# Oral History Interview of
# Robert Salem

**Interviewed by: Fred Allison**
**June 15, 1998**
**Lubbock, Texas**

**Part of the:**
***South Plains Healthcare Interviews***



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# Transcript Overview:

This interview features Robert Salem, who discusses the background of hospital merging, Lubbock's historical evolution of medicine, and the unity of St. Mary Hospital and Methodist Hospital to create Covenant Health System.

**Length of Interview**: 01:04:24





**Keywords**
St. Mary Hospital, Methodist Hospital, Covenant Health System, University Medical Center

**Robert Salem (RS):**
Are we rolling?

**Fred Allison (FA):**
Yes sir.

RS:
Okay. So this whole business of managed care in today's era of medicine is very controversial. I think—I guess it depends on who you talk to. I would say that, certainly, the majority of physicians don't like it. Probably, most patients don't like it, from the standpoint of they don't have—the doctors, for example, feel like it's an invasion of their ability to render care effectively, and the rewards they receive are not based on their initiative, their expertise, their level of care, because everybody gets paid the same thing. For example, I may have thirty years of experience in doing something, and I may think I do it more [inaudible 0:01:10] quicker, with less complications than somebody who's still in training. There's no measure of that factor then to payments for that same service. So doctors—plus the fact that it takes—there's so much administrative red tape associated with providing care under a managed care contract. For example, we have to hire an extra person, or two, at the office just to call the HMO [**Health Maintenance Organization**] to make sure that we see the patient, to make sure the forms have been filled out properly. They tell us the patient's going to need an operation, when they can be taken into the hospital, how long they can stay, report to them after the operation, if they're going home, when they're going home, why they're not going home, if they don't go home, and all those things. So it has severely impacted the daily lives of physicians. And then from a patient's perspective, they have to learn that they just can't—if they self-diagnose themselves—most patients know if they've got a hernia or not, for example. If they do, most of them know of and find a surgeon. Several years ago, they'd go directly to that surgeon to get taken care of. Now, they've got to call in, get an appointment with a busy primary care gatekeeper, who has to have them come in, and examine them, and confirm the diagnosis, then set up another appointment with a surgeon. So there's an extra step or two along the way that frustrates the patients. If they've got something they need and want to get it fixed, most of them would like to go see and get it fixed. With today's medicine, it doesn't work that way if it's not an emergency.

FA:
You've got to go through your family doctor.

RS:
Right.

FA:
And in some cases, get a second opinion.

RS:
And some of them have to have a second opinion, that's exactly right. So it's gotten a lot more cumbersome. It's supposed to be saving money. I hope it is. Healthcare did and has gotten—the cost of healthcare has gotten, or was getting, out of hand. I think that that inflationary standard of healthcare delivery has been lessened somewhat by this managed care environment. That's good. It'll take another ten or twenty years for this to play out to where it's going to settle out to where the bad and the good come to some level of compromise—healthcare that we can all become comfortable with. And I think it will. I think there's no question that in the next ten years, we're going to go through a severe change in the way healthcare is being delivered. We may have gone to the other extreme. I'm hopeful and anticipate that somewhere in the middle will be a balance that we all can accept. And, you know, it might spin off into this other [inaudible 00:04:22] that we talked about. With what's happening—what has happened in the last eight or ten years—all hospitals had to develop a strategy to deal with the changing times. Methodist and [inaudible 0:04:42] made a lot of strategic changes in the direction of the way healthcare was being delivered. The first thing that impacted the hospitals was the Medicare reimbursements. Medicare payments for Medicare patients was directed toward a diagnosis rather than the actual cost incurred. For example, if a patient comes in—a Medicare patient comes in for gall bladder surgery, the hospital is paid for that diagnosis of acute chronic cholecystitis. It's called a DRG, diagnosis-related group. So the Medicare patient, through the hospital for the diagnosis of cholecystitis with cholelithiasis—that's gallstones—is a fixed amount. And it is prorated over a one or two-day hospital stay. Now, if the patient goes out of the hospital early—earlier than that program—number of days that have been allocated and fixed into that figure, then the hospital makes money. If the patient stays in an extra day longer, the hospital loses money. Well, as it turns out, and has turned out, most of the payments for Medicare patients for all procedures and all illnesses—the payments did not begin to match what the cost was. Most of the payments were totally below what it costs the hospitals to deliver that service. And so what happened was they—the hospitals, then, had to make up that loss on Medicare patients on the non-Medicare patient population. So they jacked the prices up for a room, what it costs for a chest X-ray, an EKG [**Electrocardiogram**], what it costs to go in the operating room, what it costs to stay in the recovery room, what it costs to stay in the ICU [**Intensive Care Unit**]. They jacked those prices up so that they could compensate for the losses incurred on their Medicare patients. So that's the first thing that triggered what was happening in medicine in the last ten years. The hospitals started seeing that they were getting strapped, financially, from the income they were getting from the services rendered. And this is what caused some of the smaller, rural hospitals to go under. They had a large Medicare population. They did not have enough of the non-Medicare patients that they could shift the costs to. And they had to close.

FA:
Why was the cost of medicine going up—escalating? Or why was the government not setting the appropriate prices for services rendered?

