

Wright State University

## CORE Scholar

---

Boonshoft School of Medicine Oral History  
Project

Boonshoft School of Medicine

---

11-25-1983

### John R. Beljan M.D. interview (5) conducted on November 25, 1983 about the Boonshoft School of Medicine at Wright State University

John R. Beljan

James St. Peter

Follow this and additional works at: [https://corescholar.libraries.wright.edu/med\\_oral\\_history](https://corescholar.libraries.wright.edu/med_oral_history)



Part of the [History of Science, Technology, and Medicine Commons](#), and the [Medicine and Health Sciences Commons](#)

---

#### Repository Citation

Beljan, J. R., & St. Peter, J. (1983). John R. Beljan M.D. interview (5) conducted on November 25, 1983 about the Boonshoft School of Medicine at Wright State University. .  
[https://corescholar.libraries.wright.edu/med\\_oral\\_history/48](https://corescholar.libraries.wright.edu/med_oral_history/48)

This Oral Recording is brought to you for free and open access by the Boonshoft School of Medicine at CORE Scholar. It has been accepted for inclusion in Boonshoft School of Medicine Oral History Project by an authorized administrator of CORE Scholar. For more information, please contact [library-corescholar@wright.edu](mailto:library-corescholar@wright.edu).

**WRIGHT STATE UNIVERSITY**  
**School of Medicine Oral History Project**

Interview date: November 25, 1983

Interviewer: James St. Peter

Interviewee: John R. Beljan, M.D.  
Founding Dean, WSU School of Medicine  
Interview 5

**James St. Peter:** The date is November 25<sup>th</sup> 1983. This is the fifth in a series of interviews with Dr. John Beljan, founding dean of the Wright State University School of Medicine. The time is ten o' clock and I am with Dr. Beljan in his home. Dr. Beljan, today I'd like to talk to you about the recruiting of faculty for the School of Medicine. Were there any priorities that you and your staff set on recruiting the faculty?

**John Beljan:** Yes, very clearly there were. The first set of priorities was how to get the critical mass on board to do the kinds of things that needed to be done - curriculum development and so forth. And then the second cluster had to be those who were necessary to build some of the clinical programs in town so that those could be used as a basis for clinical education. So clearly the first priorities were put in the field of basic sciences and we developed then with the help of the people who were currently on the campus and with their representatives in the several disciplines from Miami and Central State put together a group of people who were responsible for two things – to begin the general direction in terms of the curriculum in terms of their discipline and secondly to be the search committees for the chairmen of their departments. So clearly the first group to be put on board was the basic science people.

**J.P.:** When you're talking about those basic science positions, did you create the positions in the school first and then bring in the people or did you bring in the people and let them create their own positions?

**J.B.:** Well, it's more complicated than that because this brings into focus the situation with the university in which the disciplines did not exist except as they might be represented by the people in the biological sciences at Wright State. So the first thing that needed to be done was to create the concept of departments and then secondly see how those could be fitted together between the two schools and then third, the question of the chairmanship. So when the dean of the college of Science and Engineering developed the structure, which was essentially a matrix structure analogous to the space program, and the head, in essence chair, departments which service both the School of Medicine and of Science and Engineering. That was largely a one way street, on my part to placate the university and the college and the benefits for them were far greater than they were for us, but it was an important strategy to at least make the department acceptable on campus

and even then that was imperfect. So having then developed the matrix departments, we raised the question of who could chair them. In some instances there were people on board who had the credentials to do this on campus – relatively few of those. But we looked at those people first or had them acting as interim situation before the first full permanent chairman was selected. A good case in point was biochemistry where Ira Fritz became chairman pro tem of the group but it was clearly with the understanding that he would sit in that role only until a permanent chairman was identified.

**J.S.:** Did you have any places where you wanted to go first in looking for faculty for these basic sciences positions?

