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John R. Beljan M.D. interview (3) conducted on November 11, 1983 about the Boonshoft School of Medicine at Wright State University

John R. Beljan

James St. Peter

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WRIGHT STATE UNIVERSITY
School of Medicine Oral History Project

Interview date: November 11, 1983

Interviewer: James St. Peter

Interviewee: John R. Beljan, M.D.
Founding Dean, WSU School of Medicine
Interview 3

James St. Peter: The date is November 11, 1983. This is the third in a series of interviews with Dr. John Beljan, founding dean of the Wright State University School of Medicine. Dr. Beljan, the last time we were talking, you mentioned that you had a real role in selling the program in the development of the School of Medicine to the community after you got here. Can you go into detail on that?

John Beljan: Yeah. I think that obviously what needed to happen were two things: one, to explain better what a school of medicine was all about, and two, to ensure that the group in town were going to accept some of the obligations and problems that a school brings to a new community, and obviously very different from their perceptions. For example, clearly the prevailing thought that was in the community that I'm sure had been sparked by the feasibility study that we talked about earlier that I thought was significantly faulted, essentially said that you can build a medical school by, one, having a basic science series of departments, and two, a series of clinical hospitals for clinical experience, and you mix the two together and you get instant medical school. That's, of course, a lot of horse feathers, and so what one had to do was to dissuade some of the people- and particularly some of the hospital leadership- that in fact this is a complex undertaking, that there are inter linkages between the two, and that once the program was instituted life would never be the same for either party. So the way that we went about doing this were several. First, I developed a schema of where we were, how we were going to get there; it was my so called infamous flip chart routine which was a series of flip charts that talked about the purposes and objectives and timetable and strategy to get there, and I walked around with that to every hospital staff meeting and every organized group and went through that drill so that everybody had a pretty clear picture of what I was talking about and how we were going to get there. So in selling the program, two things had to happen: I not only had to soften the community and change their image for that kind of perception, but I also had to set the framework to develop the support in each of the clinical disciplines so that many of the players in town could become faculty members in this new department, and I used that same flip chart for those folks and did involve them in the early formation of those departments, including the search for the early chairmanships. So the sum of what that meant was that I was doing a lot of the conceptual, strategic legwork in the development side, in the community, while others of the team were developing the other pieces of the operation, and we would also, of course,

meet at very regular intervals, oftentimes two, three, four times a week as a dean's group in order to keep everybody abreast of where we were and where we were headed. For example, the folks at home who were in the main offices doing what needed to be done for their areas, where people like Ed Spanier who was worrying about the budgeting and financial end and that sort of thing in the business end; people like Bob Stuhlman who came to develop the animal resources area, which was essentially totally nonexistent at Wright State; Ray Palmer, who came from the Countway Library at Harvard, who developed the library and bibliographic organization because that's another story in and of itself; and Dr. Zappalla, who was taking a key role in the curriculum, and Sam Kolmen, who was taking a key role in by-laws and organization, and it was that kind of interaction and frequent meetings and wrapping in then, as they came on board, the early clinical chairmen that created the cohesion that's necessary for this kind of complex and disparate organization.

JS: What were the various affiliation agreements worked out with the hospitals? Were all the hospitals prepared to come on-line when you got here?

JB: Yes and no. I think the major hospitals were and I think on their terms, so that took a different set of discussions to change that perception, and then there were a series that I think wanted to become partners that we simply did not discuss programs with early on because they were going to be, obviously, peripheral to the early main thrust. You also have to recognize, if you remember, that the charge given me was to get the school put together in as rapid a time as we could and that was done for very important reasons, namely the shifting sands of the political scenes in Ohio and the fact that once in place it's very hard then to disassemble. But once you're still building it's easy to knock some of the link pins out and so it was critical if the institution was to survive that it had to be put together quickly, and it had to be a functioning entity to prevent it from the vicissitudes of Columbus. So, here we are with a time frame on you and a very complex organization and an interesting lack of understanding at the central administration about what it takes to do all this, and someone has to make a series of key, priority decisions as to what are the first things that you have to do ahead of the things you have to put aside to pick up later as you move along.

JS: Were the affiliation agreements a standard type form, or were they substantially different-

JB: Ultimately they became reasonably standardized, but our first agreement with all the hospitals were simply a statement of understanding, and that was preceded by a memorandum from me in which I simply laid out what I thought to be the essential commitments that needed to be met for them to play a major role in the enterprise. And I think that went a long way, because I made it very clear that that same letter went to each hospital administrator, and I met with them individually and in groups and in total to discuss what all of this meant and what the expectations were, and the fact was that in many ways they were going to have to subsidize the program, either by providing resources in terms of space and people in support, or in some instances where our faculty would provide services, reimbursement for those services. So I laid that out pretty coldly

I would say, and objectively and perhaps almost a take it or leave it basis, and fortunately almost everyone took it.