RS:
Well, probably a number of reasons. I think that, you know, probably one of the things with Medicare is that the—it's just kind of like bidding on the cost of the house construction. They rejected what they thought it was going to cost to run this program. It was underbid to start with. They just underbid the projections of the cost of delivering that Medicare service.

FA:
Kind of like billing another airplane for the Air Force or the Navy.

RS:
Yeah. Exactly. I mean, you see that in different scenarios. "I think it's going to cost this to run this program. This is what our payments will be." Well, after you get to doing it, you say, "Hey, I don't have enough money here to cover this project," so they have to start cutting back what they pay. That's one of the things.

FA:
Plus, do you think it was an idea since hospitals thought, Well, we're going to be getting this government money now for all these services, and then, more and more people are on Medicare that—it was an elusive, sort of a check in the mail sort of a thing that even hospitals were thinking they were going to get—it was tempting to do things when they thought the government was going to pick up the cost for indigent care.



RS:
I think that's true. And for a while, it was that. For a while, they did do well with Medicare payments, until they started cutting back on this DRG thing. For a while, the hospitals were a doing bonanza business because they were getting paid for—

FA:
Things that they used to not get paid for.

RS:
Yeah. That's right. And they started delivering services—more [inaudible 00:09:34] so did doctors—started doing things that they weren't doing before. So this snowballed. I think those are the major factors. As a result of that, the hospitals started to look to ways—other ways—that they could generate income, other than the traditional just the hospital delivering a service to the patient. And some of those things were an HMO. Methodist, under the leadership of [inaudible 00:10:11] thought that this was a strategy. They did their own HMO that they could regulate the costs. Prices wouldn't be driven down, and if it was run properly, they could perhaps show a profit. Although, from the very beginning, the motive behind Methodist, during the first year, was not to make a lot of money, but, for one thing, hopefully, to keep out other HMOs that might

drive the prices down further. That was one strategy. They wanted to be useful for them. They wanted to pay the hospitals and the physician panel an appropriate amount for their services. To take off just enough to barely, you know, break even on the administrative side, not to skim off a big administrative chunk [inaudible 00:11:10]. So that was one strategy that was undertaken. We had consultants in for years on that, although that was a good strategy. Another strategy was to develop the regional network, to go out and align the regional hospitals with your hospital. Therefore, you know, "You scratch my back, I'll scratch yours," type thing. "We support you if you have a problem. We'll take care of it if you send it to us" type thing, you know?

FA:
That's not a bad idea.

RS:
No, it isn't. And so, that was another thing under the leadership, at the time, that was done was to develop this regional affiliation with thirty or forty different healthcare facilities in this whole area. That costs money as well. And then the other thing that was done was to develop a—and add onto the hospital, the large—[coughs] excuse me—cardiac tower and cardiac facility, which costs fifty or sixty million dollars. And that was another enterprise that was too grandiose. The facility was too big. It was underutilized. [Coughs] There were other competitive aspects of it with the competition of [inaudible 00:12:51] hospitals that impacted on the whole usage of it. And then, finally, another strategy was the strategy of developing a physician group at Methodist. A lot more practices and about ninety physicians. This was an expensive project. Here, again, the strategy was to align those doctors with this hospital. And all the consultants—

FA:
They were buying practices.

RS:
They bought up their practice, and then, subsequently, became employees of the group, which was financed by Methodist. And you take all of those four or five things within a short time frame—all cost money, all depleted or diminished the cash reserves, in an era when you see declining income. And that's what happened.

FA:
Now, a decline in income—

RS:
From the revenues from Medicare, from—also other insurance companies, now, they're jumping on the Medicare bandwagon. They say, "Well, if Medicare doesn't have to pay this for this amount, why should we?" So they started decreasing—

FA:
Everybody's cutting costs.

RS:
Everybody is cutting what they pay for services. So this has further impacted the income that the hospitals receive. And so all this came, you know, during that period of time. From strictly a strategy standpoint, it all sounded good. It was the thing that consultants said we ought to be doing. It's what the administration did. As it turned out, it was too much too quick in a very difficult market situation, in terms of revenue. That's kind of the [inaudible 0:14:53] story, in terms of what happened, and the timeframes, and the reasons why. I don't know that it's any one person's fault. I think a lot of this is—what happened in time—the times are very difficult to—a period to manage hospital practices. Like I said, some of them actually went under. And I think if we did one thing wrong: we didn't project or didn't anticipate the amount of reduced income. It's just kind of like [inaudible 00:15:29]. And you do five-year financial performances based on what you project or think the income's going to be. Losses were a factor then, but the magnitude of those losses was appreciative.

FA:
One interesting thing about this was the perception that once the government's involved, that there would be plenty of money to go around. I think that it's comparable, in a way, to what happened to farmers, with various farm programs. I see a comparison there that they, a lot of times, see the government subsidies and then, over expand.

RS:
Right. Very similar analogy.

FA:
—and get in debt. And then the government programs aren't what they're—they thought they were, for some reason.

RS:
Or they change.

FA:
Or they change, that's right. They become arbitrary.

RS:
And we get a government program in place and we think this is going to go on forever. Well, the next session of Congress can wipe that out or change it completely. And we base our ten-year

plan on something that we've got today, and don't recognize or appreciate the fact that that plan could change tomorrow. You're absolutely right, it's a very similar analogy.

FA:
It just occurred to me.

