Interview with Charles Schwindt
Marquette, MI
September 21, 2009

SUBJECT: MHS Project

START OF INTERVIEW

Magnaghi, Russell M. (RMM): I guess I can call you Chuck?

Schwindt, Charles (CS): Yeah.

RMM: Okay. Chuck, my first question is a difficult one. What is your birthday?

CS: July 23, 1938.

RMM: You're going to be telling us about your coming to Marquette and something about the medical history or how you perceived it and so on so that will be the focus of the interview. I'd like to get back to your origins. Where are you from? Can you tell us a little about your background?

CS: Yes I grew up in a little town in southeastern Ohio called West Lafayette. It's described as being in Appalachia but basically it was a farming community. My father was the general practitioner there having graduated from Ohio State somewhere around 1931-32. I graduated from high school there and then went to Ohio State University because my father said the price was right. So that's how I ended up there and eventually spent all eight years there. I graduated medical school there in 1964. I got into medicine primarily I guess because somewhere along the line I wanted to become an engineer but someplace in my employment I decided I didn't want a boss telling me what to do. So I think that's how I gravitated to arts and sciences hopefully to prevent that. Anyway after medical school it was about the time in 1964 at which time everybody in medicine was liable for draft up until age of 35. Well I didn't know what I wanted to do other than be a physician but not what kind so I went into the Air Force right out of medical school and the pay was good and we would get to see the world. I was married by that time. So I spent 4 years in the military internship in the Air Force and then 3 years of which one was over in North Africa and then my wife got a malignancy and we had to come back to the United States. So by the time I got done with the Air Force in 1968. Actually how this came about was in 1965 I was taking an internship at traverse Air Force base and met four different orthopedic surgeons from different parts of the country and decided that they had proper attitude about what to do and how to do it. So I interviewed at the University of Wisconsin on the way to North Africa which the professor said we'll take you if you promise not to interview anyplace else. Well I was going to North Africa, who was I going to interview with so I said fine. So by the time I got out the slot was open at the University of Wisconsin so I went there in 1968 and spent four years there.

RMM: Now was this for some advanced training?

CS: This is for orthopedic surgery residency. So that's where I went and from there came to Marquette. From '68-'72 at the University of Wisconsin, Madison and then in 1972 I came to Marquette.

RMM: Now how where you lured or attracted?

CS: Well actually I wanted to go out west but every place that I went and looked at by the time I got ready to go where already full. There was a resident at Madison in Nephrology, a specialist in kidney disease who had come up here and looked but apparently there were no other nephrologists at the time and he said they're looking for an orthopedic surgeon I'm sure too and I said why aren't you going up? I heard you were going someplace else? He said, well I didn't want to be the only nephrologist on call all the time. So that's how I got interested in Marquette. I then came up to interview in March of 1971. I met Dr. Newman and Dr. Elinza and Dr. Elinza senior. My wife loved the area even though there was 4 feet of snow everyplace and I like the area and the way everything looked from what I could tell. So that's how I got here.

RMM: Did it sort of remind you of the west in any way?

CS: Well in a way yes. The main thing that I liked was the idea of hunting and fishing and being out in nature more than anything or in the woods, whatever and it turns out that I would therefore be closer to my parents if there was any problem. It turns out that the snow stopped every, every time there was a crisis and I needed to go home I couldn't get out anyways but that's the way it went. No, but I liked the idea that you could hunt and fish. Dr. Elinza took me back into his camp up inside the Huron Mountain club at that time of which it was a major undertaking but we snow-shoed into his camp which was very interesting so from that point I decided that this looks like a good place and my wife probably wouldn't have let me go anyplace anyways. She was 4+ cheerleader, I thought here's a lady who grew up in central Ohio in a city, obviously this was a city but we did not want to go to a large city so it fit the categories of everything that we could thing of so that's how we got here. I went into practice then with Dr. Newman, Dr. Elinza and at the same time Dr. Romney came. He and I came together and we thought that that might be a problem because of two of us coming at the same time but we sorted it all out, where business would go.

RMM: So but you were also attracted because there was some other orthopedic surgeons?

CS: Yes, number 1: there were two or three other orthopedic surgeons actually there were four in town. One of them wasn't practicing much but they said they needed more people so that plus the fact that we had enough sub specialties that a lot of the things that I trained extra for just in case I had to be in a small town I would have at least support with it or there would be other people there. We did not have a lot of subspecialties in internal medicine at that time but we did have some and pretty much would be able to take care of it. One of the problem things we didn't have at that time is we didn't have a position anesthesiologist at that time when I got here but that soon changed over the years anyway.

RMM: What would they do without?

CS: Well the biggest thing was, there where nurse anesthetists and these are usually males that had gone to nursing school and then had gone to an 18-month anesthesia training. The problem with that and also with orthopedic surgery was that it's a high malpractice specialty and if anything happened to the patient while the nurse anesthetist was give the general anesthetic and it turned out to be an anesthesia problem I was still responsible because I was still the MD or the captain of the ship supposedly and so malpractice wise and cost wise that would have been prohibitive. So it decreased some of the more complicated cases that you might want to do because to didn't have someone else to

share the responsibility of whatever might go wrong which did not happen but on occasion there was some problem. After physicians came, physicians who had taken anesthesiology residence then we didn't have that problem. We still had that problem in some of the outlying hospitals but there was we did was not do as complicated cases in the smaller hospitals.

RMM: Then how would that work? The anesthesiologist physician would be there in the operating room or in the hospital and could be called in?

CS: Well sometimes he did the case and a lot of times the first one would come and then he would be over all of the nurse anesthetists. He usually had to be in the operating room when the patient was put to sleep and then he could be called in at any time if there was a problem during the case and hopefully he was also available when the patient came out of anesthesia too. It's like landings and takeoffs, that's when all of the problems occur.

RMM: So this person would be extremely busy if you had a series of operations?

CS: When we started we only had 4 to 5 rooms. We had 5 rooms after a cardiovascular surgeon came and then 1 urology room or TUR room. So we only had 4 operating rooms and eventually five and by that time when we had the fifth one with the open hear and then more neurosurgery then we had two nurse anesthesiologists and so that made it a little bit better. Eventually was had ten to twelve rooms so we had to have 3-4 anesthesiologists so it depended. We didn't want to expand faster than the anesthesia could cover.

RMM: Would they have any subspecialties, the anesthesiologist?

