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Douglas Durko interview (3) 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 3

INTERVIEW TRANSCRIPTION

[Beginning of recorded material]

J.S.: My name is James St. Peter and this is the third in a series of interviews with Mr. Douglas R. Durko, Associate Dean for Hospital Affairs in the Wright State University School of Medicine. The date is May 8th, 1985. The time is four o'clock p.m. and Mr. Durko and I are in 110D of the Medical Sciences Building here at Wright State University. Mr. Durko, I would like to talk about in this next interview on the impact of the Office of Hospital Affairs on the residency program.

D.D.: I have become deeply involved in the residency programs in the non-education administrative side as opposed to the educational administrative side. There is probably a lot of chicken or egg in terms of what brought that about but I would have to say that the primary impetus, the single thing that comes out of this office that caused that, is the contract negotiations once again. I will show you why. As opposed to undergraduate medical education which is funded through tuition at dollars we receive from the state for the medical school, so on and so forth. Graduate medical education is funded through the third-party reimbursement system for the delivery for healthcare in hospitals. The driving force in terms of what the model is for both private insurers and Medicaid which is a state program is the federal Medicaid program. Generally, if it is okay by Medicare it will be okay for the private insurers although they may calculate how they put the dollars in a different manner. For example, the Medicare negotiations with hospitals very often are line item retrospective negotiations.

J.S.: For reimbursement.

D.D.: For reimbursement. One of those line items that is an allowable cost under Medicare is that the direct cost of medical education. That includes resident salaries, resident fringe benefits, other cost associated with the resident as well as reimbursement for administration supervision and teaching of residents. The majority of my contracts with the hospitals are for our faculty to do those three things in residency programs.

J.S.: Which are?

D.D.: Teaching, supervision, and administration. Those are allowable cost in the party of Medicare. Now BlueCross may not get down to line item negotiations but when they are doing total negotiations for BlueCross as well as those other commercial insurers who rely on BlueCross negotiations to set their reimbursement rates. BlueCross may look at much boarder categories but they say, "Medical education is one of those categories that can be included in the package in terms of things they will reimburse for, graduate medical education."

D. D.: At the same time that we, meaning the school showed up, at that time liaison committee on graduate medical education which is now the accreditation council for graduate medical education which from here on out I will refer to as the ACGME. Begin to increase their accreditation requirements in order to accredit a residency program. One of the requirements was that they required more- and I am not talking about school of medicine when I use this term, I am talking within the program- more faculty time, more teaching time, and in some cases criticized the amount of part-time faculty activity that an attending on a staff that they needed more full-time people involved and that varied from program to program. As a result of us being here and that a lot of the programs moved into the integrated mode and under the institutional responsibility of the school of medicine and became multi-sided. Then I was able to go out and make my case that you're going to have to spend these dollars regardless. In order for us to keep an accredited residency program going, here are the resources necessary. You are the source of those resources whether you like it, I like it, whoever likes it. The fact of the matter is third-party reimbursement pays for graduate medical education so I have to look for you for reimbursement, therefore the contract negotiations I would say seventy-five to eighty percent of my contract interactions with the hospitals is for residency, training, and supervision on the part of the faculty. And this is not only in the integrated programs. We have some of our faculty who are responsible for an affiliated program, with the best example of that being orthopedic surgery, which is a residency program. It is a Wright State affiliated program and the institutional responsibility is that of Miami Valley Hospital, and yet contractually the individual who is the program director and the people that serve as the faculty are our faculty in the Department of Surgery, the section on orthopedic surgery- Dr. Klaaren, Dr. Poppy [sp?], and Dr. Lehner. I

would say that probably seventy-five, eighty percent of our actual contractual relationships with the hospitals is involved in reimbursement for the cost we have to bear. It is some of the cost, not all of the cost that we have to bear in graduate medical education. They would have had to bear it anyway. There is sometimes not enough recognition on the part of our affiliated institutions that they don't make the connection between what it takes these days for accredited residencies with my contract negotiations even though it spells that out. An understanding that if the school was not there, they would have to spend those kinds of dollars in many cases more than what they are spending now. I can't prove that but I know it to be true.

D. D.: For an example, we have difficulty some times in terminology. I may have one of my counterparts or contacts in the hospital say I contribute to the school on an annual basis x-amount of dollars. I will say we have a contractual relationship which means that there is considerations on both sides. One in terms of service and the other in terms of dollars with your institution. To give you a good example of that, the one that I always use, is the former and current Director of Medical Education at three institutions. former and current at Good Samaritan- former Dr. Agner and currently Dr. Holli- are faculty fully affiliated and fully paid by the School of Medicine in the Department of Medicine. They have served as Director of Medical Education at Good Samaritan Hospital. Dr. Warden is the same in pediatrics and is the DME at Children's Medical Center. Dr. Roden is the same in Post-Graduate Medicine and continuing education as well as chairman in his case and is also the DME of Green Memorial Hospital. There is sometimes a mix-up in that all the money flows one way and that is to us. However, my question when it comes up is that is this a contribution, implying a gift with no consideration coming from the other party and if it is who is doing the contributing. Let's take Dr. Warden at Children's for an example. Is Children's Medical Center paying for half contributing support for half of a faculty member in the department of pediatrics or am I contributing through time half of the DME at Children's Medical Center. They would have to have a DME anyways as much as they are involved in teaching. What I say is nobody is contributing. What we have done is entered into a contractual relationship that has allowed us to matrix a position to achieve economies of scale that serves the needs of both parties and provides a quality situation in education. That is what is happening, there is no contribution on the part of anybody. That is sometimes because all the money flows from the hospitals to the school because I am paying them. There is a question of support versus contribution versus contract.

