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Douglas Durko interview (2) conducted on May 8, 1985 about the Boonshoft School of Medicine at Wright State University

Douglas Durko

James St. Peter

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WRIGHT STATE UNIVERSITY
School of Medicine Oral History Project

Interview Information

Interview date: May 8, 1985
Interviewer: James St. Peter
Interviewee: Douglas R. Durko, Associate Dean for Hospital Affairs
Interview 2

Interview Transcript

[Beginning of recorded material]

J.S.: My name is James St. Peter and this is a second in the series of interviews with Douglas R. Durko, Associate Dean for Hospital Affairs in the Wright State University School of Medicine. This date is May 8th, 1985. The time is two o'clock pm. Mr. Durko and I are in room 110D of the Medical Sciences building here at Wright State University.

Mr. Durko one of the things that I would like to discuss in particular about the operations of this office, the Office for Hospital Affairs, is your interactions with some of the particular development offices of Wright State. One of those is the University Medical Services Association. The practice plan for the hospital. What is your relationship between your office and that office?

D.D.: Those individuals who are associated most during this discussion with UMSA, which is the acronym for the office opposed to the full name of the organization, the one thing that we have in common, the bases in common, is that the largest part of the revenue generated through the faculty practice plan is by, takes place, as a result or comes in as a result of the clinical activities of are fully affiliated faculty in the clinical departments. In that all the clinical department are out in the community affected institutions. UMSA has reason to interact with the same people I do, for different reasons. Often the director of UMSA and I will go together on a particular issue. Especially if it involves putting a package together for the purposes of recruiting somebody into the School of Medicine from outside of the area for a faculty slot. This is one of matrix with the hospital expands and it could take all kind of forms. It could take the form of us saying to the hospital or the hospital says to us it will take this pot of money to get this individual here to fulfill a school or hospital function. One will agree upon that and depending on the specialty the pot of money may be of such that it would unrealistic to pay all of that through a

university salary and fringe benefit program and let's say that it is someone in a super specialty that demands...

J.S.: Surgery?

D.D.: Probably even more specialized than surgery.

J.S.: Thoracic surgery?

D.D.: Physiatry or GYN Oncology which is surgery. Perinatologist in terms of maternal fetal medicine and maybe the package that is needed to get someone here is one hundred and forty thousand dollars. Well, Allyn Hall, among others, and Columbus, you know, is not going to write a contract for one hundred and forty thousand dollars. On the other hand, that individual should receive from the university side an amount that is reasonable for somebody with their academic rank and academic background and should share in that responsibility to get them the rest of the way. That could take form of them having sole responsibility or primary responsibility over a clinical activity in a hospital. Perinatologist are responsible for all diagnostic ultrasounds done in obstetrics. Therefore, can bill for all of the professional components for all the diagnostic ultrasounds that are done in OB in a particular institution. Well there may be some question, especially if it is a newly developing program, about whether or not that individual – there will be no question about what will be done in two years – but can't be done on day one. So, when I put together a package that include a two-year guarantee against income and if they fall short the hospital has made that guarantee through USMA. If they go over a certain point it is a moot point.

The other kinds of things that may be involved is that in our matrix function they will have a medical administrative responsibility. Go back to Perinatology. Again, I am talking about a real-life case with Dr. Hildebrandt. Dr. Hildebrandt, in addition to being a professor in the department of OBGYN, in the Department of OBGYN he is also the head of are department's Division of Obstetrics. At the hospital he also holds the title of the Medical Director of the Miami Valley Hospital's Macintyre Perinatology Center. So, they may say for this medical administration we will pay to Dr. Hildebrandt x-amount of dollars and that will go into the practice plan which is one of the three formed formulas set up to handle that kind of thing. Then there is also reimbursement coming to him.

J.S.: What is the largest range that you have experienced so far in contract negotiations with individuals for subspecialties?

D.D.: In terms of dollar amounts? I don't know if ever reached one hundred and fifty thousand.

J.S.: Are there joint contracts between the School of Medicine and UMSA?

D.D.: Not at this point in time. There is a system that will allow dollars to come from, well dollars currently come from – the Dean and others can tell you about how dollars come from UMSA to support scholarship activities, developmental funds, and those other kinds of things that I am not familiar with. In terms of the school contracting with UMSA for services, that has not been realistic up until this point. It will be soon. Mechanisms have been put into place where major cost items can be paid for out of earnings. This includes another faculty member, a surgeon scrub nurse, and rent space, before UMSA overheads are taken out. Therefore, I would guess that we would have, there is the potential for after June first for some of those kinds of contracts. I do not think that they will be great in number.

