EPISODE 28

[INTRO]

[00:00:06] ANNOUNCER: You are listening to 10,000 Swamp Leaders, leadership conversations that explore adapting and thriving in a complex world, with Rick Torseth and guests.

[EPISODE]

[00:00:19] RT: Hi, everybody. Just Rick Torseth, and this is 10,000 Swamp Leaders, a podcast where we have conversations with people who've made a decision to lead in the world and, in particular, a decision to lead in areas, in arenas that are quite messy and complicated, and test the mettle of people who are choosing to lead.

Today, I have an honor to have a guest on, Terry Rogers, MD, who we're going to talk to from several different angles. Terry, welcome to 10,000 Swamp Leaders. I'm very glad to have you here.

[00:00:51] TR: Thanks, Rick. It's kind of you to invite drive me.

[00:00:54] RT: You're welcome. So for those of you who are regular listeners, I come to know Terry quite recently through a conversation and referral by John Scherer, who I've known for a while, who Terry's known for quite a while. John told me off recording that I needed to talk to Terry. In fact, I recorded Terry. I think you remember. I recorded this episode while he was in your house. So I didn't have very far to go to find Terry, and I'm sure glad John recommended him to me because I think, Terry, you've got a great story, an important story that I want to help spread.

So I'm going to ask you to begin with is, for our listeners, what is important for them to know about you before we get into any more details about your career and your life and your work?

[00:01:37] TR: Yeah. Well, I think maybe, and this just comes to mind at the moment, it's the juxtaposition of an objective science-based occupation with the involvement with the fine arts. I didn't actually plan to do this. But in college, I knew I wanted to go to medical school, but I did not want to major in a science. So I was actually a fine arts major, and I took my prerequisites or some of them in summer school for two summers to satisfy the criteria for getting into medical school.

So as I reflect back on it in the moment, right, in this moment, it's like how do these two disciplines, if you will, work together in a way that enhances both of them and, hopefully, enhances those people that I interact with and with whom I surround myself. That's been sort of the reality for me for many, many years. I enjoy visual arts. I'm not particularly gifted in visual arts, but I enjoy other people's productions. I've been involved for leading a traditional Dixieland jazz band for the past 40 years.

More recently, in the past few years, I've worked pretty hard at my art of photography, particularly doing portraits. So I think if it were to be distilled down to what is this guy all about, it'd just be the balance of the science and the art.

[00:02:59] RT: Thank you for that. I did a little digging, and I learned that perhaps this has got some genetic history to it as well from your father, who was an engineer and also a lover of art and a bit of an artist himself. Is there a fair connection there do you think?

[00:03:14] TR: Yeah. I'm afraid that the apple doesn't fall too far from the tree in this instance. My dad was a very smart guy. He was an engineer but also gifted as an artist. He sang. He played instruments. He was a good oil painter, much better than I could possibly have done, and was a curious and intelligent person. He had lots of interests. He put together his own printing press. In his later years, he was into archery, was into raising birds. It goes on and on. Yeah. So good for you, Rick. You caught the connection.

[00:03:50] RT: And we should say, for your listeners, they know that I have a long history in Seattle, but you've been in Seattle for quite a long time too. So I'm familiar with the organizations that you have spent time in. I'm just really caught up by this, Terry, that you did the calculation here. A large hospital in Seattle, 15 years, elder care field for 10 years, a not-for-

profit for 10 years, and then 20 years at an alcohol and drug and rehabilitation center. I make that out to be about 55 years of service in varying platforms here.

So you did art to get into medical school. That is really unusual to me to start with. I may be sort of stuck with my art classes. But what drew you to the medical world, first and foremost? What was that about, and how's it turned out for you 55 years later?

[00:04:39] TR: Yeah. That's a reasonable question. I had an uncle who was a surgeon with whom I had virtually no contact. He was a surgeon who went to Europe in the Second World War and actually stayed in Paris, became head surgeon at the American Hospital in Paris. I never met him until late in his life, actually. My family was all – My dad and my brother are engineers. My mother and my two sisters were teachers. I had toyed with the idea of becoming a music teacher, actually. I really have involved in music.

During my – At the end of my junior year in high school, I was chosen to represent the US in a program sending scouts. I was active in the Boy Scouts and become an Eagle Scout and was chosen to represent US in a program, spending six weeks in Europe. One of the young mentors in that program was a person who was in medical school at the time, and I got to know him pretty well, became quite friendly. It occurred to me, “Hey, maybe this is what I should be doing.” So from that point on, that's kind of where I pointed myself.