JS: How difficult was juggling all those [xx] egos?

JB: [Laughs] Very difficult, because the difficulty in town was that it's a highly competitive hospital situation- it was then, it is now, and it probably always will be- and the hospital one-upmanship was very interesting. I made it clear from the beginning that I wasn't going to dump all my eggs in one basket, and secondly, that I was going to capitalize on strengths where they existed, and third, that I was going to use the educational program for leverage in trying to better define different roles for each institution, and I think a lot of that came about. A good example would be the mission at St. Elizabeth's Hospital. They saw themselves as having a heavy investment in family medicine and physical medicine and rehabilitation, and so that's where we coupled those programs initially and those became the primary foci for those two areas. In the same way, surgery became prominent at Kettering [Kettering Memorial Hospital], and psychiatry and Good Sam [Good Samaritan Hospital], and internal medicine at the Valley [Miami Valley Hospital], and OB/GYN at the Valley. And I think we brought credibility and respectability to Greene Memorial Hospital by putting our department of post-graduate medicine out there, which was I think a very good move because not only did it give that hospital substance and a program that they could embrace for a very small community hospital, but it also permitted the director of that department to operate relatively easily among the other hospitals where they saw that that was not a threat to them and their integrity. So that was another, I thought, reasonably strategic move to try to put into place in an appropriate place an important function that was inherently threatening to everybody else.

JS: Did you ever have to split up a function between two hospitals to sooth the waters?

JB: Yeah, we tried to on several occasions to try to distribute a program elsewhere. A good example of that would be obstetrics and gynecology, which was based at the Valley, and which a major effort was to try to extend that program to Good Samaritan Hospital. It has been extended subsequently, but the initial attempts to do that were very painful and frustrating. But that was done very deliberately, again, to try to broaden the base, the concept of not only having a hospital base, but that base for the program being important to have a primary identification but to be decentralized and for the educational program to be focused at the university. So, subsequently new programs were easier to handle, because where there was not a pre-existing focus for that we were able then to develop a consortia of hospitals to put the program together. A good example for that is emergency medicine, which was done primarily as a thrust between three hospitals, and I think those later initiatives worked very well. Where the real problems came up is where a power position had already been established, such as at the Miami Valley Hospital.

JS: How was it painful and difficult to extend these programs?

JB: Well, because there is the competition between the institutions, the sense in all of those kinds of arrangements that the one hospital is doing the other as favor, the other hospital thinking they're getting screwed by the other institution, staff perceptions about what their roles ought to be, who ought to run the program, who ought to pay for it, those kinds of questions.

JS: When you set up the various affiliation agreements, these also covered the establishment of the residency programs at that time?

JB: At that time they did, but only in generic terms.

JS: What do you mean?

JB: I think they were just statements about general interactions about the educational programs, and then each of the specific programs were developed as a separate kind of agreement. But to try to have done all that in one fell swoop would have been almost impossible, so the first thing we did was to get the spirit of a general sense of affiliation done with a statement of broad responsibilities then to move from that to specific programs.

JS: You created a group called the joint coordinating committees. What was their major focus? Was it peace keeping between the hospitals or-

JB: Yes, I think so. Not only that but as a separate device for communications, I used that, and peer pressures occasionally to bring some recalcitrant players into line. It served a very good purpose because I think having that group meeting and comprising a very broad array of players and each with their own self interest, and to hear me giving the same story to each of them I think they finally believed that I was not telling them one thing and doing another, and it worked very well I think. It caused some discomfort among some of the players who thought they were superiors among peers. On the other hand, it helped me handle that situation because the peer pressures of the others in that group were far more effective than I would have been in a screaming session in a one-on-one closed room. I think a very good example of that, and I think it's something that ought to be recorded for posterity, was at one of these meetings the director of St. Elizabeth's Hospital- who I'm afraid to say the name escapes me at the moment, but immediately preceded Tom Beckett- [he] grew up at St. E's and was a very sage, experienced person, and at one of these meetings he looked at his fellow hospital administrators and he said, "I don't know what the hell you guys are concerned about. A strong educational program means strong hospitals, and that's where I'm coming from". That one statement immediately put a lot of noise to rest and I'll never forget the impact of that statement, but it took someone like that to make it and to make it to his peer group and to do it in a sense of an open forum.