J.S.: When UMSA deals with the hospital and your office deal with the hospital, do you do that separately? Is there any overlap?

D.D.: To this point in time because of personalities, willingness to work, and responsibilities that has rarely, especially on the policy level, been done without me. There have been follow-ups done without me. Now if it is a pure UMSA issue that does not involve the school, I will not attend. There had been some of those occasions. But where it is a school driving the situation, a faculty position driving the situation, it is not our policy to let the tail wag the dog.

J.S.: How do you interact with specific departments out in the hospitals after the contracts are written up? Is there any day to day interaction?

D.D.: I would not call it day to day. It is item to item, and there's a lot of little things. Not only do I negotiate the contracts, I'll get phone calls, "Hey how do I get a recorder for this guy? How do I get a pager for this guy?" Get a call from a medical student that says, "I'd like to change rotations. Who do I see?" I get a lot of interaction with the residency programs about how many slots a hospital is going to support in a residency program. A lot of program development that has at the core, once again, the recruitment of faculty, but it almost becomes secondary trying to put together a real package. Right now I am dealing with sleep clinics between our Department of Psychiatry, Kettering Medical Center, Sycamore Hospital- their satellite- in the attempt to recruit a guy from Ohio State. We have the resources to fund him but he is not coming without a sleep clinic. So, he has become secondary and we have spent the better part of the last six months working on understanding what it is he is talking about, seeing how that fits into the scheme of our Department of Psychiatry, and seeing how it fits into the scheme of a hospital, with much of it related to the bottom line, dollars wise.

J.S.: How much time does it take for you to research these items?

D.D.: They vary from...

J.S.: Let's take the example of the sleep clinics. Do you have to become conversant with the ideas that they are talking about?

D.D.: Yes. But I do that mainly through others educating me as opposed to reading it. For instance, I have been up twice to Ohio State to see this place that he has up there now. You need to begin to understand what sleep apnea is and pupilometers, and the funds. I do not need to know how they do it, I need to know how much money we can make off of it. That is what apparently becomes important to the hospitals. Not as much as a profit center but as an 'I don't want another loss center in my institution'. There is things that when I was planning on going into city management when I was in college that if any told I would be dealing with magnetic resonance centers and walking through Cleveland Clinic with a cardiologist looking through a screen at a valve of a heart opening and closing. Or talking about sleep labs or being involved in adolescent substance abuse programs or negotiating emergency medicine contracts with emergency room groups and hospital. It's just incredible the amount of, amounts sound quantifiable... about the number of different types of things I have been able to be involved with, in the past six years. Except for the bad days, I feel refreshed as I did the first day I came on the job. Other than knowing how to get to the medical school, that is how much I knew about medical education. I knew healthcare in Dayton, but I did not know anything about medical education.

J.S.: What new departments have been established in your six year tenure?

D.D.: Emergency medicine, dermatology... Emergency medicine, dermatology. That is it. Any number of departments that have changed their nature significantly.

J.S.: What's those?

D.D.: Ophthalmology, anesthesiology, and physical medicine rehabilitation.

J.S.: When you are establishing a new program what is the procedure that you do? What are the first things that you do?

D.D.: The first hand is to talk to the dean and we will discuss the ramifications both positive and negative on the school and the department as we sit. This is after I have had a discussion with the chairman who in theory is the source of my own information and says, "Can you do anything about that?" Then we will talk about who may or may not be interested and we will determine at what level the first communications should take place, whether that be at his level, my level, or the chairman's level. If the general guidelines, which are not written down, is if this is a M.D. to a M.D. thing between specialties. Almost drive that out of the departmental level, especially if it does not involve contractual relationships between hospitals.

J.S.: What do you mean?

D.D.: There may be a choice between two departments. Let's say emergency medicine and medicine that when emergency medicine residents need to do their internal medicine rotation in their first year that the program director in internal medicine may say, "They have never gone to the VA for these rotations but I really think that ought to spend some of their time there." It is a new interaction but that is between residency programs. The VA doesn't care who they get as long as they get the right amounts. So it is not that big a deal. Then if the other potential is with specialty referrals which is a normal physician kind of activity that does not involve me and does not really involve the practice plan, except for than billing. Then departments may talk about doing something, doing a research project together. I know that there has been residence and faculty say between emergency medicine and aerospace medicine who have an interest in doing things together. Unless they need hospital resources to do that, other than the ones they currently have I may not be involved that. I'd like to hear about them. That's about it.

