Interview with Dr. K. Charles Wright
Marquette, MI
March 19, 2009

START OF INTERVIEW

Russell M. Magnaghi (RMM): Interview with Dr. K Charles Wright March 19th, 2009. Okay, Doctor Wright usually the first question I start out with, so that we get the proper perspective here, is your birthday?

Dr. K. Charles Wright (KCW): November 15th, 1926.

RMM: Okay, and could you tell us a little bit about where you were born and grew up and a little bit about your educational background and maybe how you got interested in medicine?

KCW: I was born in Evansville, Indiana. My father's side came up through Appalachia and my mother is from Germany and I went to school there through high school, Indiana University for a degree and then to medical school at Indiana followed by a year's internship at Cincinnati General. In those days everyone took a year's internship, a genial internship and followed by a residency at Henry Ford Hospital, Detroit Michigan and there through a contact of a classmate at my medical school Jack Hettle, I came up to Marquette Michigan, where he was practicing.

RMM: Could you spell the fellow's name, Jack Hettle?

KCW: Jack, its Paul Jackson Hettle.

RMM: And how did you lean towards and then go into medicine?

KCW: I was interested in, oh being with people and this type of thing. I was interested in science and that's a nice combination. I found it very rewarding.

RMM: At the beginning of the interview I would like to bring this in, it might come out later on as well, but of all the physicians I'm familiar with over the years in town you seem to be the most engaged with the community and engaged with people and so on and involved in a lot of human affairs. I mean helping people and so on. How did that come about?

KCW: I just enjoyed doing that. I was in the rotary club and I always enjoyed that, although it was a terrible job to get through the meetings but it kept you in contact with the community.

RMM: Was your family an influence?

KCW: Oh I'm sure they were. I know my dad would have been a physician except they were poor farmers and he knew that he couldn't do that. He taught school for a while and then went into banking, so that was the thing there and I thought medicine too, it's one thing you try and be as good as you can in your field, but then medicine is such an integrated commodity there. I mean you have to have numerous positions and now it's more than when I started there. Dissertation, you would have two or three doctors back in the fifties whereas now maybe, ten, eleven probably more physicians would see a critically complicated patient.

RMM: When did you and Katie then get married?

KCW: We were married in 1952 in Indianapolis. She was from Anderson, Indiana and took her nurses training at Methodist Hospital in Indianapolis and I was at medical school in Indianapolis and met her through some mutual friends.

RMM: So then she was with you when you started to do your internship?

KCW: Yes we were married at the end of the internship and residency we were together and have been ever since.

RMM: And then you were going to get into how you came to Marquette or was there something in between?

KCW: Yes, well how we came to Marquette was that Katie had a diploma in nursing, RN, which was the standard thing. She started out college at Franklin, Indiana, Franklin College, to get a degree program but she would have a couple years of colleges. She learned by just one year at Wayne State she could get her bachelor's in nursing which she did. While she was in this class she was befriended by another nurse taking the classes whose last name was ____ and she and her husband were from Tri Mountains in the Copper Country and they were great outdoors people. They took us trout fishing, skiing, boating on Lake St. Claire all in the Lower Peninsula, so then when my classmate, who was contacted by a general surgeon Matt Dennent, he was probably the leading physician for many years in the Marquette area, to come to Marquette and I thought, well here's the place to do all those recreational things, if I can just make a living doing that it would be a nice life and that was attractive and the Wara's, this Fred Wara who they named the Trout Unlimited Chapter after. He was a brother to Bill Wara, who sort of introduced us.

RMM: So you'd never been up in the Upper Peninsula?

KCW: No, no, we didn't know it existed until we had this opportunity.

RMM: Then how did you find, when you came up here, how did you find the medical conditions, the hospital, the facilities and so on, would you want to talk about that?