JS: What was the composition of the joint coordinating committee?

JB: Oh, gosh, I don't remember now, because there was a whole variety of coordinating committees, but the joint coordinating committees I recall was largely hospital administrators and some directors of medical education and that group. But I think I had more committees than there were people, because we had joint coordinating committees, ultimately, for each institution, and we developed a coordinating committee for directors of hospital medical education, and we developed a coordinating committee for just about any imaginable topic. So we wound up with the same people serving on a multitude of committees, but it was critically important for that to happen because the opportunities to do something required that you had to get those players together in the same room that shared that common interest so that you could get movement. Otherwise, it would have been nothing but empty talk.

JS: Tell me about the role of the Associate Dean for Hospital Affairs.

JB: Well, that person was a later person on the scene, but was first Jim Schieve, who came from the University of Cincinnati, and Jim was a very experienced guy, an internist who had I think a very good appreciation of what it meant to have clinical affiliations in town, and Jim did a lot of the early work in developing the linkages and sitting with the various individual institutional joint coordinating committees and their directors of medical education and so forth to hammer out these agreements. Then Jim was succeeded by, as I recall, Bob Jewett took that role for awhile on an interim basis when Jim retired, and then Fran Paris and [xx] Doug Durko filled that. The latter two were more administration oriented, [and] Jim Schieve was more clinically oriented. I think when Fran Paris came on board though, it really moved a lot of the hospital agreements because Fran was the hospital administrator at Children's Hospital, and so as he began to interact to finalize these agreements, people saw him, particularly hospital administrators, as a peer and therefore it really facilitated those developments. So in terms of some of the formalized interrelationships, very clearly Fran Paris played a pivotal role.

JS: What was the University medical Services Association?

JB: What it was and what it is is the private practice corporation for the medical faculty, and that exists in every medical school, law school in the country, dental schools, some dental schools. In essence what it is is an attempt in each of those instances to regularize the professional practice of full time faculty, to assure, one, that the academic program is properly maintained, and secondly, to assure balance between professional and academic activity, and third and probably as important as the other two, provide a vehicle for salary and compensation augmentation, which needs to happen particularly in most state supported schools. So what it is is a corporate entity which is very similar to a specialty group practice but clearly with the goals of the academic institution clearly in focus. I had two options when I came: one was I could design a plan and say take it or leave it, or tow, I could wait until the key players got here and then develop it once that happened. So I chose to go the latter route because I felt that if the early players helped design the plan that it would facilitate its development, and I think that proved true. So what we did was to develop a statement of philosophic objectives for it and then take legal counsel to tell us how that could best be achieved in terms of statutes of Ohio, which, by the way, are

medieval in their nature, and then try to make the best trade-offs where there were obvious incompatibilities. Then I think we came up with a plan that was overwhelmingly and enthusiastically supported by the Board of Trustees at Wright State because very clearly it was laid out with university objectives in mind that had appropriate controls built into a freestanding corporation that they could support. There's an interesting prologue to that, though, that this hits me with because it's an interesting situation to be the new guy in town as well as the new guy in the state. One of the first things that I did when I came to Ohio was to make a visit to each of the medical schools that were existing to pay my dues and greet the court that existed and ask a few questions about what was going on, and it was very interesting because I was very cordially received by everyone; everybody knocked themselves out to try to give me useful information with one single exception, and that was The Ohio State University, which the dean lied through his teeth to me.

JS: Why?

JB: I don't know why. I think maybe the reason was that he did not have that situation under control as subsequent events proved, and that he was sitting in a bed of hot charcoals and didn't recognize I think at the time that I was capable of keeping a confidence, and the fact that he told me a few untruths which became very evident in short order caused me to have very little confidence in the credibility of that institution. All of the others, on the other hand, were inestimable sources of benefit for me in a variety of ways, but it's an interesting kind of game that gets played, but I'll never forget it. I knew he was lying at the time, but I didn't challenge him. [Laughs]

JS: Did you go up to Toledo?

JB: Sure, and had a very good interaction in Toledo. That preceded, of course, Dr. Rupert's going up there. Marion Anderson was the dean, and he had been the chairman of Surgery at Ohio State before going up there, and was very helpful to me in terms of some of the interactions that had occurred at Toledo, because he had faced some similar problems. We wound up using the same law firm for our university medical services associates group, to develop that as he did up at Toledo.

JS: What was the group set up at the hospitals, the Medical Educators of Dayton?