CS: No he was a physician like myself who after he became an MD would go for a residency at the university or at a large hospital. We would go for four or five years, they go for I think three years. So they learned all of the fine point about all the different ways to give anesthesia including locals and blocks and hypothermic and all sorts of those things, plus the fact that we didn't have to worry about the malpractice part of the anesthetic then because then we could concentrate just on what we were doing.

RMM: So when you first came there were no anesthesiologist physicians?

CS: No. In a year or two or three then we got one but it was hard for people to get used to that and he eventually left. Then the next year or two then two guys came and that was good because those two could trade off and confer with each other. That worked out better.

RMM: That would work out then if you look at the malpractice then he would have some back up in his decisions.

CS: Yep.

RMM: I could see where, you be blowing in the breeze if you're up there by yourself.

CS: Oh yeah if you're in the middle of the night and somebody's got compound fractures and a chest injury and something else and something bad happens to them are you going to be able to help with the anesthesia for it or what and a lot of the nurse anesthetist where very experienced but not in severe

multiple trauma which in the past I think most of it was shipped out. Once we had an anesthesiologist, a general surgeon, a neurosurgeon, a chest surgeon then you had to keep expanding the services for them because multiple injury cases would then not have to have one surgeon but maybe two or sometimes three. Somebody to put a chest tube in, somebody to check out the neurological status, plus they could have a belly injury that you would need a general surgeon for, so we had to have a combined approach to it.

RMM: Of course, a lot of times, myself included, you just think of the illness patient coming in with one problem but now you're bringing in an accident victim or something that might have a whole series of problems.

CS: Which always occurred after 5 o'clock, between 5 and 7 the next morning. Not always but most of the time.

RMM: Really?

CS: Well, up here with the snowmobilers and the four wheelers and the mountain bikers that go out in the woods, we actually when I first got here did not schedule any elective surgeries during august because you where on call, everybody was out in the woods, most of the patients, most of the people up here where up at camp and so they didn't want to come in and get operated on in august anyways and we didn't want to be doing elective cases during the day and then be up all night with the trauma that was going to come in.

RMM: And you knew this was going to happen because everybody was going to be out in the woods?

CS: Yeah. Well Dr. Elinza tells us you might as well not schedule anything. "But we've got all these openings?" He said, "I'm telling you save yourself the grief." We would see patients in the office but not operate at least for the first couple years and then we had enough guys that we could spread it back and forth.

RMM: So this is the August edition of hunting season?

CS: Just about.

RMM: Everything kind of shuts down.

CS: Back then august was, we were too early we didn't have (inaudible) or know anything about it but where told to, look you're going to better off if you take the call for whatever because you're going to be busy because everything gets sent in. The outlying doctors don't want to take care of it because they're gone to come so everything's going to come flowing in here. I don't remember how long that lasted but I know it lasted for a few years.

RMM: Is that a problem today?

CS: I don't think so, no. I'm sure… I think we've come kind of full circle. I think I was told some of the surgeons now that want to be off in August and instead of taking their call in August hire local tenets form someplace else to take their call so they can go enjoy the summer, enjoy August if it is a good

August like it was this year. It was interesting to see how it all developed because at first we were still limited in some ways but the more specialists came the easier it was to do more difficult things.

RMM: While we're talking, I want to get back to St. Mary's but while we're talking about patients. Where there particular orthopedic problems that you encounter that were common to the Upper Peninsula? That you could say was a local problem more that?

CS: I don't know if it was a local problem but some of the experiences that came up where related to it. One of the things is that many of the doctors, there weren't as many doctors even in the outlying communities. At Marquette general there was a Crippled Children's clinic which was run by the state. Dr. Elinza the older Elinza, Eugene, that was his main job I think back when he got here maybe in the 30's. So that clinic was still running. It was interesting that I came to the University of Wisconsin that had a children's hospital so we saw things that were shipped in from everyplace and a lot of unusual things. It was amazing to me the first few years that I was here how many congenital dislocated hips that we saw in the crippled children's clinic because they never really where seen by a physician after they were delivered in outlying communities and people just didn't know what to do about a dislocated hip. The children are usually examined right away in a nursery and a little hospital didn't have a nursery. They were examined as, they've got five fingers and five toes on each limb then they are okay. So we would see these children at 1, 2, and 3 years old that had a hip that was not in its socket which is kind of a catastrophe and now it would be considered a catastrophe back then we would be doing operations on little babies which was a problem since we didn't have an anesthesiologist yet so it was a little shaky. So sometimes we would just say you're going to shrines' hospital over in Minneapolis but for the most part once we had an anesthesiologist we were doing those types of hips. Those where more emotionally charged because the parents are worried so much about it but most all of us had been trained to do those operations which weren't insignificant but I don't think anyone had done one of those around here in ten years since the children are seen by at least one or two physicians and then maybe a pediatrician and then it is taken care of conservatively. My daughter is a pediatrician over in Maine now and I had to call her and say I just heard about this, what do they do with this, and she said oh we don't anything with those anymore we take care of them real quick. I said you do it, she said oh yeah. So she does the treatment so that they won't become dislocated and it's all through the use of splints. That was one of the things that I noticed early on. There was a lot of different history from before that. I can remember getting patients from up near Baraga and L'Anse and I'd say this fracture looks a little bit old? Oh yeah I saw the bone breaker. I said, bone breaker? Years later I met the guy who was a neighbor someplace up there who used to, someone would call him up and his arm looks a little crooked can you do something with it and supposedly he'd bend it. Then they hid it after I started getting a little interested in it. They said he was a nice guy but he was not a doctor. Maybe he was a masseuse from the old country

RMM: Was he Finnish or could be anybody?

CS: No I think anybody. In that area of course there was a lot of native Americans there to so I could never quite get all of the story but the name bone breaker came up four or five times. I'm thinking I've got to find out about this, "Oh well I don't think he's around anymore" you know.

RMM: That's kind of interesting because years ago I did a study of Italians and there was a woman, Harry Rostello. There's a family picture and she's in it and you do a double take on the picture but she was considered a bone breaker up in calumet.

CS: It may be the same one.

RMM: Well this was in the…

CS: Yeah, probably not.

RMM: But she would go and they'd say in the interview oh yeah, she takes your bone and so on and reset it and it was like perfect and so on. I said what was the training? She was the bone breaker. When you saw her picture you think there's something about this woman that is not like other women. I know the Finns were also into bloodletting and that was a whole practice that you don't hear too much of. I had a student do a paper on it. I accidentally ran across somebody that wanted to talk about it. Now you had problems because you were a physician, probably if I came, laymen, they'd say oh he's right here. A physician comes in they think oh wait a minute, we don't say anything.