RS:
Yeah. You're absolutely right. I think—

***[Pause in recording]***

FA:
This is a resumption of the recording with Dr. Robert Salem. This is on June 25, 1998 in Lubbock, Texas. And I'm Fred Allison. Okay. Dr. Salem, can you give some background on the merger that's going on now?

RS:
Right. You know, we had discussed, I think, previously about the evolutionary changes in healthcare. Starting back in the eighties, the governmental restrictions concerning payments and so forth that reduced the payments to the hospitals and those providers, and how Methodist, through those years, began to do a lot of things, like forming an HMO, Firstcare, construction of the large cardiac tower—fifty, sixty million—balled up a bunch of physicians and practices and expanded their rural health connections and affiliations. All that cost money. In the face of all this, we had further declines in income, and suddenly, we realized that we might have to look around for some type of partner—partnerships. So we started looking for a merger partner. And this was going on all across the country, even before we did it, actually. In medicine, hospital merging occurred all over the country to support different regions of the economy. So Methodist considered all the options, in terms of putting it up for sale, what type of department to have. Methodist is not-for-profit, non-taxable institution based on the Christian foundation, and so, we felt like, after looking at the options, that St. Mary hospital had some of those same basic values and based on the same type of foundation. They, too, are not-for-profit, non-taxable institution based on the Christian foundation. Obviously, the religious bases were different: one being Methodist and one being Catholic. So, actually, discussion started about two and a half years ago.

FA:
That far back?

RS:
That far back. It was anticipated that this could probably be done in a year. What slowed it down

was—one thing was that Methodist had a lingering dispute with the Internal Revenue Service that had to get resolved that had to do with—I think we've talked it about, too, in the past—helicopter service that was owned by cardiologists in the [inaudible 00:19:58] building. Those business transactions were looked upon as maybe not a—well, they led to an increase of [inaudible 0:20:15] issues to the physicians involved. So that was an ongoing problem. And that had to get resolved before the merger could proceed. And that ultimately was resolved. That took about a year or more. And then also, the other thing was that we were still waiting for the Federal Trade Commission. During this IRS problem, there was still an ongoing evaluation by the Federal Trade Commission as to whether they would approve us or not. And that took a long time. So anyway, those two issues got resolved about the same time, about a year and a half ago. That's when this merger really got cranked up in high gear. Even though we had been working on it superficially and talking about it, we really didn't get out into the brass tacks until about a year and a half ago. Finally, over a period of—the past year and a half, got it done. The event finally occurred. The actual signing was June tenth in Dallas. All the affiliates got together June the tenth, in Dallas, and got it signed, about three hours before the FTC deadline. They gave us one year to put this deal together, otherwise we had to re-apply.

FA:
Oh really?

RS:
So we went down to the wire, three hours before midnight, June tenth.

FA:
I couldn't imagine all the details and things that had to be worked out.

RS:
Oh well, these operations—both of these operations were very complex. I mean, Methodist has—is the big hospital. It has an HMO. It has a hundred-member physician group. It has Southwest Clinical Laboratory. It has air care service—ambulance service. It has reasonable affiliations in several areas.

FA:
With community hospitals.

RS:
Community hospitals: Levelland, Littlefield. We had fifteen rural health clinics in other towns all over this part of the region. It's a very complex, widespread operation. Any one of those entities, in themselves, would've been difficult to deal with, in terms of a merger or sale. Mix all that together, and then you mix everything that St. Mary has, which was similar.

FA:
Similar, right.

RS:
Not quite as involved. Not quite as extensive. But on the other hand, they had their St. Mary medical group of physicians that were quite a bit larger in number than Methodist medical group. They extended it well into the region, and even into Eastern New Mexico. They had about thirty physicians in Eastern New Mexico: Roswell, Hobbs, Clovis. So anyway, this was a very, very, very lawyer-intensive driven merger.

FA:
Are there lawyers that deal in medical—this kind of thing that are now specialists in it?

RS:
Absolutely. We have an antitrust lawyer. We have an antitrust lawyer in San Francisco. We use representatives from law firms in Dallas and Houston, plus our local. We have go-to specialists in the healthcare field to the larger law firms.



FA:
And there are specialists that do that now?

RS:
Absolutely. They'll do anything with this whole operation: put mergers together, everything. Healthcare lawyers. Under that, there are lawyers that specifically deal with mergers. So it's a very specialized process.

FA:
That tells you how many mergers have been going on.

RS:
Absolutely. And we drew off of the experiences of the other lawyers who had dealt with other mergers. So at any rate, the vision that we have is that this new entity will be able to consolidate services, cut costs, deliver quality healthcare, hopefully at a lower cost, because what was happening before the merger was that each of the hospitals were—Methodist and St. Mary—very competitive, had a long history of rivalry. Inevitably, when you've got competition, you cut costs to try and get more business. When you're cutting costs further and further and further on down, each institution realized that the revenue stream is dwindling and we keep cutting costs for our services, each of us could get further into trouble. So that was one of the things. And then you lose your capital reserves and you can't buy new technology. You can't stay abreast in the field of medicine with technological ____ [00:24:59]. So at any rate, those were the main reasons that

we felt like the merger was good. We, of course, did an extensive analysis as to how money could be saved and how that can be passed on to the consumer. One of the premises of this merger is that we would take 10 percent of our net profit each year of the merger and give it back to the community through outreach and charity programs.