J.S.: Do you run into a lot of those questions when it comes times to renegotiate affiliation agreements?

D.D.: Questions generally arise. None of them are renegotiations. Renegotiations at this point in time are difficult because it was really easy two years ago, three years ago when the hospitals were doing real well. We at the university were giving five percent pay raises, sure I gained a five percent. Now that the hospitals are under DRGs and other situations [*phone ringing*].

J.S.: When the contracts come up, are you suddenly reminded about the things done in the past like this question of contractual agreements on your part versus contributions?

D.D.: No, generally it happens on an annual basis when a new player is introduced. Either somebody who has not interacted with the School of Medicine before by reason of a change in assignment or promotion or because they have come in to take a job that was vacant or vacated due to contact. It will take a significant amount of time to begin to understand what the relationships are and why they are. There is never the full appreciation that existed from the people who were originally involved. Somebody may come in and say I understand what you are doing and I understand why you are doing it but I do not like and if I were here ten years ago this is not something I would have ever recommended.

J.S.: How do you deal with that?

D.D.: Thank god we have not had that great of turnover in the chief executive officers and that they accept it and buy it. I try to educate and say look we don't have an eighty-man department of medicine competing with your medicine staff for patients and look we do not have a seven hundred bed hospital sitting in the fairgrounds or out on campus some place that is called University Hospital and is in competition with your institution. The basis was that we would interact, we would contract, we would matrix in return for not doing these things. Building a seven hundred bed hospital or recruiting having a five hundred-man to seven hundred-man faculty most of whom are physicians with the people in town.

J.S.: Has there been any situations where you have lost ground to do a change over?

D.D.: Yes. Ground... ground. Not due to a change over. No. It's been tougher.

J.S.: What about has there been a residency that have been cut back?

D.D.: Yes. The Yellow Springs Family Health Center. The family practice residency that is based at the Yellow Springs Family Health Center that is supported by Greene Memorial Hospital, Mercy Medical Center in Springfield and Community Hospital in Springfield has chosen to phase out that residency over a two-year period.

J.S.: Why?

D.D.: Mostly financials as well as the physician shortage that they anticipated, especially by the two institutions in Springfield, that has not happened. At the time that they came in and developed their program there was a concern about the age of their physicians. There has been physicians who have located in the Springfield area that were recruited by existing practices to come in as partners- younger physicians. At the same time, because of the decrease in the demands, stabilization, or decrease in the population, some of the subspecialists started to do primary care. It was basically a financial decision in the face of the cost factors that hospitals are facing today. Now it was easier for them to make the judgement to get out of medical education than it would be at Miami Valley Hospital, Good Sam, Kettering, St. E's. That is an easier decision for them to make than Miami Valley Hospital about a particular program or their educational role and mission as they define it. It was easier to pick on and then was isolated. It was one program. Where Miami Valley Hospital it's whole, or Good Sam, Children's, or Kettering it's history has been involved in medical education therefore while education in these hospitals have between fifty and ninety residents that they pay for is going to take its lumps like everyone else. It is not going to completely disappear from their institutions as it will in Springfield.

D. D.: Greene Memorial had to go along with the decision to phase out the program but would have preferred not to. They still have emergency medicine residents that rotate over there. We are trying to find something else, another way to have family practice residents over there out of one of the affiliated programs. We are currently trying to work on that. We were told very plain by one of the administrators, "I have list A". That is all the things that I have to do to be a hospital. A1 is all those things I have to do to be a hospital that I lose money on. List B consists of all those things that I lose money on. Period. But I do not have to do them to be a hospital, but I choose to do them for various reasons. It was pointed out to us that this residency program is in the middle to the bottom half of his commitments to loss items. That was one of the Springfield Hospitals.

J.S.: He was on the B list in those?

D.D.: We were on the B list, but we were in the bottom half of it. Therefore, when he made his decision it was based on priorities that they had set. Greene Memorial on the other hand had said, "I have A and I have A1 and I also have B. The residency program is on the top of my B list of things I am willing to lose money on." You see the difference in terms of priority of education in the institutions while we are trying to put something back together for Greene there was no malice. We understand it. It is a part of your reasonability to administer an institution or organization you set priorities. If that is the way you choose to set them fine. Now there are

programs that will take their lumps in terms of need. I would imagine that pathology in Dayton is going to take some lumps.

