Oral History Interview of
Robert Salem

Interviewed by: Fred Allison
April 30, 1998
Lubbock, Texas

Part of the:
South Plains Healthcare Interviews

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Transcript Overview:

This interview features Robert Salem, who discusses his views on Medicare, the history of Lubbock's medical center, and what it was like to unexpectedly be the head of the surgical department for five years.

Length of Interview: 01:02:38

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Robert Salem (RS):
And then, on the heels of Medicare in the last number of years, we're seeing more and more what we call managed care plans, HMOs [**Health Maintenance Organization**], regulations related to all these things, so that the doctor today is just inundated with all of these controls and seeing lots of autonomy, and independence, and that sort of thing. People come out of medical school today—you know, they don't know any different. This is probably the norm for them. They wouldn't have the same feelings about it that I do. But I saw medicine—practiced medicine the first half of my career, where it was—all of the—I made all the decisions. I had no interference with anybody as far as—I was accountable for what I did to my patients. I didn't have to have all the insurance companies and Medicare tell me who I could operate on, how many days they could stay in the hospital, and all that stuff. So I'd say the first part of my career was sort of free, autonomous, no regulations, other than the normal medical regulations, of course, on the medical side. In the last half, we're seeing progressive regulatory efforts put into place by Medicare and other insurance manage care activities.

Fred Allison (FA):
Which would you assess is better for medicine in general?

RS:
Well, you know, that too is debatable. I guess, it depends on who you talk to. I would say that the standard of care of medical care delivery really hasn't changed that much, I mean, in either scenario. I think that the physician that has been where I've been finds it is more difficult to deliver the same level of care, because you have to spend so much more time on—I'll call—paperwork. But I think that the level of care has been consistent.

FA:
Would there be any facets of the earlier style that is preferable to what it's become today? Any negative—what negatives have occurred with the government involvement?

RS:
I think it's primarily related to the—let me just give you an example. To the regulatory things that pose—if you accept a patient nowadays, for example, who's in a—let's just say he has an insurance—he has health insurance with some entity, some insurance company: Aetna, insure, or whatever. Medicare, you name it. Before you can put the patient in the hospital, you've got to call the company, tell them what you want to do. You've got to get approval to do it.

FA:
Now, are you talking—when you call the company, are you talking to physicians?

RS:
There's usually a screening panel. The first line is usually done by nurses who are looking at criteria. They have a list. "This is what the criteria are to do a gall bladder operation." There's protocols that they look at. If you meet all these criteria, they approve you. If you don't, they reject you. Now, you can appeal to a physician who reviews the case with you. That's just a broad example. That's just the first thing. You've got to have all of this—you've got to get pre-approval for many, many things nowadays. Then, they tell you when the patient can come in. It used to we would put patients in the night before surgery, make rounds on them in the evening, go over and check them while we talk to them about their surgery, discuss the potential complications, et cetera, et cetera, et cetera. Give them instructions for the night to the nursing staff, whatever preparation they need to provide the surgery and operate on them the next morning. Nowadays, you can't do that, most of the time. You have to—they tell you the patient has to come in in the morning. We can't admit them the night before; they have to be admitted the morning of the surgery. So all this preparation really has to be done before they come in. It takes more time in your office. And then, after that, they tell you how long they can stay in the hospital, and they won't pay for it if it's longer than that. If there are complications, you have to call them on a daily basis and tell them what the complications are, why the patient is staying in the hospital, and so forth. That's the sort of thing that we're dealing with today, as an example, of what makes it much more cumbersome to practice.

FA:
Right. It's almost as if the doctor's a technician or just—

RS:
Yeah. To some extent, yeah.

FA:
Just do what you're supposed to do on this procedure and that's it.

RS:
Yeah, that's true.

FA:
It doesn't take into account intangibles, like the psychological state of the individual patient. They might need extra time in the hospital or whatever.