FA:
Ten percent?

RS:
Ten percent of the net profit.

FA:
Did it have anything to do with the tithe?

RS:
Similar to a tithe.

FA:
Yeah, because that's the same thing. According to the Old Testament, that's ten percent.

RS:
So at any rate, that is a commitment that has been made from this new Covenant health system, which I think is great. We've also pledged to support the medical school, which is good for the community.

FA:
Support it—

RS:
In terms of residency and giving access to the medical school faculty to do clinical residency and student teaching over here. This is a good thing. Everybody's had to put aside their own personal historical relationships with each institution. I don't suppose anybody's had more of a challenge in that area than I have because of my long relationship with Methodist, and because of the fact that my father—I think we talked about earlier—was on the original executive committee of the Northwest Texas Conference that actually was responsible for assuming ownership and making it Methodist in 1954. So my ties go all the way back to then and even beyond, through Dr. Krueger and my relationships I had with that family. So I had as much of an emotional and historical tie to Methodist as anyone. I could see the wisdom of this merger going forward. So we just had to put aside the past and look to the future. This seemed to be the best thing for continuation to deliver a high quality healthcare product to people of this area. This seemed the

best way to do it, legally. This all came together, as I said, June the tenth. We had a gala celebration this past Tuesday night at the community center to commemorate this event. I was one of the live speakers there at the event.

FA:
You were in charge of giving the historical background?

RS:
Yes. They wanted me to at least elaborate some on the historical background of how we got to this married entity, starting way back whenever I wanted to start.

FA:
So you took it all the way back—

RS:
So I took it all the way back to 1918.

FA:
That is, kind of, the start of Lubbock medicine, all right.



RS:
Well, I—and I know that one's—anyone's interpretation of history depends upon one's perspective, and maybe mine's a little bit slanted, perhaps. But at any rate, I tried to be fair and objective in making the comments that I did. And I started out by saying that the first—I started out by saying I thought there were about five major events in the historical evolution of medicine in Lubbock, Texas. The first major event, in my mind, occurred at the end of World War II—correction, I'm sorry—World War I, and that year was 1918. That's eighty years ago this year. And that was the grand opening of what was called the Lubbock Sanitarium at the corner of Broadway and Avenue L. This was a beautiful three—and I've got pictures of it. I think, in fact, I gave you some pictures. You'd have to go back and reference that. We had pictures of this. It was a magnificent three-story brick structure. It was the product of the vision of three of Lubbock's earliest pioneer doctors: Doctors, Ponton, Peebler and Overton. Of those three, Dr. Overton was best remembered. He became a very city-minded physician and practiced for about fifty years here. The other two left to go to other parts of the country. Dr. Overton stayed on. Overton Elementary School in Lubbock, now, is named after him. But this was a thirty-bed facility. It was very impressive-looking for 1918, and it really sort of set the tone and the tenor for Lubbock becoming a major medical center. And then the next even that I think is most significant occurred in 1953 when Lubbock Memorial Hospital was opened at 3615 Nineteenth Street. That's the address of the current Methodist Hospital. Lubbock Memorial Hospital was the successor hospital to the original Lubbock Sanitarium. It was erected and owned by three doctors

as well: the original Dr. Overton, Dr. Hutchinson, and Dr. Krueger. And this was a majestic 280-bed, eight-story hospital, which was literally years ahead of its time. It was the premier facility of this area at the time, and still exists today in the form of the West Tower of the current Methodist Hospital. And then I thought that the next major event occurred just a year later in 1954, when the Northwest Texas Conference of the Methodist Church assumed ownership of the Lubbock Memorial Hospital and renamed it the Methodist Hospital. I think the significant event—significant part of that event was the fact that at that at that point in time, Methodist opened up its medical staff, and then this ushered in the era of the modern-day trained physicians and specialists in Lubbock. Prior to that time, all the hospitals were owned by doctors, and you couldn't get on the staff unless you worked for them or something contractual. So it was sort of a closed deal. You either worked for the doctors or you didn't work there, under their terms [inaudible 00:31:39]. But when Methodist assumed ownership, they made it an open staffed hospital. Anybody with the proper credentials and certification could get on the staff. This started the influx of modern-day trained doctors, and physicians, and specialists—[audio cuts out 00:31:57-00:32:08]—and I thought that the next major event in the history of medicine in Lubbock occurred in 1972. This year heralded the beginning of the Texas Tech University School of Medicine. The first freshman and third-year classes were enrolled that year. Then, over the next two decades that followed, saw the emergence of University Medical Center and St. Mary's hospital as major health care facilities. But then, I thought that the fifth, and without any a doubt, the most colossal even in the history of medicine in Lubbock, in my mind, occurred on June tenth of this year, and that was the merger between Methodist and St. Mary's. Because in terms of economic and financial impact, and in particular, in the scope of the delivery of healthcare in this vast area, the previous events sort of paled in comparison to this enormity of this event. Only the medical school event rivaled this one. At any rate, I went on to say in that speech—and I'll just give you the highlights of that speech—that I felt that we had the opportunity to create one of the finest healthcare facilities in the entire world. I felt we had the talent and expertise. We had the physical plant. We have a solid financial base. And above all else, what we have—what really brought me back to West Texas in the first place to practice my art: the finest, most sincere, hardworking, dedicated, God-fearing people in the world are true West Texans. I went on to say that I didn't think, though, that we could rest on our past laurels, that the task before us was enormous and the challenges would be immense, but the opportunity was unparalleled. I felt that for Covenant Health System to achieve its rightful place as the leader in medical care delivery in this part of the United States that one thing had to happen, and that I sensed that this has already begun, and that one thing was unity. We had to have unity of mind and unity of purpose. We have to become one. We have to put aside the past and look to the future as a cohesive-bonded unit with a single person—single purpose in mind: to deliver the finest healthcare possible to the people we serve, under the guiding principles of the Covenant Health System mission and value statements. And I felt—had every confidence that this would happen, and I pledge to work toward that end along with the executive staff of the Covenant Health System. My counterpart at St. Mary, like Jim Burrell, the new CEO of the entity. Charlie