[00:05:47] RT: Then you get through medical school, and you become a doctor. You went to Cornell. So help us get from Cornell to Seattle. Where did you begin, and what was that like?

[00:05:58] TR: Right. So just a word about Cornell, at least I think it's important. My grades in college were okay but not superb, and I had sort of a varied background. I was fortunate to come down for an interview at Cornell and met at the time the dean and director of admissions, who was a person who understood or was willing to take gambles on people who didn't have a strict scientific background.

Our class, actually, had a number of people like that. We had an engineer from Stevens Tech. We had a concert pianist from Yale, who, after a distinguished orthopedic career, went back to music school and is now in his 80s, performing Mozart concertos with orchestras, that sort of

thing. So he saw something in me, and I've always been grateful for that. We became good friends, and I have a gratefulness about that.

I interned in Philadelphia. At the end of my internship, I was obligated going to service. This was in the late ‘60s, where every male physician was conscripted into the service. I don't know if people understood that, but you couldn't not go into service. So I chose to go on the Air Force, and I had one year of residency to spend before I was obligated to present myself. I had a handful of friends who had gone to Seattle, University of Washington, for training.

My dad, actually, was an engineer for the Boy Scouts of America, and his area of supervision was the Northwest. He'd always come back with stories of Seattle and the Northwest. So I pulled the stringer June and was accepted into the University of Washington Program. I came out for a year. Then I went into service for two years as a flight surgeon and came back to Seattle to finish my training in internal medicine and then in pulmonary and critical care medicine.

Then finishing that in 1973, I had a lot of trouble deciding where I was going to go work. So I eventually accepted a position at Springfield Hospital in Springfield, Massachusetts. Thinking of being back on the East Coast, closer to family, was the right thing to do. After a little less than two years, it was – I had been offered then a job to come back to Seattle. After some pondering, and some teeth gnashing, we decided to come back. So I've been here ever since, and I've never looked back, actually.

[00:08:15] RT: So take us through a little bit your medical career, and then I do want to make a jump. Because somewhere in there, probably early on, but somewhere in there, you begin to become a manager and a leader in these organizations. I would like to touch a little bit on your learnings and your experience in that role inside the medical world because, as you know, we're discussing that's a bit of the focus of this conversation and this podcast.

There's another piece we want to bring into play here. But just walk us through a little bit about your journey as a physician. Maybe bridge for us where you start to find yourself in positions of having authority and leading capacities in these organizations.

[00:08:53] TR: Yeah, thanks. It's hard to put it all together. But there are little pieces that I think makes sense when looking back on it from this vantage point. When I came back to Seattle, I decided I wanted to specialize in lung disease and its associated critical care piece. That was a very nascent sort of specialty at that time. Modern critical care medicine really never started until the reality. So the Vietnam conflict where very sick and acutely injured soldiers were able to get to tertiary care in a very short period of time. So a lot was learned about acute care medicine at that time, and I was drawn to it for that.

For another reason, at the time, when I first trained here in Seattle, there was a tuberculosis sanitarium. That was part of our training. We don't think about that now. But 40 or 50 years ago, 60 years ago, there was a hospital that once had almost 2,000 patients in it with tuberculosis. Yeah. So anyway, that was sort of the start of it.

When I went into service, I was a flight surgeon in a short period of time. I was in charge of six docs or seven docs in our base. So that was a bit of a leadership, a dip into the realities of the same. When I came back to Seattle to finish my training, I went to Springfield and then came back to Seattle. I joined a multispecialty clinic. At the time, I was the 21st physician in that clinic. It now has about 250 physicians. But that's way back when.

After, as we decided to or as we addressed the issue of growing as a clinic and as a presence in Seattle, I became president of that clinic through a major building program. It's interesting when you think about I didn't necessarily plan this at the time. But here's something that happened that I think is relevant to our conversation today. There was the president of the clinic, who, in addition to doing all his practice work, was good at president stuff also. But we had a little executive committee, so who we would meet on a weekly basis.