CS: We don't want to bring that up. So about the same time as that because of the problems we would have with outlying doctors getting patients into us in time for the various injuries, the orthopedic group, I think we were the first ones, started having clinics in outlying hospitals. Before that about the time that Dr. Newman came there were a number of physicians all from the same medical school class who came to the Upper Peninsula at the same time. There was a Dr. Strong in Ontonagon, Dr. Schrader in Ishpeming, Dr. Newman here, Dr. Kublin, a group down in Escanaba. I'm not too sure about someone in Manistique and there was another guy out in Newberry. So they all kind of knew each other so we started going to Crystal Falls and Manistique first in 1973 or something like that. One of the stories that doesn't have to do with the U.P. but it's interesting. I went down to Crystal Falls with Dr. Elinza who was about six years older than me but apparently he was in the same medical school class as Dr. Shirk who was GP down there and when we got there I don't know if it was before or after the clinic or after he saw the patients but he said to Doc Shirks we have a presentation for Dr. Elinza today. I forget exactly what plaque it had but I know it had a knights head and on it. I said what's this all about? I'm about to tell you. He said that when they were in medical school there was a professor of OBGYN who had some family practice background too but he routinely did this in his large lecture hall at medical school and he'd say to somebody, tell me who is the most recently married medical student here? Somebody said Elinza. Elinza would you stand up please and of course Don was by this time older and probably working a lot just to get through med school and had to be kind of woken up to get up. He said okay Dr. Elinza you are seeing a young couple who are coming in just before they're going to get married and they have some questions for you. They want to know how many times a night should they have sex. Of course, Don who was usually pretty quiet and he mumbled. He said no, no I can't hear you? Well whatever. No, no they have to have a number. They have to have something to tell them exactly what it should be. So apparently Dr. Elinza said well I don't know but I've always heard the slogan, once a king always king, well once a night's enough. So that was the plaque that he was handed. I guess the professor once everybody started laughing and so did he that he just let the class go, they couldn't get any discipline after that anyways. That was funny. I think I've seen that plaque a couple time is Dr. Elinza office.

RMM: He had it for years?

CS: He had it for some time. Anyways we had outlying clinics and that brought more contact with the outlying physicians to Marquette. Marquette was looked at as the ivory tower for the Upper Peninsula, maybe not Michigan but there where enough people here who had gone to Michigan medical school. So we started going to the outlying hospitals and having a clinic and doing minor surgery procedures

there and eventually we did more of that so we ended up in multiple different ones but those two where the first two ones in the early 70's. We were well received and got more referrals from that.

RMM: Then has this process continued to the present day? Clinics?

CS: Oh yes. We've expanded significantly – Newberry, Manistique, Ishpeming, L'Anse, some in Houghton-Hancock, Iron Mountain, Crystal Falls, so we had multiple ones all around. Then other subspecialties started going on other days. Maybe it was cardiology next but a lot of them would have to have general practitioners who did a little surgery or OBGYN to deliver babies and so they'd have to have the basics just about but a lot of GP's were very good surgeons and very good OBGYN physicians. There was some real talent out there that we didn't hear about.

RMM: Was that sort of because they had to?

CS: They had to.

RMM: I mean they sort of got the theory knowledge in school and then they were actually out there and had to do things.

CS: And they had experience, they went to an internship and developed some interest in one thing or another. I had some difficulty getting into L'Anse because they had a surgeon there or a general practitioner who was an excellent surgeon and he thought I was going to take all of his business away from him but I guaranteed him he wouldn't after a few drinks in the back bar and few things like that we worked it out but that was the UP. That's how you had to do things.

RMM: In general you saw that there was plenty of work for everybody?

CS: Yes. You had to be careful because I could see patients, patients would see me up in Ishpeming but they would not come down to Marquette you see. That was just the way they were. If I had a clinic it was totally busy. If I had a clinic down in Marquette I didn't see any Ishpeming patients but eventually they moved around a lot better but at first and the same thing going to Crystal Falls which is just a two hour drive for them back and forth but with the snow they weren't going to do so we all had trucks and went to the outlying clinics.

RMM: That's kind of interesting because when they had the closure of the airbase they talked about people from Marquette as the "suits". There was this tension between the people out at Sawyer, the township out there and the "suits" from town. It's kind of a similar thing as you were saying, people saw this as a big time city that they didn't want to get involved with.

CS: I've thought that multiple times. I've seen episodes of it where people were treated differently because they were from Marquette. I remember they used to have a little train out here and I can remember this father getting on the train and he had his little boy with him and he went in and sat down and the train was run by people from Marquette that just took tourists up and down and I can remember the guys saying now where are you from and the little boy said I'm from Negaunee. The conductor said you're not one of those Negaunee rats are you? I'm thinking what is that? But I think that, whether it was true I know it was perceived. So there had to be somebody who was in between working things out so I would get called about something different in orthopedics and they'd say what should I do. I'd say send um up and I'll make sure he gets the right person. So then maybe I'd send

them over to the cardiovascular surgeon or to the chest surgeon or the urologist for whatever the problem was here in Marquette. There where time when I would be getting patients in that had nothing to do with orthopedics but they didn't or couldn't send them someplace else. There was a lot of public relations that needed to be done not so much because it was actually active but kind of a passive, oh you don't want to go up there. So we had to work on that. There are different attitudes throughout even Marquette County. The more we saw there the more they sent to us because it was helping their little hospital too. I can remember when I retired one of them said, one of the board of trustees someplace said we really miss you know that you're gone. I said no you miss the money that I made for your hospital.

RMM: You mentioned something about their where differences here in Marquette County, could you highlight that?

CS: Well the differences in Marquette County were basically between Ishpeming and Marquette. At one time I was the chief of staff here and I had been up at Ishpeming for some time and one of the board members came in and said I know you're up as the chief of staff here but you know we can live with you being the chief of staff here but not being the chief of staff here and Marquette at the same time. I said okay that's no problem to me, that's not my big interest anyways, I'm just here to do orthopedics. There were physicians up there that would not refer to a physician down here. It was just the way they were. There were patients that wanted everything done there and not here. It was just a matter of personal loyalties and growing up with basketball and football, everything had that separation. It's interesting. You had to play the game and you had to be careful to not make any offhand comments about some patient because there's probably four relatives in the room with you.