RS:
And they have criteria for determining those things, and they say, "Well, because of the things you just mentioned"—you know, I used to keep my patient in the hospital a day or two. Well, they say, "That patient doesn't need the hospital. He needs some attention. He can be discharged

from the hospital and go to a motel. They're not able to go back Clovis, New Mexico. They don't need to be in an acute care hospital. It costs money, and they can just as easily check out, and go to a hotel, and recuperate there, and then go home." Those are the things I don't like about modern day medicine.

FA:
Right. The lack of just general control the doctor has?

RS:
That's right.

FA:
It's almost like they don't need all that medical training anymore.

RS:
Well, it's taken a lot of decisions about patient care out the hands of doctors.

FA:
What about the relationship with patients? Is this—

RS:
This has created problems with patients as well. They're inconvenienced. I don't think there's any question about that. I've been a patient myself, and it's not like it used to be, in terms of patient convenience. And I don't know how far this will go. I can assure you that there are very few patients who like this, in terms of the restrictions that are imposed upon them. But, you know, very few things in life stay the same. I think we're all adjusting to what we have to adjust to, doctors and the patient population as well. This is the way it is. We have to learn to be adaptable to changing times. We're in that phase right now.

FA:
Do you foresee any changes for the better, or is it going to get worse?

RS:
Well, I don't know. We still see—today, we see things ratcheting down. On the other hand, you do see signs of this thing turning around, because there were—I don't know whether you saw it in the newspaper or not—during the last year, for example, some insurance companies required OB patients who delivered—they had to be discharged from the hospital that night or the next day. There are state laws enacted now that require—that make it—that mandate that the patient that delivers a baby stays two days. So we're seeing a reversal of some of these—

FA:
Against Medicare procedures?

RS:
Yeah. Well, maybe not Medicare, per say, but other—other manage care entities, who were saying, "You have to get out of the hospital," you know, "within twelve hours." There are laws now being enacted that say you don't have to. Mastectomies. Another thing, same thing. There are some insurance companies that after a mastectomy that say, "You've got to be discharged that night or the next morning." There's a law saying that you don't have to. I don't know whether you've ever had a hemorrhoidectomy or not?

FA:
No, I haven't.

RS:
Because there's some insurance companies that say you've got to be discharged that night.

FA:
That doesn't sound like a lot of fun.

RS:
I guarantee you. The patients don't like that either.

FA:
Well, I have had a hernia surgery before, and I remember I stayed in the night before.

RS:
And probably the night after.

FA:
And the night after, I believe.

RS:
Nowadays, you come in morning of and go home the same day of.

FA:
You're kidding me.

RS:
Absolutely true.

FA:
That's the worst thing in the world.

RS:
Absolutely true.

FA:
It was just the most painful thing. I couldn't imagine going home.

RS:
You do. And if you don't, you've got to justify why to the insurance company.

FA:
Do they do those by laparoscopic surgery now?

RS:
Yes, laparoscopic surgery is being done for hernias, as well as some other things. I guess the jury is still out on laparoscopic hernias. Our group has done a lot of them. I think our group, in particular, is not completely enamored with the laparoscopic hernia repair. I'm talking about inguinal hernia, which is down here in the groin.

FA:
Yeah, that's what I had.

RS:
There is a procedure that's being done now, fairly commonly, called hiatal hernia that's being done laparoscopically. And we've done a number of those. I guess a hundred or so the last two or three years. That's been very successful and certainly does reduce the surgical morbidity of a very big incision. That's been pretty successful. Probably the most acceptable procedure we did in the general surgery in laparoscopic was gall bladder surgery. It's completely revolutionized gall bladder surgery. Gall bladder surgery used to be five or six days in the hospital, and now—through a big incision that we used to do—and now, most of our patients go home that evening or the next morning and feel fine. So it's certainly—innovations in laparoscopic surgeries have been very, very accepted by physicians, surgeons, and by patients. That's a new technology that has really been beneficial.

FA:
Do you think that's one of the most significant for your—

RS:
Absolutely. From my perspective, and as practicing surgeon over the last thirty-five years, this has been the most—single most important innovative technique that's been developed for laparoscopic procedures because for the first twenty years, we did things, you know, just the same as we did when I trained. In the last ten years, the innovation of the laparoscope has completely revolutionized portions of our surgeries.