One of my colleagues, for lack of a better word, was sort of a doubting Thomas, sort of dart throwing, “I don't like this sort of thing,” critical person. When I – It was a struggle for the clinic to respond to that person's approach to being part of the clinic. So in a moment of perhaps inspiration, perhaps frustration, I'm not quite sure, I went to visit him, and I said, “Bob, I'm going to be president of the clinic, and I want you to be on the executive committee.” He said, “What?” He said, “All I do is be critical.” I said, “Great. That's what I want you to do. I want you to be part of the executive committee.”

It was a learning experience for me. I'd love to tell you that it all went smoothly. It didn't, but it went okay, and it was a lesson for me about, you know, there may be an element of truth, and there probably is an element of truth and whatever. To have this balance of the people who were saying yes and yes, with someone who has been critical of and makes a living doing that, it was a learning issue for me, and I appreciated that. We did okay. We continued to expand and to do things that we needed to do.

[00:12:06] RT: I'm just curious to that experience and having that critical voice inside a collective, where, as you say, a lot of times, people can be, yes, people to the leader. Is that a kind of framework that you carried with you over your career? Was that something that you paid attention to and sought out?

[00:12:20] TR: Yeah. Actually, it did. I spent 15 years in the clinic. I left **[inaudible 00:12:26]** and I had – In the meantime, I also spent half of my time at the major hospital, running the division of respiratory and critical care, which oftentimes is a challenge to particularly with addressing physician behavior. We're not very good at that within the medical profession of pointing out and saying, “Hey, Joe. You really shouldn't be doing this.” It's an issue that’s still present today. I’m sorry that it is, but that is the way it is.

So I had the opportunity to interact with those who either were behaving in a way that was not particularly beneficial or helpful to those around them, but to seek them out and to see what was really going on over there. What’s it that led them to either behave or interact in ways that were not seen by others as positive? I think it has been helpful. Then when I was recruited to go down and work for the insurance company.

By the way, some of those jobs that you outlined were concurrent. So it was not one then to the next and then to the next. I'm thinking particularly with a person who was running our claims department. Now, the insurance company was a fairly large outfit. We, back in the early ‘90s, were a billion dollar company. We're spending five to six million dollars a day on health care. So it was not insubstantial.

The vice president of claims was very by the book, rules-oriented, strict, and had interest in everyone else's business. I used to call him the vice president of everything. I'd send a memo to one person, and somehow he'd hear about it and comment on it. So finally, I brought him in and I said, “Joe.” His name wasn't Joe, but I said, “Joe, look. I know that you have a lot of experience in many things in your insurance environment that could benefit that experience, could be a benefit to many of us. The way you present it, however, is not working for most people who receive unsolicited comments. What if you were to set up an educational seminar, where you offered to address a topic? Send out an invitation. If people wanted to come here, then that's a terrific way for you to impart your experience and your information to people who could use it but who, otherwise, get put off by the way you've been approaching?”

He said, “Oh, yeah. That's a pretty good idea,” which he did, and it worked. We actually became very good friends. In a small venture later, small business venture partners. So, yeah, I think you may not like the style of someone who is being critical or observant of ways in which you do it. You may not like the content. But hidden in there may be something that is valuable, not only for you but the organization that you represent.

[00:15:03] RT: So, Terry, this is, I think, a really useful place to take a pause and maybe pull from you that small bit of knowledge or wisdom or experience that recognizes those kinds of distinctions in people. Because I think that a lot of times, people can be really put off by the irritating behavioral part that is reoccurring and block out everything and just not see it. So given that we have people who listen to this, who are further back on the journey than you and I are, what advice or what kind of coaching do you have for those people about how they can help themselves to hear the subtlety of the value of a difficult conversation or a difficult complaint and pull out of it? What's useful there? What's the trick? What's the thing you're doing there?

[00:15:47] TR: Yeah. So let me take you back to one of the first – I think it was one of the first nights that I was an intern in Philadelphia. We had a fairly skeleton crew. When we were assigned to the emergency room, as an intern, so you're two or three months out of medical school, and you're the only physician that you can call on a surgeon or somebody to come down and see a patient.

I'll get to answering your question. It's part of the story. One Friday afternoon, a woman came in. A husband brought his wife, and she had been struck as a pedestrian by a car in a crosswalk, and her leg hurt. So I examined her, and there was no visible outside damage and whatever. I thought she was just bruised, and I said, “Look. I think you're going to be okay,” and sent her home. I didn't consult the orthopedist. I didn’t consult the surgeon. I didn't do an X-ray. I just thought, “Hey, I know.”