Trimble who was the current CEO of St. Mary. And then the Assistant Board—Covenant of the Assistant Board, chaired by Allen White. And that's, basically, the comments that I made at the dinner and gala the other night. So I summarized a little bit of the history and a little bit about the Covenant Health System, the opportunity it has in consolidating services between the two hospitals; the opportunity to provide high quality care at a lower cost to the people of this area. And that's really what our primary objective is, is to provide people of this area the best medical care that's possible.

FA:
Sounds good, Dr. Salem. How hard of a job is that going to be to make that unity that you said—

RS:
That is going to—that is going to be monumental.

FA:
I would think so.

RS:
I've been working on it for two years. I've sort of been the point person at Methodist, head up most of the committees, along with Dr. Burrell, we sort of co-chair most of those. He's the St. Mary counterpart to me over here at Methodist. Literally, we've been working and looking at this for two years. We set into place, during the last couple of years, forty or fifty task forces, which he and I chair most of, to look at consolidating services. For example, the two biggies—the two we felt had to happen first, before anything else could come down, were surgery—the surgical piece—and the cancer piece. For example, we had—Methodist has about twenty operating rooms. St. Mary has twelve. St. Mary has an outpatient surgery center that has four. So we're looking at thirty-six operating rooms. We needed to get—decide what we were going to do there before we could decide what we could do to anything else, because surgery impacts so many things in the hospital. Both of our hospitals do high volumes of surgery, and have always been very surgically-oriented, in terms of attracting surgeons of all specialties to practice here. So it took months and months and months to get all the information behind us in order to make a decision about what do to with those services. Obviously, we wanted to try to consolidate, because if we could consolidate three operating arenas into two, for example, we could cut down on more expenses. It's just more efficient if you could consolidate and do everything under one roof, or as much as you can under one roof, as far as personnel and equipment, cost efficiencies of back and forth travel. So we went through a long, long process. In fact, it's not complete yet, as I speak, definitely. But the master plan was to—it seemed—prove we have consultants. We have one or two consulting firms, primarily. They brought people in and we had other consultants from other firms. We had architects brought in. A very exhaustive, extensive analysis. As I say, in the first part of this, we spent months collecting data: how many minutes of

operating time were done in each operating room, for example, by specialty, and so forth. We even had it down to the minutes for each doctor, to be sure that we had the right mix going forward. So we spent months and months and months collecting data, and then analyzing data, then trying to program that out going forward. We have made a determination that we wanted to move all the acute care, including all the inpatient surgeries at Methodist—because Methodist had the bed capacity that costs less in remodeling and very little new reconstruction. Another very little new construction to do that at Methodist because of our bed capacities. We have about 920 beds that we utilize, and our staff is about four hundred, about half that. So we looked at that first to see if we could absorb—Methodist could absorb all the St. Mary inpatient volume, and we felt like we could.

FA:
The surgery volume?

RS:
All of the volume?

FA:
All of it?



RS:
All of the acute care, now. By acute care, I mean everybody that comes in for surgery. That includes surgery. You can come in for a heart attack, or have a heart cath **[cardiac catheterization]**, or have pneumonia or anything of that—anything that requires acute hospital care, we felt like we could accommodate all of that at Methodist by shifting some of the chronic care to St. Mary's, like rehab, psychiatry, skilled nursing facility, that sort of thing—by shifting the chronic-type, long-term care at St. Mary's—out of Methodist to St. Mary's, and then shifting all the acute care over here to Methodist, that we could make sort of a swap there a little bit and handle all the acute care, including surgeries, at Methodist. Now, that means remodeling and adding to the operating suite by some eight or ten operating rooms. But even with that cost of that construction and remodeling, the efficiencies gained are far outweighed keeping two operating rooms open at St. Mary Hospital and Methodist Hospital.

FA:
Because of the duplication in equipment?

RS:
Exactly. Duplication of equipment. We're going to move some of the operating room equipment that's in the operating room at St. Mary's over here, and we will utilize those beds—I mean, those operating rooms at St. Mary, like, for rehabilitation services and that sort of thing. And

then we're going to also expand the St. Mary outpatient surgery center, which has four beds, into eight, because the trend in surgery is toward outpatient surgery. You know, you come in and do it the same day and go home.

FA:
Yeah, you were talking—and we talked about that when you were talking about HMOs.