J.S.: Why?

D.D.: Question of whether the City of Dayton number one should be training pathologist.

J.S.: Why not train pathologist and train orthopedic surgeons?

D.D.: You come down to the two. In terms of demand from medical students, they'd rather go into orthopedic surgery than pathology, so there is a better applicant pool in terms of quality. At the same time there is the question there is only so many pathologists that you need to run pathology labs in a county. Montgomery County has seven hospitals. I mean, and we have stabilized population. Orthopedics on the other hand, in some ways it has been limited by the accreditation process in terms of how many get in, the number of slots available. More importantly is technology has significantly increased the need for orthopedic surgeons. To show you what I mean, thirty years ago orthopedic surgeons generally set bones and fixed compound fractures. Then plastics, Teflon, started to show up. Joint replacements, hip replacements, in terms of things that could be done and all of a sudden the bomb in orthopedic surgery for things that couldn't previously be done happened. While we have a stable population, technology has increased the capabilities of the services to be delivered so therefore there is an increase in demand based on what you can do, not on the number of people around. You can do more for the same number of people. That's an example.

D. D.: There are other things in orthopedic surgery. God knows that and other specialties that don't have anything to do with us. I have a friend who is a podiatrist in San Diego and his comment, jokingly, was that thank god the orthopods don't recognize anything below the ankle because between the population growing more elderly and joggers leading a very good life, the exercise phenomena has hit orthopedic surgery also. The weekend athlete. There is an orthopedic surgeon who is starting this sports medicine clinic that is doing very at St. E's. Dr. Mannarino The only requirement that I had knee surgery myself and went over there and one of our people did the surgery. I went over there to talk to them about rehab. I said, "What do you have to do to get into the sports medicine opposed to regular rehab program?" I never really got the definition. I think if you watch ESPN on your cable system at home you are qualified to get in. It generally is sports related in terms of your injury or problem. That it happened then or it keeps you from participating in something as opposed to a general rehab program. Those kinds of things impact the specialties. Also there is emphasis certainly in primary care even more so now that help from maintenance organizations and preferred provider organizations are starting to pop up all over the place.

D. D.: Residency programs will be doing different training in different sites. More ambulatory sites than they are currently doing now because they are trying to limit the access of patients to hospitals. Once they get here they are trying to limit how long they stay. That is the perspective reimbursement system whether it be Medicare calling it DRGs or HMOs calling it whatever they want to call it. Others things that I did... there are a lot of issues other than, I became a member of what was then AD HOC residency policy committee. I think we talked last time about the hospital affair committee and the joint coordinating committees in the hospitals and how when medical students became the boiler plate in the hospitals. The function for those things become obsolete for those communities. The action moved into the residency policy committee and out of those because for the most part the residencies are multi-institutional. For you to do something in a joint coordinating committee in one institution will not necessarily have the same agreement than another institution who is a part of the residency program so you have to have a mechanism to get those institutions together.

D. D.: Also, Dr. Sawyer has talked about this quite a bit lately, essentially chairmen who are teaching medical students are responsible in a big way to the dean. Okay, the accreditation process for the school of medicine is an institutional accreditation process. The liaison committee on medical educational does come in and review the medicine partnership. They come in and review all of the educational process at once. In graduate medical education, with the exception of the institution, whether it be the school of medicine or the hospital, having the right to hire or fire a residency program director with that one exception based on the accreditation guidelines, the new essential for residency education and even before the new essentials were published. That individual, in terms of controlling the program and how the program is going to be designed and who is responsibility for what. The program director is almost autonomous. That is because the accreditation is done program by program by the ACGME and they put the responsibility for filling their requirements into the program director, not into the dean of the school of medicine or the chief executive officer of the hospital.

J.S.: How does that affect the hospital politics?

D.D.: When we have a multi institution situation the key is to get the directors in medical education and the residency program directors into one room. That is the residency policy. It had been very successful. I now chair that. I started out as an AD HOC committee and now it is a permeant committee of the school. It is not a bylaws committee.

J.S.: So there not a residency policy committee for every residency. There is an overall one policy committee.

D.D.: One policy committee. Now we do... each department and each residency program has their own committee structure for those things that they are responsible for. Now we address things like and have developed things like Steve Peterson, who is the assistant to the dean for residency education and works along with me with these things. Generally, we do it through sub committees to develop particular policies necessary. Dr. Bob Jewitt, who was the associate dean for academic affairs before he left, and my predecessor, Fran Paris, were the individuals who started the committee. We deal with things like parity and residency stipends so we do not have institutions trying to buy residents during the recruitment process. We have put together a due process policy for residency if they are terminated from the program for either academic or nonacademic reasons. Risk-management policy. Policies concerning uniforms. It goes on and on and on. This committee has been going on now for I think this is its seventh year. It is a very important committee in terms of communications. The new essentials for residencies education requires an institutional review of a program. The dean has delegated the institutional review of the integrated programs to the residencies policy committee. So all the program directors for an example, last month Dr. Barnes who is the director of the Wright State Integrated Program in Internal Medicine appeared before us, had handouts, talked about his program, we made comments, asked questions, and essentially this process by where we do not review and approve anything. It is a review and comment function. That is what we do.