So Friday nights pretend to be quite busy in that emergency room. We were the third busiest ER in the City of Philadelphia, actually. Around eight o'clock or so, I got a call from her husband saying, “You know, Judy's leg is really hurting.” I said, “Well,” whatever, whatever, and I pulled the, “I'm the doctor, and I know best,” kind of play, right? I said, “Well, I know. [**inaudible 00:17:04]**. But if you want to come back, yes, come back. We'll do what we can.” In the meantime, I was busy. They come back and waited four or five hours and got an X-ray. Sure enough, the story is her leg was broken. Her bone was broken.

So one of the most common and useful varieties of nutrition for medicine is humble pie, and I’d sort of grabbled to them, and I was very apologetic. I said, “I'm really sorry, but I missed this earlier than I – You’ve had to wait so long, but you do it.” It was a broken fibula, so it was not the major bone. But nonetheless, it was broken. That was an extraordinary learning experience for me and has sustained me for quite some time, actually, is that when I find myself getting aggrieved or righteous about something reactive, I say, “Terry, slow down and stop. You are missing something here because –”

I've used this. I've been a full professor of clinical medicine at university, and I'd say this over and over and over again to entering residents and medical students. It's the worst kind of characteristic that you can have, the most dangerous, is certainty in medicine. Because once you're certain that this is what it is, you'd shut out the possibility of seeing what really is going on. So when I find myself being reactive and certain about something, I step back and say, “Okay.”

The other component is something that John Scherer taught me, and perhaps he mentioned it in your conversation with him, is that when you are reactive about somebody or something,

because we all have those people in our lives, stop and ask the question. What is it that they get that you wish you had more of?

[00:18:49] RT: I've heard him say that before. That's not what I thought you're going to say. I'm glad you did.

[00:18:53] TR: Yeah. It's like there's a part of me. Without going into the John's program and so forth, but he talks about you wake up and boot up in the morning. You become this person automatically that you want people to think of you in positive and helpful and complementary ways. So that we don't want to be seen as something who is at the opposite end of the spectrum, like we're mean or we're insensitive or we're hurtful or whatever.

But the fact remains that we have all of those characteristics within us and that there's something to be learned from the negative side that can help us be more potent, more effective, more capable on our good side, if you will. It's sort of a two-minute piece about that. But that's exactly right. It's like, okay, if I'm reacting to somebody, I sit back and ask what am I missing, and how can I be helpful about that.

[00:19:47] RT: So let's integrate some art into this world of medicine and leadership because I suspect in doing my bit of homework and reading about your history that all along, there's been at least a soft song line of some kind of exploration of art and creativity and imagery and etc. Is that a safe assumption to start with?

[00:20:09] TR: Yeah, I think so. I've always been involved in music. We had a really strong music program in our public school system in a small town in New Jersey, where the band and orchestra and chorus work was celebrated in supporting. So from – I'm the youngest of four, Rick. My sisters and my brother were all involved in music. They all played in the band with instruments. So my dad loved music. He had Beethoven symphonies and opera that he would play.

I mean, I remember growing up listening to the Triumphal March of Aida, and all I wanted to do was I wanted to baton because I wanted to be a conductor, right? In fact, there was a music

store in Concord, New Hampshire. I was, what, seven years old, maybe six or seven. I go down and look in the music store window, and there is this baton. I love one of those.

So music was always there. Playing the band, did chorus in high school and in college. When I was in medical school, I sang in a chorale for four or five years. I was there. We sang in Philadelphia. So, yes, it's been there.

[00:21:18] RT: Where did the camera come into your life, in photography?

[00:21:21] TR: I have to blame my father, once again. He was a good photographer, actually, back in the day. I think he gave me or I had access to an old Leica way back when. In the medical school, I had a Leica and a Rolleiflex, both of which were stolen from my dorm room. So I used to do street photography in New York City, and I'd come – I'd have the film, just in contact prints. They developed film for me. Then I'd take that film, and I learned somehow. I figured this out that the pathology department had dark room. So on Saturday night, when nobody was there, I'd sneak over to the dark room and make my prints and carried on that way. I just discovered some of them not too long ago. It was kind of fun.

