Oral History Interview of
Robert Salem

Interviewed by: Fred Allison
May 26, 1998
Lubbock, Texas

Part of the:
South Plains Healthcare Interviews

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Transcript Overview:

This interview features Robert Salem, who discusses why the day of the solo practitioner has gradually disappeared over time, repairing a ruptured abdominal aortic aneurism at two o'clock in the morning, and the world renowned surgeon, Dr. Debakey.

Length of Interview: 01:09:42

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Fred Allison (FA):
You were talking about politics. Do you think that Clinton's given up on this idea?

Robert Salem (RS):
You know, they—I really think that, yeah, they've given up on their master plan, in terms of the all-encompassing elements of it. I think that they'll—[sighs] there will probably be continued efforts to enact various parts of it or pieces of it, less all-encompassing. And here, again, I don't think it's necessarily all bad. I think that there are good and bad parts of it. I just think, inherently and basically, anything that regulates the practice of medicine any more than it's already regulated—the cons outweigh the pros of that. I think that now doctors are legislated and ministered to death. It takes several hours of the day to take care of—to get done the administrative bureaucracy imposed upon us. Which means what? That we have less time to regulate medical care. We have less time to work with patients, in terms of doctor-patient relationships. And all the elements of practicing medicine [inaudible 00:01:53]. That's not to say there's not a business side of medicine because there certainly is. [Inaudible 00:02:03] But most doctors will say they want to minimize that part of it and maximize the amount of time a patient is in hospital care. I think that that's what's happening [inaudible 00:02:20] with OSHA [**Occupational Safety and Health Administration**] guidelines, with all the managed care plans, the insurance companies. We're so inundated with all of that that it has impacted how much time we have with the patients.

FA:
Doctors are, again, caught in a funny situation, because on the one hand, it's important to be a private—a private care—you seem to indicate that that's what made—has made American medicine the best in the world is private initiative and reward for private initiative. Which requires some profit to continue to do that. Some monetary reward. But on the other hand, if you have too much business emphasis, it's also bad for medicine. Would you agree with that?

RS:
Yes I would.

FA:
Too much—

RS:
And I certainly think that you're absolutely right. There has to be a proper balance. And I know that the private practice thing—the initiative, and the drive, and the compensation things, and all that—that takes money. It takes—it drives prices up further. You know, prices of medicine are getting out of control. I had a hard time, a few years ago, trying to find health insurance for my own family, you know, because the rise in costs. I can understand, coming from the other

direction, why, you know, the federal government and other insurance companies are doing all they could to try to control that cost by capping things and restricting services and that sort of thing. I understand that. Here, again, as I say, I think there has to be a proper balance. Maybe fifteen years ago, we were at one extreme, and today, we're at the other extreme. So maybe—I think, probably, a final balance there in the middle somewhere is going to be where it's all settled out.

FA:
Did you know many minority doctors? Were there many minority doctors when you were going through medical school?

RS:
You know, there weren't very many. For example, in my class, there were no colored doctors. There were a few Latin American doctors. But not very many. And I think that has changed over time. I know, for example, here in Lubbock, I helped a colored student become a doctor. In order to become a doctor, I have to get into medical school here and support, morally. Incidentally, he's practicing here in Lubbock now. And I think that over time, though, in the last twenty, twenty-five years, that more and more minorities have become physicians in practice. [Inaudible 00:06:10] And also women, for example. More and more women are [inaudible 00:06:35]

FA:
Oh really?

RS:
Yes. She came in two and a half years ago, [inaudible 00:06:43] women surgeons in the area. We're seeing more and more women in family practice. The last—let's see—the last five family practitioners that were employed at Methodist, four have been women. Pediatricians, opticians. We're seeing more and more women—I don't know exact—I haven't seen the statistics, but I guess most of the medical school admissions must be approaching forty or fifty percent [inaudible 00:07:25].

FA:
Is that right?

RS:
Certainly, [inaudible 00:07:27]. I'm just ball-parking that figure. But about ten percent of my class were women. And over time, that number has increased through the years, as long as [inaudible 00:07:39]. So that's a national phenomenon.

FA:
Yes, it is. I wonder—I guess just the women's equality movement is driving that.

RS:
I guess that may be part of it. I guess. I don't know why, really. Women—some of the things—some of the reasons I went into medicine, I'm sure, they've had those dreams of wanting to help people [inaudible 00:08:16]. Why, suddenly, in the last twenty years we've seen an increase? I don't know. Part of it may be what you said. I know several women who have husbands that are physicians, and that's a nice balance. Women in the type of practice that they are in, can sort of control their hours, and [inaudible 0:08:50] I think that's another big thing, too, that's happened in the last few years, [coughs] and that is that when I started out in practice, I was by myself. I was on call for six years, twenty-four hours a day, seven days a week, [inaudible 00:09:19]. The tendency, nowadays, is to get into a group-type practice, where your schedules [inaudible 00:09:30], where you have more time off, where you have some free time. And that may be a thing that the women, in a particular, with their schedules, they can have more of a lifestyle outside of medicine. Twenty years ago, most people were, at least in this area, in solo practice.