FA:
Well, we've talked about some of the negative aspects of Medicare and government involvement or managed care. Are there any positive things that have come out of this?

RS:
Well, I think there have been. First of all, I think that the statistics have shown that the level of care that the complications, et cetera, have not been significantly altered. I think, probably, the major, most significant impact has been cost attainment. We found that it does—that you can do these things—some of these things without running up big costs. So I think that this has been—and I think this was what was driving these things in the first place was costs, because, let's face it, healthcare was out of control and was escalating significantly. It was getting—for a family of four, health insurance was getting out of hand. Something had to be done. And I think that, from some respects, this has helped to contain a part of that. I'd say that's the major benefit of those things. I think there's probably got to be a happy medium somewhere. I think we were, maybe, we were in one extreme twenty years ago and now, we're getting to the other extreme. Maybe the final thing is going to be somewhere in the middle somewhere, and I suspect it will.

FA:
What do you attribute the rising costs to that led to—I assume led to managed care, right?

RS:
Yeah, right.

FA:
What started the rise in costs?

RS:
You know, as I look back on it, medicine in America has always been very, very progressive. This requires new technology, new experimentation, new equipment, new expertise, and all that costs money. And to get the money, you have to charge the patients.

FA:
Because it's privately—

RS:
Yeah.

FA:
It's a private enterprise.

RS:
That's right. And this here, again, has just sort of compounded itself. I guess that's one of the prices we pay for the modern day technology that we enjoy and experience, both as physicians and patients. I can cite you an example of kind of what I'm talking about. My experience in France. France was a completely socialized country, as far as medicine was concerned. In fact, a lot of its industries are socialized. And I can remember on three or four occasions going to a French hospital where a—one of our airmen had been injured with a badly mangled leg, commonly a compound fracture. Because of socialized medicine over there—they would amputate that leg, because to rehabilitate that leg would require multiple operations, long-time hospital stay, more and more and more and more and more expense. That's what we would do over here. Over there, they would amputate the leg, get him out of the hospital in four or five days, buy him a wooden leg and get him out. The cost would be less. So the price of doing medicine and practicing medicine in this country, as we've traditionally done, has been expensive. Like everything else, the cost goes up every year. So I think that's—I think that's where it's come from.

FA:
Do you think Medicare and Medicaid, in the first place, had something to do with it? With the costs starting to escalate?

RS:
Actually, I really don't. I think this occurred, of course, prior to that escalation, during the time of Medicare and Medicaid. Their efforts were to put a ceiling or a lid on what they would pay the hospital for services and the doctors for services. So from that aspect, it was to be cost-contained, so it wouldn't cost the—so the patients could get healthcare and other relations on a fair price. On the other—on the flipside, to compensate for that, on the private side, on the commercial side, the prices may have been driven up. You see what I mean?

FA:
Kind of.

RS:
Kind of? [Laughs]

FA:
Are you talking about indigent care? Does that enter—

RS:
No. I guess what I'm saying is that if a hospital, let's say—if Medicare says, "I'm going to put a ceiling on what I pay you for this Medicare patient," to offset that, they escalate the price on the other side to compensate for that, to the patient who has commercial insurance. That's kind of—

FA:
Medicare set a price for everything you did, kind of?

RS:
Yeah.

FA:
And it wasn't enough sometimes?

RS:
Right. It was less than what they normally would get. So then they made up the hospitals, then—made up that deficit by escalating the price on the other side. Can I take a quick break?

FA:
Sure.

[Pause in recording]

FA:
Yeah. I wanted to ask you, maybe, do you think indigent care has been improved with Medicare's involvement, or government involvement?