RS:
And we're going to expand—double that outpatient service, and anticipating that as we move forward, more and more surgeries can be done as an outpatient—could be done in that locale. So that's just one piece of this thing. The other big piece is, of course, the cancer. As you know, there are three cancer centers in town. UMC [**University Medical Center**] has one, Methodist has Hodges, and St. Mary has Arrington Cancer Center.

FA:
Was that named after the doctor?

RS:
Doctor Joe Arrington.



FA:
Joe Arrington.

RS:
He's a friend of mine, and also a Texas Tech graduate.

FA:
I didn't know he was affiliated with St. Mary.

RS:
Yes, he's affiliated, actually, with both places.

FA:
That's what I was thinking. I always think of him as being at Methodist.

RS:
Yes, he was. Actually, I don't know exactly. He probably split his time, or maybe he did a little more here. I don't know exactly. I just remember he was one of three cardiologists in town.

FA:
Yeah. Him and—King?

RS:
Sam King.

FA:
Sam King.

RS:
He and Sam King were instrumental in getting the heart catheterization program started here, which led to open heart surgeries in 1969 and '70. And he and Dr. Sam King were partners. Before them, they were in a group with [beeping noise] Dr. Brandon Paul and Dr. Bill Borden. Dr. Borden was the first cardiologist in town back in the late forties, early fifties, somewhere in that timeframe. Dr. Brandon Paul was next. Dr. Arrington and King were in that group. Of course, that group has expanded to be several since that time. Dr. Arrington and Dr. King were instrumental in doing the first cardiac catheterizations. They were able to do coronary angiograms. They'd make X-rays of the heart arteries. Dr. Sam King did the first one in 1970. Later in that same year, Dr. Bricker did the first open heart surgery in Lubbock.



FA:
In 1970?

RS:
It occurred in 1970.

FA:
That was a big year.

RS:
Big year. At any rate, back to the cancer center thing. We decided that the best thing to happen in that area—again, to consolidate services, instead of trying to maintain two cancer centers. The decision was made—since that was the newest facility over there, and since we needed this Hodges Cancer Center space for expansion—the emergency room, lab and X-ray over here—the decision was made to move the Hodges outpatients to Arrington, and that's the plan. Now, that takes another year, at least, or year and a half. By the way, the surgical construction is going to take at least two years from now, so that the physical consolidation of all these services will be probably in a three-year timeframe before it all gets done.

FA:
So it's nothing that's going to happen tomorrow?

RS:
We're not going to see any changes around here for several months. We're going to be running two hospitals. Now, there are some things—and we'll talk about those in a minute—that we think we can consolidate right away. Ongoing meetings. Got one tonight and at seven o'clock in the morning on pediatrics, how we could consolidate that right away. But Arrington Cancer Center on the St. Mary campus is going to expand to accommodate all the Methodist-Hodges cancer patients, and then, that space there, where Hodges Cancer center is now, Methodist will be expanding—I mean, will be used to expand the emergency room at Methodist, which will then accommodate all of the emergency patients. We've closed down our St. Mary emergency room. Just have a mini emergency room. But the major emergency room here—here again, consolidating all the trauma, all the big cases on the rougher economies. You can see everything we're doing is going to be economical. Right on down the line.

FA:
But still aimed at providing the same service.



RS:
Absolutely. In fact, a better service because by saving money, we'll be able to continue to provide the latest in technology, the latest care. And, you know, medicine is driven on technology. You've got to have to be state-of-the-art. You've got to stay in touch and in step with the newest things that come out. And that costs money.

FA:
It's absolutely vital.

RS:
Absolutely vital.

FA:
You get the Flyover Syndrome.

RS:
You better believe it. [Laughs] Absolutely. And, you know, patients want to stay here. We pride ourselves in rendering the best—as good a care as any place in the country, and I think we do. But in order to do that, we've got to stay abreast with technology. In order to that, by consolidating, we can do that. So at any rate, we anticipate the cancer change will take place probably a year and a half from now. All that construction will be done and we'll renovate over

here to expand lab, and X-ray, and the emergency room. And then, other areas that we're looking at right now to consolidate are pediatrics. Methodist has a children's hospital—fifty-bed children's hospital. St. Mary's has a pediatric service, in terms of they have—they put their pediatric patients just on a wing in the hospital. But we plan, as soon as we can, to move all those patients and personnel—put all the pediatric patients in the children's hospital. Just had a meeting last night with OB [**Obstetrician**] Services. We plan to move all the OB practices over here. We do have to have some antepartum rooms, where patients can come in that—before they go into labor. And also, some new labor rooms, but that's a minor expansion. To accommodate the OB practices, we want to move all the labs and X-ray over here—consolidate rehab services. Cardiology is another big one. We feel like we've got an adequate cardiac cath lab now. We accommodate—we have six cath labs.

FA:
Here at Methodist?

RS:
Here at Methodist, over in the cardiac tower. Two rooms that we use electrophysiology. Two of the eight rooms. Here again, we went back—in every one of these scenarios, we spent months gathering data and information from both hospitals, and then put that data together, then looked at what we had to see if it would fit. We've done that with every clinical service, as you can see. This is just a spattering of what all we've done. But I—

FA:
It's a tremendous undertaking.

RS:
It is tremendous. Like you alluded to at first, it'll probably—it's not going to happen tomorrow, and probably will take three or four years to get done. But that sort of gives you an overview of the merger and the historical aspects of it, and what's happened and where we are today.