J.S.: How do you feel operating among all these MDs?

D.D.: It probably sometimes bothers them more than me.

J.S.: Why?

D.D.: That I am not an MD. I recognize my limitations. There are things that I could very well do no problem but it is inappropriate for me to do because it needs to be done MD to MD. Alright. There are things that I can't do because I do not have the background. The dean and I have talked about that. I have encouraged him over the years and at some point it may take place, may not, but maybe we need an associate dean for clinical affairs who is an MD to do doctor to doctor things like I do hospital, school of medicine, administration type things.

J.S.: What is your working relationship with the associate dean of administration? How closely do you work?

D.D.: Jack and I work very closely, because somebody will call him and a need for a particular resource and he will say, “Has Durko arranged anything through the hospital?” Jack and I will have to communicate about that. If I had arranged something where it is a fifty-fifty, I have to inform him because that is going to be revenue that he has to count into the budgeting process.

J.S.: How do you impact- besides what we have already talked about in recruiting- at what point in the recruiting process are you brought in to discuss something?

D.D.: If I would have to pick- it varies, but if I would have to pick a specific time, it would have to be... I may be included, depending on how the chairman feels about my judgement, in the initial round of interviews. Okay? When the first cast of candidates comes through. But specifically, I would begin to function on the second visit when people start spelling out there needs, and all of a sudden we would be talking about space, people, equipment, and money. And all of a sudden we are talking about school of medicine, groves in administration, and my counterparts in whatever hospital that the individual would be functioning in. Very much like the Hamilton situation.

J.S.: And that point it goes until the person arrives?

D.D.: Or, in the case for emergency medicine and most of our other departments, it’s never quit going on.

J.S.: You have to make reallocations in some cases of resources when a person comes in?

D.D.: Right.

J.S.: Do you ever have to make reallocations when a person leaves, dies, goes to another position?

D.D.: Yes.

J.S.: Does that process work pretty much the same in reverse?

D.D.: In some ways.

J.S.: Is it difficult to get resources away from hospitals once you've given them out.

D.D.: A good example is anesthesiology. A little bit of history and I will not take as long as I did on emergency medicine. Dr. Brian Roberts was chair of the department of anesthesiology. He had a number of faculty that were fully affiliated with the school and I don't know... they were here before I got here. At one point they decide that they wanted to go to another model with the school. Essentially come out of the school and become volunteer faculty. Brian would retain chairmanship of the department and the residency program director role, and we would put in minimal resources, and they would essentially try and earn their keep through their earnings. Because they had some earning capabilities at Miami Valley Hospital, they perceived that they would better than to be in the university payroll, plus what they got out of the practice plan, and the dean approved it. Then Brian passed away later, about six or eight months after that took place. I think that took place in like July or September, and he passed away in January.

J.S.: Of what?

D.D.: '83, I am going to guess. The years get mixed up in your head. So, the answer to your question, two things had to happen. Okay. You had to cover your short-term problem as a result of his passing, and your long-term problem which was- the short-term being who is going to be responsible for this residency program while we are solving the long-term program, and that is to search for a chairman and a model for his ultimate replacement.

J.S.: Did you get involved in the model generation?

D.D.: I was aware of the first change in the model. I was not really involved, because there wasn't a lot for me to do in that, but I sat in on discussions and gave opinions. The second one, the majority of the residency program, while Brian was placed at Miami Valley Hospital, the majority of the residency program was at Kettering. There were two candidates internally in town, either individual was very well qualified to be chairman and residency program director. One was at the Valley, and one was at Kettering. There were discussions that went on, and if in fact the individual at Kettering was going to be chosen, we were talking about moving the chair and the department, and that resources would be demanded from Kettering and resources would be down at the Valley. That develops a level of sensitivity that first has to be address before you begin to make your choice. What if? And you have to talk to Kettering, the dean and I both at our various levels have to talk to the Kettering people- if this happens, here is the demand on the

resources if this is what you want to happen. At the same time, we have to say that the people at Miami Valley, if it goes in the Kettering direction, you know, it's yours to give up. We are not going to jerk this. You have to make sure that the sensitivity issue is solved before you can go into the normal process of replacement. So, yeah, that is a problem with undoing. And there is also a problem with the undoing of ongoing things. For an example, somebody may say, "Yeah, I want to stay in your residency program, but I do not want to support as many residents as I used to or as much faculty as I used to." One of two things happens there. I either have to go out and find alternatives for that support, or the chairman has to do what appropriate cuts has to be done or deal with it in their current budget or earnings to deal with it. So that happens also.

J.S.: How often does that kind of retrenchment happen?

