program of that third-rate medical school, having been here before there were medical schools, I took their advice with a grain of salt and said, "Well, let's swim up this river and see how it goes." And that's how I came here.

I was not interviewed by anybody in Oklahoma City for this job. I was interviewed by Jim Hammarsten—was I out of my mind going to Tulsa? Come to Oklahoma City and take a job there. Remembering that conversation saying that the only reason I would consider taking a job in Oklahoma City—which would be okay—would be [if] you would agree to focus on primary care? Would you agree that internal medicine and family medicine are important elements of the healthcare system? And the answer was, no, that isn't what it's all about; it's all about health sciences centers and the specialties and researching, of which there was almost nothing there to begin with. And so that was the vision that was clearly a different vision than my desire to have a community-oriented experience, and actually to be engaged with the real practicing and community-oriented activities. So, you know, I probably had drunk the community medicine Kool-Aid right from the get-go.

THOMPSON: Very good. Since you mentioned Dr. Fitzpatrick—is there anything you want to say about him because I think he is important because he was the first dean, but he didn't stay dean very long. And so, is there anything you would like to say about him?

DUFFY: Well—

THOMPSON: You may be one of few people that can give us some information about him.

DUFFY: Marty Fitzpatrick was a very classy guy, and he was a classic academic. I would call him a classic east coast academic. And unlike Bob Bird, who was a classic southeast academic, Marty didn't quite have the Tulsa good-ole-boy routine down, and so it was a culture clash in some ways. Secondly, I think Marty was part of the Oklahoma City establishment, which never sat well in the early years with the Tulsa community. And the Tulsa community was actually the TMEF [Tulsa Medical Education Foundation], and it's probably worth mentioning the TMEF. The Tulsa Medical Education Foundation was a brilliant idea spawned by about four physicians. Burr Lewis was the one that was the most vocal, but he may not have been the leader of it. And they got the idea very early on that there was now Medicare money coming into hospitals to fund graduate medical education. They got it. And they realized that none of the Tulsa hospitals had the capacity to mount a really good residency; they were just developing specialists and so on. And so, the Tulsa Medical Education Foundation drove the politics to get a school here in Tulsa. A DO—an MD school never would have happened if it hadn't been the osteopathic community established the then Oklahoma Osteopathic College. Once that was done, it became now

incumbent on MDs in this state to say, “You can’t do that; we’ve got to have the same thing.” And there was no stomach in Oklahoma City for a campus in Tulsa until it meant a beachhead against the osteopathic invasion. And I’m probably telling you things that aren’t on the record, but that, that really was pretty profound. And the politics behind that were pretty complicated. So, when the legislature said, well, we can’t build an osteopathic school without extending OU. They started a tradition of tit for tat—whatever the DOs get, the MDs get it equal, equal share. And it wasn’t going to happen in Oklahoma City. The beachhead, Normandy, was Tulsa. And that’s where this tension, this dynamic, would play out over the past forty or fifty years. And it’s playing out even today, although the acrimony is way less than it was back in those early years. So, I got kind of lost.

THOMPSON: Nope, you’re fine. So, you’ve been talking about—I was asking you about Dr. Fitzpatrick.

DUFFY: Yeah, okay. So, Marty Fitzpatrick walked into that quagmire. So, it was a political maelstrom. I mean totally a political maelstrom, and he came in from the academic spectrum. A terrific guy, who came from the academic world of “well, this is all handled.” And I think if I can say anything, he was somewhat of a naive politician walking into a field. And he did not have the credentials as a clinician—he had been an academic—and didn’t have the clinical hutzpah to stand up to some of the pretty outrageously outspoken clinicians in the Tulsa community, who had a great deal of hubris—most of it earned—and that didn’t go well. And he, of course, was sent here not to make this work, but to make it not cause problems. And that’s been a common theme throughout the entire history of Tulsa Medical College. We have to just keep it under wraps. We have to keep it under control. And that’s understandable because, you know, the University of Oklahoma Health Sciences Center was fledgling and growing, and it really needed to grow and needed its space to grow, and this is not a wealthy state that can be spreading money out among three institutions. So, you know, there were all these money tensions, political tensions, and then this unspoken MD/DO battle that was always going on. So, Marty fell into the middle of that, and I think just got intolerable, as a way of handling it. If anything, it was the lack of the support in constituency that made it wise for him to move to take on a leadership role at the Muskogee VA [Jack C. Montgomery VA Medical Center], where he did terrific, really terrifically well.

THOMPSON: Great. You were hired as the first Chair of Internal Medicine?

DUFFY: Well, I was hired as a faculty member in Internal Medicine, but in two or three years, after we had gone through trying to recruit a chair. And you have to remember the time—this was the time that the heyday of internal medicine. It was a very different time, and internal medicine was being filled by really vocal, prestigious research physicians, and so people would look at this job going into the Department of Internal Medicine in a community branch campus.

By the way, there were only a few branch campuses back then; that was the beginning of the branch campus movement. And the big powerful departments of medicine were only about twenty-five years old, even at that, they began after World War II. So, it was hard to find somebody who was interested in primary care at the time. I was one of the very early ones interested in that—community-based activity after all that. We just got rid of all of those volunteer faculty. Why on earth would you ever go to a school that was based on volunteer faculty? And for God's sake, we just got our own hospital. Why would you go to a place where you don't own the hospital? And none of those things seemed to be of any relevance to me. They seemed to actually be more relevant than the alternative.