**J.B.:** No, we knew we were doing to need all five of the areas and the questions were to see who would be available when and were really looking for people. The dilemma of course is with a new school development to try to find someone who, in both clinical and basic science departments, who would be willing to come to a new school development at an unknown university and in a very nontraditional, nonclassical modern medical education. So you were looking for a select group of people within a relatively select group. So we were targeting for the five areas and felt that we were really interested in people rather than the discipline so the order was not that important in terms of the basic sciences but certainly the people were. In terms of the clinical areas it was no question that we tried to focus in on the major clinical areas first- medicine, surgery, pediatrics, and so forth and try to do that to get the cluster of the fundamental disciplines before we went out after any of the specialties. That strategy was generally successful though we had a long delay in getting a chairman of medicine, some delays in getting the chairman of surgery, and maybe some delays in getting the chairman of biochemistry. But the others all fell in place very well.

**J.S.:** You mention five areas that you tried to get chairmen for first - what were those five?

**J.B.:** Well the five basic disciplines. Anatomy, biochemistry, microbiology, physiology, and an area that came to be known as the department of medicine in society, which at that time I called the fifth program and that was a program in which we wanted to include things which hadn't been classically included in the medical curriculum before. Law, ethics, philosophic issues, and that was headed initially by Bob Reece who became its permanent chairman. That is a good example of someone who was on site and was fully capable of doing it and did an excellent job.

**J.S.:** Dr. Reece is still with the program, isn't he?

**J.B.:** That's right.

**J.S.:** How would you go about – did you advertize for these particular spots, did you put an ad in the Chronicle of Higher Education?

**J.B.:** Well, recruiting is an art, as well as a science and you need to do a variety of things. You need to advertise, you need whatever informal networks you have with people in the discipline, you need to have the cooperation of people within the discipline, you need to, in many instances, write individual letters to chairmen of the departments throughout the United States. And we did all of those things. Then in addition you call people and try to solicit additional names and then from that you might even get names of people who would not apply and you would go contact them to see if you could get them to apply. So it's a lot of work because for every one of those positions, and there were some twenty-odd, that whole scenario was carried out. And if you figure there's 125 medical schools in the United States, and you're writing the deans and chairmen of each of those departments, and you're doing that with each of those positions, there's an awful lot of work going on.

**J.S.:** Who did most of that?

**J.B.:** I'd say that probably I was responsible for most of that but once the recruiting phase got in high cycle, then everybody had to participate in terms of the interview process and so forth. My wife was extremely instrumental in some of that early recruiting, by taking on the other side of the house, the spouses of the candidates, and making sure they were comfortable with Dayton. And then we had the other interesting experience when shortly after I came here I became ill and was hospitalized for a month and recruited out of the house as a matter of fact. Again the wife and the people in town played a major role with that. Literally there were people who came here for interviews, to this house, and met me in my bathrobe and we talked about the philosophy of this new school.

**J.S.:** What were – Dr. Zappala was the first anatomy chairman?

**J.B.:** That's correct. And assistant dean.

**J.S.:** What was the second position that you tried to fill? Was it a simultaneous process?

**J.B.:** No, actually the first position I tried to fill was that of Ed Spanier. Ed had come here to help create the concept paper for the program. He knew his way around the university, he knew the people in town, and I was anxious to get him on board. So literally he became my first appointment. Then Dr. Zappala came with me from California. And the three of us were the cluster of three to begin with. Then there were a series that came on board relatively quickly. We were able to get Dr. Kolmen and Dr. Rodin from Galveston. We brought down Bob Siriano from Medical College of Toledo. He came down to head up the student affairs/ admissions areas which was again another parallel development. The health sciences librarian was an early priority as well as those chairmen. But I was less concerned about the urgent need to identify the chairmen as I was to build the structure that would develop the staff support for the school. Each of the department areas had enough people involved that with a pro tem leader that that could be functioning but clearly to put together a library network or animal resources network or that sort of thing you need to have a staff person who would assume that responsibility. So although the academic chairmen were very important, and we got most