FA:
That's a good point.

RS:
And the tendency is more and more in that direction, to get in some type of group practice. In fact, most people predict that with managed care entities that if you're not in a group practice, you're going to have a hard time making it as a solo practitioner because what happens is if, say, Aetna insurance company has thirty thousand people enrolled in their healthcare plan, they go to providers to provide all that service in a one stop shop. That is to say when they come to Methodist Hospital and they look for a panel of doctors already in place that has the family practitioner, pediatrician, the obstetricians, and surgeons, they don't have to go out and negotiate or solicit the services of individuals when they could do it all at once. So the tendency, nowadays, is for more and more doctors to get in groups so that they can participate in the healthcare plan as providers. They know the healthcare providers, insurance companies, are going to go through a place, rather than two or three places, where they can get all the doctors they want on their panel in one stop. So we're seeing—also, this is another major trend in medicine is to go into a group practice of the same type of specialty or multi-specialty groups. This is a phenomenon across the country.

FA:
Is that kind of what the Methodist medical group is?

RS:
Exactly. That's right. Methodist medical group is like that. And St. Mary has a similar group. Their emphasis at St. Mary has been more about primary care doctors. Ours is more of a multi-specialty. We have about two-thirds primary care and one-thirds specialty. But that type is what more and more people are going into. In fact, nearly every request I get today from people coming to Lubbock that I see come across my desk as the Medical Director of the hospital—their applications—they are coming into practice with somebody. Very, very few people set up shop independently, like I did thirty-five years ago.

FA:
Everything's against it now for doing that, isn't it?

RS:
Absolutely.

FA:
It would cost so much money just to set up, wouldn't it?

RS:
Absolutely.

FA:
It would be prohibiting.

RS:
Plus, with more and more patients in this area signed up with a healthcare plan, whose plan is then going to look to larger groups to provide all your services. They don't need a whole bunch of individuals. So the tendency, as I said, for physicians coming into practice now in Lubbock is to join some type of group practice.

FA:
Has the Methodist group and St. Mary's group—do you think they've forestalled an outside-type HMO from coming in and made it—and curtailed some of the what you would consider negative aspects of an HMO here in Lubbock?

RS:
Well, I think, as far—perhaps so. I think that what happened when the HMO market entered Lubbock is that—at Methodist, you know, we started with Firstcare. The strategy to do just that, to hopefully keep out other HMOs from coming in.

FA:
With Firstcare?

RS:
Firstcare. And then, of course, they have their doctor panel in the form a Methodist medical group. Then what happened was that HMO Blue and St. Mary Medical Group—HMO Blue came in with another HMO. I think the two of them have actually, you know, probably kept others out. Now, the question, though, is what would have happened had Methodist not done that in the first place? [Laughter] There's one school of thought that says we cut our own throats because we were—

FA:
You brought it in yourself.

RS:
Yeah. And I'm not so sure that thing is not correct. So that, here, we've had an HMO product now for almost three years and we—

FA:
Created it yourself?

RS:
Yeah, and we could've practiced here this long. Now, somebody, I'm sure, eventually would have come. And that's not to say that others won't come, in spite of Firstcare and HMO Blue, because this is the way of the world now. This is what's happening in medicine. There will probably be another. That wouldn't surprise me at all. I'm sure there will be. At any rate, that's just the way of the times.

FA:
You have insurance companies that—not integrate, but they're working medical groups now, is the way it's working. And the doctor is down the chain of command there somewhere.

RS:
As far as an individual, yes, I think—

FA:
As an individual?

RS:
That's correct. I think that—most consultants in most meetings I've been to in the last two or

three years just validate that thinking. They say, without exception, that the day of the individual solo practitioner is slowly fading away. Whereas, twenty years ago, that's all there was, basically.

FA:
What's interesting, now, in this country is on the other hand, you have a lot of interest in folk medicine.

RS:
You do.

FA:
And I think that's because—don't you—well, that's my thinking.

RS:
No, I think that's right, no question.

FA:
Don't you think people want this relationship with a healer? Someone—not a technical relationship, but a personal relationship that even has, maybe, even spiritual aura.

RS:
I think—yeah, I think they do. I think a lot of people do. I think that that's an area where it's not an exact science. There's probably a lot to it. I don't discount anything in those terms because I think there's a lot we don't know about disease and healing. It's not very technical, analytical, spiritual, natural. There's something to that [inaudible 00:17:22]. We need that [inaudible 00:17:27] healing and their disease processes. So, you know, there's that search for someone to seek out that sort of thing.