So, I agreed. I did a good job in putting the residency together, had done a pretty good job in working with the TMEF, and I had credibility as a clinician. I was one of theirs, I mean I was, did the internship here. And I did know Oklahoma City a little bit, but you know I'm not politically savvy either. And what was the last thing? Oh, what we did because it was primary care community and mission. Bob Block and I, he from Pediatrics and me from Internal Medicine, realized that our educational program here for the residents had clinics in each of the three hospitals, and we said that's just not doable. If we're going to really do good primary care, what we have to do is we have to bring those three clinics together in one place. And so, he put together the Tulsa TAPC, the Tulsa Ambulatory Pediatric Center, and I put together the TCIMC, the Tulsa Community Internal Medicine Center, and we brought all the patients that had been managed in these individual hospital clinics together in one place under the University direction, or TMEF direction, to back that because the residencies were not the University's; they were the TMEF's. The TMEF had, in essence, hired university faculty to administer and teach in the residency program. It was a smart move on TMEF's part. They kept control of the money, but they had professionals doing the education. And so we built some really good residency programs in that early, late seventies, the early eighties. Recruited every year terrific residents, and it was really, really a lot of fun because it was brand new. We had something that nobody had ever seen before—a residency program that actually trained these people to practice medicine? That was really quite novel and exciting to people. Many of those physicians are still in practice. They're in the process of retiring now, but they have been very successful primary care internists all around this area for a long time. Sorry I wandered off.

THOMPSON: No, you are doing great. Do you want to talk about some of the faculty that you had in those early days?

DUFFY: So, the early days. Let me give you a—talk a little bit about the residency and then I'll get into the faculty from that. So, in the residency—you remember I got here July of 1976. Having, just had a really exciting three years in the Navy working with physician's assistants and building out a healthcare delivery system. We didn't even use those words back then, but we had built a healthcare delivery system that was based on non-physicians. We had a primary care

crisis in the Navy, and so we had corpsmen who were trained to take care of civilians. That was unheard of at the time. We had PAs, we had nurse practitioners, they weren't called nurse practitioners then, but they were nurses who did nurse practice work. And all of it done under protocols, and it was really kind of a fun thing to cut my teeth on. So, I had that under my belt, came back, and had this residency to deal with. I had pretty much—I'd been very active in the education in the Navy, and so I thought the residency was going to be fine; it was going to be a challenge. And I had this view of ambulatory care is the center, and the hospital is your failure point. That if you can't keep people well, then they'll have to use the hospital. That is exactly the reverse of the way training in medicine was. Particularly in internal medicine the idea is well, all the action is in the hospital, and when you've done with the action and you've created the cure, let them go to the LMD [local medical doctor]. Let them go to the local medical doctor in some office somewhere that nobody pays any attention to. I wanted to flip that on its head and say, "No. No, primary care is really important. That's where care actually is delivered."

So, the residency, the residency that we had back then—I thought—I came on board on July 1976—and I said well, we have a new group of residents. They had done a good job recruiting residents. Think I'll give the intern on call tonight a call at 10:30, and see how things are going. Called the intern, and he said, "Well, I have a guy with an MI who's scratching, I have GI in here who's on his fourth unit of blood, and a patient in diabetic ketoacidosis." And I said, "Oh my gosh!" That, that's a big load for an intern on—in the beginning of July. And I said, "Can I speak with your senior resident?" He said, "Oh yeah, here's his number 1-9-1-8—." Now, that was way back in the days where we didn't use zip—area codes to make all our calls, so that was a long distance call back then. So, I thought the residency was in Bartlesville, which is up the road, and I, and he was on call with that intern, managing those three patients, moonlighting in Bartlesville. So, I knew we had a problem here, that the community environment wasn't everything. The—

THOMPSON: So, the senior resident was in Bartlesville?

DUFFY: Yeah, so, the senior resident was [in] Bartlesville. That meant I knew we needed to get the residency under tighter control. Letting a medical student, or just a brand new doctor, manage those kind of complicated patients was not—this wasn't fair to those patients, absolutely, it wasn't fair to the student, unfair to the resident, wasn't fair to anybody, nor was it fair to the senior resident who wasn't there actually honing his or her skills. And I think it was those kinds of things that gave a poor reputation to community-based programs. So, it took a couple years, couldn't happen overnight to actually change that so that senior residents were in the hospital at night with the junior residents, and they worked as a team, and they began to really learn the care, and delivered really high quality care as we began to measure.

What's intriguing to me [was] that the support for doing that was there from the younger doctors in the community, but not the older doctors in the community; and it's simply a matter of "We've always done it this way. We haven't had any problems, so why are you making waves now?" So, we did make some really substantial changes to the residency program. Added this clinic, the idea of a continuity clinic, that you need the long-term relationship with patients over a three-year period. You needed to be in hospitals. We—over my term as chair of Medicine, we moved from a St. John's service. It started at St. John's and then it became a St. John's, Hillcrest, and we went to those two hospitals with our separate clinic. St. Francis always wanted a residency in those early years. They really wanted a residency. It was such a new hospital, and such a ritzy, private hospital. It was really difficult to mount it. So, St. Francis became part of the TMEF, and the three hospitals as TMEF pooled their money and agreed to take pooled money and have one residency program. And it was okay to rotate residents among the hospitals so we could get the very best educational experience from what that hospital offered. And that was really good because we were now based on quality education and quality patient care. So, the—we moved along with three services in internal medicine, and the program grew to mount that, but that was now getting to be a big burden.