FA:
Are you going to—are the hospitals going to keep their respective names, or is it going to—

RS:
The name is officially changed to Covenant Health System. But there's a byline that says, "A healthcare ministry of St. Mary Hospital and Methodist in Lubbock—and Methodist—Lubbock Methodist Hospital System." So we've got a byline that retains the St. Mary and the Methodist name under one common name. So we sort of retained—we've added a new name for the entity, but retained the individual names as a byline.

FA:
So this'll still be Methodist Hospital?

RS:
Well, it will to a lot of people, yeah.

FA:
I mean, but will the name come down?

RS:
Yeah, the name will come down.

FA:
The name's coming down?

RS:
Everything—yes. Everything—the name in both places—



FA:
Is coming down.

RS:
Will be coming down, and we'll have a Covenant Health System name, and a Covenant Health System symbol, which is yet—they're still working on it. Methodist is the cross with the flame, and that will come down. Whatever the symbol is for the Covenant Health System will go up. There's part of the tugging at the heart strings and the emotion of passion. It's sad, in a way, in terms of losing something that has been part of you for years and years and years. At the same time, things are—things do change. Looking at the current situation and going forward, it's as simple as putting it behind us and looking to the future.

FA:
Yeah. Do you think it was hard for your—well, maybe not for your father, but for, say, the old-time doctors, like Dr. Krueger and Dr. Hutchinson and Overton, to relinquish a privately owned hospital that they had created to a public organization like the Methodist group?

RS:
I suspect it was. I mean, they lived—Dr. Krueger, I think, came here in 1918, 1919, and so he spent—as an owner and really, in control of his hospital, until 1954. That's, what, in years? Thirty or forty year there that he sort of ran the show, then he gave this up. I suspect—I'm sure there were a lot of emotional—emotions that went through his heart and mind at that point in

time. But at the same time, I guess, that he, having done that for so long, probably, and as that thing got bigger and bigger and bigger, you got more and more headaches, you know? So he probably, at the same time—kind of like now—the mixed emotions. He probably was glad to get rid of all the headaches associated with running a big hospital. At the same time, I'm sure he had some thoughts on the historical and passion part of that side [inaudible 00:51:40]. So it was probably mixed feelings, as there are with me now.

FA:
Especially, you know, going from a closed staff concept, like you had, where he was in control of who came in here.

RS:
Absolutely.

FA:
And that's why—

RS:
He gave up a lot of autonomy.

FA:
Do you think that his ability to pick and choose physicians was a lot of the reason why Lubbock got a good reputation back in the forties and fifties, as being a good medical community?

RS:
I think so. I think he—

FA:
Because he hand-picked who came in here.

RS:
He did. And he didn't—he picked what he thought was the best at the time, and I think he did a good job with Methodist. Lubbock got a good foundation there, because he was very-well—he was a very thoughtful person, and a very well-trained person for his time. He was revered, as we said before, by everybody that knew him, and did good work. And he wanted that standard of excellence to continue [inaudible 00:52:47]. So he really set the tone, even before the staff became open.

FA:
So in a way, you know, you hear a lot—or I've a lot of doctors say that that was—well, not

necessarily a good thing. But other doctors have said it was, you know, that the closed staff had had its good side to it and that was it.

RS:
Well, I guess I lean—

FA:
But the open staff was—

RS:
I come on the side of the open staff, because you still could control the quality of all the staff, and that's done today. You've got to do certain standards and training to demonstrate excellence, to provide proof that you're competent to do certain things. It takes the personal bias out of it. It does not lower the standard of the physicians, by any means because we have very tight, rigid controls about anybody getting onto the staff. The open means you have the privilege to apply. It doesn't mean you gain automatic admission, unless you meet this high standard of training qualifications. So that might give you a little better of an understanding of an open staff. It doesn't mean that anybody and everybody can get on the staff. It means you have the opportunity to apply, and if you meet those standards and credentials and you're trained and have the expertise that you [inaudible 00:54:12]. So it did open the door up, though, for a lot more people and a lot more specialists to come in at will.



FA:
And making it public, they didn't have to buy into it.

RS:
That's exactly right.

FA:
Or they didn't have to contract on it.

RS:
No, absolutely not.

FA:
With a private hospital.

RS:
Sir?

FA:
With a private hospital, such as what it was before.

RS:
That's right. Otherwise, I don't know what the requirements were then. I know that you had to have some type of employment contract.

FA:
Are there any theological implications to this?

RS:
Well, yes, there are. You know, we have two religious—different religious organizations behind each one of these institutions. We recognize that there were differences, theologically. One of the task forces that I mentioned, the task force—various task forces to consolidate clinical services. One of the first task forces started was the Cultural & Religious Integration Task Force. We had representatives of the Catholic Church and representatives of the Methodist Church. The first thing they did was—this started, also, a year and a half, two years ago—and looking at each other's religion, and looking at the mission and value statements of the Methodist church, at the mission and value statements of the Sisters of St. Joseph—St. Joseph Health System and St. Mary Hospital and Methodist Hospital. They got all those things out on the table and started dissecting them.



FA:
Were you on this task force?

RS:
I was not on this task force. That's one of the few I wasn't on.

FA:
I would assume they would've had the Chaplain.