FA:
Plus, you have chaplains on staff here, and I'm sure at St. Mary's too—

RS:
Absolutely.

FA:
—that make that connection.

RS:
They certainly do. I don't know anyone that would discount the value of that emotional support

that patients get in their time of need. With their backs against the wall, what else is there? And they all, I think, search for extra spiritual comfort they can get on the religious side [inaudible 00:18:23].

FA:
With the number of women doctors—increased numbers of women doctors coming into medicine—is this changing the—do they practice differently, being women, as far as patient care? Because women have traditionally been seen as caregivers more so than men. Does this carry over into their—

RS:
Well actually, the women physicians that I'm associated with—and there are quite a number of them—basically, I don't perceive them to be any different than their male counterparts. They're all trained equally. They practice the same standard of medicine as their male counterparts do. I think there is one aspect of them, though, that maybe is different, and that is the fact that there are a lot of women patients, particularly those that have gynecologic or breast problems that feel more comfortable in going to a woman than they do to a man. [Inaudible 00:19:50] professional doctor [inaudible 00:19:54] someone who is at a comfort level of being examined and treated by a woman under those circumstances. But I'd say, overall, that the [inaudible 00:20:09] practices at Methodist Medical treat them and respect them just like any other physician [inaudible 00:20:27].

FA:
Do you think women have an advantage over men, as far as patient relationships or bedside manner?

RS:
Well, I think some of them do. As a group—you know, I guess I relate, in part, to my own level of expertise in that area. I think that, personally, I'm just as passionate and caring as any other human being can be. I suppose that I wouldn't characterize that as a generic characterization. I think that there are probably individuals on both sides and gender—you'll find some of both sexes. I think that that's maybe a feeling that some people have because their doctor has a motherly, caring attitude.

FA:
That's what I was kind of thinking.

RS:
And I guess that may be true in some situations. And yet—I know male physicians just as caring,

and considerate, loving, and kind as some females. I just don't know. I tend to look at that more as a one-by-one, case-by-case [inaudible 00:22:11], personally.

FA:
How has nursing care changed over the years?

RS:
Well, right now, we have about 150 in the hospital—nurse shortage, I can't find them anywhere. And the same is true at St. Mary's hospital. I'm not sure about UMC [**University Medical Center**], but I understand that they are short as well.

FA:
Any level of nurse?

RS:
Yes.

FA:
RN [**Registered Nurse**]? LPN [**Licensed Practical Nurse**]?

RS:
Yes. What has happened over the last ten or fifteen years—this wasn't the case ten years ago. Methodist has its own school of nursing. Ten years ago, they graduated about 135 students per year. Ten years ago, Methodist could not sort all their graduates that wanted to practice here, because we were full.

FA:
Ten years ago?

RS:
Ten years ago. And then over the last ten years, with managed care and the emphasis on costs to get the patients—of course, by keeping the patient out of the hospital, once they got in the hospital, you'd have to get them out as soon as you could. Then, this created the next level of care in the form of nursing homes, or home care. Get them out of the hospital and you can continue their care at home or in a nursing facility or some type of facility, provided they have adequate nursing. So this required more nursing force on the outside of the hospital. So what happened was that the nurses, then, when the hospitals began to drift away into the home healthcare industry, nursing [inaudible 0:24:18]. For one reason, they have better time schedule. They had less night work. The schedules were more uniform and orderly. So we had this mass excellence over the last ten years of nurses leaving the hospital environment to outpatients. So

this created this huge shortage here in the hospital. And we've had recruiting efforts all over this country and out of this country.

FA:
Even out of the country?

RS:
Out of the country. Canada, India. We had some East Indian nurses here for a while.

FA:
Really?

RS:
Yeah. Australia.

FA:
Do they get citizenship or a work visa?

RS:
Work visa. It's just a patching the dike type of deal.

FA:
I'm sure it costs terribly expensive.

RS:
It is. You have to pay signing bonuses. You have to pay travel—moving expenses and all that. But then, the balanced budget fault of last year—you see, this is a constant, dynamic flow. Medicine [inaudible 00:25:35] [sighs] regulated the services and the payments to the nursing homes. They suddenly saw all their tremendous revenues being decreased [inaudible 00:25:50]. So that they had to cut their expenses. The way they cut their expenses is by cutting staff, which means they're cutting nursing staff, which means now that we're seeing them flow back through the hospital from the home healthcare agency. So this is what's happening in nursing in the last ten years.

FA:
When a nurse is doing home healthcare, who does she or he work for?

RS:
They work under the direction of a doctor. In other words, if I have a patient that I'm discharging

from the hospital, I will contact the home health nurse supervisor and give her order—actually write the orders.

FA:
Oh, I see. But they would work under the auspices of this hospital?

RS:
Under the physician.

FA:
Under a physician.