of them in place within the first year or year and a half much of our early efforts were not faculty so much as staff support and clearly there it was probably even more important to get the right person for that role because if we got a dud in any of those it wouldn't float. Doesn't mean to say we didn't get duds in some areas but there were relatively few and they were quickly identified. So some very important things came up in terms of the development of the school that were rapid and well done and that was due to people like Ray Palmer who was the first librarian and Bob Stuhlman who's still there and Bob Siriano and others. Another fellow who doesn't show up on this chart except quite casually is Dr. John Lindower, and John came on early as chairman of pharmacology. Not that we needed pharmacology so much as John was known in this area and had an interest in this school, it's development, played a very useful role for us with the Miami Valley hospital in the early days of the program. So again I think the bottom line was that we knew what we needed to have and that was a huge cluster of people and we went after people really as much for their personal and interpersonal attributes as much as their technical qualifications.

**J.S.:** Do you feel that having most of the staff support set up before the faculty came in for the interview, do you feel that was a selling point for the program?

**J.B.:** For the faculty or for the staff?

**J.S.:** The faculty.

**J.B.:** I think that the fact that they could see that there were things in place and things underway was useful, otherwise you're just talking a concept. And when you had some people who had obviously cast their lot in with us it certainly made the operation one that would appear to have stability. So the answer obviously is yes and that's very important. You have to understand how risky that situation would appear to be to the first few players coming on board. If we were starting a new medical school at Ohio State that would be quite a different thing, but starting off with a relatively young campus, relatively little in the way of graduate programs, relatively little in terms of senior faculty, in an area that probably is not the garden spot in the world, that's a risky situation. You have to have a person who is willing to take that kind of risk and see the opportunity to do some different things, to come in and be part of that enterprise. So I guess as much as earlier you're really looking for a select group out of a select group, and therefore the recruiting is very intense and you spend a lot of time identifying a relatively few people who would fit that kind of situation.

**J.S.:** Were you looking for people with a lot of development experience or people who had the probability to teach or people who had been in large publications?

**J.B.:** Neither of those. We were looking for people who had the academic credentials to be creditable, so that meant we were looking for people who had research publication records, but not necessarily encyclopedic in nature. It was important that we have academic credibility, and that the people who were with us have some visibility in the national scene in their discipline. But most of all, I was looking for not only that but

people who had the vision of doing something different, who did not expect and educational model in a traditionally or classical mode. So obviously some people were very uncomfortable with the idea of not having a university owned and operated health facility. Well clearly if they're uncomfortable with that, they don't fit the picture here. Others might be uncomfortable with the fact that they were coming to a relative unknown institution, and they could see that there was a chance to build and that there was no place for them there. I was really looking for people who thought that they could deal with ambiguity and risk and with something different and innovative and wanted to become part of that. And I think that characterizes almost the entire initial slate of people. As we became bigger and more established and more clearly identifiable and there were buildings, then obviously others came on board who were less innovative and so forth but you can tolerate that at that time. But for the first group they've got to have a vision and they've got to be able to work with a lot of ambiguity.

**J.S.:** With a community based model of a medical school here, were you looking for full professor types of faculty or were you looking for people with more community clerical experience, more the doctor rather than the professor type?

**J.B.:** No, I think we were looking for both as a matter of fact. We tried to find the blend between the two and we're willing to look at people with practice credentials if they had some academic credibility as much as we were looking those with technical abilities. A good example in point would be Dr. Manny Cowder who was the first chairman of pediatrics. He was also the executive director of children's hospital where we had clearly planned to put the department of pediatrics. He was well published and had a reputation in his field of hematology and oncology so he was a natural for that post, he had the clinical background and he had the research and academic background and he carried the opportunity to influence that major health facility so not to have chosen him would have been stupid. In most of the areas however we did look for people who had clinical credentials whether they were indigenous here or elsewhere. We were looking for people who were nationally known or at least on the rise and had some semblance of national reputation who also had a reputation for clinical skills and people who would come to mind there, people like Larry Blackwell who was the first chairman of psychiatry and came from the University of Cincinnati and was active in a lot of ways, had a good research record, had been an outstanding faculty member down there, had won the student teaching award. Those were the kinds of things we were looking for and you wanted those people to be the leadership in that discipline.