D.D.: It has only happened on one or two occasions. Family practice in terms of a total program and Xenia/Springfield. It has happened in Emergency Medicine at the Valley, who said we wanted to cut over half of what we are doing over a three-year period. So, it will be a planned cut in terms of support of residents and faculty. That way if we are supporting six residents now, when you graduate one of our residents, we do not want him replaced as a first-year resident. When you graduate another one, we will over a three-year period- which is the period of time of a residency program- we will be where we are at. There is nothing that can be done about that. You say to Hamilton, "This is it, if you can't change their mind programmatically and I cannot change their mind administratively, we have to look for alternatives or you have to be prepared to make the cuts.

J.S.: In this case which option did you choose?

D.D.: He was- is able to at this point to deal with that in terms of faculty of having one fewer faculty in terms of an open slot, I believe. Some dollar savings and doing some things through earnings. His residency support he has managed to pick up a slot or two someplace else, and therefore has chosen to not cut back on the number of residency recruits each year. When he came to town and we were recruiting ten a year, and one of his requirements once again, to be chairman, was that is too big of an emergency medicine residency program, I want a twenty-four person residency program, which is eight a recruitment. So, he has chosen at this point in time not to make further cuts. But he may choose to go to seven or six eventually. There is going to be more of that.

J.S.: Is there?

D.D.: Yes.

J.S.: In specific fields or across the board?

D.D.: Probably in specific fields.

J.S.: What are the fields?

D.D.: Like, emergency medicine is one that is up for grabs. I think some of the medicine programs in town.

J.S.: Are there any programs that look like they are booming?

D.D.: No, everyone is going to take their lumps. Booming includes a lot of categories. It includes quality, as well as money, practice, numbers of patients. [*Phone starts ringing*] Orthopedics is certainly one of them, we talked about that. Looking at my list, certainly the demand for surgery slots by students, they have their choice of some of the best students. The question is how many more surgeons do we need. You get your glamour residencies- [*intercom buzzer sounds, and recording is paused*]

D. D.: We were talking about residencies thriving, like with surgery, because of new technologies, as an example. Some thrive just because they're quality residencies. It is a good thing whether it has direct impact on need or whatever. It is just a quality thing, and for the sheer purpose of quality and intangibles that it supports, like the aerospace medicine residency program, and I think we talked about that before. Then you have whatever might be your current glamour residency. Emergency medicine is a current glamour residency. They are getting two hundred applications for every one of their eight slots, and that's exciting to medical students. St. Elsewhere's Dr. Fiscus with his Boston Red Sox hat doing blood and guts, and every show that has involved medicine on TV, whether it is a soap opera or whether it's Dr. Ben Casey or Dr. Kildare, the action is always in the emergency room or the OR. No one ever goes up and sees someone doing a history, or a physical, or someone that has some unidentified chronic pain in the abdomen. Unless it is going to be an acute appendicitis and they send him off to the OR eventually. The new one is medicine pediatrics, which is a combined program. You do two years in medicine, two years pediatrics, and you are eligible to be double-boarded in medicine and pediatrics. That is the new glamour, "Oh, if I do one more year of residency, as opposed to three years in medicine, three years in pediatrics, or three years in family practice- if I do medicine peds, just one more year and I can be boarded in both medicine and pediatrics." There are some

people that say, “Can you learn medicine in two years?” and “Can you learn pediatrics in two years?” What is the quality? There are others that say you are going to have to do one or the other in terms of where you put your emphasis in order to pass the boards, that very few won't ever go for both boards. There are others that say that it is a positive for individuals who want to do kind of a general practice that encompasses the family, but may want to do it in a different way than if they do a family practice residence. And it's so new that nobody knows, but that is the current one that is starting to achieve glamour status. Nobody knows how it is going to wash. They will all take their lumps somehow, at least through scrutiny. They may not lose resources, but they are going to be looked at.

J.S.: Let's talk about the future of the School of Medicine.

D.D.: Okay.

J.S.: What do you see in the immediate future for the school, besides a gradual reduction in most residency programs?

D.D.: Not most residency programs, a gradual reduction in residency slots, and not that great of a reduction. Two things will happen. Number one is status quo. Number two is the changing scenario that will be created by all the unknowns in terms of help maintenance organizations, preferred provider organizations, and where and how training takes place for residents. Beyond that, the status quo for the next three to five years, for the most part. A plus here and a minus there, but nothing big.

J.S.: When we were talking about topics for this in the last interview-

D.D.: Now I'm talking about our interactions with our affiliated institutions.

J.S.: Okay. What do you see for the future of the School of Medicine in general?

D.D.: Much greater emphasis in research, especially clinical research. Especially in medicine, and especially at the VA.

J.S.: With the increasing integration with the school at the VA?

D.D.: Yes. Also, some significant research activities either in or around magnetic resonance.

J.S.: Are there any other institutions that are eligible for the same degree of enhanced integration that the VA is doing?

D.D.: You mean of our current affiliates? Sure, if they want to.

J.S.: All of them could?

D.D.: They all could.

J.S.: Do you perceive anyone of them doing that?