JB: That was a group that annodated [?] my coming to town, and it was a loose affiliation of the players who were the full time, salaried people in each of the hospitals hired by the hospitals to oversee their graduate programs. It also included others who might have perhaps a more peripheral interest to what they were doing. But it was a loose organization of people who I think attempted to be in the center of the focus of trying to bring a medical school here, and were people that I interacted with as perhaps the focus of that hardcore group of folks interested in medical education when I first came to town. I think it was useful in many ways, although obviously everyone of the individuals there had a vested self interest, namely their own institution, but on balance it was a useful group to deal with.

JS: Is it still around?

JB: No, it's defunct. As a matter of fact, I think they disbanded themselves by formal resolution of disbandment a couple of years after the school was started, because they were intimately involved in the school and they felt their goals and objectives had been achieved, therefore they voted themselves out of existence.

JS: There are two medical institutions in the area that are not the normal type of affiliates for a medical school. That's Wright-Patterson Air Force Base and the VA Hospital.

JB: Correct.

JS: Can you describe some of the interactions with first of all the VA Hospital?

JB: Well, the VA Hospital is an interesting one because this VA hospital dates back to the Civil War, it's one of the largest in the country, and it had at the time I arrived an affiliation with Ohio State. It still has a minor affiliation with it in one program, but essentially it had been a hospital that with that affiliation had been pretty broadly ignored by Ohio State. It had a series of educational programs, a number of them were on probation and several were in the process of being disapproved. The staff had been permeated by foreign medical graduates because apparently that had been the only way to resolve the medical staffing problem there, and had become more of an enclave and removed from the community, and yet the interesting thing was that many of the folks in town had been at an earlier time trained at that institution, particularly in internal medicine. So it was an interesting kind of thing, over a couple of decades it had lost its prominence as an educational institution had fallen into disfavor and was relatively remote. One of the things that we saw, of course, was that one, we had an opportunity to couple with Public Law 92541, which was the VA Medical School Assistance Act, and two, that we could do some things here that were done at a number of other medical schools in the country with which the VA institution plays a key role in the educational process. Getting there from here, though, is quite a different story because again you are dealing with staff attitudes, and you're dealing with a federal bureaucracy, and you're dealing with the vicissitudes of a Center Director who may not necessarily appreciate the nuances of what all that means, a concern of takeover by the university and all those kind of specters. So it was an interesting interaction. I do not believe that it went as well as our relationships elsewhere in town; the VA did in fact support the new school tremendously, financially and otherwise, new buildings were put up, but infiltrating and changing the behavior of that staff was incredibly slow and it was difficult to do because of the mindset of the key players out there, not the least of which was a chief of staff who came with a clear marching order by somebody in the system that he should not be co-opted by this new medical school and hyper-reacted in a different kind of way. Fortunately, that person finally came around and became one of the real contributors, but it took a couple of years to get him to the point of view that the school was important to the VA's future.

JS: Would you describe that as a wind blowing out of Columbus?

JB: No, that was a wind blowing out of Washington, and it would be a piece blowing out of a section, a disenchanted section, of the academic affairs office of the VA central office. That has consequently changed, but I think there was a patterning or mindset developed there despite tremendous support by others in the VA central office. They were putting a couple of people into the operation here and leaving one stay who, although gave up service to the affiliation program, did not do a whole lot to facilitate it. It's an interesting kind of situation, I think that if the right people had been here the VA right now could be a showplace for medical care and medical services. Unfortunately, that is not the case and it's probably going to take another ten years before they're there. On the other hand, the one that should have been the most difficult to deal with turned out to be just the opposite, and that was the Wright-Patt arrangement. There are a lot of successful models in the country of VA interactions with medical schools, relatively few of military installations with medical schools because of their sense of need to mobilize or be available for a completely different mission and relatively short time frames, and a concern for long term commitments. But fortunately, the hospital commander here, a fellow named Joe Wesp- W, E, S, P- was an old friend of mine who worked with me in California and was the chief of obstetrics and gynecology and professional services at Travis Air Force Base, which was an affiliate of Davis. So he came here as commander and then I followed shortly after, and between us we fashioned a new model for affiliation for a military installation- and it's the only one of its kind in the country, as a matter of fact it's the only one in all three services- and literally totally integrates that operation into a university educational mission. That had to be very carefully walked by Joe and me through all the levels of the Air Force, and at that time the people who were in the Surgeons General Office were acquaintances of mine from longstanding, so by his pushing from below and my pushing from above, we got the intermediate commands to buy off on it and wound up with what I think to be an outstanding model of cooperation, and that exists today and gets stronger rather than weaker. So, the Base is where the VA should have been many years ago.