**J.S.:** Was there any immense pressure from the local area to give local physicians the prominent positions?

**J.B.:** Well, there sure were. That goes on all the time and the same pressures were analogous to the academic people at the university who wanted to get situated or positioned in this new enterprise. I think some of the areas that were hardest to deal with were in the area of surgery and a few others where there were people who felt that they should be crown prince of that area and were clearly not suited to be.

**J.S.:** What were the four types of faculty in the School of Medicine?

**J.B.:** Four types? I don't understand the question.

**J.S.:** Were all the faculty in the School of Medicine full time teachers?

**J.B.:** No. We had a small network of full time faculty and there were a series of volunteer faculty members who were primarily clinical people. Then we had some shared faculty with Miami and Central State, and then we had some adjunct faculty who were the equivalent of the voluntary faculty in the clinical areas. Those were the four basic areas of faculty. By far the largest category was the voluntary clinical faculty. There were relatively few people in town who did not participate in that program. I think there are some interesting sidelights with that though because simply having the interest is not sufficient to do what needs to be done. So we actually put on a series of seminars for our voluntary faculty, initially to talk about the philosophy and organization and development of the School of Medicine. Then once they knew what we were about I put on the program how to teach and how to organize the course material and how to use audio/visual stuff and how to set goals and objectives for educational purposes and a whole host of things like that. And we used that also of course as a screening measure. And the people who showed up to those things are the people we largely relied upon, those people who just signed a board and never showed clearly were identified early and we avoided them.

**J.S.:** Were there any positions in the faculty that were more difficult to recruit for than others?

**J.B.:** Yeah, I think probably the area of surgery was, not only because of the politics in town but also because of some of the financial restraints that were on us. I think the same thing might be true in some of the scarce disciplines like biochemistry at the time. But the clinical areas and particularly the surgical specialties were I think the hardest. I don't know if you are aware of it or not, but at the time that this was formed the maximum limit that could be paid to a full time faculty member was equivalent to the governor's salary, which was the princely sum I think of \$55,000 a year. That makes it damn hard to recruit somebody to come in under those kinds of constraints and without having yet put in place a plan for supplemental income generation and things of that sort. Clearly I did not want to develop a practice plan for the faculty where they could in fact earn additional income until all the players were on board. So in many ways a catch-22. So that became I think a major problem and that was not really relieved until about four years ago so the first 6 or 7 years of our existence we had that constraint.

**J.S.:** What kind of supplemental income generation plan was finally developed?

**J.B.:** Well it's a typical partnership, a practice partnership which defines a broad series of guidelines in terms of how much time and effort can be spent to do that. What the constraints are in terms of additional dollar amounts, and to assure that there was a flow

of monies back into the schools, so in fact that practice helped support the budget of operation.

**J.S.:** How much did you have to draw from university resources?

**J.B.:** In what way?

**J.S.:** Well hiring the faculty. Did you have a separate budget, a line budget formed?

**J.B.:** Yeah the decision was made early to keep all of the activities separate so there would not be the allegation that this new entity was siphoning off university resources. So we operated under a separate line budget, a separate contained budget. There was an expectation that if we used university services we paid for them which we did. Oftentimes we did not get our value for the money because clearly the operations in many areas were not up to the standards that would be required for this kind of operation. So in many instances, we not only paid for the services, we duplicated it and then transferred that back into the university to help build the university operations.