If there is, if it is a situation where nobody is really pressing, i.e. sleep, we might say, "Okay, Doug. Why don't you go out and feel if the hospital has any interest with your contacts?" Then if it is big enough or controversial enough, i.e. the new development of technology of some kind, the dean might write to each of the chief executive officers and say, "We have this particular opportunity that we are interested in it from the aspect of education and research. If you are interest please contact me, I will have follow ups done by Doug Durko and whatever appropriate department or program that might be involved once he gets responses."

J.S.: From there on it's a question if the hospital says, "Yes, I want to get involved." Is the question between you and the Chief Executive Office of the hospital?

D.D.: No. Well, I know of the chief executives are first name basis. With one or two exceptions the chief executives have gotten to the point, including the dean who is the chief executive office of the medical school, they want to be in the decision making capacity and one if they get

involved number one they don't have to time but number two if they get involved in the nitty gritty negotiations and the development of details they then become invested interest in saying yes and they do not want to be put into that position. That is why they hire people like myself. That is why hospitals hire three piece pin-strippers.

J.S.: So who is your immediate contact in the hospital?

D.D.: It will vary anywhere from... like I said there is one or two places that is a chief executive officer, Green Memorial and St. E's at this point in time, but mostly it is either the senior vice president who is designated to have medical school interactions. It will be the senior vice president who is the chief operating officer. That is on contract negotiations. Then on educational matters I have a lot of contact with the Directors of Medical Education, DMEs.

J.S.: Let's take a specific example. When the emergency medicine was started, where was it at?

D.D.: Kettering Medical Center apparently, and this was before my arrival by about a year arrival the second time, had an interest in developing an emergency medical residency program. There were apparently discusses with other institutions and in the school of medicine some people said "Yes, this would be a good idea." At that point in time, they recruited for a program director and they hired Carl Jelenko, M.D. who become the residency program director. Dr. Jelenko was in the Department of Community Medicine. Although, Dr. Jelenko had faculty appointment because he was a surgeon. They were located actually upstairs, where we are processing this now, that's where their offices were. He developed the program. He was essentially a one man show with volunteer faculty out in the community. A number of rifts were developed in the community over this. In many ways around Dr. Jelenko. There were some that were not too thrilled with a surgeon running a medical emergency program. They thought you should be broader in emergency medicine or in medicine as it traditionally has been.

Then there were personality rifts. In some ways Dr. Jelenko was named, he wanted out of community medicine and wanted to become a department and did. I was trying to find, in those days, a way to make my mark. I had determined that you do not walk down to medicine or OBGYN and say, "Durko is the name, and hospital contracts is the game." With my background having snuck into the back door in medical education, or the back door of healthcare for the matter, I didn't think anyone was going to pay attention to me. I choose somebody I thought would need some help and would welcome some help. At the same time would allow me to go through a learning experience and if I did make any mistakes it would not be a catastrophe. I happened to hit it off fairly well with Carl. Another thing that drove me is that it was at that point in time and still is, expect for the people up at Fred White, it was the only clinical department

that we had that was not located in a hospital or a healthcare facility that will include Fred White. I talked to Dr. Jelenko –

J.S.: So emergency medicine was a clinical department but it was not located in a healthcare facility?

D.D.: Right. It was located upstairs, on the second floor of this building. Medical Sciences building. So I talked about him going out and in those days it was still desirable on the part of hospitals to have the department located there. I think our hospitals have finally made the transition from your department being there to program interaction is more important. That is where the action is these days. As opposed to where the chairman happens to sit and do his paperwork. So I set out to see what the going rate was on emergency medicine in the hospitals. I made that determination in a number of ways. As I sat down with Jelenko and I said, "To run your present residency program optimally, what do you need in terms of numbers?" and he gave me some faculty numbers which I think were at the time was himself and two. I sat out and said one of the first things that and we talked about some UMSA supplements. I went out and said "Okay, the first thing that I need to do to make my mark I will find a clinical department which I have chosen to be emergency medicine and I will try to locate it in a hospital, fully equip it, fully furnish it, and fully fund it out of hospital support." That was my goal and it worked.