RS:
You know, actually, from my personal perspective, I, and the hospitals I've been associated with, both here and St. Mary, have always taken care of the indigent population. I mean, I've never refused a patient care, nor has this hospital, in my experience. And I don't know—I guess, across the board, I can't speak for everybody. So I think that, at least in Lubbock and at this hospital where I work in, mostly, indigent patients have always been taken care of. Medicare, I guess—Medicaid, I guess, has afforded patients a defined format or something tangible that gives them something that does represent some security on their part, in terms of if they have Medicare or Medicaid involvement. Particularly, in this era of modern managed care, there are Medicaid HMOs being developed that are ensuring patients get care by some hospital, some group of

physicians. So I think that, in that respect, it's becoming more formalized, more systematic, and organized, and structured to afford Medicaid patients access to physicians on a more formal basis. So I guess [inaudible 00:19:14].

RS:
It sounds like it was almost—I mean, that's why it came into being, didn't it, in the first place, was to take care of indigents?

RS:
That's true.

FA:
It sounds like from what you're saying, at least in Lubbock, it wasn't even needed, in that sense.

RS:
There might be people that disagree with me, but I think that's right. I think that if you showed up in the emergency room at Methodist, for example, as an indigent patient that needed medical care, you got it. Now, that's in the emergency situation. Now, on an elected basis, like for immunizations, for example, for children, it was more difficult to get. Although, there were clinics established in town, you know, by churches and other organizations to provide that type of care. It was harder to get access than Medicaid. Mammograms for women were certainly an example where Medicaid helps to make that more affordable and accessible for certain patient populations. But in the emergency setting, I don't know any doctor or any hospital that's [phone rings 00:20:34].

[Pause in recording]

FA:
Okay, Dr. Salem. Along those lines, it seems like with the changes that were brought in by Medicare that it would cast doctors in a new light in society. Whereas, it seems like before, where people depended on them, even if they couldn't pay for it, doctors were willing to take care of them, that they were perceived more as servants or ministers to society in needing healthcare. Whereas, nowadays, maybe that role has been supplanted by government, or HMOs, or something. Would you agree with that?

RS:
I think, to a certain extent, that's true. I think that—I know some colleagues—and I don't necessarily agree with them, because they never restricted my practice—but I know some doctors that actually refused or don't want to take Medicare and Medicaid patients for a couple reasons. One is they think for the services they render, the compensation they get is not worthy.

And secondly, because of all of the other administrative regulatory paperwork-type chores that they're encumbered with by accepting that type of patient. So I never did that myself. I took all patients. I didn't worry about what type of insurance they had, or didn't have, anything like that. That's just me, and that's what I practice in my career [inaudible 00:22:18]. But there are doctors that, because of this invention, the fact that the government, through Medicare, imposes all these restrictions and tells you what you're going to receive regardless of how much effort you put out. It's changed the doctor-patient relationships that we used to have.

FA:
That's really interesting. Whereas before, you didn't know of any doctors that would turn anybody away for any reasons? Now, there's at least some doctors, a few doctors, that are turning patients away because of Medicare.

RS:
That's true.

FA:
Which is very ironic.

RS:
It is. It is, in fact.

FA:
It's very ironic.

RS:
And they say, "Well, I've got a busy practice. I can take these other patients when I don't have—get compensated for, and I don't have the hassle, so why hassle with it? You know, I guess a person's got a right to do what they want to. In my view, that's sort of, morally, is something I've never subscribed to. I just feel like if the patient needs care and you're a doctor, you ought to care of them. My philosophy is pretty simple. Come in.

[Pause in recording 00:23:44-00:32:13]

FA:
This is the second part of the interview with Dr. Robert Salem, and this part's done on May 15, 1998, in Lubbock, Texas, and my name is Fred Allison.

[Pause in recording]

FA:
Okay, Dr. Salem. We were just talking about some of the roots of Lubbock as a medical center and how that developed. If you could just give us your take on that.

