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### Douglas Durko interview (1) conducted on April 29, 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 date: April 29, 1985  
Interviewer: James St. Peter  
Interviewee: Douglas R. Durko  
Associate Dean for Hospital Affairs  
Interview 1

[Beginning of recorded material]

**J.S.:** My name is James St. Peter and this is the first in the series of interviews with Mr. Douglas R. Durko, Associate Dean for Hospital Affairs in the Wright State University School of Medicine. The date is April 29, 1985, the time is two thirty p.m., and Mr. Durko and I are in his office room 110D in the Medical Sciences Building at Wright State University. Mr. Durko can you tell me about your prior to coming to Wright State?

**D.D.:** The first time I came to Wright State, I came right out the University of Dayton and I went back late. Prior to that I was Corporate Quality Control Manager for a company called Kurz Kasch which is a plastic firm that had plants in Dayton, Xenia, and Newcomerstown, Ohio. I went back to the University of Dayton. Graduate in '74. In August of '75, I came with the medical school under a man power grant that was called The Greater Miami Valley SOHMET which was an acronym for Sub regional Organization for Health Manpower Education and Training and I worked for a guy named Frank Holden in Dayton who was the first and at time the only member of the Department of Community Medicine. His salary was spilt fifty percent between the Department of Community Medicine and fifty percent through the SOHMET grant which was a grant out of the Old Regional Medical Program. In fact, I think it was unexpended dollars that came to us because it was not renewable once the money ran out.

**J.S.:** What were your responsibilities under that project?

**D.D.:** We did, it was kind of interesting, we did three things. Number one we funded a training program at the Good Samaritan to train RNs to triage in the emergency room. We funded that program, the training took place at Good Sam, and it was essentially, as I said, to train nurses to see a patient when they came into the door and to triage them into the proper place whether it be to x-ray before they see the physician or they must see the physician now and also to set

priorities in terms of who would see the patient when. The other thing that we did is we funded in part the first individual in the Department of Post-Graduate Medicine and Continuing Education, John Barton and I believe his assistant when they first came. I can't remember her name. Barton is now Dean of Continuing Education at the Kettering Center. They developed the Continuing Education Department at Wright State that was the beginnings of that. Frank and I specifically, we had out Secretary Leann Smith who is in the Department of English right now or a secretary in the Department of English, our function was two-fold. Number 1 to look at some man power data to see if we could begin some man power planning and Number 2 to look for other things to do including the other funding to keep the SOHMET alive. A number of things became very apparent to us. First of all that those things that consortium type institution and consortium were actually very weak in Dayton and always traditionally had been through joint purchasing and all those things and we were a consortium of consortiums and therefore we got probably a better education than money can buy in terms of year in examining the health care system in Dayton, trying to find a niche. It led to what I am doing now and furthered my career. It gave me some insides, some backgrounds that someone that was just entering would have never gotten by reason the people who interacted with us. Our board was made up of the Dean of the School of Medicine, Dr. Beljan, President of Sinclair Community College, the Dean of Kettering College Medical Arts, the head or President of the Montgomery County Medical Society, the President of the Dayton Dental Society, the President for the Academy for Osteopathic Medicine, three hospital administrators the heads of them, three other individuals one being the Chief Executive Officer at Maria Joseph Living Care Center on Salem, I am trying to think of what the other two categories were. We had hospitals, educators, I think that there was someone who was the head of the RNs in Dayton and somebody that was the head of the LPNs or something like that without digging into old files. We got to rub elbows with a number of people that normally we would not have rubbed elbows with just by reason of the organization.

**J.S.:** Where you the administrator for the program?

**D.D.:** No, Holden was the director and I was the assistant director. Eventually in our work we discovered AHEC, which now exists across the hall, stands for Area Health and Education Center. There was a first generation of AHEC's that had been funded, there had been seven of them I believe and there funding was a declining funded base, it was supposed to decline over seven years. They were looking for a second generation of AHEC's and Holden, most people don't know about this and some wouldn't even acknowledge it, was the first to plant the seed for two significant ideas. The first was when he was in Washington. He talked to a guy named Dan Smith who was the head of the national AHEC program and pointed out to him, Smith knew this but has never made the connection that AHEC, the intent of AHEC was to place health care professional's one sort or another into medically underserved areas. They defined medically underserved in the first generation was rural. Holden was the first to point out to Smith or encourage Smith to include in the second generation inner-city areas in the AHEC determination.