D.D.: No. Not in a three to a five-year span. If you asked me to look beyond three and five years in terms of our interactions with our affiliated institutions and what I can go- quote unquote- "sell" to our affiliates, it is going to be interdisciplinary research involving clinical faculty. Faculty from clinical departments, whether they be clinical faculty status or fully affiliated status, and faculty from the basic sciences doing research in clinical settings in our affiliated institutions.

J.S.: What types of research? Just broad-based types?

D.D.: Some will spin out of the magnetic resonance activity. Others will be, for an example, I could see ophthalmology, infectious disease, and micro-biology and immunology. We've got three departments here- ophthalmology medicine, microbiology, and immunology- doing something in our affiliated institutions, for an example, in Aids because it is an infectious disease that involves microbiology and immunology and has significant- according to Dr. Bullock- impact in the area of the eye as the disease progresses. There are other infections that relate to microbiology and immunology that affect... a natural is infectious disease and microbiology, immunology studying various things in the immune system and associated with infectious disease, and doing that within our clinical settings in our affiliated institutions. You could get

more specific and say microbiology, doing something with ophthalmology as it relates to infections of the eyes. I would give those two as examples because I have heard some people's fantasies for five years and beyond. If in our basic sciences, physiology, someone has a real interest in oncology. You have people coming to the VA in hematology and oncology who have a research interest. If that same research interest could be developed through the DAYCOP program of Dr. Ungerleider, the Dayton Area Cancer something... Cooperative- I think it is- program. Maybe people would develop an interest in research that have been in practices for ten or fifteen years, "Man, I'd like to do some research". It would depend upon matching up of interests in the basic sciences and the clinical sciences, then finding that institution that is far-sighted enough that they want to do something. We have one example of that that I consider a real success already. That is Dr. Robert Glaser, who is very involved with research in areas of physical medicine like physiology, who we put together with Miami Valley Hospital and one of their individuals who has since left, Dr. Eric Steve Feinberg, who was in physical medicine-rehabilitation there, for them to be able to do some clinical research, and that has progressed even though Dr. Feinberg has left. And now one of our own faculty, Dr. Kim Goldenberg, who is working at the Valley and talking with Dr. Glaser about replacing the MD component that he lost as a result of Feinberg leaving. The first that was funded at twelve thousand dollars and the second year it was funded at sixty-five, because the Valley was so happy with what was going on. That does a number of things. It may result in some applications, clinical applications, that they can generate revenues on in the long term. In the shorter term it could result in the generation of grants that could offset costs, bring revenues into both the school and the hospital. If nothing else, their successes and publications resulting in it enhancing the reputation of the institution and the marketability.

J.S.: Do you perceive your office growing with the increase in research? Or your responsibility growing as well?

D.D.: My responsibilities grow every day. I told you that I never thought I would get involved in some of the things I am involved in. I am in a Catch-22 about that, and I think that yes is the answer, the office will need to grow. The question I haven't figured out yet is how, because many of things that are done, either by Dr. Sawyer or myself, are done because and succeed in some ways- not the whole entire thing, you have to have a quality program- but because of long developed relationships with particular individuals and being able to access the system in the right place with the right person, in the right way, at the right time, and that is not something you can bring somebody in here and say, "Okay, you come in here, you are now responsible for Kettering, St. E's, and Good Sam and I am never going over there again." It can't be done. So, the question is what they can implement, and I don't know the answer. I don't know whether I need secretaries, or more of me. Until I figure that out, I won't expand. I always keep thinking that things are going to get less busy, and they never do. I'm an eternal optimist that they will level off one of these days. It doesn't. [phone rings]

J.S.: How would you perceive the development of the School of Medicine so far?

D.D.: Outstanding. And maybe this is the time to get into the two deans.

J.S.: How would you characterize the leadership of the two deans in the development of the school?

D.D.: We have been absolutely fortunate that we had the two deans that we've had, in the order that we had them.

J.S.: What do you mean?

D.D.: If they would have been reversed, there has been the question- and maybe this is being too harsh on them- about whether or not the school would even be here. If we had them in reverse order. John Beljan had the... both recognized quality academics and set that as the standard. That is a consistent line between the two. Beljan, however, based on the strength of personality and charisma, got things done. Just based on personality, charisma, and agreements made, and with a goal of "let's get it done" was willing to leave things undone along the way if it weren't absolutely critical. He was the perfect person to start something. Or to clean something up, which apparently is what he is doing, currently. To come in and start where he left, he would be a disaster, because it wouldn't interest him. When Sawyer showed up, especially during the fiscal crisis, what this school needed was administration, pure and simple, to get ourselves in order. To this day, there are still little odds and ends I am cleaning up from Beljan and my predecessors, but that's okay. I'll probably do it for another five years. Some that I'm aware of that I am not cleaning up, because I feel like Beljan did, or my predecessor did, and said, "Well, it needs to be cleaned up sometime, but not right now." Also, that Beljan didn't... while he was committed to quality academics, he did not come from a strong academic background. Sawyer did. The second dean had to be a very strong administrator and a very strong academician to take this school into the next phase. Sawyer fills both of those requirements. He is... while I doubt anyone would characterize him as charismatic as Beljan, he understands the politics as well as John did, and deals with them in his own way very well. His way, opposed to Beljan's- and I don't mean to imply that Beljan ever misstated the truth- Sawyer's approach is absolute truthfulness on a situation. This is the way it is, this is what I can do, this is what I can't do, and here is why. Up-front. Caused some problems, that approach.