J.S.: So you essentially went to Kettering?

D.D.: No. I went to Kettering and Good Sam. Good Sam wanted it and I thought at that point in time that was the best place for it to go cause he had quite a bit of interaction over there. That was my recommendation. They had the space that Kettering didn't have. Kettering has terrible space problems because of zoning limitations in terms of what they can build and not build. Good Sam had Rosary Hall and there was the whole third floor of rosary hall that was their old nursing school building that was up for grabs. That is what I went after. Good Sam said and I do not agree with this quote but the comment was "I need a school of medicine department here that is in the main stream of medicine."

J.S.: What does that mean? [30.00.00]

D.D.: Well, that is what I said and the comment was "Well, while psychiatry in an academic sense is one of the clerkship departments. It is not a hands-on. They do give drugs but it is not surgery medicine, family practice, OBGYN, pediatrics kind of thing. Community medicine was even more removed in that it was preventing medicine and aerospace medicine and those are the

two things I have right there and I need something that my physicians in medicine, surgery, the main stays that my medical staff can interact with and the certainly can do that out of emergency medicine because that is one of the feeders in term of in to the hospital and other specials as well as refers and elective admissions so on and so forth. My comment was "How much support can you give us?" I had dollar amounts in term of what I knew the department needed from a combination from hospitals and my comment was "How about one hundred thousand dollars?" and they said "Fine." So what we worked out was a package that was worth somewhere between two hundred fifty and three hundred thousand dollars from Kettering, Good Samaritan, St. Elizabeth's, and Green Memorial who at that time the acting participants in the residency program. Which would have funded the department as defined. There was a significant rift between Dr. Jelenko and Mike Urban, Dr. Michael Urban, who is the head of the emergency renal group that staffs Miami Valley Hospital. Miami Valley Hospital absolutely had to be into this program.

J.S.: Why?

D.D.: The volumes that go into the emergency room, even though they don't do things that much different. They were designated for more political reasons than any other reason by the Western Ohio Emergency Services Council as the trauma center in town. Dr. Urban was the medical director of the Western Ohio Emergency Services Council. They were very involved and they had a lot of things going on in their emergency room and it was right for us to be there and right for them to have us. We needed to do was to solve this rift. The rift got solved and it got solved the day before Dr. Jelenko's surgery. Dr. Jelenko unfortunately during his surgery had a stroke.

J.S.: How did you solve the rift?

D.D.: Talk to them individually.

J.S.: And then he went into surgery for what?

D.D.: His blockage in choroid arteries.

J.S.: And he had a stroke during the surgery?

D.D.: During or right after in recovery.

J.S.: Was it fatal?

D.D.: No. It was debilitating on his left side I believe. Right side. Paralysis and also in the speech centers. Dr. Jelenko eventually, I think that was in January, the day before he and Urban had talked on the phone. Dr. Jelenko had talked to him as I understand and they had agreed to agree on some things. Then in June he had the prognosis and the rehabilitation had not gone as well as people thought. Dr. Jelenko went on disability and still remains with the school as a full professor but he is on disability and they are now in Maryland, I believe.

Once that happened we went into a recruitment process for a new chairman. I should mention that in the interim. After Dr. Jelenko went on disability, Dr. Jamagna who is a professor in our Department of Medicine and at that time was the Director of Medical Education also at Good Samaritan Hospitals and had a background in emergency medicine when he was at the University of Cincinnati School of Medicine, became acting chairman. Dr. Jelenko had recruited one faculty member and his name was James Jager. Jim kind of did the day to day things, Jim Jager did the day to day things and along with the outstanding administrative assistant they have, Rosetta Boaty who has been with the university for over ten years. Dr. Agnick (sp?) over saw things during the interim period. We then went into recruitment process to replace Dr. Jelenko. In January, selected Dr. Glen Hamilton from the University of Cincinnati who is now currently our chairman. Dr. Hamilton's requirements to come were consistent with what we tried to do with Dr. Jelenko but were more extensive.

J.S.: What do you mean?