As a result of doing that the number of underserved areas in this eight county area increased significantly because the time in the City of Dayton from the West Side to the East Side there was a number of census tracts that were medically underserved and it looked something like a Coke bottle with downtown being the skinny part in the middle and then it would widen out West Side East Side either for the Black population or Appalachians with center line being Third Street almost. Then by reason of being in Columbus and we talked about this, he met Dr. Rupert who is now President of Medical College of Ohio who was then Vice Chancellor for the Board of Regents for Health Care and talked to him about number one the potential for an Ohio AHEC and number two about a consortium of all of the SOHMET-like organization and there were a number of them. There was another SOHMET at the University of Cincinnati. There was another AHEN I think that was in Toledo or Akron that was an Area Health Education Network. There were all kinds of acronyms around the state that were funded by the RMP money who were also looking for . . .

**J.S.:** RMP is what?

**D.D.:** Regional Medical Program.

**J.S.:** Okay.

**D.D.:** That had funded the SOHMET. All of them with the RMP being phased out were looking towards AHEC type activities and at that point in time I had left to go to the Miami Valley Health Systems agency and Patt Winning who was with the Western Ohio Emergency Services Council, she is currently a Vice President with Health Facilities Corporation which is a consulting firm in Chicago. She came on, took my place, and I came back abroad on a part-time capacity as a consultant.

**J.S.:** What were you doing in the interim?

**D.D.:** I was working on Miami Valley Health Systems Agency as the eventually Director of Health Resources Management which was essentially the head of all their review programs. We were on the same floor so it was easy for me to come over after hours and weekends and consult and Holden then left and went to Boston. He is with the Boston VA still. He splits his time between the Jamaica Plains and the West Roxbury VA with most of his time at the West Roxbury, I believe. She wrote the original AHEC grant. It was not funded state wide in the first year. She became the administrative assistant for the Department of Community Medicine and moved them to being responsible for the move from the VA to Rosary Hall at the Good

Samaritan Hospital. Funding for AHEC still didn't come through. She left and went to complete her masters at the University of Chicago and then in March of '79, I believe it was, Dan Canelli and Don Gendelson were across the hall were hired to start up the AHEC when the first year of the planning grant. They can give you the information since then. So that was, and I left in June of '76, started in August of '75 and stayed three years with the Health Systems Agency before I came back of August of '79. So that is a bit about the SOHMET and the AHEC and what that was all about. There was something interesting going on at that time. There was a four person task force put together by Dr. Beljan to study what it was a Department of Community at Wright State University should be. The group initially split two to two on what I would call a traditional model which was teaching biostatistics, epidemiology, and preventative medicine. That was Alex Alexander and Dr. Hamilton. Alex Alexander being Chief of Staff at the VA. Then with Holden and Reece coming down on a document that Holden and I has prepared for a very progressive Department of Community Medicine that had computer and planning capabilities not only in manpower but also in facilities, patient origin studies, we even suggested that a board reporting to the chairmen called . . . they oversaw what was called the Center for Community Medicine and we had a whole list

**J.S.:** Where was that at?

**D.D.:** It never took place. In that with Dr. Jack Breakham who was Director of the Western Ohio Emergency Services Council would have seriously concerned brining the WEMPs grant Western Ohio Emergency Services Council Emergency Medicine grant into that setting and into the school. Plus we had he AHEC plan to go in there and a number of other things and Dr. Alexander so vehemently opposed that and Dr. Hamilton eventually, actually not the same Glen Hamilton, came around and supported the progressive model and it was three to one. For whatever reason Dr. Alexander's view were up hill then it eventually led to Dr. Hamilton, who eventually became acting chairman of the Department of Community Medicine, leaving followed by Dr. Holden leaving.

**J.S.:** This was all still before you went to . . . ?

**D.D.:** This was, it might have been right after I left. It was in the '76 time frame. '76, '77 time frame.

**J.S.:** When did you come back into the School of Medicine?

**D.D.:** August first of '79.

**J.S.:** Into this position?

**D.D.:** I came in as Assistant Dean for Hospital Affairs reporting to Fran Paris who was then Associate Dean for Hospital Affairs. Well, in theory, Assistant Deans did not report to Associate Deans. I worked with Fran and reported to Beljan.

**J.S.:** What brought you back in at that time?

**D.D.:** Actually, health planning was not an arena that I wanted to make a career out of. It was equally important as my and maybe more important as my days with the SOHMET in that running the review at the health systems agency. My boss there use to call it the City Desk of Healthcare. We use to tag it as the run of [unintelligible] health care because anybody who had a project that had to be done had to come to me and more often than not the first person to show up, although work would be done with others later, was the Chief Executive Officer to sit down and discuss whether or not they had a chance, what was my views, the things that they should consider in their drafting of application and those kinds of things. There was a review at Children's Medical Center in probably early '78 and Fran Paris who part of it had to do who the school location and the facility that they were planning was going to do with how they housed residents in the Department of Pediatrics. Fran Paris was there. Fran used to be the Administrator at Children's also. We walked out into the parking lot together and I asked him if anything was going on with the school and he told me about a position that they were going to be looking for in was budgeted for January and at one lever then it got upgraded to another level and had to do a national search. I got the position. I had minimal knowledge as it related to medical education as result of SOHMET and the health systems agency there was nobody in the city that knew this town better than I did. What motivated some individuals, turned off other individuals. That's the reason I think I had the part that I had in terms of getting this position.