RS:
Okay. As we were just talking, really, I think the first major event in the history of Lubbock medicine was back in 1918, when three doctors came together and built the old Lubbock Sanitarium, which was about a fifty bed facility located down on Broadway and Avenue L. The three doctors involved were doctors Peebler, Ponton and Overton, and they made—they constructed this facility in 1918, which was a very modern-looking facility and the first of its kind in this entire area. And really, this started an influx of patients and other doctors into the community. And almost simultaneously with that was the 1923, when Texas Tech came into existence and opened its first class in '25. So think these two things, along with the evolving agriculture community, made Lubbock a landmark site for this whole area—for this whole area. And on the heels of this Lubbock Sanitarium, more and more doctors came into Lubbock. They saw the first modern facility to put their patients into a modern hospital. And then, of three original doctors, only Dr. Overton remained, and then subsequently, he joined Dr. Krueger and Dr. Hutchinson, and these two—these three doctors then formed a partnership that spanned over the next several decades. Then Dr. Krueger, Hutchinson and Overton ultimately developed the Lubbock Memorial Hospital in 1953, and it was a two-hundred-bed facility, and is now incorporated into the Methodist hospital and consists of the West Tower. But I remember going back—my mother and father were particularly acquainted with Dr. Krueger back in the forties and fifties when they used to come over here for some treatment from him. I had a personal acquaintance with him when I arrived in '62. In fact, he invited me to join him in practice, but I preferred to go in by myself, which I did. And had the opportunity, though, for the next two years to operate side-by-side with him in the Methodist Hospital's operating suite. He actually had a stroke in the operating room one day, 1964, and then died from complications of that stroke a few weeks later. But he was probably the most well-recognized, revered surgeon of this Lubbock community since 1918. He was really a god to a lot of people, and his name was revered in all circles. And it was really a privilege for me to know him personally. Then, they opened—Krueger, Hutchinson and Overton opened the Lubbock Memorial Hospital in 1953. Then the following year is when Methodist—the Methodist church—the Northwest Texas Conference over the Methodist Church assumed ownership of the hospital. And at that time, the Methodist church made this an open staff hospital. Prior to that time, if one came and wanted to work in this hospital, you had to be employed by Krueger, Hutchinson or Overton, so the staff was very limited and restricted. But the Methodist Church took it over. They took an open staff policy. And this is really when all the modern day specialists, as we know them today, started coming into Lubbock. In '62, eight years after the Methodist Church took it over, was when I came to town. I was just one of many who came into Lubbock at that time.

Unknown Speaker (US):
Excuse me, doctor.

RS:
Yeah.

[Pause in recording]

RS:
In '62 is when I came to town as one of the early modern day specialty-trained doctors. Since that time, there's just been a massive influx of specialists into this town, which has further enhanced its reputation as a tertiary care medical referral center. Then the other major event that has enhanced Lubbock's image as a medical center was the beginning of the medical school around 1970. Prior to that time, over the next—for several years prior to that actually happening, there was a concentrated effort on the part of the city officials, Texas Tech University, and the local medical society to secure the medical school in Lubbock. At that point in time, in the late sixties, I was president of the Lubbock, Crosby, Garza County Medical Society and also served as Chief of Staff at the Methodist Hospital. So I had a major part in the effort to secure the medical school here at Texas Tech and in Lubbock. One of the major players back then was an old college classmate of mine, Bill Parsley. Bill and I were in college together. He married a mutual friend, Alice. We were all in college together at the same time at Texas Tech. Bill was a lawyer. He was a state representative for a number of years. He had a lot of political clout as a result of being in the legislature in Austin. Texas Tech hired him after his career in the legislator as the Vice President of Development. He was instrumental in lobbying, both formally and informally, for the medical school at Texas Tech and in Lubbock. He and I were good friends. I was sort of his medical informant. Any time he needed some medical background, he came to me. In fact, he asked me to accompany him to Austin on several occasions to—as he was lobbying and jockeying for this school—medical school. I remember on two or three occasions staying over with him at the Forty Acres Club in Austin. I don't know whether that club is still in existence or not. But back in the late sixties, it was sort of a political hangout. I think a lot of the laws that were enacted in the state were actually—the groundwork and some of the deals were actually done in the bar of the Forty Acres Club at two o'clock in the morning. I can remember Bill meeting with Frank Erwin, who, at that time—I forget his exact title—but he was the most powerful political democratic University of Texas person in the state, and most people say he was much more powerful than the government. And I can remember, after two or three scotches, I'd have to go to bed, and Frank Erwin and Bill Parsley would discuss on into the night [laughs] their political jockeying positions. At that time—

FA:
Okay. When was this?