D.D.: He wanted Miami Valley in, period. He needed one or two more faculty members in order to come. As a result of that I went to the dean inter-seated at Valley at the CEO level and I did some negotiations at my level and they became the bottom line on the department is that it had three major players in terms of dollar amounts were about one hundred thousand dollar total package. We are talking School of Medicine and UMSA each one hundred thousand dollars each. Two minor players in terms of St. E's and Green Memorial and they were in for about twenty five thousand dollars each. Then the dean put in some school resources and Dr. Hamilton came then in January '82 I believe this is.

J.S.: Where is Good Samaritan? Does it stay in the picture here?

D.D.: Yes, they are one of the major players at this point in time. The three majors are Kettering, Miami Valley and Good Sam.

J.S.: And it is physically head quartered at Good Sam? [37:55]

D.D.: At Good Sam.

J.S.: What does Greene Memorial get out of it?

D.D.: Greene Memorial has residents rotating over there. In addition to that there is major activity on the part of the faculty and the residence in terms of the administration of their... for a hospital that size it is an ICCU as opposed to an intensive care unit and a coronary care unit. They have an intensive care coronary unit combined. Your major tertiaries will have one of each. You have an intensive care unit and you have a coronary care unit. A place like Greene Memorial, 200 beds combined, so they call it there ICCU.

J.S.: This was developed as a result of their participation in this program?

D.D.: Right. And there was a rotation over at St. E's. Some of our people spend time over there. To bring you up date in terms of how I interact with people, Dr. Hamilton and I also developed another set of UMSA contracts in terms of the package that he needed. There was the university salary, then there was some supplements to UMSA as a result of them being in the emergency room teaching residents. There was a by-product of service that resulted in income to the hospital and the emergency room group. You can't teach a resident on a person who's in the emergency room broken arm, gunshot wound, whatever, when all is said and done, someone is going to bill for that.

J.S.: Right.

D.D.: So while on the one hand they are there for a teaching component there is a byproduct from service that results in revenues. So the hospitals agreed, yes, as a result of that we will also send x amount of dollars to the practice plan as a result of their practice activities during their supervision period. Dr. Hamilton said to Dr. Sawyer during the negotiations "I am still x amount of dollars short for what I think I need to recruit faculty for each one of them." the dean said, "You're right, new chairman that is your responsibility." So we had a set of school of medicine

contracts and we had a set of UMSA contracts then we developed a second set UMSA contracts, third set overall, that Hamilton and I would get so mixed up about this we developed our own means that are only acceptable in conversations between Durko and Hamilton. They are School of Medicine, UMSA 1, UMSA 2. Now these contracts, these UMSA 2 contracts as we called them and still do, are between his department and emergency room groups for his faculty taking time not in a teaching setting although there could be residence there but taking some time in the emergency room. This was positive from two stand points. The first standpoint is, actual more than two. The first thing it that Hamilton was, through that mechanism, able to generate the extra dollars needed to recruit a faculty member. He has to work for it but it was there to be gotten. Number two, it was important to Hamilton and his people because they need to maintain their clinical compeonce and the way you do that is it do it, is to go in and do emergency medicine. It was important to our affiliated institution and more important to the groups because they now had this pool of five people who were all board certified emergency medicine physicians who they could tap as opposed to. Let's say I am an Emergency room group. I have twenty hours a week out of 7 days, 24 hours a day that I do not have covered. Well I could tap Hamilton's people for two shifts as opposed to hire an individual when I do not have 40-50 hours of work for that individual and I have to pay them a full salary or make them a full whatever within the department.

J.S.: So it is the emergency room program extra flexibility.

D.D.: Right.

J.S.: and extra income.

D.D.: Vacation periods. Illnesses. To go away on trips. Profession continuing education. Worked out very nicely. Some institutions made better use of it than others but that is fine. We expected that. Some do not have the needs other do. So having completing that process we done had the total package together of dollars to get Hamilton here and the department as he wanted it.

One of the most difficult things to do during this whole process was the original package put together for Jelekno between the time we first talked about it, and when I first talked to the hospitals, and we moved the department and that Jelenko did not get to recruit all the faculty. And that we had to recruit Hamilton and six months later we had to hold together for almost two and half years this original package that we never implanted. That was one of the most difficult things. Cause you continually had to say to these guys every time you sent something over, "Don't forget what you committed to an emergency medicine, I am not going to be there for another year." And now I'd see them six months later and it is still going to be another year because things are not going as fast.

J.S.: So the original package that you put together in effect changed?