**J.S.:** How long were you Assistant Dean for Hospital Affairs?

**D.D.:** Until, let's see, June 30th of '83.

**J.S.:** At which time you came into here?

**D.D.:** Well, I have always been here then I became Associate Dean for Hospital Affairs. Fran Paris left in, whenever Health Affairs was created. That was, Sawyer came in '81 I believe and I think Fran left in January of '81 and went with Beljan to the Office of Health Affairs when Beljan gave up the Deanship. Sawyer came in and I remained solely responsible for the office at the time.

**J.S.:** What were your responsibilities as Assistant Dean of Hospital Affairs? What are your responsibilities now? How do they differ?

**D.D.:** When I first came to work with Fran we kind of split up what was going on in the office. There were contract negotiations, placement of students, coordination of some activities and residency programs. The primary thing was contract negotiations with the affiliated institutions and the development of a few of the affiliation agreements. Most of those were in place by the time I got here. The difference now is the level and depth of my responsibilities as opposed to things being different. For example, before I was a member of the residency policy committee, I now chair it, which is a very important committee with the School of Medicine. It is made up of Program Directors from the integrated residency programs and the Directors of Medicine from Medical Education at each of the affiliated hospitals involved in residency programs and generally sets policy for residency interaction throughout the city. I think especially under Dr. Sawyer my level of responsibility in terms of assignments received is far greater than it was under Beljan. Also I am more heavily into program development and implantation. Before when we interacted with affiliated programs it was to do those things that was necessary to get the school going. To get them to agree to have students taught within their walls, to convert or merge residency programs and integrated residencies to start new residencies and to place clinical faculty. Our clinical department is the faculty where clinical departments for affiliated faculty in each of the various institutions in order to teach. Now we were able to do that more often than not we were able to kill two birds with one stone and that happened in a couple of ways. The reimbursement or the group of individuals who pays the bill for medical school education is the State of Ohio. That group of individuals that pays for residency education is the third party reimbursement system. Medicare, Blue Cross, so on and so forth. It is a part of everybody's bill. In that we do not have a university hospital and will never have one as far as I can see. Hospitals in many ways turned us to teach their residents. Not total but in many ways. And since they are the individuals or organizations that had access to Blue Cross and Medicare and other providers or payers not only was it their job to pay for residents' salaries but also in some ways to pay for faculty salaries. So we would in some cases split the cost on an individual to come in and run the residency and also to teach students. In other cases it could have been two fold which was when we needed a faculty member somewhere and the hospital needed an individual who served a function within the hospital clinically. For example, currently we have Dr. Hildebrand in OBGYN who is the Director of the Perinatal Center at Miami Valley Hospital, McIntire Perinatal Health Center and he is also on our faculty. That was a contract that was negotiated out. So that is an example of a two way clinical and teaching. And actually Hildebrand represents a

three way split he is responsible for medical students, residency, and that function as Medical Director so there is all kinds of variations. About two years ago we capped out on being able to matrix the recruitment of individuals with our hospitals for the purposes of teaching.

**J.S.:** What do you mean?

**D.D.:** The hospitals number one were faced with new payment systems through DRGs and Medicare and diagnosis related groups and we had enough individuals in place to teach residency students for the most part and to go to an affiliated institution and say we need more people to teach these residencies was something that wasn't viable. So we had to get a little bit more creative and start talking about programs. The Magnetic Residency Center is an example of caring medical center. Right now I don't know if it will go anywhere but right now I have hopes we are with Sycamore Medical Center which is a part of Kettering Medical Center should we this week come to a decision about whether or not we will pursue individual who is a Senior level faculty at Ohio State in Psychiatry to come and develop a Regional Sleep Program, for sleep disorders. Also we are looking at substance abuse is becoming an area that is very attractive. We're, right now, Sycamore has submitted to the State of Ohio a Certificate of need in adolescent substance abuse program which those individuals in the Department of Medicine and Society in the weekend intervention program the holds key slots including the directorship and the onsite director and will be Dr. Siegal and someone will be hired if that goes through. And that is going to be a unique program that we have it designed. There are about six or eight components that an individual can access in the system. Any component can come into an evaluation in treatment system that will once again channel them, it has the flexibility to channel them into any of five or six different areas.