RS:
The physician is still writing the orders for what that person receives. It's administered through the home health agency.

FA:
Is a home health agency part of the hospital staff?

RS:
It can be. There are some free-standing. Methodist does have a—owns and operates its own home health agency. But there are fifty in town.

FA:
Oh really?

RS:
Yeah.

FA:
Home health agencies?

RS:
Home health agencies. Obviously, most of them are free-standing. That is, they're not affiliated directly or owned and operated by a hospital.

FA:
How many nurses do they usually have in their agency?

RS:
[Sighs] You know, it varies from the mom and pop deal, you know? Just a few to—

FA:
Just a couple?

RS:
Yeah. A few just to—Methodist has—gosh—Methodist, actually, is statewide. It has two or three thousand [inaudible 00:27:52].

FA:
That's interesting. Do they include nurse practitioners?

RS:
Most of them are RNs. They will take LVNs [**Licensed Vocational Nurse**] who have experience. Their first line is RN, because they have so much more responsibility. They go out on their own into a home. And they have more responsibility than a nurse in a hospital who can immediately contact her superior for a problem. So they look for a higher level of care in that situation, for the circumstances that are present. Consequently, it pays considerably reasonably [inaudible 00:28:35] hospital.

FA:
That's phenomenal, you know, because what's happened is that they have become the ones that do the—make the house calls.

RS:
That's right.

FA:
Like the old-timey doctors, like Dr. Payne and Dr. Green did back in the old days.

RS:
That's exactly right.

FA:
They are the—they're the—

RS:
They are the doctors' extension into the home.

FA:
Right.

RS:
They certainly are.

FA:
So they, even more than ever, are perceived as the natural caregivers.

RS:
That's correct. I've had a number of patients in the last few months that were unable to see earlier because of the fact that we have now extended our care to that venue. Furthermore, here, again, I'm taking two breast cancer patients that the insurance companies said I had to discharge this patient or they weren't going to pay for it. So that was my stimulus for getting them out, so the patient wouldn't then get billed for the extra day or two. But it worked out fine. We sent them home. I immediately accessed the nurse and I told her exactly what we needed to do. We provided that care in the outpatient setting in their home, without any untoward side effects or complications.

FA:
That's amazing. It's almost like we're going back in time.

RS:
That's what's happening.

FA:
That's just like taking a step back in time when so much medicine used to be done in the home.

RS:
You know, doctors worry about this because they're worried about their liability if something happens, primarily.

FA:
They're still on the hook, aren't they?

RS:
They're still on the hook. In fact, if an insurance company says you've got to do this [inaudible 00:30:40]. And that's the main concern as a doctor, I think. When these patients go home too early and they have a complication, if they stayed in the hospital where I could've watched them myself—that might not have happened. This is the concern of doctors. And this is another aspect

of managed care. As I said, we've done a lot. It's been taken out of our hands. The care of the patient is a tiny [inaudible 00:31:05].

FA:
But you're still responsible.

RS:
You're still liable.

FA:
Legally.

RS:
Legally. Absolutely.

FA:
Has anything been—it seems like that would be a good cause for a—I mean, a good—something—

RS:
It's a major point of debate, in terms of the physician's perspective and the AMA.

FA:
That's what I was going to say.

RS:
Lobbies against this sort of thing. That was a major, major [inaudible 0:31:35].

FA:
That's something the AMA is heavily involved in?

RS:
Absolutely. When Senator Graham was here, this was an area I addressed directly to him.

FA:
In your meeting in 1993? Has any improvements been made?

RS:
[laughs] No, none that I could see.

FA:
It seems like that—

[Audio cuts out 00:31:53-00:32:02]

FA:
This is a resumption of the interview being done with Dr. Robert Salem. Today is June 15, 1998. My name is Fred Allison. The interview will be conducted at Dr. Salem's offices on Twenty-Second Street. Dr. Salem, we were just talking about this first rupture—you repaired this—

RS:
It was a ruptured abdominal aortic aneurysm.

FA:
The thirteenth time it had been done in the world, and the first time in Lubbock.