When I went into service, I bought a nice camera in a PX in Germany. Actually, it was – I bought a Japanese camera and did family photos off and on, as the kids grew up, but never really got back into it, Rick, until about a little less than 15 years ago. So I've been married twice. I have three adult children in their 50s. I have six grandchildren, two of whom are out of college, one in college, two in high school, one in middle school.

Karen and I, my second wife, had two children. I have a daughter who's 34, is an ICU nurse at Cedars-Sinai in Los Angeles, and had a son, Luke, who we lost at age 19 in a boating accident. Luke was the artist. He was a very gifted vocalist, a visual artist. He could draw and paint and sculpt, and a really good photographer. When I – He was a senior in high school. I bought him a Nikon. When he died, I inherited his camera. This was 14 years ago, and I started shooting again, just a little casually and then a little more seriously.

I decided I needed to learn more about photography. It's a discipline, where the more you learn, the deeper your hole of ignorance becomes. So I did YouTube's online courses and in-person

courses and did many sessions at a studio north of us, where you can rent time for an hour or so with models and learn lighting and all of that. I did a couple of trips. My brother and I went to Cuba. Then I did a trip to the Eastern Sierras and then a more extended trip with a group in southwest. A

It was during that trip that it occurred to me that I was more interested in actually capturing images of the people who are on the trip than I was of capturing the geography of the trip itself. It became evident to me that this was what I not only wanted to do but at some basic level needed to do. Thank you for accommodating me, just carrying on with his very long answer, but it all ties together.

One of my job's positions had been as a medical director of a unique way of caring for frail, elderly people. It's a wonderful program. I offered to do some portraits of their workers, which then expanded into doing portraits of the participants, and that expanded into other programs associated with this provenance system. So I ended up over time doing a couple thousand portraits, actually, of elder people and their caretakers. By that time, the die was cast. I mean, there was no turning back, and it's just gone on from there.

As the medical director of the program, the drug and alcohol treatment program that I did for 20 years, I started to offer portraits right at the beginning of the pandemic and then had to be shut down. After the pandemic was mostly over, I started again a year or so ago, and those are some of the images that you've seen.

[00:25:02] RT: Yeah. So let's talk about it a little bit. This was the point where John, in my conversation with him, thought that you and I should talk. He told me about the book and the portraits. I, honestly, didn't really fully understand, therefore appreciate, what he was trying to convey because I don't think words actually captured the images. Then you and I exchanged, and you sent me a PDF version or a portion of the book.

I find that very arresting, and may I ask you to explain the book? What I will say as a starting point is it was stunning to me to see the before and after pictures of these people. For some reasons, we can get into here beyond just photography, I think. But tell people what it is that the book contains. I also think useful is what did you see that led you to this? Because imagine the

first portraits – I mean, something's going on there that you saw and understood there was something here happening that was useful for them, much less when you turn it into a book or not.

[00:26:06] TR: Right. Where to start? So let me start, Rick, by talking a little bit about substance abuse and addiction. It's a polarizing topic for many people. But I think it's fair to say that there isn't anybody who is listening to this podcast, whose life has not been impacted by drug and alcohol use, a sibling, a coworker, a parent, another relative, a neighbor, a church goer, whatever. I mean, it's a ubiquitous and all too present issue.

I got started in the field of addiction medicine almost by chance. I was asked to consult with this organization because they were having a struggle with the insurance company that I used to work for. At the end of that successful consulting gig, the CEO said, “Terry, I'd like you to become our medical director.” I said, “No, I don't want to do that.” He said, “Why not?” I said, “Well, I don't want to work full-time, and I don't want to do any clinical medicine.” He said, “Well, how about if I pay you for 10 hours a week to be our medical director, and you hire ARNPs to do the clinical work?” I said, “I'll try it for three months.” That was 1990 or ’91. Sorry, ‘99 or 2000.

For 15 years, Rick, I didn't actually see patients. It wasn't until about five years ago that our then medical person went off to practice solo, and he asked me to step in and start seeing patients. So I've been seeing patients again for the last five years or so. The treatment of this disease, and it is a disease, it rests upon education, counseling, person-to-person contact, movies, lectures, whatever. It sets the stage. It's an educational and supportive sort of process. The ultimate success is measured or is attained not so much by absorbing all this information and saying, “Oh, yeah. I got it. I'm this kind of doc. I don’t do this anymore.”