**J.S.:** What is the name of the program?

**D.D.:** We don't have a name for it. It will be an Adolescent Substance Abuse Evaluation and Treatment Program. We don't have a name yet until we get it approved. We did sell the Harvey Siegal, sold is probably the wrong word I guess, put in a weekend intervention program. Harvey put it in, I negotiated the agreement with Deaconess Hospital in Cleveland last year. That was exciting.

**J.S.:** So is Briggs going to help with the weekend intervention project?

**D.D.:** Yes and Dr. Seagull has done a number of things with his involvement. He has done some stuff in Wyoming and Missouri with their Department of Transportation



**J.S.:** These are all a part of your ongoing responsibilities a part from day to day responsibilities?

**D.D.:** Yes. My primary function is contract negotiations and we update those annually. For instances, I do those twice a year. For those hospitals on a July fiscal year of the major affiliates which are Children's, Good Samaritan, and one of the Springfield Hospitals. They are on a July fiscal year and we will begin negotiations in February or March. The rest of the facilities and major affiliates are nonfederal. Miami Valley, Kettering, St. E's, who am I missing . . . Greene are on a January fiscal year. Those negotiations begin in the July, August, September timeframe. So each of the contracts we have to date renegotiate, people may leave, pay raises are given, programs go well, some want to expand on the number of individuals so we go into new recruitment. Others may want to cut back on things so we cut back on contracts and times of the faculty members and that is in conjunction overseen by the Dean in conjunction with the Department Chairmen run out of this office.

**J.S.:** When do you negotiate with the federal hospitals?

**D.D.:** We don't really. The Air Force is not, that is a program development, and they are mostly education. If you are faculty, some of our faculty go out there but they don't get paid for it. It is kind of quid pro quo. We certainly do not joint recruit with them. Unless you are trying to put some of your faculty into the Air Force. The Air Force is very interesting. As far as I know, and I know it is true with the Air Force plus they are not as big as the Army and there is another branch for example. I think they are the only military facility in healthcare who has residencies that are integrated in with civilian residencies as a partner. They are full partners. I think that there are Air force residencies or Army residencies or Navy residencies that may rotate with civilian institutions but as far as I know this program at Wright Patt is the only one where they are integrative in a civilian medical school operated responsible residency program and that's three of them. Psychiatry, surgery, and pediatrics and obstetrics and gynecology. I am sorry, four. So that is very exciting and they are very important to us. In a time where psychiatry is not attracting a whole lot of individuals it is very important to maintain the quality of the psychiatry program. The other thing that Wright Patt participates in, in a large way, is the aerospace medicine residency training program. That is the only civilian aerospace residency medicine program in the United States. Dr. Moller has a grant, Stanley Moller in Community Medicine, has a grant from NASA. In addition to that, there is a group of individuals who have come on their own and there have been a number of individuals who have been sponsored by their governments. I know that he has had one individual who was sponsored by Canada. One by Australia and one by Taiwan. Dr. Moller is an expert, nationwide and maybe world-wide expert,

in the area of pilot aging. It is a very exciting program and it is nice to have it here. They do quite a bit of their research that is required in the residency program at Wright Patt.

**J.S.:** What about the VA?

**D.D.:** The VA is an interesting story. It was the VA grant or one of the VA medical schools. The VA has always been a major affiliate. Interestingly enough, the VA was never fully taken advantage of until this past year.

**J.S.:** What do you mean by that?

**D.D.:** The relationship between an academic VA and its medical school is very similar to being a university hospital. Now there are limitations that would stop it from becoming a soul university hospital. Number one, it is federally owned. Number two, the lack of women and children for both service and teaching purposes. However, the faculty that is recruited at a VA [unintelligible]. To fill slots at a VA for physician's slots is a joint recruitment process by faculty. Now there is a concept that is known and does not exist in Dayton really at medical centers, especially where you have a university hospital that is known as the geographically fulltime equivalent fully affiliated faculty. What that means is that at a, let's take Good Samaritan Hospital as an example as how that could take place at a community hospital. If in fact a hospital administration said to the Chairman of Medicine, "I am making you my chief of medicine. You are responsible for my division of medicine. You are responsible for the recruitment of physicians of medicine into my hospital. You have the right to hire and fire. Or your designee has the right to hire and fire. And part of their job description is academics but I'll pay the bill." That is a geographic fulltime equivalent. We do not have such a system in Dayton. For two reasons. Number one we do not pay physicians who are not fully affiliated with the school and number two hospitals are not interested in turning over their divisions to our chairman. Well the VA did, to a degree. It was the responsibility of Dr. Barns to recruit the current Chief of Medicine, it was Dr. Hank Bolton. Dr. Bolton is also one of two Vice-Chairmen in the Department of Medicine. Everybody that they are currently recruiting are fully affiliated faculty with the school and must meet requirements of the VA and the School of Medicine in terms of academics and the faculty development committee in order to accept the position up there. So this is how closely we are wed. Now, I talked about the lack of progress because the previous individuals in the previous administration in the VA were unfamiliar, and uncomfortable in my opinion, with such a program that is the VA's problem. As well as our first generation chairman being unfamiliar with the program and slightly unfamiliar and uncomfortable because in some ways we caused individuals to be replaced. There was resistance. And the VA was not fully utilized for the first nine years. Last year, Willard Hitchings the Director of the VA retired and an individual named Alan Harper who was Associate Director at