**J.S.:** What was one of those examples of not getting the full value?

**J.B.:** Well I think in the personnel shop would be a very classical example of where personnel was not staffed or not sophisticated enough to help us develop our recruiting position listings and so forth. We wound up identifying a couple of people with personnel's help that were situated in the School of Medicine that did a lot of that work then at a later date were transferred back into the personnel shop after all the organizational activity had been done. That's a classical example. We had the same thing in finance, we had the same thing in – you name it. Animal resources there was none so in essence that was built from scratch. Health sciences library there was none and audio/visual there was none or marginal. And you know, I'm not saying that to be deprecating about the university but it was in essence an overgrown junior college when we got there. It operated like that and it thought like that and I think one of the one of the values that will be unappreciated on that campus is the maturation of that institution in a relatively short time by the insertion of the medical education program. It brought them into the big leagues, where they would still be the equivalent of a Wilberforce or Central State or Wittenberg right now.

**J.S.:** Was it an advantage for the medical school people to have that ability to think big and help the university?

**J.B.:** No question about it, and in this kind of thing you have to think big and you have to just go ahead and do it and bring the other players along. And if there were not that pervasive feeling of looking ahead to what this might be it would never have happened. Because it would clearly have been far easier for us to just have been able to start that operation from scratch, de novo, with all of the support structure. But to have to literally live with and inadequate, rudimentary support structure and then have all those prejudices and opinions and self interests that have to be dealt with and neutralized and carried and

then revitalized, there was probably as much energy spent on campus as there was outside.

**J.S.:** What was the role of Miami University and Central State University in recruiting faculty?

**J.B.:** A self-interested one. The reason they got into this game initially of course was to assure themselves a piece of the action. As it turned out however, the players who came from Miami and Central State were very, very helpful and the two people from Central State and the two from Miami that became part of the coordinating committee helped to identify individuals who could be shared faculty members in the early start-up phase. Again Central State was not in a position where there were many people on board who could be useful in the enterprise because it's largely an undergraduate college. But there were several from Miami and the people from Miami were instrumental in getting those people to play ball with us. That was true in microbiology for example and certainly true in biochemistry. So they were very helpful in that regard and of course they had the oversight committee which permitted us to use Miami and others and some of their contacts to identify potential people. But when this was first developed they thought of course that they'd have a direct pipeline into medical school admissions and that was I think the bottom line for much of that early participation.

**J.S.:** Let's go on to some of the residency programs. Was there a move to keep the residency programs right off the bat or was that considered to be a later step in the development?

**J.B.:** No, the first item was to rescue a few that were dying on probation.

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

**J.B.:** Those are programs that have been identified as having major problems that if they did not improve they would be disaccredited and there were several of them in town at several institutions. Obviously to support an institution of medical education, those programs are critically important. In fact we did lose a couple of them that we were unable to get the leadership or the problems resolved quickly enough. But the others, there were some in town that needed to be developed so where we first threw the lifesavers out for the few that were on the ropes. We then developed a strategy with the people in town, although some of the institutions were reluctant to look at developing these programs on an area-wide base. So that they would not be solely the creatures of the hospitals but be a joint effort with the university. That was an interesting exercise because it meant everybody giving up a little bit, but in some instances that was possible while in others that was really tough to do. Surgery was a really good example of the latter. Ultimately, however, surgery became the first to really fall in line and that then helped the others move along. Then with the new programs it was easy to where the need was identified, like emergency medicine, to develop the concept that it was going to be multi-institutional from the start. So generally our approach was to try to get the clinical chairmen involved to try to get the program on an integrated basis and to try to have at

least two institutions involved so that we weren't in a situation where it was – where we were the captives of another single institution. And I think that worked very well.