RMM: That's true. So these are all things you didn't learn in medical school?

CS: No, no, no. I learned some of them, I can remember even in the 60's, I went to medical school in 1960, there was just the starting of the specialists a lot in the hospital and routinely the junior staff people there would make comments about this patient was seen by LMD which meant his local MD which was kind of a derogatory comment and of course I'm standing there, my father was one of those LMD's who I had been out on calls with going up into the snow banks and hills of southeastern Ohio and seeing four patients given two shots and charged ten bucks and this guy has no idea what's going on but I'm not going to punch him here. So those attitudes, if you where a specialist and you're the expert from someplace else which is the man with the briefcase just 50 miles away.

RMM: Interesting.

CS: A lot of nice people out there that are very pleasant and very appreciative.

RMM: Earlier we had kind of just mentioned in passing that you might want to discuss a little of your memories of the St. Mary's and St. Luke's merger and development there?

CS: Yeah I came in 1972 and I think at about that same time Dr. Elinza was the chief of staff. In fact I think he may have been the chief of staff at both places. Out of there was a group of townspeople and business men that where on the board of trustees at St. Mary's and there was a group at St. Luke's. SO they where all local businessmen and the problem with that was there was not really enough for the size of the town, or there was not enough room for two hospitals. There was a lot of overlap and emergency rooms. We had to take calls to different ones and a lot of it got to be where it was expensive to have all

of the increasingly more sophisticated instruments for both places. Each one couldn't afford it and back then the hospital had to own them all. Now orthopedic company owns more, the surgical company owns more. Exactly what all persisted I wasn't sure but I do know that eventually everybody, if you were on staff here as a physician then you were on staff at St. Mary's although there were some that chose not to be. At that time they still had surgical patients but rehab with Dr. Coyne and I think he was the first physician in rehabilitation but they had a rehab unit here in Marquette too. So there where two different ones but I know Dr. Coyne was in one or the other and whatever exactly happened I know that whatever it was St. Mary's was not going to just fold and go away so somehow, it must have been some political pull someplace it was sold to the VA hospital for a certain amount of money which went to the diocese I'm sure. The problem that we had basically was having enough people at St. Mary's. I think there were enough physicians who didn't go to St. Mary's that it became a problem so that eventually it worked out. I did some cases over there of which I was not happy with, number one they had no MD anesthesia and number 2 I can remember the nun in the operating room and I'm sure she thought that her black gown was sterile by god's grace but it somehow wiped across my table a couple of times and so I had quite a few words to say about that and eventually I did not do any elective cases there. It was just like wait a minute. We've got some problems here you know. I had a couple of bad experiences with anesthesia and with sterile techniques there that I was not too happy with. Given that basically there was a push-pull-shove between the town and city fathers at the time as to how things could work but I think the upshot was that for some reason or another a lot of the physicians at St. Luke's did not want to go there. There weren't enough people who wanted to go to St. Mary's to take the patients there and keep in functioning and not be the other way. In other words it's closer to the university, it's going to work out better. There were things like the hill going up to St. Mary's during the winter it's terrible even though it was right on the highway. There was a lot of different peddling back and forth. Dr. Elinza was in the middle of the discussions at all times and I think that he probably worked both places for many years as his father had and that was one of the moderating factors. It may have been somebody else in there that was pushing but I don't know. It did need to be consolidated. There was a little bit of talk about having one hospital in between Ishpeming and Marquette so that everybody would be out there. Well there's too many apparently local feelings to keep to ourselves. So they didn't want to move down the road and we didn't want to move up the road. At that time I could have cared less one way or another. As I remember it was some time after that before St. Luke's even expanded.

RMM: You mean once they merged?

CS: Once they merged I don't think St. Luke's, or then Marquette General…

RMM: I think they merged in 1974.

CS: That early? But they didn't add, what was the first edition? I don't remember what the first edition was but I knew they didn't want something in the 70's. The big building wasn't until the 80's.

RMM: There was the wing, I know my daughter was born in that one wing going south.

CS: Yes, that was here when I got here in '72.

RMM: Okay so that had been built before the merger?

CS: Right, we didn't move the orthopedic floor until we moved to the tall building and that must have been about '83 or something like that.

RMM: I think in one of the other interviews someone said early 80's.

CS: They moved to the sixth floor, the sixth or eighth floor. I can't remember what it was. I know we went to the top.

RMM: Did you have any other additions to the St. Luke's, St. Mary's story?

CS: No, I can think of any. I do know that it seems to me we inherited the administrator from St. Mary's to St. Luke's at the time but I'm not sure. I do know that the administrator for St. Luke's thought he had a tumor or some sorts and did commit suicide and that was early on when I got here so I don't know whether that fellow came in from St. Mary's or not I can't remember the exact details.

RMM: They were going to have to put him out and hire an independent administrator.

CS: That sounds right, I can't remember all of it at that time but I do know that one of them left or died and then another one I thought chose to go someplace else. But I thought there was some part of the administrative level that there was some blending. Some individuals moved in and stayed there from St. Mary's but I don't think there was a lot of people having to leave the job because they had too many people or anything like that.

RMM: Did you have any interaction with the old polio patients?

CS: yes I did. Basically what happened was since, the old polio patients, a lot of them had deformities in their feet and legs and we inherited them through crippled children. Where I trained we had a lot of them also at Madison. I can remember scheduling this one patient to do an operation on their foot which was an operation that wasn't done much anymore because the only patients they were done for where from congenital defects which you would see in a large center or an old polio patient which should have already been treated. I can remember them saying you've got to ask Dr. Eugene Elinza to come in with you because he's done hundreds of them. I said really? That would be great you know. I didn't know it at the time when he came in, he scrubbed in and walked into the room with me and said nurse can you put those three nitroglycerine tables in my mask now? I'm thinking is there a problem? But apparently he'd been doing this for years. For some reason or another he had them in his mask so that if he needed them he'd pick them up or something.

RMM: Oh I see. He would kind of move the mask around…

CS: and get them if he started to get chest pain. Why I wouldn't just give it to him? But I thought what have I gotten myself into? Anyways, he helped and it was very nice.

RMM: But there weren't a lot of them?