RS:
Of this particular type, that's correct. This was a—this was the case that, I think, we referenced earlier in our discussions that Dr. Sam Dunn—I hadn't—called me late on Saturday night, I think around midnight—I hadn't been in town very long. He called me up about midnight from West Texas Hospital, from the emergency room, and said, "Dr. Salem, I understand you do—you've been trained by Dr. DeBakey to do this vascular blood vessel surgery." I said, "Yes sir, I do." He said, "Well, I have a patient down here in the emergency room at West Texas Hospital that I think has a ruptured aneurysm, or a dissecting aneurysm." He said, "I'd like for you to come down and see him and take care of him." He told me, he said, "I'm not going to be around. I'm fixing to leave to go make ward rounds on my oil wells." I didn't realize at the time he was really, in fact, telling the truth about all his oil wells because he—so anyway, I went down and saw the patient in the emergency room at West Texas and felt that he needed immediate surgery and brought him back out to Methodist Hospital where we had the proper equipment and types of grafts—blood vessel grafts, types of instruments and stitching material that are specifically designed for doing surgery on blood vessels. And we had all that available out at Methodist. So I ended up operating on him shortly after he arrived out to Methodist. At about two o'clock in the morning, we got started on the surgery. I think the surgery lasted about six hours. And what made this so different was that the aorta that had ruptured—and the aorta is the main artery in the abdomen in the stomach. Right adjacent to it, right next to it, is the vena cava, which is the largest vein in the body, located in the abdomen. And the artery blood comes from the heart down through the aorta, down to the lower extremities, and then the blood comes back through the veins up back to the heart so that the—and there's a major artery in the abdomen called the aorta, and there's a major vein in the abdomen called the vena cava. And this aneurysm—which was, I guess, about the size of a fist—had ruptured, but instead of rupturing into the free

abdominal cavity, it had ruptured into the vena cava right next to it, so that there was a hole in the big vein in the abdomen and a hole in the artery, and the blood was then being shunted. It would come from the heart into the aorta. Instead of going down, it would be shunted into the big vein, and then it—and then, all this excess blood in the vein would then come back to the heart, where it had caused an acute right heart failure. So he was also in a heart failure, but his heart failure was due to the fact that so much blood was suddenly being shunted back to the heart. It had overloaded the heart. And I had never seen this particular type of thing before. I had seen ruptured aneurysms before, and had helped to have done several of those in Houston before I arrived. But this particular entity ruptured the abdominal aorta into the vena cava, causing a—what we call a massive AV, arteriovenous fistula. Fistula is a communication between two organs. So I'd never seen this before. I wasn't really sure exactly, technically, how to handle it. But having had the vascular experience that I'd had for four years in Houston did manage to do the surgery successfully and replaced the—resected the aneurysm, which is a big dilated sack on the main aorta that just weakens. It's kind of like a balloon. It gets bigger and bigger and bigger and stretches. Finally, the wall of the aneurysm, or the artery, gets so thin it just blows out, just like a balloon would. So we resected that, and I fixed the hole in the vena cava, sewed it up, and then I replaced the abdominal aorta with a synthetic graft, a Dacron graft that we were using.

FA:
What kind of graft?

RS:
It's called Dacron. It's a nylon—style of nylon that Dr. DeBakey developed. And I had used those extensively in my training with him in the fifties and early sixties. We had those available in Lubbock at the time, so I replaced his abdominal aorta with one of those Dacron, or synthetic nylon, grafts. He tolerated the surgery well, and we restored normal circulation to the lower half of his abdomen and to his extremities. The patient had, really, an [inaudible 0:37:27]. He was in the hospital, maybe, ten days, two weeks, and recovered completely. He got out of the hospital. He was a businessman from a nearby city. He went back to work, back to his job. I think he was fifty-three at the time. Lived a normal lifespan after that. In fact, fifteen years or so after this surgery, I had the occasion to re-operate upon him, doing another abdominal operation where I removed his gall bladder and fixed a diaphragmatic hiatal hernia. And at the time of that surgery, I could see where we had done the surgery fifteen years earlier, and everything looked perfectly normal. So he survived this other operation fifteen years later, and went on and lived several more years after that. And so after that surgery, I thought to myself, Gosh, I've spent four years in Houston. I've never seen this particular entity. So I did a search—literature search of collecting data from all over the world on this particular entity. That is, the rupture of the abdominal aorta into the vena cava and creating an acute AV fistula and acute right heart failure. I found only twelve other cases successfully treated in the world. And mine was the thirteenth. So I reported this—these findings, in this article that you have that is published in the *Texas*

Medical Association Journal of 1965. And ironically, another interesting anecdote is that the first case that was ever done successfully was done ten years prior to my case in 1954 by Dr. Cooley and Dr. DeBakey in Houston. And ironically enough, this was also a patient from Lubbock, Texas.

FA:
Is that right?

RS:
That is the truth. And this patient was sent from Lubbock—was sent from Lubbock to Houston for Dr. Cooley and Dr. DeBakey, who were working together at the time, to fix. They did the first successful case in 1954, and then my case was done ten years later, which was successful. So I did make this report, which was published, about this unusual entity and also, had the occasion to present this to a group of surgeons of the Texas Surgical Society several years later. Just an interesting side note on this is that Dr. Cooley got up to present this—to discuss my paper on this subject, and he told the audience—and I may have already referenced this before. It's kind of an amusing thing because—I think I did, but I'll say it again. He got up to discuss this paper and he told the audience that—which was a group of several hundred surgeons—that this was a classic case of the Flyover Syndrome. Does that ring a bell?