J.S.: Why?

D.D.: In the case of some of our hospitals, the administrators had to get used to it, because I think they missed the love affair. Even though maybe they were getting a little shafted in the early days. Maybe I don't want to know the truths, you know? Don't tell me that you like me but you don't love me, because I want to think that you do love me, as opposed to like me, and you want to be a friend as opposed to- you see the analogy? That is a different approach. With some it took them awhile to get used to it. And there were some problems, communication problems, I think, that have all been solved. With others it made no difference. Changed the style, no problem. With others it made a very positive difference. I think our relationship under Bill Sawyer with Kettering Medical Center is not even close. Our relationship with Kettering under Beljan was a disaster. I mean, he and Willett, they did not get along.

J.S.: Some hospitals don't want to be wooed, they want to be dealt with.

D.D.: It was not so much that, it was John's perception of Kettering, and to a degree he was right. I think that Bob Willett has done more than any chief executive officer we have. I am not saying he is better than any chief executive officer we have. You know, how on bowling league they give the most improved bowler for the year. If I were during my time to give the most improved hospital administrator award, it would be to Bob Willett.

J.S.: What kind of dean do you think should come to the medical school next?

D.D.: That's interesting, because Sawyer is so good that one day someone is going to make him an offer he can't refuse, and most of my fantasies about the next dean have been nightmares, because thinking about- I know that there is nobody that can't be replaced. Quite frankly... let me backtrack a minute. If you are talking about CEOs who have grown in my tenure, as opposed to hospital CEOs, Willett would get the hospital CEO award, Sawyer would get the CEO award.

J.S.: Why?

D.D.: He has just grown immensely, coming in from a department chairman where he had limited things and activities, to the point where he is a community leader. He has always had the academics. I think that the freedom that Wright State offers has allowed him to grow. In that we are a new school, we still had the flexibility and we don't have what we talked about last time, the turf guarding in the fiefdoms that exist in some schools that are one hundred years old, fifty

years old. The chairman of medicine who through his group's practice puts in eighty percent of the resources of his department, and if he does not want the dean of the school of medicine, he can absolutely get rid of him. They don't have that here. So, from a leadership standpoint there were undefined- in terms of limits- potentials to be involved in, and I think that Sawyer, as a leader, has exploited that in his own personal growth. I am glad he did, because he has been directly involved in a significant way in my own personal growth in that I worked that closely with him. I am concerned at this point in time. I think I have heard the statement that we will never be a Harvard medical school, but right now we are the best Wright State in the country. And I believe that. However, I am probably significantly biased in that this is the only medical school I have ever worked for, but I still believe it. Even with trying to shed my bias from people I have talked to and their problems around the country, and where we are at with our problem-solving period versus where they are. That an individual that we would recruit to replace Sawyer and that would be interested in Wright State would not be at the level Sawyer currently is right now.

J.S.: We're getting more dean for the money.

D.D.: Absolutely. Bet the ranch.

J.S.: His tenure as dean is a lot longer than the average, isn't it?

D.D.: Yes, but that comes back to flexibility, and therefore excitement. Get to do things and all the stuff that I am describing. I mean, Sawyer isn't saying, "That is what Durko does, I don't become involved." I am an extension of his office. He is directly responsible for magnetic resonance being the standard. Absolutely. Whether people like it or not, he is the guy that knew about it when he was interviewing here and has talked about it before he was named dean. There is another school that is analogous in some ways. They were started in the same model we were and that is Southern Illinois University. That dean has- his name is Dick Moy [sp?], who was close to both Beljan and Sawyer- Jack has worked for him- who also has the flexibility to be able to do particular kinds of things. He has been here for 12 years. Remember that the average dean, and there are a lot of deans that come in who get caught in situations that are not of their own doing that had to leave, and the guy who comes in to replace him is automatically going to be gone in a year because there is no way he can solve the problem, because nobody will recognize that it is this big of a problem until they lose the second dean. Then the third dean will be successful in working out the situation. See what I mean? Then there are other deans who are just people who had either been determined by those people who selected them to have reached the Peter Principle and it was a mistake selecting this person, or they have decided themselves, "I went too far this time. I should have never applied to be dean either because I am not capable or because-", forgetting the Peter Principle, "-this is never what I aspired to be." "I just went too far

professionally.” And had to step back and say, “I'd rather be a chairman or I'd rather be a faculty. I want to go back to research.”

J.S.: Speaking of things that once were and are no longer, tell me about the health affairs office here at Wright State?