the Gainesville VA in Gainesville, Florida which is probably as strong as any VA in the country in its teaching affiliation right there with the University of Florida is the prototype for what we are looking for. He was brought in and understood the system and understands it now. The progress that we have made, especially in medicine or the medicine disciplines in terms of recruitment for this July, people have already signed the dotted line or will be here soon. It's incredible. I am very pleased with that and it is going to be of major, major importance to us. Not only clinically and teaching but in terms of potentials for research.

**J.S.:** What will that do in terms of specific residencies?

**D.D.:** Nothing. It will strengthen the medicine residency.

**J.S.:** So the major application of this new development is in the area of education medical students?

**D.D.:** And residents.

**J.S.:** And residents.

**D.D.:** But it won't change the numbers. It will change the quality because we are going to have more quality individuals. Also in the medicine subspecialties. It will make the VA experience much better than it has been.

**J.S.:** Where do these individuals fit into the individual departments of the School of Medicine?

**D.D.:** The ones that are currently being recruited where we are having the most success will be in the Department of Medicine but I would expect in surgery, where we are currently looking for a Chief of Surgery, and eventually in psychiatry that over the years there will be as much impact there as there is currently in medicine.

**J.S.:** Let's turn to the affiliation agreement themselves. Are all contractual obligations between the School of Medicine and a particular institution under the affiliation agreement?

**D.D.:** Yes.

**J.S.:** What all do they cover? Let's take a particular model for instance.

**D.D.:** Okay. Well the affiliation agreements I should speak to first.

**J.S.:** Okay.

**D.D.:** They are a bunch of why's and where's forms in terms of what's good about us being affiliated. There is an awful lot of apple pie and motherhood in these things. The one substantive thing, and let me take you back with some history as I understand it and this was before my time. What was in them was joint coordinating committees. Each of the affiliation agreements still has Joint Coordinating Committees in them. Only two meet. That is Wright Patt and the VA Deans Committee. They were very important in the early days when the affiliation committees were limited to the major seven or eight affiliates that were the original affiliates. What would happen was Dr. Shivey, who was in my position before me, and Dr. Beljan would meet with the Executive Officers of each of the affiliates and what was a bylaws committee at that time called the Hospital Affairs Committee they would then set policies as a group. Then within each institution was a Joint Coordinating Committee made up of members of the School of Medicine and members of the institution who would then implement those policies as it related to medicine students, what medical students were called, where they would be, what they were allowed to do. And the Hospitals Affairs Committee and the Joint Coordinating Committees went on and started to decline in importance up through about '80. The reason for that was that the action moved into different arenas. We became concerned with residencies as opposed to students. Students were in place, things were going on, and they became a normal course of events in a hospital. Departments were placed. The contract negotiations since I told you turned towards residencies and faculty for the residencies. Therefore the only interaction between this office and the Dean's Office but specifically this office, moved into an individual contact within the hospital in terms of that individual designated within their administration. It's generally either the CEO, which is Chief Executive Officer, or the COO, which is the Chief Operating Officer is my designated contact. And the Director of Medical Educations office, the DME's office, and joint coordinating committees became obsolete. You cannot contract negotiate by committee. It's a one on one. Generally the way the process works where it is most successful, which is very interesting, is that an individual and I will sit down and hammer out from our particular views a contract. We'll sit down and we'll hammer out a contract. For it to work best is, now we might have disagreements and we will compromise so on and so forth but once we've reached agreements the system works best if we as individuals then become advocates for what we negotiated back at our own institutions. Sometimes we'll come back and the Dean or somebody else will say "You've got a problem here.", "We can't live with that", or they will say the same