Now, we come to the cancer of the TMEF. Paul Goodwin, a very dear mentor and friend, who's no longer with us, was on the TMEF board when Marty Fitzpatrick was still chairman of medicine. He went from dean to being chairman of medicine and from chairman of medicine to head of the VA. He—a big grant came along, I think it was real big for the time, about \$1.2 million, which came from the federal government through the VA to support new medical schools. Okay? Well, you know, nobody in academics turns down a grant of that magnitude, and so that got Bill Thurman involved in this as well. And so, now we had money in the Tulsa campus, and I think it was that \$2 million—\$1.2 million I think, that may not be right, but it was that amount of money that actually allowed for the bringing of the OU branch campus in because it meant that the VA in Muskogee was the recipient of the money, and it had to go to Tulsa. Well, this made Jim Hammarsten ecstatic because he was struggling to be able to keep some of that money coming by supporting Muskogee VA from Oklahoma City. In fact, when I was a resident, I came from Oklahoma City to Muskogee and spent some time there. So, it was a way of getting that federal money through the VA into the University. So, I'm sure Hammarsten was absolutely ecstatic that Fitzpatrick would take over running that money, its increase, and was able to be used to build Tulsa. [I] haven't heard anybody talk about that in a long time. But what it meant is the VA wanted residency, and that meant that the VA needed to become part of this TMEF residency. Well, these three hospitals were getting a lot of money now from Medicare. They were getting cost-plus back then, so they just put the cost of the residency on them. Money kept flowing in, as Evita said, and the TMEF wasn't about to have it divided with the VA in Muskogee. Surgery and Medicine both needed the VA because the patients at the VA were different than the patients in Tulsa, and they would be a really good educational experience. It was forty-five miles away. That was a problem. Did have a good turnpike to get there, but it was

still a ways away, so we tried lots of things. Should we build housing for residents? And that wasn't going to work—it turned into things we don't want to talk about. We, should we do, what should we do? So finally, we negotiated a deal that VA would not be part of TMEF, but the residency, the TMEF residency, would use the VA for some of its training. That grew to a point that the VA was about half of the residency program, and the three Tulsa hospitals were the other half. The clinic was here in Tulsa, but the VA was now a critical part of the training program. Marty, Marty, that's why the VA was such a landing place for Marty Fitzpatrick to get back to that. He drove as program director and then ultimately chair. It was a really difficult thing to balance three hospitals and the VA hospital. So, four hospitals and a clinic, in a forty-five resident program.

Now, you asked me about faculty, well that meant we needed faculty. So, where do we get faculty from? The very first full-time faculty member I hired was Arnold Katz, and Arnold Katz was a rheumatologist right out of fellowship. Just wonderful, loved to teach and was one of the very best clinicians I have ever met. And he established the concept of a private practice for faculty and began the—that work. I had done practice as a faculty member from the time I came, he came about three years after I was here, and I practiced with Frank Clingan, one of the first chairmen of Surgery, in his office. I practiced with Steve Landgarten, in his office, and then by that time the faculty practice plan was beginning to form, and neither of those were satisfactory. And so, I can't remember exactly where I went with that. If we get a chance I'll tell you about my very first patient in practice here. Do you want me to do it now?

THOMPSON: Do it.

DUFFY: Okay, so I go my first day into Frank Clingan—we are now under the University of Oklahoma's practice plan—and I'm in the office, seeing my first patient, who called and made an appointment. She was feeling terrible. She was a nineteen-year-old woman. And she came in the front desk, and the woman in the reception area said, "You got to come out here right away! She's fainted!" And I walked out, and there this terribly ill woman, high-fever, bright red all over, and had passed out; she had no blood pressure; she was really sick. So, I said, "Well, we got to get to the hospital right away." Now, we, our office is right up the street from where one of the banks are on 21st Street, so we went right over to St. John's Hospital, admit her into the hospital. I did everything, cultured everywhere, found nothing that was abnormal in in her at all. [I] had all the consultants I could bring in, come in—had no idea what was going on. We only had steroids and penicillin and gentamicin at the time, which we used, and treated her with these antibiotics. Ultimately, her skin all sloughed off, she went into kidney failure and liver failure, and I thought, she's going to die. My first patient, nineteen-year-old, and I have no idea what she has. I'm a total failure at this game. So, she survived, she got better, and she left the hospital, and we still didn't have any idea what was going on. Two years later she came into the office, and she said, "Well, I guess we know what I had." And the disease toxic shock syndrome had just

been discovered, and I went back and looked at her records, and sure enough, she met all the criteria for toxic shock. Having been having a menstrual period, used a tampon, and, in fact, had the staph I cultured out of her vagina. At the time, that staph was considered normal. So, I could have been famous reporting the first case of toxic shock, but as my mentor, Sol Papper, always said, “The question is not how many cases of X have I seen, but rather, how many cases of X have seen me, and I didn’t know it?” So, that’s the private practice.