JS: Do you feel that your military background helped in cementing that relationship.

JB: Absolutely. I think not only was it important to know how the system worked so that you can work with the system, but also to have people who knew you and trusted you in key, influential places where things could be made to happen. So it takes that kind of interaction; I wouldn't call it political favoritism- they knew I had no ulterior motives and they had a need, and they saw this as a way to meet that. Obviously, the services had a difficult time getting specialists and medical officers in their programs, and to have now a new opportunity within the system to select their own for training in what is essentially a civilian institution was very attractive to them. A model they hadn't seen before.

JS: They provided you with one of your associate deans.

JB: Well, we created that title to assure that the liaison would be there, so the person who fills that is largely ex-officio, the commander at Wright-Patterson Air Force Base. And we used the same titling for the Veterans Affairs, to be the chief of staff at the VA. The purpose there is not only coordination, but to permit those two people to attend the

planning and interactive sessions of the dean's office so that they knew what was going on and they could be part of that action.

JS: Who were the first two people involved in those positions?

JB: The first two people involved in them, at the VA were- gosh, what's his name- Al Alexander, an interesting fellow who was a former medical graduate from India and had a background in preventive medicine through Johns Hopkins, And the first person at Wright-Patt was Joe Wesp, and Joe was not here for a long period of time but he was here long enough for us to get the program wrapped up and put to bed.

JS: When did Dr. Halki enter the scene?

JB: Dr. Halki entered the scene I think after Joe Wesp. Yeah, that's correct. He was selected by the Air Force to come to Wright-Patt because of his interest in medical education, and then he was folded into that role and continued to work very actively to support it and did a super job in doing that. He built on what Joe Wesp had left and he understood what was going on, had a clear picture of it, so he was able to continue that effort relatively easily. Al Alexander stayed on here until just a year or two ago, and Al initially was very suspicious of the school of medicine operation, I think when he left became one of its biggest boosters. The new chief of staff I have not met but that's a key role- that role and the role at Wright-Patt are very important because it expands the base of operations and it also provides a federal component to a relationship that could otherwise be dominated by the civilian hospitals. So they understand that, and we built this in conceptually that we would have retreat positions if anything turned to you-know-what. And we went through that exercise saying what if this and what if that, and it was very clear that we could build a viable program if we had one of the two federal hospitals and Children's Medical Center. Fortunately, Children's Medical Center was a situation very early on where its leadership was very supportive of the School of Medicine program, and we saw clearly that they had a major vested, self-interest in this and therefore we were not concerned about this blowing apart, which might not have been the case elsewhere in town. That operation with Dr. Manny Cowder was very useful. Manny wanted to build Children's from a general children's hospital to a multi-specialty pediatric center, and for him to accomplish it he needed to have a medical school link that was very close, so Manny and I had a very cordial, close, and intimate working relationship. As a matter of fact he became the first chairman of pediatrics, and that really tied the hospital in tightly.

JS: You mentioned before in our earlier discussions the importance of the role played by Dr. Taguchi. What position did he hold at the VA Hospital?

JB: At the time that I came to town, Jim was the chairman of the Department of Medicine and had been active in this group of Dayton medical educators, had been one of the proponents for a school of medicine here, had trained many of the internists here in town, I think was highly respected as an internist and a teacher of medical education, and was one of the few voices in the wilderness at the VA that helped us in trying to change

some of the image and perception that many of the VA people had about this new school of medicine. So he fortunately was an early player, got on the bandwagon and helped us tremendously from his position within the VA, and many times got pounded and scarred in doing that. But I think [he] played a key role internally that really facilitated the movement of the VA into the total integrated picture.

JS: Is the importance of the Greene County and Montgomery County Medical Societies still at the same level it was at the development of the medical school?

JB: I think so. Because I don't believe that the school can exist without their support; if it isn't overt and enthusiastic, it would still require tacit support for it to continue, and the reason being that so many of its membership are on the voluntary faculty, and I think the fact that they are the professional organizations for this area that their support is important for the continued viability of the school. Particularly this kind of school where you do not have a university owned and operated hospital. That's always a retreat position in those communities where this is a problem between a professional community and an academic institution; the faculty can always retreat to that hospital and tell everybody else to blow it out their ear. Here you can't have that happen, because there is no retreat position, and that was part of the design as well. Because clearly it said when we recruited chairmen that they had to be people who could live within that professional community and could appreciate the fact that there was no fallback position to a university hospital if they did not develop the right interactions. So as a result all of the early players here were people who, with maybe one exception, had a very clear understanding of what it meant to live with a group of community professionals and what it meant to be part of their hospital staffs.