at the hospital and as a result we will have to come back and make some modifications. Where is has been a disaster is when one individual does that. I have had more than one individual, meaning one I can think of – one major affiliate, who was unwilling to be an advocate. The guy was a consultant at a major consulting firm before he came to the hospital and he acted as a consultant in the negotiations. He would listen to my proposal, not negotiate back, then would take a piece of paper that he wrote up and place it before what is essentially a hostile group that will say, “That damn medical school is trying to take our money again without being an advocate and explain why this and so and so”. So that is how can work on a positive manner and some can work on a negative manner. Generally, as I said, everything is done under an affiliation agreement. The one way that you can side step an affiliation agreement, it’s not done often but it’s possible, is to place a student with a volunteer or clinical faculty member who may have a major function with an institution that is an affiliate. The best example of that is we have some important osteopathic physician who are on our faculty. However, we have here a hands off policy as it relates to Grand View and not because it is osteopathic medicine but because it is a major affiliate of the Osteopathic School at Ohio University. If we in Dayton gobbled up Grand View and Ohio State gobbled up Doctor’s Hospital in Columbus and I can’t remember the name of the facility in Cleveland was gobbled up by Case who is an affiliate, we would destroy the clinical teaching needs of Ohio University. So hands off. However, we do have some people, for an example, I know there are some physicians in ophthalmology who is very important, some in family practice, and a student may be assigned to them, and therefore go where they go. And at the same time they may have residence needs who are important in our affiliated institutions. For instance, need to do some pediatrics. Some may go to Children’s. But that is essentially how our affiliations work and the contract negotiations. I should tell you that in 1981 I took steps that are necessary to discontinue the Hospital Affairs Committee as a bylaws committee first of the school of medicine designated by the bylaws and as a body period. My reasons for that go back to the joint coordinating committees and their obsolescence’s. The Hospital Affairs Committee became obsolescent for two reasons. Number one that was, as I told you, a delegation on that part of Chief Executive Officer and the Dean to my office and to individual within their institutions to do the nitty gritty and it became a one on one issue. Secondly that somewhere along the line affiliations became status symbols, which they always were, but also political. To the point where it became the normal course of events where every health care institution in the area, our eight county area, became an affiliated institution.

**J.S.:** Of the medical school?

**D.D.:** Of the medical school. The plaques were going out to where we have 29. Other than a once a year state of the school message there was no reason for, there was no agenda you could put together for that diverse of a group. For somebody who was president a seven hundred bed hospital, for somebody who has a small clinic in Wilberforce, for somebody who is the Director of Community Health Agency, to somebody who has a hundred and eight bed hospital in Greenville. It was impossible to put together an agenda for these individuals. Attendance

slumped. We put off meetings. We canceled meetings to the point where it served its purpose and its function. So therefore I took those steps before the bylaw committee to have it done away with as a bylaws committee and a committee in general. I think that there is a need for some kind of a group and I don't know what it is or what it looks like that would replace that at least for the major affiliates. Because I don't think that they know enough about each other. They know about us and to a degree, especially when it comes to the VA and the Air Force, the community hospitals have very little comprehension what goes on at the VA and the Air Force and the importance of those institutions to the school of medicine. They think that they are the only act in town. The barriers are that the politics and the personalities involved say don't get these people in the same room together or it will be a disaster. We had Bob Willit who was the president Kettering Medical Center and Rush Jordan who was the president of Miami Valley Hospital battling on the front page of the Wall Street Journal a couple years ago. Calling anything that was fit to print. So you have some problems with institutional parochialism, personal parochialism. I have not quite figured that out yet. We talk about it periodically and put it on the back burner. We are doing fine as is without it.

**J.S.:** Are there elements that are common to all affiliation agreements? Is there a central model that you would apply of an affiliation to another institution?

**D.D.:** It is essentially the same wording cut and paste. I would guess that one written in '75 and one that was written in '79 might have some different elements. One is probably more legalistic than the other but I think all the elements are basically the same and for some of them it's the same wording.

**J.S.:** What are the basic elements of an affiliation agreement?

**D.D.:** Essentially it is a preamble followed by talking about the school of medicine developing programs and common facilities and hospitals desires participating in education. When they see it is for their mutual benefit so on and so forth go into this agreement. Then there is a list joint responsibilities essentially things that they are once again doing this again to go into education. They agree that it is desirable to promote the facilities and for both institutions to be used for education. The Joint Coordinating Committee is a component. Maintenance acceptable accreditation standards addressing the issues of federal and state regulations in regard to hiring policies to discrimination. Potential for location departments that won't be a conflict between individual policy rules and regulations concerning faculty versus medical staff policies.

**J.S.:** So it is also a series of protocols?

**D.D.:** Yes. Then they go into the school of medicine responsibilities concerning faculty appointment disparaging the staff about hospital... to give you an idea of generic, the faculty of the school of medicine shall develop, operate, and evaluate a quality in the graduate medical education. Talk about timely planning and coordination. The faculty and students will be under the control of the School of Medicine they will make sure such participants will comply with the applicable regulations of the hospital.