Arnold Katz was the first, he was a rheumatologist, and we needed rheumatologists in town. The specialists were just beginning to grow into Tulsa. The second was a friend of Arnold’s from residency, Fred Garfinkel, who is still on the faculty today. He has come back to the faculty after private practice, and he was a pulmonary specialist. Now, I had done some pulmonary training in my fellowship in Oklahoma City. The third person was Dala Jarolim, and Dala Jarolim was a fa—a resident, a resident in the residency, and we hired her on right out of residency as a junior faculty member. So, we had me, Fred, Arnold, and Dala. And then the fourth per—the last person we hired was Ralph Redding, who was a really terrific guy who was part of the early hospice and palliative care movement, and came to Tulsa. He was also a pulmonologist. So, now we had three of us who did some pulmonary work. We established a critical care unit and did some pulmonary work. Arnold established a rheumatology practice, and Dala was the general internist interested in oncology. That was the faculty. The rest of the faculty were volunteers, and the volunteers were spectacular. Eric Westerman in infectious disease, Jose Medina and John Coughlatch(??) in cardiology. Gastroenterology was Norm Simon, endocrinology was Bill Sevier. David Jenkins also in gastroenterology. Wayne Neal in cardiology. Harvey Blumenthal in neurology. This group was just spectacular; they were young, vigorous, just out of fellowship, wanted to teach. The idea of specialty practice was just new and evolving, and it couldn’t have been a more spectacular place for a resident pursuing education. And then we began recruiting as residents graduated from the program—people to stay on for a year or two until they decided what they wanted to do and where they wanted to go. And they were all just, just terrific. (laughs) Whew!

THOMPSON: You’re doing excellent!

DUFFY: (laughs) I’m tired thinking about it.

THOMPSON: (laughs) I would be. The residents, any of them—obviously Dr. Jarolim did.

DUFFY: Dr. Jarolim did and Dr. Saizow stayed on; he’s now the DIO [Designated Institutional Official]. Michael Weisz stayed on as faculty, and he is now acting chair of the Department of [Internal] Medicine, and has been for two tours, so he stayed on. Karl Hoskison who joined our residency—or joined our medical school program when the Oral Roberts University [Medical School] closed. He came on, and he is still on the faculty. I told you Fred Garfinkel had left for a

number of years, and then he's back on the faculty. The others—you know, if I had pictures or a list it would come back to me, but it—you know, I remember Holly Heaver [Heaver-Jennings], who's in practice now in Arkansas, who's just a terrific chief resident and stayed for a couple of years. Then we had a whole VA faculty, and the VA faculty was a wonderful group of people. Ned Nichols(??) took on chair of internal medicine down there and Vincent Fiorica was in endocrinology and Dr. Gistudis(??) of gastroenterology, who's now here in Tulsa. Kola Danisa in cardiology. And many of them came from Oklahoma City where Nick was, and he brought them to the VA because it was a good place where we were beginning to have a residency program that was, was a vibrant place of work. And I went and joined the RRC in Internal Medicine, taking what I had learned in Tulsa and bringing it to the national scene, which really did make a big impact initially, but we began getting too involved in writing regulations that made it more and more difficult to do a program like we had here in Tulsa. It couldn't be so spread out. There couldn't be so much travel time. It was too dangerous for tired residents to travel forty miles after being on call for, you know, thirty-six or forty hours. So, there were a lot of bad things that were occurring during all of that that needed to be corrected.

THOMPSON: Any students that stand out to you?

DUFFY: Oh, my goodness. Oh, all of the students who became faculty members here, they were all stand-out students as well, Mike Weisz, Ron Saizow. The—there are so many students. You know, the ones that are most recent in my memory are here right now, that are residents like Peter Madden who was a medical student with me, but there are—I just can't, no can't recall.

Pause in recording.

THOMPSON: You were talking about students.

DUFFY: So, talking about students. So, a couple of students really stand out because they're here still, and I think that—there are many who have gone on to greater things. And I—that, that come to mind, and I think of them frequently. I can think of Bill Marshall for one, who's now at Mayo Clinic doing really well. Mike Maxwell is a terrific internist here in town. He was a great student, did his residency here. John Hubner is an outstanding clinician here in town. And he did his residency in Arizona, but as a medical student here. Michelle Phillips [Hubner], his wife, is a child psychiatrist here in Tulsa, and she was a terrific medical student as well. David Nierenberg. I mean, I can just think of—some come to mind that just really stand out as making a name for themselves and having careers that are quite rich in fulfilling the lives of other people. Just really, really terrific. Three of the, three of the medical students Karen Gribben, Marty [Martina] Jelley—who is now on the faculty here—Martina Jelley, Karen Gribben, Marty Jelley, and Jan [Janis] Finer were all medical students staying in the residency program here, and all, I think, came into my office as program director during the same week announcing they were pregnant in

residency. And I thought, oh my gosh, this is going to raise havoc in the in the call schedule. So, I remember them, they're just terrific internists. Marty's a wonderful faculty member here. Her husband David Jelley I remember as a medical student. Just terrific. So, I would, I would hate to bring up names because I'm leaving out people who are highly meaningful, and—

THOMPSON: Totally understandable, we just, you know, we're just picking your brains.

DUFFY: Okay, good.

THOMPSON: I—while we're talking about students, can you talk a little bit about going to Oklahoma City and recruiting students to come to Tulsa?