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JS: Do the medical societies in Montgomery County and Greene County- do they serve the same purpose in keeping the School of Medicine close to the community as they did before?

JB: I think they do from a standpoint of purpose but maybe in a different kind of way. I think both societies were instrumental in getting the establishment of the School of Medicine here, and did that by a series of public statements as well as by being politically prominent during those machinations in the early '70s and late '60's. And I think once we were in town they were incredibly supportive in terms of helping us develop the new enterprise. The example that comes to town is their changing their by-laws to permit me to serve on the executive committee of the medical society, and that was very useful because it permitted us to spike rumors before they began, to share information, and to short circuit a lot of things that could have been problems but were non-problems unless they got out or the facts weren't shared. So it was a very useful exercise. That continues to date but I think is less prominent that it was. What is happening now, however, has been the continued integration of the school into the societies' activities and vice versa: there is a regular column about the school in the publications of the Montgomery County

society; its membership is heavily contributed to by the medical faculty, [xx] the people who came in; a role that we played early on was to encourage new faculty to become members in organized medicine and played a major role in it. And I think all of that has gone a long way to where it had been kind of a courting game to where it became a family, and I think that exists today. So my sense is that there is tremendous support in the community, and it is not phony support. It is built by integrating their interests and our interests and by cooperating together. It could have been very different if we had brought in people earlier as I mentioned who were against organized medicine or who felt that wasn't important, because instead of being part of the action it would have caused confrontation, so that was avoided. An early thing we did to encourage that was to pay the medical society dues of all the new faculty who came in just so they wouldn't have the excuse to say no. So every one of them became a member of the medical society and I think that investment has paid off. So the long winded response to your question is that I think that with the kind of operation we have the continued interaction has to continue; it has to be part of the strategy of the continued survival of the school, but the kind of support now is a very different form, it is one that comes from within the substance of the organization rather than as a statement of the organization back before the school existed.

JS: In reading your history of the development of the medical school, it occurred to me two major sources of funding for the school that were above and beyond the state allocations, and those were the Kettering Fund and the funds provided by Public Law 92541. Do you want to describe those?

JB: Yeah. There were two pieces- not only the Kettering Fund, but also the Thelma Fordham Pruitt Fund- and those two private gifts were very important. Let me speak about those first and we can talk about PL92541 later. During the formation of the school, or the formation of the enabling legislation, it was very obvious that some kind of statement needed to be made to the politicians in Columbus that there was grass roots support for this institution, and through the leadership of a number of people, including Chester Finn and Bob Oelman- who was chairman of the board at that time- and a number of other people, two major gifts were obtained for the school even before it had been formed. One of these was the Kettering Fund, from which one million dollars was donated, and the Thelma Fordham Pruitt money, from which a half million dollars were given. The latter funds were developed for a health sciences library. Actually, a medical school library is the term that was used but clearly it became a health sciences library. And second, the Kettering Fund was an unrestricted gift and an early decision was made that that gift would be used to create an endowment fund to provide discretionary funds for a variety of things that couldn't be done through state purposes. For example, a simple business of buying somebody a drink, to have that reimbursable was impossible with state funds, so that kind of thing was done with the interest that was obtained from the endowment of the Kettering gift. So those became critically important and it helped to organize- the Pruitt gift permitted us to move ahead with the library and was one of the main reasons that Ray Palmer was attracted, because he not only had state support but he had the Pruitt endowment to work with. And then of course the Kettering fund was essential for all the early kinds of ad hoc expenses that you have that you just can't

handle through a state arrangement. So those were very, very useful and obviously were very eloquent statements of support about the community support for the institution.