D.D.: It did not change, it expanded. But the original package is still the basis for how the department operates today. Now Hamilton and his people, there were some other things that I guess this is an example of the involvement in the dean's office and my office in how you can be involved in the department. And I am kind of giving you my view of the history of the emergency medicine here. I think this is good to explain how something goes on through the years. Once Hamilton is here and he has his people and has his recruitment done. The guy is the type of an individual, well it is time to start doing new things. He becomes concerned with the issue of clinical control and he said, "I am really worried about clinical control."

J.S.: What is the issue with clinical control?

D.D.: And I say "Boy that is too bad Glenn, what is clinical control?" and that is, you know, you ask do I research things. That is how I research things. These guys come in with their words and I have completed maybe a third of the clerkship in medicine here, I never did the basic sciences as a political science major. And he says, "I am concerned about what is being taught to our residence, in terms out state of the art emergency medicine." He said, "What they are doing in the emergency room may be quality. That is fine but sometimes the things that we are seeing at the academic level has not reached the 'what I am doing at the ER level'."

J.S.: New advances.

D.D.: New advances, new ways of doing things that will get there. So we are telling our residences in didactics sessions and other people are saying, "Well we do not do those things that way here in clinical settings." Dr. Hamilton was all fired up that he needed to control an emergency room. Well, first of all the School of Medicine controlling anything in this town, those words are gasoline on the embers that constantly smolder. Good Samaritan had a contact with a National Emergency Room Group out of Texas to run their room. I should mention here and digress that one of the things that Dr. Jelenko, I can't remember the name of the group leader, the head physician of the group from Texas that ran the ER at Good Sam. One of Dr. Jelenko's requirements to locate the department at Good Samaritan Hospital, I think it has had a long term impact, was that emergency medicine be named its own section as opposed to reporting to medicine. Being part of medicine. Histology is now physical medicine and other kinds of things were all apart of medicine. That this individual who ran the Texas group be named the chief of that group, of that section, and the administration said, "We'll consider it."

They reviewed it and thought it was a good idea and went ahead and enacted that. That is to digress. Back to Hamilton.

They had been to, they meaning Good Sam and this Texas Group, has been through one difficult contract negotiation already and another one was coming up. They were for a period of three years. It was almost a self-fulfilling prophecy from both sides that they were not going to be able to reach agreement. Good Samaritan were looking for alternatives. One of the things they said was that we have these group people sitting across the parking lot why don't we talk to them. I am not so sure that Dr. Hamilton didn't precipitate some of that himself, in his own way, which is a very pleasant way as oppose to how someone else might approach them. We had dinner one evening with some administrators from Good Sam, we said, "We would think about it and explore it." Came back and met with the dean and this was like in the June time frame of '83. Hamilton was going off to Australia on a visit down there for emergency medicine in Australia. He was invited to do some things. Others were going on vacation and we said, "Ok we laid out the list of issues and said let's all go off and do what we are going to do for the next three weeks and think about it. We will meet again."

There were all kinds of considerations. The political ramifications. How would the group at Miami Valley Hospital feel? How would the group at Kettering feel if all of the sudden there was an alternative for their administrators to hold under their nose which is essentially the school of medicine? All of a sudden are teaching program falls apart just by result of that. We said to Glen Hamilton, Do you want to spend the next two years of your life putting this together? Do you want to sacrifice your pursuits, your interests and academics and in research potentially. We came back and we said, "Essentially it is not a good idea. It is not something that we want to pursue." Good Sam said, "Would you then help us recruit?" and Hamilton said, "Gladly." They went through a recruiting process and came close on two people that were Glen's recommendations but could not come to closure.

They were critically approaching the time that the Texas group was going to leave. They then came back to us again. Jack Groves, Bill Sawyer, Glen Hamilton, and I, and a consultant that we had based out of Cincinnati that Glen knew. It was a consultant practice groups sat from early one Friday afternoon to late one Friday night, studying this. I think it was a ten hour session we went through, never left the conference room in the department of emergency medicine and said "Ok, under these circumstances, we will do it." Unbeknownst to us, Good Sam has not gotten a consensus with their medical staff and not even polled them. They approached us and said "Will you do this for us?" and we are willing to go on the line and take the political heat that was going to come because it was unlike the first time even though there was the question of clinical control. In some ways, the incentive was more mercenary in terms of generating revenue than it was when we were reconsidering when it became, we got an affiliated institution in trouble here. We didn't put them in trouble, but they are in trouble and they are coming to us for help. Also a consultant concerns we had a clinical control. Also we can fund some things educationally with the revenues and that had been thought out. So we were, while I am not saying we were mercenary on the first discussion, we were far from mercenary on the reconsideration.