DUFFY: Yes. There are two stories in that: the old and the new. So, the old story is going to be pre-1996, and so that 1976 to '96. We would go to Oklahoma City—back in those early years. Tulsa got a reputation of being the “country club” or “resort” medical school, and rather than being offended by that, which we could have been, we said, “Oh, let's capitalize on that.” And so one of the recruiting brochures actually had a sailboat out on one of the lakes, saying, come and do your residency in a resort setting—which was a little bit of a stretch, but we did that. And the early recruiting was actually based on the philosophy of a resident-centric, non-malignant, community environment where you do real things with real patients and real doctors. That wasn't entirely true, I mean, it was true as we were saying it, but the comparison wasn't quite fair between Oklahoma City and any other campus. The facilities were very modern here, and varied depending on the year. In Oklahoma City they became really spectacular, as they are now. So, we were able to recruit a group of—and this has always been the case—a group of pioneering medical students. I mean, they wanted—they had a vision. They had a different way of what we do. Things were, they—I don't know why they came, but we were pretty good at recruiting. That went on for years—the twenty years I was here it was really pretty good. And we—rarely—we recruited a lot from Arkansas, Missouri, Kansas, and Oklahoma City, some from Texas. We had a good—so, we had a pool of people we recruited from. In the later years, when I came back in 2006 and was then in the dean's office, we did some more recruiting. And then I found it much more difficult to recruit to Tulsa. There were many years when the number of students recruited from Oklahoma City to come for the third year was a smaller number than I had ever remembered in the pre-1996 years. And I wasn't entirely sure what that was all about. It became pretty clear that most of the people were coming to Tulsa after 1996 had a Tulsa connection. And that was always the case to a degree, but there were others who would come here. And the recruiting just had a different feel and flavor. May well have been I was different, I mean, I was obviously older, and the primary care wave had crested and broken. And I thought we may have been not quite as popular here. The campus here was undergoing a personality change. It had the Schusterman Campus, so it was no longer in—literally in temporary buildings. And it was not so much the community as much as it was now a campus. And so, it had some of

the characteristics that were the same, but not as grand. And, I think that actually had an, had an influence.

THOMPSON: Very good. Administrators—you mentioned a couple—any of those that stand out from the early days?

DUFFY: Well, all of them. I mean, they're still around. (laughs) Leeland, he and I are trying to fight for who is going to be the longest man standing on the campus. Leeland was spectacular. I mean, Leeland Alexander just kept this place together, and such a soft-spoken, kind, charitable person. And understood the University finances and state finances and higher education finances better than anybody. And that was, that was truly very good. Leeland always had this capacity—as chair I was always befuddled—because Leeland always seemed to have a pile of money that no one could know about. And he would never say anything, but if you became desperate enough—and he determined the meaning of desperation—there was always a bailout available, and that was good and bad, you know. People need not to be bailed out when they grow up, but on the other hand, it did keep things afloat. He ran a safe ship financially, and I think that was really terrific. Mike Lapolla is the other unbelievable character, and there's no way to say anything more about Mike other than he is a great character, clinic administrator, good researcher. He—we wouldn't have the clinic system of the University of Oklahoma in Tulsa, were it not for Mike Lapolla. He made it happen, and he knew how to do it. He's certainly a salty-tongued guy, who brought—has a capacity not to offend using phrases that other people would use and offend everybody. So he, and he's become a really great friend in the second half of my career, in the School of Community Medicine side of it, Mike has been a stalwart worker with the Kaiser, the George Kaiser Family Foundation, and planning, thinking through the idea of community medicine. His public health background just changed the dynamic of this school enormously. So, as somebody who's had three or four careers, Mike Lapolla and I have parallel each other along that line.

I mean, Mike Newman, Connie Trantham, and June Holmes in Resident [and] Student Affairs were just spectacular people, who knew how to create—Rhea Sulzycki and Mike Sulzycki they are people who knew how to treat students. And then there was Marty Thompson. And Marty Thompson took on the Tulsa County Medical [Society] Library. There wasn't going to be a library for the University of Oklahoma here, but he was able to build a library out of a temporary building that was permanently here for sixty years, I think. And, honestly, built a library that was a service-oriented library. And it was not a place for smelly old books. It was a place for service, and fun, and enthusiasm, and excitement. So, Marty, you were, you were a highlight of that era.

Dean Tomsovic, of whom I probably spent the most time with, was a military man, soft-spoken, very kind, gentle, whom I gave no ends of garbage to. I would have hated being, I would've hated being in his shoes, having me working with him—lots of amends along that line. The other

chairs were always an interesting lot. Dan Plunket was a very private man; did a terrific job, understood a view of pediatrics that embraced both specialty and primary care medicine. Bob Block is still a good friend. Outstanding in his contributions, particularly developing a whole specialty of abuse medicine in pediatrics. I mean that's, again, a great contribution coming out of the faculty here. Jim Allen in Psychiatry, I remember vividly, in fact, Barbara Allen, who was part of a grant that we had. And, I'll never forget it; it's been the most memorable lesson. Bob Block and I were talking about the developmental stages and drawing a diagram that we'd start out as a nothing, and then as an embryo, and grow through childhood, adolescence, and reach adulthood at our pinnacle and then we fall off. And I remember Barbara getting up and taking the pen right out of my hand, for the whiteboard, and she said, "There's another way of looking at this." She says, "Yes, I've grown to the line along here, and then when that adult levels off," and she drew the thing right off the blackboard going straight up. And she said, "That's a way that we need to look at growth and development." And she said, "The body fades away." And I thought, wow, that's a way physicians and clinicians need to approach life, illness, and death. Is that there is something else, and I couldn't believe I was what, forty almost, and I was beginning to learn that lesson from somebody who could be pretty outrageous at times. Jim could be, too. He was the mild mannered one of that duo, which she unfortunately is no longer with us.