CS: No, not a lot of residuals left by the 70's when I got there from the 50's. There were still a few people that where older who had been treated but still had, in the clinic, in the Crippled Children's Clinic you could see those patients back and they'd be fully grown but they had been in the crippled children's system back then and so they still took care of the problem. So basically by that time…

[SIDE A ENDS]

[SIDE B BEGINS]

CS: There was a Mr. Shilinger here in town that ran the orthotics business. In other words he made splints and different things the patients would wear on their shoe or foot and interestingly enough we obviously called him the old German because his name was Shilinger but if sent him a prescription and a patient 9 times out of 10 he'd call you back and tell you I gave them what they needed not what you asked for. Anyways he was a pretty good guy but he was usually pretty correct too but it was interesting that you had too…

RMM: You didn't have any problems?

CS: No, no, but we would talk about it. Dr. Elinza would say just do what he tells you because you'll save yourself a lot of grief.

RMM: So that was his occupation?

CS: that's right and he did that for some time because everybody came to the crippled childrens clinic and if we had anything that they needed and there were a lot of treatments back then that we don't do know but a lot of them in Wisconsin I heard later was that 95% of the splints and braces and stuff that you prescribed ended up in the closet 6 months later. We'll probably 50% of them decided that they didn't need it anyways but that was a method of treatment taught to us back in the 60's. You have to remember the amount of technology that changed particularly in the orthopedic specialty was so dramatically different from when we were trained in the late 60's and early 70's. Compared to ten years later you wouldn't have recognized half of the operations that we were doing compared to when we got here because of technology. There was new knee joints and new hips joints, arthroscopies, all of the technology that stepped in instead of putting them in a cast and telling them to come back in six weeks, you operated on them and made them well. It was a big increase in technology so we had to go out almost every couple-three months to a meeting about some new procedure and new way of doing things. It was very different but very interesting.

RMM: Now does that progress continue?

CS: It does to a degree, it's just more sophisticated now I think but I can remember for years having to keep patients in the hospital after procedures where as now the sooner you get them out the better for them because with physical therapy and physical therapy came along a lot too. Rather than just having the muscles and the range of motion to get them going. Then techniques are just tremendous.

RMM: So in the past then they would have and operation and then there was no therapy?

CS: They'd sit around in the hospital and we'd try to get them to do straight leg raising and standing up to walk and things like that.

RMM: It was just sort of in hospital?

CS: yeah it was in the hospital. Well they're from 50 miles out, well so what but they don't have anybody to come help them so the patient would be in the hospital for a week or ten days just waiting for them to get better. First we were pushed by insurance to say hey we've got to get them out sooner.

It was just too much expense and the hospitals by keeping everybody there and in treatment, pretty soon the insurance company would only pay so much so you would have to get everything tuned down to where it was cost effective. That was another problem that we would have with administration, they'd say well you know you have to get the patient out of the hospital in 3 days. Send them home tomorrow as far as I'm concerned but you've got to make sure liability wise they don't fall down. So now over the years it got to the point where a new knee joint I can remember leaving the patient in bed for two or three days so that they could recover which didn't make any difference. At that time they were half stiff. Now the patients get out of the operating room, went into the recovery room and was put in a machine to passively bend there knee for them right away. Then next day they stand on it and they're home in two or three days. That was totally different from what it used to be.

RMM: So they could start using after the operation?

CS: In the first 24 hours we would put cold packs on them which would numb the leg essentially and then have an automatic bending machine that would keep their knee going back and forth which help getting the bleeding out besides with tubes in the joint to express the extra swelling because the extra swelling just makes the knee joint turn. Then standing them up on, before they let their muscle get to atrophied then they were obviously working right away with crutches or a walker with someone always there. The interesting part was the Fin-landers took off right away. They had never stopped. So it was different, some took off right away, some you had to crack the whip with. When you got down to it as soon as you get out of the hospital and get back to home the better off they are.

RMM: Then during your time in practice and so on did you see a, well you saw things like hip replacements, how about, did you get into any sports medicine?

CS: Oh yeah. A lot of the outlying patients would be sent in and Dr. Rundy did a lot of sports medicine and so he would try to be at the football games and whatnot but at the outlying hospitals if was on the sidelines for Marquette nobody from the other team was going to come to him. Eventually it worked out. Of course it depended upon how tough the teams were. I can remember in Ishpeming the year that they won their state championship I remember having a clinic the week afterwards and I had like 5 players from the Ishpeming football team all with injuries that where obviously old but they had never come in when they were injured because they weren't going to quite until the season was over. So they were a bunch of tough kids.

RMM: You mentioned this before. These injuries then could be taken care of?

CS: They weren't anything so dramatic that they couldn't do things with but they had to be in pain. They must have put a splint on or something on it and kept playing because there were fingers that where all chewed up or dislocated knuckles. It was a matter of pride I'm sure because I looked at these kids and, so this just happened? "Oh yeah, yeah." Come on look at this X-ray. This X-rays got callous formation on it which means that it's been healing for at least three weeks you know? "I don't know anything about that." So it was interesting and knee injuries that where taped back together and taped up well. I played football back in Ohio and we had no orthopedic surgeon ever around and I know that everybody in the backfield has new joints except for me so far. So we all had injuries that nobody knew what to do with and we just played. Dr. Romney was here so they got really good care right here in Marquette and many of them that came in. I can remember one he had a patient that was from someplace else and the problem was he had a hit on his shoulder and he had what was called a stinger which really is numbness going down your arm from an injury to cervical spine. So Dr. Romney says you

shouldn't be playing but the coach took that as saying he's trying to keep this kid from playing so he won't beat Marquette. There's things like that but we're not doing that come on.

RMM: You're physicians.

CS: So it went on and on with different things like that.

RMM: Now when did you retire?

CS: I retired in 1998. I was 60 then and I decided that I worked long enough and hard enough and it was time to retire. At least at the time anyways. My wife had health problems soon after that so I cared for her until she passed away in 2001 so I had another patient then to take care of.

RMM: So you stayed in the area and you enjoy the outdoors?

CS: Yes I stay in the area except for the winter I go to Florida. I have a home in Florida so the longer the winters the sooner I go down there now. This year will probably be the first year that I didn't wait until after deer camp. I'll probably go back down in October this year. But I do love the area and everything up here and in the summer is obviously the best place you want to be but I can remember those long winters I got up in the dark, went to work in the dark, came home in the dark.

RMM: It still happens.

CS: It didn't take me long that I built a table in furnace room and started raising seeds down there so I had green plants to look at in late January and February.

RMM: So you were planting for the spring?