RS:
This was in the late sixties. I don't remember the exact year.

FA:
Was this before—

RS:
But leading up to and before the medical school became an entity in 1970. Probably '68 or '69. I'm trying to think of the name of the governor before Preston Smith. I'll think of it in a minute. Anyway, Bill had come up to create the medical school for Tech, and it was—it had passed the Senate and the House but was vetoed by the governor. I'll think of his name in a minute. So then the next year is when all this jockeying took place. What happened was that the University of Texas wanted a medical school in Houston. They hadn't had the time to put it together when the Tech bill first came up, so that's why the bill was vetoed. And then the next time around, then the bill that created the medical school for Texas Tech—there was also a bill that went side by side of that to create another medical school for the University of Texas, and that's why we were jockeying between Bill Parsley and Frank Erwin. They agreed not to impose our bill. We agreed not to impose their bill. So both schools were created at the same time. So that's how all that came about. But Bill Parsley, in my view, had as much to do with securing the medical school here as any other single individual, because he did all the jockeying and lobbying behind closed doors there with Frank Erwin, and struck a mutual agreement to not oppose each other's medical schools. And not very many people know that. They were, sort of, low profile. They didn't receive a lot of publicity, but I know for a fact, because I saw it in action first-hand. He was a wheeler dealer, very articulately knowledgeable guy, and one person who died prematurely from heart disease in his fifties. He was a very talented fellow, and I have the utmost respect for him, and still good friends with his widow, Alice. So, at any rate, once the school got here, through considerable efforts on a lot of people's parts, not the least of which was our Governor Smith, who was a fine gentleman who has succeeded [inaudible 00:34:15]. But once the school got here, then this added another level of expertise to the medical community. We immediately had another layer of experts across the street at Methodist Hospital. The school also had satellite educational facilities in Amarillo and then El Paso. There were satellite branches of the Texas Tech School set up at the same time, which just broadened the scope of the Texas Tech medical school home base here in Lubbock, and also served as a referral source for these areas. And subsequently, another regional branch has been established in the Permian Basin in the Odessa-Midland area. So, currently, the school actually has the Lubbock branch, the El Paso branch, the Amarillo branch, and the Midland-Odessa branch. So all that combined just enhanced the stature and reputation of Lubbock as a medical community when the medical school got started. I think I may have referenced the fact that—they initially just started to enroll a freshman class, but toward the time approaching for the school to open, they decided also to enroll a third-year medical school class. And those students came from various two-year medical schools across the

country and Mexico. Back in those days, in the early seventies, late sixties and seventies, there were a few two-year medical schools, where the medical students just got their two years of basic sciences and then they had to go to other schools to complete their third and fourth years. This was a natural progression because in four-year medical schools, there's a certain attrition during the first two years. For example, if a four-year school started out with a hundred students, by the time they got to their third year, 10 or 15 percent of them have fallen out. So these two-year schools generated students to plug into the gaps that were created in the four-year schools. So that's how that came about, and that was a good plan. So that, at the last minute, though, Tech decided to enroll with its first year freshman class a third year medical school class with some four year students. And those students came from these few two-year medical schools across the country and Mexico. And a few months before the school opened, I was asked by Dr. Buesseler, the first dean, if I would serve as the chairman of the surgery department. At that time, I had two partners: Dr. Stirman and Dr. Allen, and we had a very busy surgical practice then. Subsequently, our group has grown to a total of eight. At that time, there were just three of us. We were all busy. Everybody knew that I had supported the school—getting the school here and that I had been politically active in securing it here. And I wanted to see it succeed, certainly, because I thought that it would enhance the reputation of the medical community in general, and in Lubbock, in general, which it has, in fact, done. But I didn't really have the time or the expertise to serve as a chairman of the new medical school and certainly, of the new surgical department. But finally, Dr. Buesseler prevailed upon me to do this, and I said that—I leaned on him heavily to do this, because he thought that I would be the guy to do it, if anybody could, here in town. I told him the only way that I would do that would be if I could have the support of every other general surgeon in town and lean on them for helping me put together a training program for the medical students in surgery. So before I accepted his offer, I went to every single surgeon in town. At that time, there were about twenty of them. I told them that I'd been asked to do this and I would do it if I had their support. I asked them to help me give lectures, and have the students rotate in the hospital, under their supervision, and so forth, and those types of things. It did require a large number of people, and certainly one person who could do it. And also, provided my partners were willing to allow me extra time to do this. So anyway, that all came together. I had one hundred percent support from every surgeon in town. I had the support of my partners. And I told Dr. Buesseler that I would, yes, do this, until such a time that he could secure the services of somebody full-time to do—full-time [inaudible 00:39:30]. So, you know, what do you do? I don't know what to do the first day. The first thing I did was fly to Dallas, where I went to medical school, to talk to the department—the surgery chairman there, and also to Houston to talk to Dr. DeBakey, and asked them—