I think it's a lot more powerful and a lot more primitive than that. There's something that has to happen inside that person's head. There's a little switch that has to go from one side to the other side. I'm a drinker. I'm a drinker. I’m a drinker. Click. I'm a non-drinker. I'm a non-drinker. I'm a non-drinker. We don't have – As therapists or as teachers or whatever, we have no control over that switch. I don't think the person themselves have a conscious control over it also. But there's something that's there. When it happens, it's like, “Yeah, I'm done. Not doing this anymore.”

I mean, the hardest fact is that all substances which are abused, and particularly alcohol, are toxic poisons. There is virtually no benefit to the human body to be exposed to toxic poison. So it was in that setting that I started seeing patients again and seeing what was going on with them. So the book is actually a picture book. When patients are admitted to our 28-day program – And why 28 days? There's no magic. It's because people won't pay for more. They have a very primitive mug shot taken with a point-and-shoot camera, which is for ID purposes. So it goes on their chart. It goes in the counseling center. So people know who. So we have about 85 or 90 in-patients at any time.

I would see somebody. I didn't get somebody on March 2nd, and I wouldn't actually see them again, formally. But I might run into them on a hall three weeks later. I said, “Oh, my goodness. George, look at you. You've just looked so much different.” It’s about that time that my interest in doing portraits. I was really quite drawn to wanting to do capture the human face. There's something so powerful about this.

Then I talk to a couple patients. I said, “Would you be at all interested in sitting for me, so I can take your portrait?” It’s the time the administrator was a woman who was not particularly supportive. In fact, she, after I did it, a dozen or so patients, said, “You can't do this anymore.” It’s a side story but it coincided with the start of the pandemic, so whatever. But when I saw them and I presented the pictures to them, so what I do is I'll have them sit through their portrait. I'll take anywhere between 30 or 40 images quick, quick, quick, quick in different positions, whatever. I'll pick the one that I think represents two they are.

Generally, think I do a pretty good job of getting the right one. I will then print that one in black and white, and I'll print their mug shot, which is a little blurry color one, and I'll give them a copy of each of them. When I do that, it's a moment of – I don't know how else to say it. They're generally stunned. They either will say, “Oh, my God. Look at this.” Or they'll not say anything, or they'll start to cry. Then, of course, I have to have a tear or two also.

So once you drink that nectar, once I drink that nectar, I'm screwed. I can't not do this anymore. I put the first few – The book images that you saw from the first 100 or so, I started this project in the mid-September, just a little over a year ago. To date, I've done 550 patients.

[00:30:55] RT: 550 patients in a year.

[00:30:58] TR: Yes. Yes.

[00:31:00] RT: Oh, my goodness.

[00:31:01] TR: Yeah. There's no end in sight. What's happened is it's become part of the therapy program. I'll share a very personal story with you. Our 34-year-old daughter got married this summer. She's a hardworking, really good post-open heart surgery nurse and a very busy intensive care unit. She got into nursing a little bit later in life. She had worked in business and whatever and decided she wanted to go to nursing. So she had to take her prereqs and then go to nursing school, whatever, whatever.

About five weeks ago, a Friday afternoon, she was to come to Seattle to help drive her friend from Seattle to Portland. She called in to stress from the airport in Los Angeles in Burbank. She was in tears, distraught. I said, "**[inaudible 00:31:46].**What's up?" She said, "Dad, I need help. I've been abusing Adderall, alcohol, and marijuana." A smart doctor that I am, actually, I knew that she like beer and wine. But I had no idea that this was where she was in her life.

So within an hour, I had her phone evaluation, and she was admitted to a program down there on the following Monday. I had given her a physical copy of this book, and she told me in a note about three weeks ago, she said, "Dad, I have to tell you, I was waffling about being admitted. Well, maybe I'm not that bad. Maybe I can control this," whatever, whatever. She said, "My husband took the book that you had given us and sat me down and held me. And we looked at those pictures." She said, "I want to be one of those black and whites."

So I told that story to the president of our organization, and he immediately ordered a dozen books and have them now in each outpatient office as an incentive, as a visual representation of what's possible. When I give these people their pictures, I tell them, "You've got a choice. Which of these two people do you want to be?" That is something over which you do have some control. So it's become, as I say, an important part of the therapy progression, the incentive, and for some the reward. It doesn't mean that they are cured. There is no cure.