RS:
They did. They had the Chaplain. And we had representatives of the Methodist Church. We had the District Superintendent from the Northwest Texas Conference. And actually, the person that probably was most involved in that was Clifford—Cliff Wright, senior pastor of the First Methodist Church. He was involved in that. After several months of looking at that, they found that, yes, there were some differences, but they found a lot more commonalities and similarities in their religions than there were differences. And they felt like that the differences that there were, were not going to be an impediment of the merger. When one looks at the common goal to provide Christian healthcare and Christian healthcare ministry to the people of this area, the

differences in religion seem to sort of become secondary, if you look at it from a more global Christian perspective. I think that's what you have to do, and I think that's what was done. We focus primarily on the mission of the hospital, which is to provide Christian ministry to the people of this area. And when you focus on that, then the different religions doing that take a secondary role [inaudible 00:57:42]. So that's how that piece has played out. It's an adjustment in some areas, you know, on each side. That's what a merger is, in my mind. A merger is a compromise, compromises on both sides. Make adjustments on both sides until you can get to middle ground.

FA:
Yeah, I guess when you really think about it, the theological differences between the Protestantism and Catholicism really are moreover—seem like things that pertain to the type of service you do.

RS:
That's right.

FA:
I mean, not the type of service, but the type of church service you have, and communion, and beliefs about that.



RS:
That's right. And I think that—as it played out, those differences did not result in any major conflict at all.

FA:
And the government didn't have any problem with the creation—fear of a monopoly?

RS:
They looked at it for a long time. You know, we were the two largest healthcare facilities in Lubbock. But in this new environment that we have in healthcare, managed care plans—companies contracting healthcare services statewide instead of locally. For example, TI, Texas Instruments. I'll use that as an example. We learned a couple years ago that TI was taking patients from Lubbock and sending them to Baylor in Dallas to have heart surgery.

FA:
Really?
RS:
Really. Because they had a contract with Baylor to provide services for the state. So suddenly, the competition is not just Lubbock. It's Dallas.

FA:
So they were able—you were able—

RS:
So we were able to expand the market.

FA:
The basic competition.

RS:
To dilute what might appear, at first, to be a monopolistic situation. And this is, in fact, true. We are—Albuquerque is desperately trying to retain all of their patients in Eastern New Mexico. Traditionally, all those patients in eastern New Mexico have come to Lubbock. They're even enacting state laws that will prohibit their insurance from being effective in Texas. Stuff like that is going on. So suddenly, as I say, we're not competing with each other locally, with UMC and other hospitals in town, we're competing with Albuquerque, and Amarillo, and Dallas. So the FTC took that more global perspective in numbers, so that when you look at it from that standpoint, it was not—and so that's, I think, one of the major reasons that they finally approved of the merger.



FA:
UMC was—is a cheap competitor.

RS:
Yes, it is.

FA:
That's your main competitor now.

RS:
Locally, that's our main competitor.

FA:
But by merging, you have definitely outsized them.

RS:
Yes, we have.

FA:
Far and beyond.

RS:
Far and beyond. We—someone recorded—I didn't verify this statistic, but I heard it just this week. But we are now the twenty-fifth largest healthcare facility in the United States of America.

FA:
Really?

RS:
The fifth largest west of the Mississippi.

FA:
Really?

RS:
Really.

FA:
Wow.

RS:
So we are big.

FA:
Yeah. Fifth largest west of the Mississippi.

RS:
That is correct.

FA:
Which would include Los Angeles.

RS:
Includes Los Angeles, Seattle, all the west coast.

FA:
Phoenix. That's amazing.

RS:
Dallas. Houston. [FA laughs] So that gives you some idea of the size of this place.

FA:
Yeah. And what's interesting is what you mentioned about New Mexico, how they're working with the state legislature to define where people can go for medical care.

RS:
That's right. Absolutely.

FA:
Do you think they're going to get away with that?

RS:
You know, I haven't been on top of that part of it. I just know that we've had our own people and lobbyists looking at that and keeping on top of it. Right now, I don't exactly know where that is. And there's probably pieces of it that have broken down, like trauma, like Medicare and Medicaid, private insurance type things as well. It's not a global thing, but it's broken down into pieces, depending on what [inaudible 1:02:42] that you're looking at. But that has been ongoing over there for over a year. I'm just not up to speed on where they are with that at this time.



FA:
Sounds like they wouldn't be able to get away with that.

RS:
It doesn't, does it?

FA:
Not the Supreme Court. Seems like they would do something about that.

RS:
You wouldn't think so. Now, people can still come over here.

FA:
But their insurance won't pay.

RS:
Their insurance might not pay, you know? Still have the freedom to go where they want to. It's just that the insurance—

FA:
But still that would be a restriction.

RS:
I know. I agree, I agree. We don't like it. We don't think it's fair. We don't like it either. Excuse me. But there's just all sorts of stuff going on like that in medicine, as we talked about earlier. Take the—doctor—take the time of the doctor away from taking care of patients, which is—that's all they used to do. They were, almost all the time, taking care of patients. Now, there's so much red tape with insurance companies and all that stuff as well [inaudible 01:03:56]. Very interesting timeframe.

FA:
Yeah. Very transitional times.

RS:
But overall, like I said, I think that consolidating—

***End of Recording***