THOMPSON: Mentors—you've mentioned some, but people that you want to highlight that were mentors to you?

DUFFY: Jim Hammarsten and Marty Fitzpatrick were obviously mentors in my residency, but my main residency mentor was C.G. Gunn. And C.G. Gunn, I remember a day I was particularly down in residency, in Oklahoma City. And you've got to remember I grew up in the mountains of Pennsylvania, lots of trees, and you know, very beautiful countryside, and I'd look out on the horizon of Oklahoma City and we'd see a forest, but it was a forest of oil derricks. And it was really, in my view, one of the most stark [sic] landscapes I had ever seen. And you've got to look at some of the pictures of 1960s Oklahoma City to get an idea of it, really was a forest of derricks and a lot of wind, I mean, the wind never stopped blowing. So, anyways, C.G. Gunn was just a—I was having a really low day and running to the cafeteria, and there was a faculty member, and we didn't talk much to faculty members, and I sat down and had some lunch with him. And then this man began talking with the greatest wisdom in the strangest way I had ever heard. And he was so funny and so wise, and such a good clinician, such a good observer, and I thought, that's who I want to be. That's how I want to be. And so we had remained friends all the way through. He was just a delightful man, and so he was a strong mentor. I quote him almost every day. In Oklahoma we have a saying, this is a quote from C.G. Gunn, "Millions for bricks and not shit for brains." And it's my favorite quote, and everybody I mention it to can identify with it a lot. So, that's C.G. Gunn.

The next mentor was C.S. Lewis, Burr Lewis, and he was a dynamite internal medicine leader, and he's probably the one who mentored me in the organizational side of medicine. He was the one that told me, "You've got to get involved if you have belief that things out [sic] to move in a particular direction." And he said, "He remembers being elected to the AMA [American Medical Association] Education Council, and they were voting on eliminating the internship—the rotating internship—and he said, "This is just wrong! This is just not going to work. It's going to destroy all these community hospitals." So, that's where the TMEF emerged because he knew that these things were happening on the bigger scene. And so, he was very helpful to me in advising me on the College of Physicians, and working with the board, and other kinds of national activities—he was my mentor there. He was so morally grounded, that he was really the person that told me, "There is right and there is wrong, but there's no reason to humiliate anybody who is falling. Everybody can be helped." And his career was one of missionary work. And was very active in his church, and very active in medicine, made a pretty big impact in the field of internal medicine.

Other mentors were Harry Kimball at the ABIM [American Board of Internal Medicine]—learned a great deal from him. And the other OU mentor, who was really strong, was Sol Papper, who also is no longer with us. I remember very much Sol Papper's sermon on the lake. And the sermon on the lake was this: We used to meet at the annual meeting at the American College of Physicians at Shangri-la at Grand Lake, and one time we were up there, and I had been asked to consider this job as chairman, and I said, "I mean, I'm doing a lot of the work right now, but I don't know anything about this, I have no connections or anything." And so, Sol—we walked kind of around the lake slowly, had a very biblical connotation to—and he began to say, "Well these are—this is how I think the chair is, and this is what you would do. Always recruit people who are better than you are, and then bask in reflected glory." And I thought, wow, that's really right, that's right on target. And he said, "Just keep the patient in the center of the picture. And have a group of people around that you can talk to in confidence." And he kept saying those kind of wise things as we walked around. And when we were done, I thought, well, you know, I probably could do this if it happens. And then that's where he told me, he said, "What I told the search committee was, you have a lot of skills and talents. The only thing you don't have is age, and that'll grow on you." So, the rest is history. But he was, he was quite a supporter, and very helpful to the program here in Tulsa, and that's when we've thrived probably the most is when we had an Oklahoma City chair who believed in us, and believed in what we were doing.

THOMPSON: Anything else that—let me ask you another question. You've touched on it, but let me ask you because you're so good at putting stuff together. How do you see medicine having changed from the time you entered medical school until the point now where you're so interested in the community medicine side? What are the issues, and what changed? You've mentioned that during it, but you do a good job of doing a concise picture, so what do you see that's changed?

DUFFY: The word I'm using now, and I've started writing about it, is the "corporatization" of medicine. Medicine has been corporatized, not for the better—definitely not for the better. So, when I started out, medicine was a profession. It was very doctor-centered, that was not a good thing. It was a profession in that it was based on specialized knowledge, skills, and an emotional attachment to doing good. That has eroded a lot. It really has eroded a lot, and I'm not seeing it any more clearly than I am seeing it now working with 250 practices in Oklahoma—small, rural, practices. And the corporatization is taking over. Right now in Oklahoma, about two-thirds of all primary care practices, and I don't have any idea how many specialty practices, are owned. An owned physician is a dangerous thing. It robs, it truly robs the humanity from all of us. Now it doesn't mean that corporations can't be good and noble; they can be. It doesn't mean hospitals can't be worthy and kind; they can be. But when the dollar is the prime mover only, medicine is on a dangerous, dangerous track. We are wealthy enough in the United States—at least we are at the moment—we are wealthy enough to be able to permit the excesses of wealth in the healthcare system, but we can't tolerate that much longer.