FA:
No.

RS:
The Flyover Syndrome. Everybody in the audience is wondering, What in the world is the Flyover Syndrome? He said, "The first case that came from Lubbock, Texas that we did successfully in Houston, obviously, is an illustration of the Flyover Syndrome. That's where a patient from Lubbock fly over Dallas to go to Houston to get their good medical care." There's always been this rivalry between Dallas and Houston about who's the major medical metropolitan center. This was Dr. Cooley's opportunity to make a dig at Dallas. So those are the interesting sidelines about that particular paper. Of course, subsequently—and I've never seen another case like this since that time.

FA:
You've never had another one?

RS:
Never had another case. Had a lot of abdominal aneurysms, several ruptured abdominal aneurysms, but never one that had ruptured and presented as this one.

FA:
That aorta?

RS:
Right. So, that's just another interesting facet of this experience with vascular surgery.

FA:
And Dr. Dunn remembered you when it came time to do this?

RS:
Dr. Dunn—yes, he did. I think, when I first came to town in '62, I made some talks to various medical and surgical groups, possibly to staffs, about vascular surgery. Because the only other person in town that had had any experience with it was Dr. Krueger's son, Tommy, who—Tommy Krueger, who was with his father. He came out the year before I did, and joined his father in practice. Of course, he had had vascular experience, having spent a year as a fellow of Dr. DeBakey at the time I was Chief Resident with Dr. DeBakey. But I presented several talks to the various medical groups on vascular surgery, and I guess he must've been in attendance at one of those because he remembered I did this type of surgery, seemed like the reason he called me in on this specific case. It was a very fascinating case that I will always remember. Very gratifying to [inaudible 0:42:38] successfully.

FA:
And that was cutting edge, wasn't it?

RS:
That was cutting edge. And that was in the middle of the night at two o'clock in the morning, and I'm a young surgeon. It was one of my most challenging cases I've ever had in my career. And very few people were experienced, even those that were working with me in the hospital, the staff. The nurses, anesthesiologists, even my assistant had no experience with this type of surgery, to speak of. So it was a very challenging case to get through successfully.

FA:
And you got this call at what time?

RS:
It was about midnight on Saturday night. [Laughter]

FA:
About midnight? What a way to wake up.

RS:
Yeah. What a way to spend Saturday night, huh?

FA:
Of course, now those are commonplace.

RS:
Those are commonplace operations now. Most abdominal aneurysms, for example, are done—if one can have surgery—or do surgery before they rupture, one can do the operation in probably an hour and a half with no blood loss. Whereas, twenty-five thirty years ago, when I first started doing these in Houston, the operating time was four to six hours, and the average blood loss was about ten bottles of blood. And patients had complications just from the blood transfusions: Blood clotting problems, hepatitis problems. So we've come a long way in twenty-five years with vascular surgery, to the point that doing this major type of blood vessel surgery without any blood transfusions necessary in many cases, in the timeframe that it takes to do just any other type of major abdominal operations. Vascular surgery has now become state-of-the-art, standard, routine, commonplace.

FA:
Do they still use the same material?

RS:
Same type of material. It's still made out of Dacron—nylon. It has been refined and improved, in terms of its porosity. The original grafts that were used—there would be bleeding through the wall of the graft into the abdominal cavity. You have to—it can't be a solid tube because you want normal human tissue to grow into the walls. You have to leave little-bitty, tiny, tiny pores within the walls so that normal human tissue can grow in between those, much like a grapevine growing on a lattice, into the wall. So those little pores, initially, were too porous, and a hemorrhage occurred through the graft, temporarily. And then—but over time, those grafts have been developed so that they are not as porous, that they do not leak, they do not have any significant blood loss associated with their use. And also, they've become much more soft and pliable, more like a normal artery. Originally, they were rather stiff. They were still made out of material, but they weren't as soft and pliable as they are today. Although, the same type of material is used now as was originally, the grafts have been much improved from a technical standpoint due to their increase in pliability and decreased permeability to blood loss.

FA:
And a lot of that was Dr. DeBakey's—

RS:
Yes, it was.

FA:
He was the pioneer.

RS:
He was the pioneer, he certainly was. He is still recognized—matter of fact, I just got an invitation to attend a number of his surgical society—all the residents that trained with him, or most of them, have the opportunity to be members of the International Surgical Society. This year, in July, it's meeting in Portugal. Every year, he goes to a different country because he gets world-renowned, world fame. I remember going to—signing up for a trip to go with him to Baghdad right before the Iran-Iraq war broke out. Wherever he goes, to whatever country, the head of state is his host.

FA:
Oh really?

RS:
President of the country, the king of the country. He is that well-respected and renowned.

FA:
He's revolutionized medicine.