CS: Yes, but I spend an inordinate amount of time going down to look at them. It took a while to get used to that.

RMM: I didn't think of that. You'd have a mini garden down there.

CS: I had a grow light built a table and had them in the furnace room so.

RMM: Is there anything I didn't ask you that you want to add?

CS: No, I think basically over the years that the problem that's happened in the UP and throughout the united states is that medicine and hospitals has become big business and Marquette General hospital got to the point that they controlled so much of the activity in town that the townspeople had enough business with the hospital that they would not say anything bad about the hospital or particularly how it was run. There was a time at which there was a movement on we would get people who would want freedom of speech or at least have the minutes of the meetings at the Marquette general hospital's board of trustees because there was a lot of 'old boy' systems going on. That all of the business from the hospital would go to whoever, let's say it was for the investments of the money that the hospital had, well that would go to whatever man that was on the board of trustees who had an investment business or was at the bank or whatever and the same with whoever had the insurance company, and

the automobile company and back and forth like that. So at one time a group of us actually had a committee together which was basically designed to get full discloser of minutes of the meeting.

RMM: Oh you as a physician?

CS: Yes.

RMM: Oh so physicians working in the hospital didn't know what was going on?

CS: No, unless you where on the board of trustees which the chief of staff is on it but I learned one night how that works because I was chief of staff and was at the meeting and after the meeting was over everybody broke up except for a group of 3 or 4 or 5 of them and I was just sitting there having a coffee and I think that everybody had thought somebody else had invited me to stay and that's when the business was done.

RMM: Oh so you accidentally?

CS: Yeah, everybody kind of looked at me and they said well it's okay and they were talking about who got which deal and how. So I was waiting at the next meeting to see what happened and they all left. I think they met someplace else. So it was a Good old boy system. I think one of the presidents of the university understood my feelings and he said but you've got to realize in the whole realm of everything it's pretty small. I said it depends upon how you look at it. I'm not saying who it was.

RMM: No that's typical. I'm good friends with him. He's going to be up here. They're coming in tomorrow.

CS: The reason why I knew him was that he found out that I graduated from Ohio State. I went to a couple of things and I'm thinking how come he invited me and I found out that he was from Ohio State too.

RMM: Yeah, he was financial Vice President.

CS: Is that what he was?

RMM: Yeah.

CS: Well he came here for a short period of time but I think he got along so well that I think he… the problem with trying to keep the finances and appropriations coming from the state legislature is enough of a problem that he ended up spending a lot of time there.

RMM: He came here for a year and kind of by acclimation everybody wanted him to stay.

CS: Oh yeah he's a nice guy.

RMM: At that meeting it was like outstanding you know. This can't be happening, we want it to happen but it can't be happening.

CS: Yeah that was great. Well the guys before that were not nearly as outgoing and friendly as he was. He was so pleasant.

RMM: he'll come back and you'll see him in front of the bookstore talking to students. How are things going? He doesn't say I'm a former president and so on he just wants to be out there talking to people.

CS: Like I said he was the only president that had a burger named for him. I heard the place is closed now.

RMM: I think I even put that, yeah I did a encyclopedia for the centennial and I included that. The burger and his thing with the tie, he'd always wear the tie backwards when we were having lunch.

CS: Well what did I hear the story was, was that one of the guys who used to be on the board of trustees here was with Vandament and some guy who was the president of Ohio state, either then or right after and they were some place like New Orleans and they had met at this place for coffee and breakfast of something but they all kind of showed up and there were kind of casually dressed as everybody was and so they had their coffee and everything and maybe it was later but the guy said, the president of Ohio State at the time and Vandament was with him said, could we get menu's? The waiter came up and said we'll I'd really like to give you menus but frankly speaking you're not dressed to be able to eat here. He said you don't understand these people are all highly educated. He said I'm not throwing you out because of your lack of education, I'm throwing you out because of you lack of dress.

RMM: Oh my word.

CS: He said I've been thrown out of better places than this. But apparently even at Ohio State they don't always get proper respect I guess.

RMM: I'll have to ask him, hey Bill.

CS: I'm pretty sure Matt Vandament was with him because this guy seemed to know Vandament very well. He didn't know the guy form Ohio State but I think he was there because of Vandament. I don't know where they were or why they were there together but who knows.

RMM: One time I went out to, we were out in California and Vandament was still president towards the end and we went to Glen Seaborg would give a Seaborg award to a former football player that had done well. It was a cardio physician from Minneapolis that got the award and Vandament goes easy. So anyway the president or the chancellor or Berkeley finds out that there is a president from another university, nothing would do, he and Marge had to go up to the presidential box and so on. So he apologized to us and I was with him and his nephew and we sat together but the president had to be the president and so on.

CS: So he moved him up there huh? Which, I'm sure he would have rather been with the boys.

RMM: It was like okay, I guess I have to and so on.

CS: He did very well. I can't remember… what was it he wanted me to do? Oh anyways between the medical center and the hospital there was, they could have someone on our board but we couldn't have anybody on their board so I think at that time I thanked whoever it was, it may have been Elwood

Mattson for all of his fine service for the medical center and excused him. We thought for sure there would be a lot of trickle down so I picked up the phone and called Dr. Vandament and said I've got a job for you. Two weeks later he called up, I've got a job for you. So he put me on one of the committees of alumni or development or something like that. He was very gracious about that and came to all the meetings and helped out. He was a people person and it didn't make a difference what it was he could help you do it. As far as anything else history wise, there were multiple different things that I had with the hospital and different things in the administration, I set up and got a surgery center for the medical center. Politically wise it came down to the point where it had to be both of us even though my application preceded theirs because they thought we were going to take business away from them when I fact all we were going to be doing would be doing patients over there that they didn't wasn't to do over here because it was too cheap. So it's had a struggle but one of the few insurances because Blues has a monopoly of the state. The blue somehow didn't pay for procedures there but oddly enough all of Northern Michigan Universities insurances where covered there so how that works I didn't know. But anyway I did have some conflict with the administration but it was all about board but I'm sure they thought that I was going to take all of the patients and move them someplace else and I know there was some animosity when I started doing toe-hips and toe-knees at Ishpeming and L'Anse and explained to them that they'd get a lot more business from those places now than they used to. There were problems here and there.

RMM: So you were an independent physician that worked at the hospital but used the hospital facilities?

CS: Right.

RMM: So you could go do whatever you wanted? So you could go to Iron Mountain, Escanaba, and do what you wanted but they would still get upset?