**J.S.:** This is still the job responsibilities?

**D.D.:** No, that is the School of Medicine responsibilities.

**J.S.:** So it is separate?

**D.D.:** Yes. Then they go into the hospital responsibilities. Talking about patient care being the responsibility of the hospital. That major changes made they talk to the role in charge of timely planning and coordination and to take into consideration has major changes will effect education. They agree to maintain high standards of patient care. They make the facilities and patients available for teaching. There is one specific that is interesting, the hospital will provide emergency first aid and emergency care for School of Medicine faculty and if students should get an illness occur while in the hospital charges for such will be at the usual rates. Hospitals determination of the duration of extended first aid and emergency care shall be conclusive. And then they talk about the terms of the agreement. Like how long. It is agreed to and signed at the Board of Trustee level for each institution. So that would be the board of the university and the board of the hospital. There is another component that you should know about and that is the ambulatory teaching facilities agreements. Why don't you shut that off while I look? I think that there was and I don't know when this was approved but there was a substitute hospital in '87 out of the state legislature that approved an eleven point nine million dollar allocation for the School of Medicine for ambulatory teaching facilities. This was divided up among institutions as follows: there was six point seven million dollars allocated to the Frederick White Center, there was nine hundred and one thousand dollars to go to Children's Medical Center, a hundred and seventeen thousand dollars went to Greene Memorial Hospital, one million five and I have rounded off these numbers, went to Good Samaritan Hospital, four hundred and sixty thousand dollars went to Kettering Medical Center, seven hundred and ninety thousand went to St. Elizabeth's Medical Center, one million two thousand dollars when to Miami Valley Hospital, and there was one hundred and seventy eight thousand that was allocated to Drew Health Center that was never spent or appropriated.

**J.S.:** Why was that?

**D.D.:** A hundred and seventy eight thousand. Drew developed problems and went out of business. Interestingly enough I reviewed this when I was with the Health Systems Agency. It was my first major review before I came with the school. Well long before I had ever thought about coming to the school. This was reviewed and approved by the Health Systems Agency and the Ohio Department of Health in the fall of '76. In the original review, before the certificate of need, there is a federal process called 1122 Review which was a regulation to review capital expenditures for Medicare and Medicaid reimbursement. The preceded the state certificate of need laws that came under new legislation creating Health System Agencies opposed to the Health Planning Councils. The original application had all the dollar amounts that I mentioned to you.

**J.S.:** This is for the Fred White Building?

**D.D.:** This is for the Ambulatory Care Teaching Facilities Agreement a massive application that had signatures by all the Deans, Dr. Beljan the President, and all of the Presidents or Chief Executive Officers of each of the institutions that I just listed to you. Now in addition to the eleven point nine million there was supposed to have been eight and a half million dollars in revenue bonds coming from the City of Fairborn to construct a fifteen million two hundred and eleven thousand dollar ambulatory care facilities or an ambulatory care facility on campus here. The basis of the need was twofold. In the hospitals it was the need to create facilities that range from office space to outpatient facilities to teach students and it could include lockers, lounges, and conference rooms, whatever. They varied all over the place in terms of the types of facilities that were built. The basis for that component of the application for Fairborn was based on a consulting firm based out of Michigan called Chi Systems. Greek letter Chi... it's a Greek letter isn't it. They did a feasibility study for an incorporated group of individuals that was brought together by the City of Fairborn called the Fairborn Medical Facilities Inc. The chairman or president of that group was a guy named Doctor Wilen Mundy who eventually came to work for the School of Medicine in the Department of Community Medicine. He gave up his position in Community Medicine and was one of the first individuals to enter into the Emergency Medicine Residency Program. He eventually graduated from the Emergency Medicine Program and is now running an emergency room in Arkansas. Let me get back to the point. Chi Systems did a study because for years Fairborn felt that they needed a hospital. They were going to do a number of things taking steps in that direction including ambulatory care facilities is the first step. The School of Medicine, and this is before my time so I am giving you second hand information, also wanted to put facilities on campus as a result of the school being created. There was action on the part of a number of individuals both in the Dayton and the Greene County community who said why don't you get together. They did and this fifteen point two million dollars facility was planned. Having received approval for this whole package the School of Medicine because Chi Systems was a originally put together with the idea in purpose to create a hospital but their



database was useable. The School of Medicine then engaged a consulting firm called Booz Allen and Hamilton out of Chicago I think. To verify the Chi Systems numbers and the size and need of the facility. As a result of their study, the first phase of the proposed facility was reduced significantly to the size that it currently which cost six point seven million dollars and was equal to the amount of money the state had allocated. There were a number of reasons why this happened and I can tell you again this predates my time at the school, there was a question at the time concerning whether or not this facility was needed in the review process with the Health Systems Agency. We were able to justify the facility based on the need for ambulatory teaching facilities. Not for the need for clinical needs for Fairborn. I think that quite frankly that Dr. Beljan probably perceived that fifteen point two million dollars was too much. There is no doubt that the interactions with Fairborn were political in terms of way this was done. I think that the Bous Allen Hamilton study verified. In fact, he engaged the Booz Allen and Hamilton Firm to verify what was probably already in his [unintelligible].