RS:
Revolutionized. And he's international. His reputation in Japan, in China, Russia. As you know, he went to Russia last year to help operate on Boris Yeltsin, when he had his coronary bypass. This is the most unique—single most unique surgeon in the history of the world, as far as I can tell. I'm sure others in different generations would have had the same impact, probably, as he has. But certainly today, he's probably recognized as the world's most recognized—at least, most recognizable surgeon.

FA:
Are there any biographies in the works on him?

RS:
You know, I'm sure there are. I, personally—

FA:
There should be.

RS:
I'm sure there probably are. I have not personally seen one, but there may be some out there that I haven't run across yet. If there aren't, then there probably are, or they certainly will be.

FA:
He'll go down in history, no doubt about that.

RS:
That's for sure.

FA:
No doubt about it. Well, it, kind of, is an instance of—I guess of why Lubbock is known as a leading medical center.

RS:
Well, it is. Even when I came to Lubbock in '62, because of the—well, at that time, Methodist was probably the most prominent hospital. In '62, when I came, the Methodist Church had just taken over ownership of the hospital eight years prior, and opened the—made it an open staff hospital, and had a massive influx of specialists of all types came into Lubbock in those years, in the late fifties and sixties, and rapidly established itself as the leading hospital in this area and leading specialists in this area in vascular surgery, which is one of those components. And then, certainly over time, the other hospitals have come into play: St. Mary, UMC. That's only further lent credibility to the fact that this is really a major referral tertiary care area with all the expertise we have. This has just gotten bigger and better with time.

FA:
How about the regional coverage for the hospital?

RS:
Well, you know, we, traditionally, have taken the position that the community hospital is very important to communities. Whereas, you know, we have expertise here, obviously, in Lubbock that the smaller communities don't have. Methodist and the other facilities in town, also, in recent time, have lent support to the local communities in many different ways: educational, primarily; financial, and other areas. We feel like that the local community hospital has a significant role in the lives of the people of the community, and have done everything we can to support those community hospitals. In fact, a long time ago, I even used to go out and operate at the community hospital in Levelland. I did that for a few years. American College of Surgeons sort of clamped down on that because they felt like if you operated on a person, you needed to be there full-time for their post-operative care as well. The operation was only one piece of taking care of that patient. Pre-operative evaluation was important because you wanted to be sure that

the tests that had been done justified the surgery and there were no complications to doing the surgery. Then, the surgery itself was one piece, and the third piece was the post-operative care. All those pieces were just as important as one. So the American College of Surgeons, back in the—oh, I'd say late sixties, early seventies, at the latest, came down pretty hard on anybody doing what they called "itinerant surgery." So it gave me an excuse not to do it.

FA:
Itinerant surgery?

RS:
Itinerant. That's what they called it. [Laughs]

FA:
That is kind of a negative connotation.

RS:
Yeah, it is. It really is. So people that are not able to have the type of surgery done locally—don't have the surgeons to do it, or backup diagnostic, or therapeutic facilities to go to—impact all that care and are transferred to Lubbock. And I think that's appropriate. Lubbock is not that far away from any of these places, so I think they can probably get better care in certain areas. But on the other hand, there are normally things that the local hospitals do in providing healthcare, and they're very important for the community. The hospitals in most of those smaller towns are the key industries in the community and have a significant economic impact. We've had two or three—I know two or three communities that because of payments of the government, the hospitals have had to close down, and jobs have been lost, people are scattered, people move. That's not good for anybody, so I've always stayed in a position to be very supportive of the community hospitals in whatever way we can do. At the same time, they need to recognize their limitations. Everybody can't do heart surgery, for example. You know? And you need to factor in the economics of what you do. We're all relying on some things. Say, "Hey, we've got someone fifty miles away that does this every day. We can send this patient over there." So we've worked very closely with support of the community hospitals. I think it's been mutually—a mutual situation, in terms of them supporting Methodist and us supporting them in various healthcare endeavors.

FA:
There's also support—there's a support agency that facilitates that that probably didn't exist before, too, and that's the CareFlite.

RS:
That's correct. The CareFlite. We've had several different types of—and by name—names of

various aircraft and transport systems in this area. That has tremendously facilitated transporting, particularly emergent cases, both traumatic and non-traumatic, to Lubbock. That, in itself, has saved many, many lives. The local communities are very, very fond of that, because if they have a patient in their emergency room, say, fifty, seventy-five hundred miles away that needs immediate care, they know all they've got to do pick up the telephone, and a flight is in route to pick up the patient. Not only provides expert care, but it also gets that patient out of the emergency room and it allows them to take care of things that they would take care of better. So it's a win-win for everybody. This mode of transportation has been very helpful in dealing with emergency situations. I think it's, really, sort of, become a standard or the norm. Everybody expects it. It's very expensive now. And if you just look at that particular segment of the healthcare delivery, it loses money. But it's subsidized by other parts of the hospital that do make money. If you look at the global pictures, it's worthwhile doing, even though the cost of doing this would be just isolating the cost of the airplane that leaves people—[person talks on intercom] costs to run and all those things, versus compensation—insurance companies pay for that [inaudible 00:55:56] money as an entity.