And that's all occurred in the past fifty years with the passing of the Medicare Act, and I remember this very vividly in Oklahoma City. When I was a student and a resident at Temple, and an intern here at St. John's, we didn't have much, we didn't have many books. We didn't have, we didn't have much. And I remember as a second-year resident in Oklahoma City, realizing that we were now able to Xerox for free, and I couldn't understand how we could afford a Xerox machine, which was brand new—they were pretty expensive back then—how we could afford it. And it was C.G. Gunn that told me, "Oh, it's Medicare. It's Medicare." So, how did Medicare do this? Well, University Hospital never made any money or had any money. It lived off of the state appropriations; but when Medicare came, we were now able to bill for services. And if you were in a residency program, the hospital just paid for the residency. So, suddenly there were resources coming available. That just increased, year by year by year by year, until as a result of Medicare, I think three things have happened: older people no longer are poor because of healthcare, it's really important. Secondly, doctors have become wealthy, and hospitals, usually wealthy. And the fourth thing is, medicine is no longer about the patient. We say we are, but I don't think we are. So that's kind of what I see has happened. The tragedy is what's going on in rural Oklahoma; we have a couple counties here that have no physicians. Now is it all bad? No, not all bad. We have a lot of things that are much better. I don't think America will maintain our—in the next thirty, forty years, we will be looking to other countries who have taken a tact(??) or attack(??) of universal healthcare as a right will actually be surpassing us in the innovations in the healthcare arena. I think we're going to begin to see, instead of the immigration of doctors from other countries to the United States, a reverse immigration. It's starting to a small degree right now.

THOMPSON: Anything else that you would like to say as far as the recorded history of Tulsa Medical College, which I still use as well.

DUFFY: Um, yes. Gerry Clancy's—and he was another mentor-friend for me—Gerry Clancy's vision that a university has an obligation to care for the most vulnerable in its community is alive and well. And that's what attracted me to this idea of the School of Community Medicine. I had an opportunity when I was here in the dean's office, to have eight years of a summer institute, where we took a group of people—interdisciplinary team of students and faculty, one hundred and twenty people—out into cars to explore the Tulsa community and understand: what does the community need from medicine? And what does medicine need from the community to be able to build a School of Community Medicine? It was extraordinary. [The] most exciting part of my career was actually going to places in Tulsa I had never been, even though I have lived here off and on for forty years. Being with students who say, "I didn't know, I didn't know." Students who have passed all the tests, are very privileged, in very privileged families, would begin to see first-hand, up front and close, the tragedy of addiction to opioid medications and the insane cops and robbers game that we do with drug dealers, drug users, the criminal justice system, and the police force. And realize that that is a medical epidemic, on-going, that we're treating in this very bizarre kind of way. Not realizing, real community medicine tells me that is—gun rights are an important topic, but we are killing more people in the epidemic of gun violence than we are in many of the other diseases that we spend our life on. So, the fact that we have—as a health of an individual depends in large part on the health of the community, in which they are nurtured and supported. And that's what I've learned in the School of Community Medicine. Is that a bright light? You better believe it. That's going to be where this corporatization, when it begins to readjust, and I don't think it will implode, I think it will correct, just like a market correction, it will correct. What will be left at that correction is this focus on the health of the community. Being aware that the robbery that healthcare is doing to the society, by taking so much money out of society and not leaving money available for schools, which are the heart of where health occurs, that's where we learn our health habits. And that's where we learn how to be intelligent voters. We need to put that money that's being, honestly, robbed by healthcare, put it back into a more balanced or corrected system. Community medicine taught me that's what we need to do, and I'm not proud to be part of that robber-baron mentality of the healthcare system of the late twentieth century. That's a downer note; I don't want to end on that.

THOMPSON: But I'll ask you a question, maybe to brag a little, because it's been mentioned by one of the other people that we've interviewed. But in reality, you may have come back and been involved in this creation of a community medicine school, the School of Community Medicine. But it really was what those four or five chairs were doing in 1976 at a place called the Tulsa Medical School.

DUFFY: You're right on target. You're right on target! And it was actually when Burr Lewis came back from his first RRC meeting, and he came up to me and said, "You know, you really know what you're doing." And that he realized that the vision of attending to the well-being of the community is what medicine is all about, honestly was part of that vision there. And that's

why I was excited to come back, because it was what I, why I came here in the first place. And will it end up? Yeah. This grant [the AHRQ Grant mentioned earlier], quite frankly, is even more exciting because it's putting the concept of community medicine into every single county of Oklahoma, and to the primary care practices of those counties. Much bigger impact than teaching twenty-five or thirty medical students.

THOMPSON: Just because of my work at the Health Sciences Center, you made a comment a little while ago about Dr. Mold, and I think he's been one of the more unique individuals in rural medicine in Oklahoma, at least from the Health Sciences Center side.

DUFFY: Wow. Jim Mold is truly one of my latter day heroes. I didn't know him very well as he was growing up in the University, nor did he know me very well. But we have been kind of soul mates on parallel tracks. And it wasn't until I got out of the political administrative scene, and the financial corporatization of medicine or corporatization of higher education, which has also occurred to the detriment of [the] student that I realized he is a truly unique and wonderful person who has really paid attention. As I've been thinking about community as a group of people in a city, or something, but not—I don't know the names of all the counties in Oklahoma—I do now, but I didn't know them before. And I didn't know what the county seat is, and all of that, but I do now. Jim Mold was out there, and he was paying attention to primary care doctors long before I was. I was in this ivory tower, and sure it was a Tulsa ivory tower, which is maybe not ivory, but maybe alabaster, but it was Jim who was out there really plowing the ground, and coming up with it. You said he was a leader in Oklahoma—he's a national leader. He is truly a national treasure. There are not a lot of national treasures that have come out of the University of Oklahoma during this past half-century, but he is one of them. And has been recognized for that. But his bringing this \$15 million AHRQ grant to Oklahoma and building upon that, some of the other things that have happened in the last, in the ten years that I've been back that I've experienced.