**J.S.:** Did you the Fred White Center's role as a clinical facility would have been impinging on the territorial spheres of the area medical schools or the area hospitals rather?

**D.D.:** There was always a belief that we were going to build a bed tower. There are still people who believe that. It never will come true. The fact of the matter is that the facility was never made. It was a need on the part of the administration of the school, Beljan in particular I believe this is not my words, that they could not divorce themselves from the tradition model that says I do not control something in terms of health care facilities. Therefore, I need something on campus. Quite frankly, the facilities that were in place in terms of planning and or construction within the affiliated institutions at the time this was purposed was sufficient for residents and medical students. It has proven out that the facilities...

**J.S.:** So the current plan as of fiscal year '85/'86 is returning it to more or what is should have been in the first place?

**D.D.:** Which is teaching and research. I don't know that we had the research needs in terms of labs that existed before... previously, I'm sorry. I do not think that the need for research, the school was geared towards research at that point in time that we needed the extra research space. What should have been done, in my opinion and the opinion of others, was that a group of individuals who were multidisciplinary in the clinical departments be hired and placed full time at Fred White to do practice. We are talking medicine, OBGYN, surgery, family practice, whatever. And then to assign students to rotate on it would be a group. So it would have a twofold function. One is clinical care and the other teaching. So essentially they are academic mercenaries. To generate funds on the one hand and teach on the other if in fact they should have built the facility at all. Now as it turns out, that it is the new model. I think that it is outstanding

because it will mix administrative functions, teaching, and functions of the school. The establishment of the medicine pediatrics residency program and the four hundred and some thousand dollars in training grant that was received in order to establish that and made the old acute medical services module viable for their utilization as a practice center for those residence therefore that was the key that could really make the facility function in terms of a teaching facility for residence and students that is the key was that residency program because there was never big interest in that part supporting institutions for faculty being placed in a practice residency.

**J.S.:** So how did you get to the ambulatory teaching facilities agreements? How are those integrated overall into the affiliation agreements?

**D.D.:** Well the affiliation agreements were established first then this was approved and there was a pot of money that was planned for school to have rights to specified space, specified to a greater or lesser degree, for use for twenty five years in the hospitals.

**J.S.:** Each agreement was supposed to work twenty five years specific to?

**D.D.:** Right. Now the space that we command in the hospitals is much greater than [unintelligible] the ambulatory teaching facilities. There is no way, well I do not want to say no way, the cost of the school for the space that we have is much greater then what we have listed in these agreements. For example, Good Samaritan Hospital we have the third floor of the twenty two hundred building and access to outpatient facilities that is on the first floor of that building clinics. What is doesn't mention is the fact that we have three floors on Rosary Hall at the Good Samaritan Hospital that houses Community and Emergency Medicine in Psychiatry. Plus there are students, residents, and faculty are in all other parts. It was a way of getting some dollars there. It was never meant to pay for our entire bill at the hospital and that was their quid pro quo to give us space and access unstated, but in return for not billing the university hospital. That is interesting. Maybe we should talk more about it. I find it interesting that the main emphasis on a community's medical school is that we are utilizing the community's facilities. What people tend to forget is that also a major component of that is the way the person planned this did it, whether that was Beljan or whoever, equally important is man power and that we are utilizing the manpower available so we did not have to put together a eighty man department of medicine to run the division of medicine in the university hospital. There has been significant savings based on scale as a result of the school being here and being in the model that it is in. As well as improvement of quality in care. I do not think enough credit is given to that. Secondly, an interesting phenomenon has taken place. As there has been turn over, in the administrative reigns of the hospitals, there is less sensitivity to the new guys in town. Well we should do this with the school because they didn't build a university hospital. Therefore negotiations and fiscal support

from the hospitals become tougher because they do not know the history and they see us as a drain. Also I would say that the levels of sensitivity in the administrative ranks of the hospital, below the ranks of the chief executive officer, are less academic and more dollar orientated because number one many of these individuals have not served in an academic environment previously. Number two the reimbursement system is driving people. They develop a sensitivity to what people are willing to pay for and not pay for.

**J.S.:** Well, that is a good place for us to stop the first interview and you have given me a great deal of information to go back and look at and reexamine and come up with more in-depth questions. I very much appreciate you taking the time out of your extremely busy schedule to talk to me.

**D.D.:** Let me, before we go, give you a list so you can [recording ends].