I've been sober, Rick, for 40 years. I woke up one morning, 40 years ago, and said, “I don't want to be this person. I don't want to do this anymore.” So I haven't had a drink in 40 years. I don't think I've missed anything. I'd love to tell you that the temptation goes away. It doesn't. It's not overwhelming, but it's there, occasionally. You just learn to dance with it. It's like, “Ah. Yeah, cool. It's there, big deal.” So anything that can add to the attachment to commitment to living a full life without additive chemicals and particularly those that are, quite frankly, poisonous, is, for me, quite rewarding.

I consider it an enormous gift and a part of people, many of whom I don't know, will have met only – I mean, I do – I was there last – I go every Wednesday to offer to do portraits. I did 13 people in an hour. They're in and out. I mean, look at the pattern down and so forth and so on. But in that moment, at some point in that exposure to them, they're willing to actually show me exactly who they are and let me capture that. I consider that a very, very special gift to me.

[00:34:16] RT: So the limitation of podcasts is it's all audio.

[00:34:20] TR: I know.

[00:34:21] RT: So I'm going to tell people who are listening that I will put into the show notes of the podcast your website. If you have other information about how they can find the book, then you can give that to me, and we'll put that in the show notes, so people can – I say that for two reasons. One is as I was going through them, the difference that you're describing is sometimes shocking for me and almost incomprehensible, those only 28 days to get from the first image to the second image. I thought whatever's going on in this program or whatever these people are doing for themselves in this program is phenomenal for 28 days. To be able to capture that point at the end, it’s just brilliant.

The other thing that popped up for me is just I grew up in Bremerton, and I just about two months ago had a conversation. I was together with four men that I played high school basketball with **[inaudible 00:35:16]** Bremerton, and we were so blessed to win two state championships. So these people have been in my life way before basketball, but continued to be in my life since then. Four of us grew up in the same neighborhood, within 100 yards of each

other. We were just talking about the degree of alcoholism that existed in the adult community in our small neighborhood.

Just to go down the list was stunning, and that list included my father, as well, eventually, as my mother. So my mother went through recovery. My father never did. I got to say, I saw my mom in every one of those pictures, and that was – I just thought what a gift to provide these people. Because I would imagine, a story I make up, and you can clean me up if I'm off, is if I've traveled that road, and then I'm in this program for 28 days, and I see these pictures before and after, I truly have at least an icon of how I can stay this way because it's me in an image. That's got to be helpful to them, I would think.

[00:36:25] TR: I would think so also. I don't hear back from many of them. But of those with whom I've had some contact say, "I put the old one and I put the new one up on my mirror. And I look at it every morning as an incentive, as a reminder of what I could be." Yeah. You mentioned, we grew up in a time, and you're probably a bit younger than I am. But I remember that there were advertisements of the family in the Saturday Evening Post of the family sitting around the table and everybody having a glass of beer. In front of it says, "Beer belongs. Enjoy it."

Well, yeah. It is not that there was just decades of this it goes back millennia. I mean, what is it Jesus made when he's given water? He made 12 proof wine, right? It goes back a long, long ways, and it's really sad. I was thinking of a wedding, **[inaudible 00:37:16]** wedding. It was a lovely affair. We have a little place in Hood River, and she got married in a place down there. People, families flew in, and one of them brought some COVID with him. So the irony is we sit around, and we wander, we marvel, and we complement this wonderful couple and wished them well in their journey through life. So in honor of all that, let's all stand and raise a glass of poison and drink to their health.

I'm not an evangelist, but I'm a realist. It's like, look, there is – The other thing you were talking about, your family situation, how your mom sort of regained who she was, and your dad probably didn't. I think one of the most potent effects of abuse like this is it chews away relentlessly one's sense of self-respect. You get up in the morning, look in the mirror, and say, "Oh, shit. Did I do this again," right? Oftentimes, people in that position have nowhere to turn.

They have no readily available button they can push to make things all better. There's a certain hopelessness about it. I do this over and over again, and I can't seem to stop.

That's not even talking about the latest scourge in which is going to get worse before it gets better of fentanyl and its availability across communities and so forth. But if you can give them the opportunity to gain back a little respect and admiration for who they are, essentially, as human beings, and, “Show me how to do that. Let me in. I'm ready to do that.” I must say it's positive feedback for me. If I go over there, I have no idea how many people I’ll shoot. I offer this to them. It’s completely up to them. They volunteer to have their picture taken. There's no coercion involved, whatsoever.