Public Law 92541 had a long and interesting story. At the time of its development it was known as the Teague-Cranston bill. “Tiger” Teague from Texas [Congressman Olin Teague] was interested in using that to develop a new program in medical education at Texas A&M, and [Senator] Alan Cranston from California was interested in using that to develop a program at Fresno. When that bill was being put together, I became aware of it through the connection with Cranston in my connections in California, and as it was being moved to be formalized and as I visited Dayton, it was clear that Wright State had an opportunity to fall under that bill even though it was specifically being written for Texas A&M. Bud Brown, a congressman for Urbana, had taken a lead role after the bill had been established to assist Wright State in the draft application of the grant, and I had an opportunity when I visited in late ’73, early ’74, to talk about that grant. As a matter of fact, it was interesting because, again, the grant that had been put together was one that was based on this incredibly naïve plan for medical education and was funded at a level that wouldn’t support a kindergarten, so with my prompting they revised that grant on the order of magnitude of four to five times, and submitted it. Bud Brown and others were very helpful in moving that through and when it became clear that I was going to be invited here I began to work through Cranston’s office on the California side and we became the first awardee for that new public law. So although it was designed for Texas A&M, they literally became number two or number three, much to the chagrin of Tiger Teague and to the pleasure of some others who knew me in California. So that’s the long and short of it. It provided a tremendous infusion of funds. As I recall it, the state had given 60 grand for planning funds and something on the order of maybe a couple of hundred thousand for the first year’s operations- which would maybe pay for paper clips in the operation- and the first award for the VA was an award for 19.7 million over seven years. Then over that period of time we subsequently submitted a proposal for an additional nine million dollars, which was successful, and then because we hadn’t spent the money out we were able at the end of that time to get a special bill through Congress to permit us an additional year to spend it. So I brought a considerable amount of bucks to Wright State University and that single stroke was worth about 30 million bucks to the institution.

JS: What kind of effect did that have on the people in Columbus, especially those who weren’t in favor of the program?

JB: It blew their minds [laughs]. And it made things interesting, obviously, for some of the newer schools. For example, Northeast Ohio did not have the benefit of the VA funding [and] as a result they were clearly a year and a half or two years behind us in their development and had a much tougher go of it. We were able with that funding then to really bring in some top notch people very early and to move the program very, very quickly. A large chunk of that was for capital improvements as well at the VA, which they needed and helped them to bring along some of the VA people who suddenly saw for the first time some movement and some improvement in facilities and maybe the medical school idea wasn’t all bad, and it all worked out very well. But it was very

interesting that once that had been blessed and we became a going enterprise, there was no stopping it after that had been awarded.

JS: During the development of the medical school there were essentially four groups that either merged with or were created by the School of Medicine: the Cox Heart Institute, the Fels Research Institute, the Bob Hipple Lab for Cancer Research, and the Drew Health Center. Can you describe how they came into the program?

JB: Okay, each one is different; let me maybe take each in turn. Cox Heart was developed as a research arm at Kettering Hospital. It was developed as a free standing unit to capture development funds. Its director had problems with alcohol, and Paul Kesde [sp?], who was brought in as a scientific director subsequently became director, had a number of major NIH grants but its board clearly saw that it could not exist in that free standing function, and so we were approached early to see whether or not we would be interested in having that operation as part of the School of Medicine. I think that was important to do because it did two things: One, it immediately gave us a clinical research unit that we would not have had otherwise, and secondly, it gave us a presence on the Kettering campus which had been difficult to achieve otherwise, because the Kettering Hospital was one of the more recalcitrant in town regarding this new beast called medical education. Several of the people there were very supportive but that was not throughout the fabric of the institution, so suddenly being grafted or transplanted there made it very clear that we were there to stay, and that was very useful.

JS: Was that recalcitrance on the part of the Kettering people any residue leftover from some of the initial plans to put the School of Medicine at the Kettering [Hospital]?

JB: It could well have been. But I think most of it was that Kettering of course is the private, private hospital in Dayton and I think a lot of its staff wanted to keep it exactly that way, and the leadership, who I think were anxious to have the school presence but worried about its influence, and those were the factors there. I think they had reconciled themselves to the fact that there was not going to be a medical school on their terms, and as long as the Valley didn't have it they weren't going to be considered. It probably was wired largely in a staff perception than leadership perception there. So the long and short of it was I was appointed to the board at Cox, and over a year we studied whether we should move in that direction and the agreement was finally made that we ought to go that way, and Lou Polk was the chairman of the board, and Lou is a very distinguished guy, nationally as well as locally, and through his leadership then the unit was transferred to Wright State. It was not done as neatly and cleanly as Fels, though, because Kettering insisted on getting the physical properties, so they had the right to it after 99 years and I figured after 99 years, what the hell, I'm not going to worry. So they ultimately have the building, the ground, after that period of time but we're there until that time.