**J.S.:** Were there any situations where you had two residency programs that were competing with each other?

**J.B.:** Oh yeah.

**J.S.:** How did you make the decision which one to keep?

**J.B.:** What we tried to do was integrate both of them into one university based program. That's exactly the model that was existing in surgery, existed in medicine, existed in family practice. Although in some instances that still was imperfect to date. Generally all of those became a university based program and each of those separate programs became a piece of the major university operation. For example even though the residency programs, for example the anesthesia program, that's one that we started in an initiative with Kettering Medical Center, and ultimately wound up with the program being based at the valley but really there were three, there were four institutions involved. Dermatology was started de novo and we did that multiple institutions. Emergency medicine started de novo with multiple institutions. The several family practice programs, those still tend to be somewhat separate although they are still integrated within the department and the reason that they did not become totally united was the peculiarity of the programs where each had to have their own family practice units in order to qualify for residency approval. So we had the several in town at Good Sam and Miami Valley but the third family practice program that was developed ultimately was a three hospital situation at Greene and the two hospitals at Springfield. Intro to Medicine was one of the difficult programs because they were freestanding and required our working to try to amalgamate them. We now in essence have it reasonably amalgamated but at the time there were four I think freestanding programs. Right now there is still a freestanding program at the Valley and there is an integrated program that is university based. OBGYN builds on the program at Miami Valley Hospital and broadened it to include Wright-Patt and Good Samaritan hospital. Same thing was true of orthopedics, pathology. Pathology remains two programs that are separate, distinct and are at the Kettering. And largely we did not see that as a target of need and we felt that we'd create more heat than light in trying to put that program together because pathology was not that essential for the standpoint of the student education as it is in the clinical.

**J.S.:** Well how do you allocate students and/or university resources to two distinct programs?

**J.B.:** Easy, you just do it through the department. I'll find out through that situation what they can handle and make the assignments but do it through the departmental program. Pediatrics clearly we've already talked about, psych was integrated and expanded, surgery was the first program that really helped cut the mustard in terms of... so we still have in each of these areas there is a mixture but the intent was to try to develop a single university-wide program and have that centered at the university. So even the instances

where there are separate freestanding programs they are tightly tied into the departments and the need to totally integrate them is less now than it was when we first began. Clearly we could not in the situation of a major program like medicine or surgery where we are reliant on those institutions for our educational programs not to have very tight relationships in those cohesive programs and that's why those were the early targets.

**J.S.:** Well I'd like to take one residency program and kind of focus in on that. To use your own analogy from inception to birth to early growth, and that is the aerospace medicine program. Is that a common type of residency program?

**J.B.:** No. And so the one you suggested is really anomalous in many ways because it is the exception rather than the rule. As a matter of fact I think that as it sits right now that is the only civilian aerospace residency program in the country. So it's unique, truly, truly unique. But the genesis of that is very interesting I think and it has in it many of the roots of the philosophy of this program. The way it all came about was an identification that had been recognized quite some time ago that there was a need for a civilian opportunity for aerospace medicine residency education recognized by not only NASA and the FAA but by others. There had been a program before at Ohio State that went defunct, and so the only opportunity that people had if they were civilians was to be able to go to a place like Pensacola or Brick's Air Force Base on a space-available basis. That was insufficient for the pipeline needs of the FAA and NASA. So with the contacts that we had there, the fact that we had developed the relationship with Wright-Patt, we were approached by NASA about our interest in putting this program together. They were willing to fund it and it was clear to us that it would fit well here because of the Wright-Patterson tie, and so we accepted the responsibility to do that. And it was interesting because it was put together with now the commonality with other programs, it was put together just like some of our other new residency programs were. We put together a steering committee of people that included the players from Wright-Patt and the VA in town and they became the ones who drew the conceptual document after a number of discussions about it. They laid out the framework, did the recruiting for the chairmen, brought in Stan Mohler who I think was an outstanding choice for this. But it was with their help and participation.