Well, Good Sam then brought this before six passed, current, and future chiefs of staff who covered a number of disciplines in the hospital. They split three on three whether or not we should do it. That was the end of that. There were some apologies that we went out on his limb and could not deliver and that we did not do things the right way. Whether or not we should have even allowed a vote, whether with should have talked to them first in terms of approaching this. So they said to us again, "Can you help us?" we said well, we had two individuals in the department who were faculty members who said, "I would consider putting the group together and outside of school," and doing this Dr. Rich Holt who was fully affiliated with us did such a thing.

At the same time, Good Sam said "Look you cannot do this alone," and they entered into a consulting contract with Dr. Hamilton in terms of helping recruit or organize this. They funded some fellows as a result of this in emergency medicine. Some dollars went to Dr. Hamilton for his time. Essentially the problem became solved because Dr. Hamilton, one of his people, left him and went over there. Did the kinds of things that Hamilton was looking for in the first place. The type of individuals that they were recruiting while they weren't pure academic types but had an interest in academics, which was one of the requirements. It has worked out very well. That has allowed Hamilton to forget about clinical control and to forget about running an emergency room. There we are again with time on our hands for a very positive and creative individual. That is the worst thing you can do, especially when you are the support for those kinds of people to yourself. I am out there one day and he says "You know now that this is over, I should really relax but," and the worst word in the vocabulary to me is 'but', "But we really ought to be doing something other than relaxing." and I said, "Well I said how about research." He said, "Yeah, I am interested in research. That has always been a goal of our department. It was a matter of when." and I said "Well, is now the when." He said, "How do I fund this, that, and the other thing?"

J.S.: Another but.

D.D.: Right. I said "Holt left to do this and you have a position of replacement. Dr. Epstein left to go to Florida and you have a physician to replace. Why don't you give consideration to talking to the dean about taking one of your MD positions and utilizes that, the dollars in there, to recruit a Ph.D. and a technician?" He liked that. He and Dr. McDade had been doing some things in brain necessitation already with a neuro surgeon Bernstein, I think that is his name, at Kettering. He talked to the dean about it and the dean said, "Fine." That brings us to today where he has replaced Dr. Holt as of July 1. He has Dr. Ilers coming in out of Texas. They have their three to five Ph. D. candidates currently visiting.

Jet Groves has in his Cox planning, previously given them a lab at Cox, a lot of the equipment from the closure of Fels. Some of that equipment when down there and McDade spent the last year working through what works and doesn't work, what is useful and not useful. In addition Dr. McDade had become the editor of an international publication called *Resuscitation*. As of July 1,

when the Ph.D. shows up and the lab is ready to go and they are very excited about interacting with the MAG, the laboratory for magnetic resonance cause that has a lot of implications in terms of the brain and the ability to do research. That brings us to from when emergency medicine sat up stairs and to where we are today and the kinds of things that I interacted upon, on, or with. Recognize that while my interactions are important, once the agreement is reached, it is the departments that have to do the work or make or break themselves. When the dean says, "Yeah, go ahead and get a Ph.D." Hamilton got to search, place the ads, and make sure the Ph.D. does the work, writes grants, and does the research. It is his faculty that has to teach residences so on and so forth. I make no claims to that. I do not make claims to anything but that's kind of something that started in late '79 to 1980 and has continued into '85. So that is how I interact on either a day to day in some point in time to a 'I haven't heard from Hamilton for three months, I probably should go see him but if I go see him I will have something to do so I will wait two more week'.

J.S.: It is interesting that one of the end results in this interaction with one department has merged the beginnings of another interinstitutional program.

D.D.: Right.

J.S.: Is that always one of your goals in interacting with the group to create as many interdepartmental institutions?

D.D.: I would be doing this with a university hospital if I had one. In that I don't have one, and that my primary interaction with our departments is the clinical departments at this point in time and most of the things they want to do have to be done in a clinical setting. If it can't be done at Fred White, where they do their practice, or some of them do their practice, the only other alternatives is in one of the hospitals. And that is why this office exists, to support and help facilitate these things and make them happen.