D.D.: Well, Beljan came in with a vice-presidency title, as I understand it. He did not just come in as dean, he came in as dean and vice-president. I don't know what was in his mind when he gave up the deanship in terms of where he wanted to go and what he wanted to do. I would guess that it was a combination of things. Two areas in particular. Number one, through the health affairs office that he saw building as an outgrowth of the medical school other health education opportunities- allied health. Because he had John Burgin for a short period from Philadelphia and nursing to become what John thought it ought to be, which was probably biased in the first place and became a total disaster in terms of his bias after his go rounds with Gert Torres. So, I think that he saw three schools under the vice-president of health affairs- school of medicine, school of nursing, school of allied health. Now, if he wanted to stay just in healthcare education, he could have very easily. Well, he did pull out the health sciences library, pulled out the interdisciplinary teaching labs, he very easily could have pulled out the basic sciences. There are models where there are schools with basic sciences within a college of medicine, or a college of health, whatever they call them. I doubt that he would have ever wanted to start a dental school or a podiatry school. I don't think he ever saw building a university hospital. At some point during his tenure, he decided he wanted to be a president. I believe that he is directly responsible- in conversations with Kegerreis and the board members- for this university going back to the provost system after the problems that they had with Dr. Spiegel, and reorganizing back to where they were and to where they are today. And you'll notice that the provost system is a chief operating officer system, as opposed to an academic provost with a VP for academic affairs title tied to it, which is certainly what Beljan's interests were, which was control. And he wouldn't have had the academic qualifications to fill an academic provost role. I don't know whether he saw health affairs as an interim toward that, that he needed to have to get out of the school of medicine and yet retain control. Because you'll notice as soon as he moved into the provost role, he abolished the office of health affairs. So I think it was two-fold. He had this one vision in terms of multiple schools, but I think it was primarily driven by ambition. It is no secret that he still works at presidencies of one kind or another. Even from where he's at right now.

J.S.: Well, I do want to thank you. You have given me this afternoon a large part of an extremely busy schedule. I think it's significant, and this has gone the longest of any series of interviews I have even done. It is extremely informative and I appreciate that very much. You have proved to be a gold mine of information.

D.D.: I have enjoyed it. In terms of the SOMAT, you're one question on the SOMAT.

J.S.: Ah. Yes.

D.D.: It is essentially- and I think we went through some of this, you may want to review the tapes- but it went out of business because the RN Regional Medical Program monies were only dollars left over, they weren't continuing funds. So, we knew when we started we were going out of business, and simply and quickly, the people at SOMAT- Frank Holden, Pat Wenning, and then myself in a consultant role at that time- but the three of us in our various roles and tenures put together the AHEC grant, what is now funding the AHEC offices.

J.S.: So, it just kind of continued in another form?

D.D.: It went out of business totally, because there was almost a year and a half, two year cycle when the one funding went out and the other one came in.

J.S.: But is AHEC doing similar things that SOMAT did?

D.D.: Yes. It was the kinds of things we wanted to do. I don't know if you got Doug Durko, Pat Wenning, and Frank Holden in the office that we'd say that the five years of AHEC funding, that they would get a letter grade higher than a 'C' from us, and maybe lower. And that may be true out of the dean's office. I have stated my concerns often about the AHEC. But I think under the new model we have when the AHEC office came into the dean's office, reporting to Dr. Lindower, and the people physically have come into here, and the fact that we have more flexibility with the state funds than we did with the federal funds, that AHEC has an extremely bright future. The problem with the federal funds was they had regulations built in, in terms of things that you had to do and could not do. What was never recognized by the feds was that the school of medicine is designed as an AHEC, and all the things that they were putting dollars up for to make more traditional schools do, we were already doing that. We wanted to go into what AHECs should be doing in their second generation, and they said, "No, that's not allowed under the regs. You are supposed to do this." We would say, "We are already doing that" and they'd say, "Well, somehow change it." So, you'd make small impacts. But under the state dollars there are none of those constraints and we can start to do second generation AHEC kinds of things. For example, the funding of an undergraduate family practice fellowship is one of the neatest things AHEC has done. What they do is we can pay stipends and expenses between their first and second year, during their summer break. It isn't coursework, but they are assigned in an undergraduate fellowship in family practices to a preceptor for four to eight weeks for that

summer, as opposed to going out and laying bricks, hauling sod, painting, whatever. What they do in those eight weeks is that they work as an undergrad fellows in family practice, and that is a positive way of emphasizing primary care, and for them to experience that early on in their education process in a positive manner, just by being exposed to primary care is something that seems rewarding and that they will want to give consideration to. So, they complete their medical education with at least some bias. If they don't choose primary care, and let's say they go into surgery of one sort or another, they at least have some sensitivity to primary care because they were in that environment. That is an excited kind of thing that has come out of AHEC, and that we can do with the second-generation dollars, and there are other and more creative things that can be done with AHEC with the flexibility that come with state funding mechanisms, opposed to the federal funding mechanisms. Also, we will be able to eliminate some of the dual administrations that are put onto us by the feds. Short and sweet, that is what the AHEC has done.

J.S.: Once again thank you very much.

D.D.: If you have any other questions or want to do some more, let me know.