The Fels is a similar situation in that the Fels Institute, the Fels Foundation in Philadelphia which supported the Fels Institute for a long time, felt that because of what was happening nationally, the drain on their resources, the fact that their capital endowment was now being eroded, that the Fels Institute could not continue to be

supported at the level that they had in the past, who wanted to see if there was another arrangement that could be effected in which was the association of that research unit with a major university center. And actually they had approached a number of institutions, including Wright State, about that. Frank Faulkner was the director at the time and Frank I think saw the logical interplay between Wright State and the Fels, so there we had a number of interactions with the board, a series of negotiations, and in that particular instance we concluded an agreement where in fact the Fels became an integral part of the university. Its land and equipment were given to the university and its senior scientists became faculty members, and along with it came a dowry from the Fels Fund, a commitment of support over five years on a declining formula basis. As I recall it was something like three-quarters of a million a year and winding up at a quarter of a million in the last year of that operation, and that worked well. Let me insert here that a similar dialogue had been going on for a long time with the Kettering Lab- which is right across the street from the Fels Institute- that never did get consummated for a variety of reasons, largely because the expectations of the people within the Kettering institute were far too high, and I think it was wise that we didn't nibble on that one.

The Hipple Lab is an interesting story, because we actually transplanted that laboratory from the Sloan-Kettering Institute in New York to Dayton, and that came about in an interesting series of ways. The way that started was that the main endower of the Hipple Lab was Bob Hipple, who made his fortune here in Dayton with a machine shop and had met Martin Murphy on a trip to Europe, and through that connection the Hipple made the lab that was run by Marty one of their main beneficiaries in New York. And I happened to meet them during one of Marty's fundraising activities here in Dayton, and I made the suggestion that I thought if the bulk of his funding came from Dayton, we ought to move the lab here and keep Dayton money in Dayton. That turned out to be particularly attractive to the Hipples and others, and some of the friends of Marty and the Hipples were influential in that. One of the proctologists in town, Chris... I can't think of his last name, was one of the intermediaries. But largely then we got the seed planted and worked with the folks at Sloane-Kettering to perhaps facilitate the divorce and then negotiate with Marty to bring it here. So the long and short of it was that we did a surgical excision of that laboratory out of New York and brought it to Dayton and then housed in the Cox Heart Institute because that space was immediately available, and I think that's worked out extremely well. They're doing very, very good things. It took a front end investment out of the university but I think it was a very useful one to have done. That immediately then gave us credibility in our research programs which I thought was important for the accreditation process.

And finally, the Drew Health Center is an interesting story. It had been a neighborhood health center that had been run through the City of Dayton as a fiscal intermediary but through a neighborhood action advisory board, and had been a source of turmoil and trouble in Dayton that well annotated [?] our coming to town. Rumors of mismanagement and graft and all those kind of things- part of which is undoubtedly true- were rife. The place ultimately closed because it went bankrupt, and it went bankrupt with the City of Dayton wringing its hands, watching it happen, because it did not want to intercede into the West Dayton politics. One of our close supporters in developing the

School of Medicine was C.J. McLin, who was [and] is a very prominent legislator, head of the Black Caucus in the State Assembly, and a person who we linked with very early in terms of support for the institution. Unfortunately, C.J. thought that the medical school was an easy way to re-infuse life into this dying cadaver at West Third Street. So it took a lot of gamesmanship and foot dancing to escape being dragged into that. Ultimately, the school took a leadership role- I guess I did, personally- in getting together the leadership of the city, the county, the health district, the Black community, the Black professionals, [and] used the university leverage as the intermediary and got them to develop that with a cooperation of two major hospitals. Good Sam took over the management of the Drew Health Center, and the Valley opened an equivalent East Dayton health center for the Appalachian white. I think that we made the commitment of utilizing both of those for our educational programs, and we also made an early commitment of equipment to both of those institutions through an ambulatory care grant that was given out at the state. So by our buying some equipment for- deftly, I would say; I'm rather proud of that maneuvering of us into the hands of two hospitals- we got out of the middle of being put into the healthcare business in what was obviously an inappropriate role for the School of Medicine. So that's an interesting story, probably worth a novel sometime in and of itself.

JS: Do you see any other research establishments in Dayton that would be perhaps drawn into a relationship with Wright State in the future?

JB: Well, I'd like to think that at some point in time there would be very close relationships with all of the research activities going on in Dayton, but I think we're not there yet and it may well be that the movement of the new Research Park may be one of the catalysts to have that happen. But clearly there are a number of linkages that are not quite so visible or so prominent as this one that are still very important to the operation of the institution. There are very close ties, for example, with the AFMRL, the Air Force Medical Research Labs at Wright-Patt. We have a number of graduate students working over there; a number of their people are on our clinical faculty; very close ties with that operation. And there are other kinds of research units like that at Wright-Patt and elsewhere that are part of the constellation of activities. So there are a number of those linkages that are already here- some very close [and] others fairly loose- but I don't know of very many in which there are not at least some peripheral associations.

JS: Thank you very much for talking about the organizational roles, and next time we meet we can start into the accreditation process.

JB: Good.