There are several other real superstars. One is David Kendrick in the health access network—MyHealth Access Network. University of Oklahoma has little appreciation of the hugeness of that enterprise, for two reasons: One is it was a community-based organization—didn't come out of a university, it didn't come out of a hospital; it came from the community. And it was based on this idea, which is a tentative community medicine, the collaborators are much stronger and better than any high-powered committee. And let's just have anybody who shows up to speak as a voice. So, David Kendrick put together this health information exchange. Jim Mold puts together the research in primary care, and the building primary care and quality together. And then the thing that I brought to that mix was my time in Philadelphia. I worked—I was on the national quality forum committee for designing performance measures, the national committee on quality assurance, and the ABIM and the American Board of Medical Specialties, introducing the idea of performance measurement into practice. So, these three things kind of come together

in Tulsa, Oklahoma, or Stroud, between Oklahoma City and Tulsa. These three units come together and begin to say, you know, this is where the world is going. What if we put those all together and built—and this is Jim Mold’s idea—an Oklahoma Primary Healthcare Extension System, just like the agricultural extension system, exactly a hundred years ago, was built? Why don’t we do that for healthcare, focusing on primary care physicians? And that’s what this grant is actually allowing us to do, and it’s truly remarkable because in my view, it will revolutionize continuing medical education. Don’t go off to Boston or Chicago to take a course and then not have any idea how to implement it into your practice. You have people who come into your practice and help you actually incorporate it. So, it’s hands-on practice transformation. Jim Mold [and] David Kendrick helping us to come up with the tools, informatics tools, the information data analysis tools, and then marrying that all together with quality improvement as a science that can be applied.

THOMPSON: Excellent. Another question because I think you did something that has changed in the Tulsa community over the forty years. When both the osteopathic school and the medical school started, you touched on it just a little bit earlier, but the attitude between DOs and MDs in the fifties and the sixties, and the current attitude between the DOs and MDs in our current healthcare system?

DUFFY: Burr Lewis helped me understand the origin of the conflict, and the origin of the conflict was 19—in the forties. It was during World War II. And during World War II, all physicians were drafted into the military, and I used the word drafted because World War II it wasn’t so much not wanting to go, it was definitely wanting to go, and DOs were ineligible; they were not considered to be medical doctors. Therefore, they were not recruited. The hard feelings that occurred was partially around that, but the main thing was an economic one. That meant that the osteopathic physicians were the physicians for the people left. The MDs took off, went off to war, and the osteopathic physicians were here. Now, how true that story is, that’s at least the mentality that carried forward. That wasn’t Burr Lewis’ generation. That’s just—he was growing up during that generation, but that obviously was told and passed down. And so there was a great animosity of competitiveness between the osteopathic and MD communities. That lasted well into the sixties, and then the competition became kind of fierce, belligerent competition. The osteopathic community was much better at mobilizing the rural county legislators, and, therefore, were able to get funding for activities done. That has passed away as about three generations of clinicians have moved on. And a couple of things have happened. First of all, the osteopathic—there is really no osteopathic medicine that’s separate from allopathic medicine. It’s one medicine, it’s the same, and the standardization across how you practice is so standard, you don’t have separate, and nor do the osteopathic physicians want to be separate. Do they teach osteopathic manipulation? Yes. Is it valuable? Yes. Is it something that is uniquely distinctive? Not particularly, it’s a form of musculoskeletal therapy that has value. What’s happened somewhere, whenever medicine switched from about 50 percent—well it used to be 30 percent

of physicians would go into specialties, and 70 percent would go into primary care, or general medicine. And osteopaths claimed that they were more like 90 percent going into general medicine and 10 percent going into specialties. Well, what's happened over the years, and it happened sometime when I was in Philadelphia, that really switched, and it was 70 percent were going into specialties, 30 percent into primary care. Now, in the past couple—past decade—it's actually dropped down to about 10 percent in primary care and 90 percent in specialties. And the osteopathic clinicians do exactly the same thing, so there's no difference. And almost all of the specialty training programs are MD training programs, so the DOs take training in the MD programs and become certified in the American Board of Medical Specialties programs. So as far as the hospitals are concerned, anybody in the corporate world, there is no difference between an MD and a DO, and quite frankly for the graduates of the past twenty, twenty-five years, there is no difference whatsoever. And so, it's more historical animosity that almost takes on a religious warfare kind of controversy rather than anything substantive in medicine.

THOMPSON: Anything else you want to say?

DUFFY: It has been without a doubt the greatest blessing I can imagine getting to be able to spend a career in Oklahoma. I never would have imagined it growing up, at all, that I would have spent an entire career here, but the opportunity to swim upstream has been absolutely spectacular. And the opportunity to be in a number of places at a number of times when important decisions of the moment were being made that will probably have, simply have, asterisks in history as we _____ (??). It's been a good way to spend a life.

THOMPSON: My comment would be that Oklahoma was lucky that you came to Oklahoma. (Duffy laughs) That would be my comment and observation.

DUFFY: Well, thank you. You're very kind.

THOMPSON: Well, we appreciate it. Thank you very much.

End of interview.