FA:
They don't pay enough for it.

RS:
They don't pay enough for it. But hospitals have taken a position that, you know, not everything in the hospitals make money. If you carve out individual sections, some make money, some lose money. As long as the total system survives, financially, it's okay to have segments of it not making money, as long as they make enough to cover that loss. That's kind of how it works.

FA:
Which has always been the problem with medical care, in a way.

RS:
That's exactly right.

FA:
In this country, it's always been a philosophy that you provide the care that's needed, not necessarily what you can afford. Would you agree with that?

RS:
I think that's a fair statement. I sure do. [Person talks on intercom]

FA:
Is that philosophy ever—going back on this managed care, and insurance, and government, and

stuff—but is that threatened by these new agencies that are coming into medicine?

RS:
I think—I personally think it is. I think that there is a—there is a balance somewhere in the middle somewhere. And that connection—I've got several letters here that I was going to show you that I've written, starting back in '84, actually. This one is to President Ronald Reagan about healthcare and so forth. Let me stop here and let you browse it.

FA:
Well, Dr. Salem, do you think with the new agencies that are now more and more involved in medicine, like the government, HMOs, and insurance, do they threaten this philosophy that's been, traditionally, part of American medicine that no matter what the cost, you provide the service? Is that idea threatened?

RS:
I think, to a certain extent, it is. There are, however, a lot of studies out there that show, or at least they tend to support, depending on who you're listening to and reading that HMOs do not impact quality of care given. You've got to look at reality and know that the reason these things are being done is from a financial perspective. And they're trying to make money off of a product. That is, the HMOs. So that they have to look at the costs more stringently than they looked at them before. And they have to make a profit or the HMO moves out of existence. There are some user-friendly HMOs and some that are not user-friendly. I don't pretend to be an HMO expert, but I have read a lot and been involved with one locally. I know a little bit about HMO operations. One of the original, basic tenants of an HMO was that the patient couldn't go directly to the traditional doctors that he or she wanted to go, that they had to go through a gatekeeper, or a primary care doctor, first. Then, if they needed a referral or if the gatekeeper, or primary doctor couldn't take of their problem, then he would then refer them to whomever. Sometimes, this doctor or specialist that the gatekeeper might refer to might not be their traditional doctor. Their traditional specialist was not signed up as a provider in the HMO, and they could not go to their doctor unless they paid for the whole bill themselves, which was very costly to the patient. So there are a lot of ramifications that this new age of medicine that we're working under now, where there's loss of the patient to go to whomever they want to go to, and also, restriction of the amount of care that their HMO contract will provide for them. Now, on the other hand, I would say, though, that anybody that's in an emergent situation, if they are sent to go to a hospital in this town, in particular, they're going to get excellent care, and timely care, and appropriate care. So I don't think that anybody is going to be denied care that's in extremely, extremely, extremely critical or serious condition. I mean, that prevails over everything else. So I think that even though there's a lot of management and a lot of bureaucratic interference in medicine, in the emergency situation, the patient is going to be taken care of, regardless of bills, regardless of HMOs, regardless of anything else. So laying that aside, though, for other things,

there is the controversy raging over how much care a patient can get in any healthcare program. For example, HMOs—and a lot of patients don't recognize this, even today. When an HMO goes into effect—it has to pass through the Texas Health Insurance Agency. The benefits that the patients are going to receive are defined and enumerated. And that is all the patients are entitled to. So a lot of patients enroll in a healthcare plan with an HMO or any private insurance company, like Aetna, or Blue Cross, or anything else. The benefits that they are entitled to are clearly elucidated and defined, and most patients don't realize that. They don't realize there's a limit, for example, to the number of times they can go to rehabilitation if they have a knee surgery. They specifically say, "If you're in this program, you're entitled to go to rehab twenty times over the next three months, period." If you want more than that, you have to pay for it yourself. So I think a lot of this business is not—maybe it's poorer communication, poorer education, so that patients' expectations as to what they have, what they're entitled to, are not clearly elucidated. So that's one—that's just a small factor here on this whole issue. You know, certainly, it has removed the prerogative of the patients to go directly to their own doctor, or specifically, their own specialist. And, you know, there's controversy over whether this is good care or bad care. Some of the specialists think that if they had seen that patient themselves, initially, they could've treated it appropriately at less cost than if they had gone to a primary care doctor who might treat them with drugs and medicines for a week or two and run up additional costs there, and then ultimately, send it to the patient—to the specialist, who then sees the patient two weeks or so later, after the condition has worsened, making their treatment difficult.

End of Recording