**J.S.:** So the conceptual part was done before Dr. Mohler was brought in?

**J.B.:** Yes, it was. And as a matter of fact the proposal to develop a masters in aerospace medicine was also headed and submitted before that. To the word recants and that became one that went through relatively without a cough because it was so unique. But that was an interesting example of how things can happen. I think another one that relates closely to that is emergency medicine, which ... because that then was in many ways generated in the same kind of way. That's a more typical kind of civilian program that you'd find nationally and there were a number of institutions here that were interested in seeing that developed. We put the program together in the same kind of way by generating a group of players to look at it, too look at the logistics and make the plans for it. Had some interesting byplays with that one. But ultimately it because a multi-institutional development and once it had been crystallized a chairman was recruited to finish the role and then the residency approval followed. It might be interesting, the

aerospace program went without a hitch, it really was just as smooth as anything could possibly be. And I think that's because it was so unique, because the need was so apparent and the fit was so good and that went without a cough. The emergency medicine program, on the other hand, also went smoothly in town except that the Miami Valley Hospital wanted to control the program and the initial starting of it was delayed a year by a very deliberate spiking maneuver that was done by the previous administrator of that hospital. One of the kinds of things that I look back on as being relatively painful because I accepted that development in good faith and lost a year by doing it.

**J.S.:** How was it spiked?

**J.B.:** The spike came by the Valley at the last minute pulling out from the proposed program by saying that the numbers were unrealistic and that the level of support was unrealistic. And that was just at a critical time in its development when we were just about ready to put the proposal in. So in essence it's like the Russians walking out of the disarmament talks that happened in that particular instance.

**J.S.:** Were all of the residency programs developed first here at the university, or were there any community based?

**J.B.:** There were a series of community based programs, but not very many. I'd say there were surgical programs and medicine, there were a couple at the VA, one of which I mentioned earlier, became disaccredited. There was a program in X-ray, there were some specialty programs in pathology, urology, orthopedic surgery. So those were there, and some in family medicine. But I think some very major programs like what ultimately became the surgical program, what ultimately became the combined medicine program, emergency medicine, neurology, pediatrics were all university initiatives.

**J.S.:** When a residency program was developed, did it have to go through the route of going through the university graduate college then go through the region's advisory graduate council?

**J.B.:** No. That did not happen unless there was a degree program involved and the only one in which there was a degree program involved was the masters in aerospace medicine. So that was put through the curriculum committee and then went through the Wright advisory group. Although the others are really professional certification programs there was no advanced degree involved therefore it fell outside of the curriculum committee.

**J.S.:** But they still had to be approved by the regents in Columbus?

**J.B.:** No. And in general where possible we would not take programs for approval. Knowing that the climate was such that any of those things would be a hassle, and therefore you tried to avoid going there if you did not need to go there. Those places by the way, curriculum committees for regents.

**J.S.:** Do you expect to see any of the residency programs developed?

**J.B.:** Oh I think ultimately there are a series of others that need to be developed in this area. Maybe not a whole host of them but I think as the program continues to mature there will be other areas that will be identified that should have a graduate training component.

**J.S.:** Can you give me a couple of examples?

**J.B.:** Oh I think ultimately a program that should be some kind of program in nuclear medicine. There should probably be at some point in time some of the other surgical specialties that aren't currently being recognized. For example cardio-thalassic surgery and some others like that.

**J.S.:** What kind of residency programs are the kind that will grow in relation to the residency? Is there a preferred type of residency program for students at the School of Medicine?

**J.B.:** Well, you know the theory was that we would try to emphasize primary care and that's what we did, and that's why the emphasis was really placed on medicine and pediatrics and family medicine. And I think that will continue to be the case and I think that will be the trend in Dayton because there is still the need in those primary areas. Medicine and psychiatry by the way. My sense is as the program matures that other areas that are going to be clearly defined needs for medical professionals in the future are going to need some attention here. And those could be well handled here. For example, no question that psychiatry will probably remain a shortage discipline. We have the program here, it's a very effective one that could be expanded somewhat for that purpose. Another identified need which is a national need is in physical medicine and rehabilitation and I think all the pieces are here to put that kind of program together. So there are two very clear examples I think where there is an identified national need. Family medicine is one that will continue in that. It says to me that the programs here will not only be stable, but will probably grow.

**J.S.:** Well thank you very much for talking to me about the faculty recruiting and the residency and when we come back we'll talk about the future of the school of medicine and its relations with the university.

**J.B.:** Good.