CS: Yes, they felt that, at that time they were counting the pennies and nickels and dimes and I know that there where millions of dollars because I even investigated that but basically I could go out and operate anyplace I wanted to and they could come back and say we're going to take your privileges but I don't think they legally could have done that unless there was some disciplinary problem. Basically what we were doing, is we were making sure that we were covering all of the orthopedics we could in the upper peninsula and whatever could be done at the outlying hospital or there little operating rooms we would do to benefit them and on the same token we would bring patients back in to be done here and it was a good referral process. I had to explain to one of the presidents of the boards one time because he wanted to know how they were going to get all the business of this thing. I said you don't understand you don't have to have, this is like a pony, if you cut off the ponies legs then you got nobody to bring the patients to Marquette. I said you just can't do it that way. He got very red faced and said, well we can try. I said that's not the name of this game. I did have some difficulty with the administrations attitude and I think basically the big problem we had for a long time was not having someone who was trained and educated as a hospital administrator. Business got so big that the little guy doing this and the little guy doing that you had to have somebody who had the training and the education because it was a big business and a lot of them where not trained or educated. There was a lot of political things going on as you might imagine. When I got here I think we had 38 doctors, I think 6 of them came the year I came in '72 and now I think there's 150 or 200 or something like that. So sometimes it got lonely back there.

RMM: It's kind of interesting, it was what we were talking about earlier and that was when you came in, anyone coming in was to mesh with the local culture and then like you're saying have these clinics work with the hospital so that people trust you and then look to you and then to ultimately to Marquette as the place to come to. If you couldn't get people from Ishpeming and doctors from Ishpeming to refer people down here…

CS: You couldn't expand the hospital and you had all the physicians coming and they needed a job and so I think that by the time we, well I don't know how long it took but a lot of people had outlying clinics in the same fashion that we did. The advantage was we could do smaller procedures at the outlying clinics and that would give them some money so they looked forward to us coming.

RMM: Then there would probably be a lot of procedures that you couldn't do at the outlying clinics, they had to come here.

CS: But after you've done a total hip or something there then they couldn't understand why you couldn't do everything there but that took a little explaining. Some of the hospital I can remember going to one and saying first thing, I'm not going to do anything until you learn how to charge for this procedure, the hospital, the hospital has to go through a whole series of how to code it, what to do with it because I said you got so much, I can get the orthopedic equipment in, you don't have to buy a single thing all you have to pay for is the implant that we put in the patient here but I said you have to learn right now how to charge for it or you're not going to make any money off of it, you're going to lose. Because a lot of them at the smaller hospitals not only were they not trained to be a hospital administrator, I don't even think they were trained to be an accountant let alone anything else.

RMM: So would they just make up a figure?

CS: No.

RMM: But I mean before?

CS: Oh, before, oh yeah. They'd just call around to their administrator friends and ask how do you charge for that, I don't know we don't do them here either. But as soon as one called the other than from 200 miles away we'd have a hospital say we'd like for you to do those total knees here like you're doing up in L'Anse.

RMM: But how do you explain this to the chairman of the board?

CS: yes exactly. We'd say hey, tell me how, I used to walk into administration and they'd say we'd really like to see you do more procedures? I said wait a minute, tell me, I know orthopedic surgery was responsible for 30 million dollars a year and every time I would come back with a different number they'd all agree to it. I said you know what, they don't know. They had no idea and they didn't because they didn't have a computer system set up and they didn't have enough information on it which is sad. For the amount of money we're bringing to you, you don't have to worry about one procedure we're doing someplace because we're bringing a lot more to for that. I can remember one time when they were mad at me about something and I needed, I wanted to borrow the little small instruments that we had ordered to do a digital nerve repair up in Ishpeming and I called them up and said I'd like to borrow them on such and such a day. Oh well I'll have to talk to the administrator. Okay. Well we can't give them to you? I said, really, is there some reason for this? He said you know as well as I do with the

problems you can cause. Well I tell you what I think that's good. I tell you what I'm going to do for you, what I'm going to do is I'm going to bring that patient in here and we're going to do that hand procedure that's going to net you about a thousand dollars and then I'm going to cancel the total hip from the same town and take it up to that hospital that your lose $25,000 on. Do you want me to tell the board about this or would you just want me to tell it on Front Street downtown? Okay, you can have them. So little things like that went on. I suppose that people might have thought that I caused a lot of problems for them but basically it was more of lets up the ante and let's do everything like the rest of the world should be doing. The big problem was I had friends from Wisconsin which unfortunately we were at a disadvantage because they were reimbursed differently and better and we were much more competitive down there. I even had the administrator from one of the big hospitals come up and talk to physicians; he said we don't have the same advantages that you do up here. He said down there all the people on my board are business owners who send their patients to me and they tell me how much profit I can make a year off of their patients and he says that's how we do it. So it's different here.

RMM: So they had sort of a state mandated thesis?

CS: We'll what they did was, you could pick up a telephone in Wisconsin and call up and find out how much a procedure costs at any one hospital in Wisconsin.

RMM: Oh my.

CS: That's never happened in Michigan because Michigan's not competitive because it's all Blue's for the most part where as there it was competition everyplace. So he said we can't do, the price for doing a total knee, total hip, or an open heart throughout Wisconsin for those hospitals that are allowed to do them, cause anybody can pick up the phone and call and say hey, do you know what they're doing over in Neenah, we're going to do that here at Marshfield. It was very much more competitive than here. It was open. You could do whatever you wanted to do except that obviously the state had something to say about it as far as Blue's anyway. Medicare was different than the Blue's but Blue Cross Blue Shield Michigan administrated Medicare in the state of Michigan except when they got caught with their fingers in the cookie jar and lost if for a few years.

RMM: So they total dominate?

CS: Oh yes.

RMM: This isn't really that well known?

CS: Doesn't get in the paper now, does it?

RMM: I was noticing there the other day they were going to raise their premiums 50% or something and people got upset and so they just raised it 22%.

CS: I don't think we can see the financial statements for the Blue's either. I tried.

RMM: They're a private corporation.

CS: That's what they say they are but I would think that, they probably have a set of book for Medicare and a set of books for the other because Medicare is obviously tax run. But you know it's a big business.

RMM: And a monopoly.