Unknown Speaker 2 (US2):
She said these have [crosstalk, 0:39:53].

FA:
Yeah.

RS:
So I went down to Houston to talk to Dr. DeBakey, and I asked both he and Dr. McLellan in Dallas—I said, "I've been asked to start a surgery department for a new medical school, and I don't know what to do first, so give me some guidance." And Dr. DeBakey and Dr. Robert McLellan in Dallas told me—gave me some ideas. I had some ideas of my own, and they just reinforced what—and gave me additional information about what to do. I didn't know what to do about textbooks, giving lectures, what the lectures ought to specifically be over to fulfill accreditation and all those things. We put it together. I set up a lecture series. I asked the various surgeons in town to lecture on—to give specific formal lectures to the students on specific subjects, and I filled in the gaps. And everybody participated in that. We set up clinical rotations at Methodist Hospital. And Methodist served as the interim teaching hospital, because when the medical school first started, there was no University Medical Center Hospital here. In fact, there was no medical school building here. We used Thompson and Drane Hall at Texas Tech to serve as the administrative offices of the medical school. And then Methodist Hospital served as the teaching ground hospital for the medical students. The medical students were allowed to come over to Methodist Hospital and observe surgeons as they made rounds on their patients. They were allowed to scrub in to the surgical operations during the surgery. Obviously, they didn't have any expertise and didn't do anything firsthand, but they were able to scrub in and observe surgeries at the highest level. In fact, I've had a lot of the students come back to me years later and say that that experience they had really was unique, because there were no interns or residents here, and the students really got to come in here and observe and assist, really, in a major operation as much as interns do. They do anything actively, but they got to get their hands in the abdomen. For example, they got to tie knots. They helped to cut the skulls [?] with retractors and really function very much like an intern would in any other setting. So the students have come back years later to tell me that that experience that they had as students was unparalleled. They felt like as they went on into their careers in various specialties, that they felt like they were as academically prepared and more so, in many instances, than many of their peers as they went into medicine in all parts of the country. So with the feedback I've gotten through the years, the students, even in the early days, got excellent training and excelled in many areas, more so than a lot of people in more established schools. So the school got going that way. The first thing I did was to start looking for someone to take the job full-time. And I really thought that I'd be doing this for about three to six months max, and it turned into a three-year job before I recruited the services of Dr. Francis Jackson, who was chairman of the veteran—surgery division of the Veteran's Administration Hospitals all over America. He was a very—he was not doing much clinical surgery at the time, but he was very—student organizational abilities and added expertise on a level of professionalism that the surgery department needed that I didn't have. My strong suit was in the clinical area. I'm an active