So I'll show up on a Wednesday. I may do five people. I may do 20. But whoever shows up gives me something that I find really necessary to keep on going.

[00:39:07] RT: Terry Rogers, I think you're – I think it's probably a fair exchange. I think they're posting pictures on their bathroom when here is an indication to gift.

[00:39:17] TR: You know, Rick, thank you for that. I kind of tell you that John and I have talked about this issue. John is extraordinarily gifted as a counselor, teacher, mentor, program runner. I mean, he has just this natural gift. One of the dangers of being really good at something naturally is that the person who has that gift doesn't know how powerful it is because it's just who they are. I mean, my son, Luke, was just a gifted illustration. He used to draw or paint or whatever. He'd sit down, and he would be drawing something. As a kid, he always had a paper and pencil with him to draw, and his sister would look at him and sometimes even get mad at him. “Damn it, Luke. How can you do that?” Well, Luke had no idea how he did it. He just did it, right?

The danger of that is that you may lose the opportunity to parlay that into something that's even better. So one of the lessons that I've had to learn here is the reverse lesson. I don't know about you, but I have trouble with, I'll just say the word, phony. It's people who present themselves as more than they really are for whatever reason. We all had, I don’t know, cows, cowboy, right? The flip side of that is equally as disturbing are those who present themselves as less than who they are.

So one of the things that I have had to somewhat reluctantly embrace is, yes, there's something about Terry Rogers that allows people to relax and be who they are in front of them. That's been a hard thing to embrace that I'm really good at this. Because we're taught, “Oh, you can't brag. You can't test,” or whatever. But in so doing, you lose the possibility of enhancing the special gift that each of us has, in one way or another. There's no value in saying, “Oh, shucks. It's nothing.” No value to anyone. It's sort of like taking the lid off. Let your light shine sort of thing.

So yeah, I am good at this. So when people come in and say, “Oh, I don't know. I take a really bad picture.” I said, “Well, I'm glad that's true. But I take a really good one. Will you sit right here, please?”

[00:41:27] RT: Terry, is it fair to say? I mean, you're 86. Is that correct?

[00:41:31] TR: 83.

[00:41:32] RT: 83. Sorry, sorry.

[00:41:34] TR: No problem.

[00:41:34] RT: But this insight of what you're really good at through this photography experience, is this a new insight based on this work? Or is it been lurking there for years, and it's just sort of kept it off?

[00:41:48] TR: Yeah. I think it's been lurking. I've had many interests in whatever. People say, “Oh, is there anything you don't do?” I've led this, I've done this, and I had musician in life, lead a band, and I – Whatever, whatever. I'm a pretty good auto mechanic. But when it really comes to what is fundamentally fulfilling for you, there is no value in suppressing the acceptance of that skill by yourself because you can only enhance what it is you offer others. Simple as that.

[00:42:19] RT: Well, this is, I think, a place to stop. I truly appreciate you making time for the listeners, for myself, but mostly for the gift that you've been giving these people through your

photography. We will let everybody know how they can find the book, I guess, and it's available for Christmas. Can we be as slightly –

[00:42:39] TR: Commercial?

[00:42:40] RT: Commercial.

[00:42:41] TR: Yeah, right. So the website to purchase it, if you have any interest, or you can actually even just have access to the PDF, is Blurb, B-L-U-R-B, blurb.com. It's an online self-publishing company, and the book is called *Faces of Recovery.*

[00:42:58] RT: Okay. So this information, I'll put it in the show notes. So when the podcast is released, they can find it. They can click it. They can chase it down. I'm going to just encourage you to do that because, you didn't say this, Terry, but in addition to the stark change in the pictures, the pictures themselves are just fabulous. The imagery you're taking is just wonderful. So there's a lot of art inside this as well that I think is worth holding on to for people.

Terry Rogers, thank you very much for visiting me in the Swamp. I truly appreciate it.

[00:43:29] TR: It's been my pleasure. I'm honored to do so, Rick. I really, really, really appreciate it. Thank you.

[00:43:34] RT: Thank you.

[OUTRO]

[00:43:38] ANNOUNCER: Thank you for listening to 10,000 Swamp Leaders, with Rick Torseth. Please take this moment and hit subscribe to follow more leadership swamp conversations.

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