CS: Yeah a monopoly that's right. As one of your presidents said in the whole realm of things it isn't very much. I wish there was something else I could think of but there were a lot of characters as physicians around too and some of them memorable. Not just characters but as people who where thought of very kindly and I can remember seeing, having a patient from Newberry, I think it was Dr. Gibson, I can't remember for sure, but he was a fellow that played a guitar and of course there was a little old bar someplace out around Newberry and he might be out on Friday night singing in there and playing his guitar and he had a great time. Don't quote me on the name but I remember the nurse telling me about it, well that he died. I thought what happened to him? She said he died doing what he liked doing. He left some bar and got as far as home and never got out of the car to get into the house. So playing his guitar and singing and everybody had a great time. Another one was Dr. Stroby up in L'Anse. He was an excellent surgeon period. When he decided he was going to retire everybody in the whole area came in to get their gallbladders or any elective surgery done. The nurse anesthetist said I had to get it done he was leaving, I got my gallbladder out. He technically was excellent and was untrained, did not have any surgical training at all but was just phenomenal. But he retired and went out to Wyoming.

RMM: He probably wanted to get out of town so he wouldn't have people knocking on the door asking him to come back for…

CS: he was amazing and the other thing he did was to collect old Winchesters and I think there was a plaque over his wall, 'Will trade services for Winchester.' I don't know that it exactly said that but something to that because he had his office in the basement of the hospital. One time I finally got to see his guns and I wanted to trade for one but not a single one left his hands.

RMM: It would have been a trade? It would have been one for one?

CS: Oh yeah, well to a degree that's the fun of the game but when he went to Wyoming I'm pretty sure that he may have donated them all to the Winchester museum in Cody Wyoming.

RMM: There's a whole wall display.

CS: Yeah there are rooms of them and they probably junked half of his but he had others that were great. Every one of them had stories to them. I can remember, "I got that from this fellow, his wife gave it to me. I operated on him and he lived for three years and she gave me the gun. I said, "Did you get a fee to John?" "No, I got the gun."

RMM: His name was?

CS: John Stroby, Dr. Stroby. The still know him up there. They'd remember him. He was quite a guy.

RMM: Is he still alive?

CS: I think he is but I don't know. I know that he had a place in Wyoming. I remember him calling me and saying I'm having coffee and I'm looking out the backdoor at a heard of elk coming down out of the mountains. I said well john just because they're on the property doesn't mean you can shoot them.

Then someone told me that he also had a place down in Arizona so that when it got bitter winter up there he would go down there but I lost track of him.

RMM: It wasn't like… when you were involved with him it wasn't like he was in his 80's?

CS: He was older than I was but still very, he was a guy who had worked straight through for 36 or 48 hours and had complications and could still take care of them and still kept going. He was the old time GP that could do anything type of thing. The only thing he didn't mess around with, the only reason I got in there I because I would operate on the knee joints where he didn't have any concern about out or knew anything about and didn't care but he would just as likely take care of fractured femur or a do a gallbladder or somebody's ulcer disease or surgery and I think the most amazing thing was I went in with him one day, he called me in to see this thing and it was like a tumor on the leg and I remember looking at it and saying John what's wrong with the leg here? There's no blood? There should be a little ooze of some sort, you must have a turn-a-kit? He says I never use them. So his ability to operate and not even cause bleeding was tremendous. I had a resident from which medical school he was down state but he had gone out and operated with different surgeons in down state Michigan so they came up rotating through here and I took him up to L'Anse with me and said I don't have anything for you to do today but why don't you go see if you can help Stroby. He told me on the way back, I have never ever seen anybody who can operate so fast, so quick, and hit tissue plans that cause no bleeding. He said this guy is phenomenal. I said I've heard he's good but I've never been inside, so you got to see something I didn't get to see. He said, I've operated with a lot of guys downstate and he said this guy for not being trained he is head and shoulders above them all. Just a phenomenal guy. There were other guys out there too that where good but this guy surgically was quite the guy. Dwain Waters of Manistique, he's up there in his 80's or 90's now I think but he was a fantastic practitioner down in Manistique. I wish I could remember the name of the guy in Newberry but a lot of them out there. I don't know it that helps you any?

RMM: Oh yeah. Like there was a urologist that Al Hunter told me about in Stevenson, Dagot. Preeminent, who would have thought? Dagot. He had a little house and then behind it he had a little shack or something and he would have two physicians come up who were in training and then they would spend six months there and so on and that's how Al Hunter got to come to the Upper Peninsula and this guy, people would come in at 2 in the morning and he would, well he would get the call but then he would call the guys in the back to take over but he was a well, if you wanted the best urologist in the area you'd go down to Dagot.

CS: I never heard that but I did hear from Al about the guy who he came up to work for and I don't know where he was but I'm pretty sure he was in the UP and the guy had shot night. I think that what they gave him was like B12 or Iron shots or something but he said on that day all the patients or patients from around the area would come in and it was just like they were on their last leg. They would be dragging but as soon as they got their shot they pepped up and went out the door.

RMM: this might have been the guy because that's where Hunter worked was there.

CS: I don't know when he worked there but for a time I know he told me that and I said I never heard of that.

RMM: I have it. It's on one of the interviews. The name and all is down there but it's sort of good to get these because otherwise I wouldn't get this information. It's interesting to get these significant physicians that are out there.

CS: One of the political guys in Marquette County was a guy by the name of, he was a physician for the mines, Reggie Williams was his name. He was up at Ishpeming and they had the Williams clinic and he was on the board at CCI and he was the physician for the clinic for the mine and then there was Shrader, Rosembom, the other guy, I can see him right in front of my face but I can't think of his name now but 4 or 5 guys and they kind of took care of everything that went on in the mines, all of the physicals and stuff like that. Politically he had a lot of clout for jobs and stuff like that but he stayed there, he didn't go to Marquette.

RMM: You've added a whole new dimension here with this insight.

CS: Well a lot of people would ignore it. If you were there every day, I mean I would go there twice a week to operate and as I said I go up to Ishpeming and listen to the stories down there and then I got to Marquette and listen to the ones there and I said they're totally different for the same topic. I said the attitude at what happened to who and what descriptions and what really happened, totally different. I think one of the times that Marquette General did have a meeting with them it did now go well. The Board of Bell Memorial and the Board here, the indication was that someone on the Marquette Board was a little too arrogant and a little too pushy. Things just didn't go well. You just had to compromise and do what was necessary and had to be done for them but it all worked out well. It was interesting. Now there's a number of physicians…

[RECORDING ENDS ABRUPTLY]

END OF INTERVIEW