surgeon with a lot of experience operating on people, but I didn't have any other skills that the department needed. The problem we had in recruiting someone—and we had a lot of people come down to look at it—is there was nothing to show them. There was no medical school; there was no hospital. We had a lot of blueprints, but no one was willing to stake their career on a piece of paper, to make a major move from a secure position to something that might be or might become. No one was willing to do that, originally, until something became more secure as to the future. So Dr. Jackson, I suppose, might've taken a little bit of a gamble in making a career move with not much structure [inaudible 00:44:42] for us, because he was able to fill in the gaps of my areas of deficiency in an academic setting. And I continued to work with Dr. Jackson over the next several years. In fact, I've continued to work with the Department of Surgery. I'm still a clinical professor of surgery, and still engaged in residency surgical training. And this was another—the next major thing that we did back in the eighties, was to establish a surgical residency program whereby the residents from the medical school's surgery department rotated on my group's private surgery practice here and this became part of the surgical resident training. We shifted our focus from students to residents, which is, of course, a higher level of educational experience. And the residents, back in the eighties, started coming over here to Methodist under supervision. They swapped surgical teams, which consisted, at that time, of probably five of us then, in the eighties. And they would spend a four-month rotation on our service. Every four months, a new one would come. We kept that up for many years. In fact, it's still in place. To this day, I swap through teams after training surgical residents at the medical school. It's been a good experience for both of us. Dr. John Griswald is the acting interim chairman of department of surgery. He and I frequently have discussions about the surgical residency training. As it turns out, because of the high volume of surgeries that we do at Methodist, this has turned into a vital part of the educational program, because the residents have to acquire, over a period of four years, a certain number of cases that they've either assisted on or done to maintain their level of certification. Some of them are dependent on the private practice over here to secure that volume that they need.

FA:
Even though they have a university hospital?

RS:
That's right. That's right.

FA:
It still doesn't provide the caseload that they need?

RS:
That's right. So this has been a good partnership, and we're looking at ways to enhance those things. Even today, we're talking about doing a mutually funded and integrated trauma

fellowship program of surgeons who have gone through the general surgery training. For an additional two years, they can become experts in trauma. And as most people know, the university medical school at UMC [**University Medical Center**] is a level one trauma center, and Methodist is a level two, the only difference being we don't have a full-time in-house staff, in terms residents, like they do there. But we're looking together to form a joint fellowship to train surgeons in the art of becoming specialists in trauma care. So we've had a long standing mutual relationship with—[cut in recording] and has been very beneficial for both organizations. And as we go forward into the future, we're looking at other ways to mutually interact in several different areas. We've developed a mutual pediatric surgery program with three pediatric surgeons in town. All of the pediatric surgeons are at St. Mary and UMC. We're trying to look at other areas where we don't duplicate services, where we don't compete with each other. We mutually cooperate and provide a service that's best for the community and the area without duplication of services and rounding up costs. So these are things that we're looking to the future to develop. Any specific questions?

FA:
Yeah. Along those lines, has this been the case all along? Or was there some competition earlier between the medical school, or UMC and the city hospitals?

RS:
Well, you know, initially, in the medical society in the late sixties, we actually took a vote of the medical society membership about their level of support for the school. It was an overwhelming. 95-plus percent of the private physicians in town were in support of securing the medical school here in Lubbock.

FA:
That's amazing in itself.

RS:
It is. It is. Now, over time, as it became a reality, as the school got here, and UMC got built and more and more doctors started coming into the school, that percentage varied because a lot of physicians, then, were in the field of competition, from the more doctors, particularly in their area, and more competition. So over the years, the support, in terms of the percentage, I think, would have decreased. I don't know what it is now, but there's still general support for the school. I don't know of anybody in private practice whose practice has been significantly impacted by the school, by other specialists from the school. There has been a competition that has developed between private hospitals and UMC. UMC is—it's another entity that treats patients, and they want to secure as many patients as they can. That's what Methodist and St. Mary [inaudible 00:51:05]. They're in the business of treating patients, and they are too, although they have a primary obligation to treat the indigent population in the area. They still

don't do private patients for financial reasons. So the element of competition has existed, but from my view that's good. I think makes us both—so I, personally, and most people don't view it as a threat. They are competitors [inaudible 00:51:30] excellence in the quality and the services. So I think it's going to help. So that's my read on that.

FA:
I think I need to turn the tape over. Let me see. Well—

End of Recording