KCW: Yes I'd be happy to. The medicine, actually Marquette then, it was interesting you go to these meetings and they refer back, you know, fifty years ago all the patients were dying like flies and everything. A very outspoken female physician named Barbara Lands we would all say, "No, that wasn't true patients didn't die like flies." At the time you think you're quite modern and this was a somewhat of a medical center at that time. Counting myself, there were twelve specialists and probably then general practitioners in the city. One of the big features of that was the Cousins Clinic, Northern Michigan's Children's Clinics or so by James Cousin the partner of Henry Ford, he was quite wealthy and he donated a large sum of money to do public health work and he established this clinic when it was quite _____ for pediatrics. Mainly to bring the information then known up to the more rural areas where it was not known and Dr. Cooperstock was the first pediatrician there. He then brought Dr. Eugene Elzing, an orthopedic surgeon, up to help with those polio patients and his job was more to educate the physicians that didn't see patients too, which he did and when I got up there Dr. Cooperstock had gone out to private practice and there was a Dr. Mathews and a Dr. Ray _____ who were both pediatricians, so three pediatricians at that time and then the ENT were already there and actually Dr. Dan ____ was practicing ophthalmology and at that time it was a double specialty ENT, ear, nose, throat and eye, but he split off and just did the eye at the time and Harry ____ was the young physician, incidentally I had as a surgical

instructor at Indianapolis General in Indiana and he took a year's fellowship there as a general surgeon, but Harry ___ and Dan _____, these people are all scattered over downtown Marquette and there's Art ___ who was a Wayne State professor. In fact my first partner Elson _____ had had Art ___. She was a pathology instructor at Wayne State. Boyd ___ was radiologist. In fact, Boyd had an airplane. He covered almost the entire U.P. and then this other radiologist came in and he gradually contracted down to Marquette. Moses Cooperstock was the pediatrician I met and then there's Nora Mathews and Ray ___ and Matthew Bennet was the general surgeon and at the time I brought my classmate up here in neurology. He felt there wasn't enough work for two general surgeons but an urologist and a general surgeon. At that time they were starting to do these trans urethral prostate resections on men and there was quite a need for that and so he thought he could share an office, share calls and it would work out better. They never got around to sharing an office, they did share calls, and he came up and stayed to about the 1960's and in orthopedics we had Eugene ___ who I mentioned the Children's Clinic brought up and James ____ was an orthopedic surgeon now retired, who worked with him and then there was a group of general practioners. Some of whom had rather extensive other work. Bob Barry was very prominent in the catholic society and I think had he been paid for all the sisters, brothers, and priests he had treated, he would have been a millionaire, but he was very reliant and there was a foster ___ Rex Johnson, William Kaz____, Jack Harkens, Lloyd H___, many of these practiced at 85, 87 something like that, they literally died with their boots on. There was a Hur____, he was Finnish, spoke Finnish. There was a Celestian L____ that spoke French and there was Warren La___ who was the Obstetrician who really had to do general practice as he could not make a living doing that until more intro medicine and nutrition people were up here and then he could refer his general practice to them and he could do the things he was trained in and there was a Hartsey Neurotsky that lived up in Ishpeming that had an active practice down here too. That was the group I went into. They were all independent.

RMM: So all these people that you mentioned here, they were, their offices were downtown in the various savings bank buildings and so on, but there was no connection? Like today we have the medical center and there are facilities there and what not.

KCW: And at the time I came, there was a medical building in progress, which was the blood blank building across from the old Saint Luke's. On ____ and College here.

RMM: The ___ Building.

KCW: Yes, that was built by the Frasier, ___ Frasier, Ann Frasier, Phyllis and Max Reynolds and they did that for them. The physicians had tried to get together to build a building and it just didn't work out for them and so Lynn Frasier talked to people. He would come around the doors and knock so he could get a variance to the zoning so that they could put the building in and they bought the land and put that building up.

RMM: So that was the first medical center?

KCW: That was the first yeah, and it was not ready when I was here so Jack Hettle let me be in his office for about fifteen months until that building was completed and then he didn't move in but, I moved in there and then Cooperstock, Bennet Dr. Bl___ had a radiology section in there, Warren ___ Obstetrics Gynecology. That was about it, and then it quickly filled up. It was about 1963-4, we asked the people if we could have more space. We had to have more space, either get more space or move out of town, because there was so much work. The intro medicine group was looking primarily for a space for themselves and finally after looking for two or three years found the present medical center spot. They

also had some space for where the terminal apartments are now and there is some space out by the golf course on Grove Street too that showed up after we found one space and then we decided to put the building in there. We thought, well we'll just ask the doctors what they want. Thinking, maybe they want their own office on the building, at least that's what the builders, the urban people from Madison, Wisconsin were doing at the time. But, Elston Huffman a partner, that's Tom Huffman's father, said, "Well gee, in this weather, you really can't have the patients putting on their coats and boots to go over to the doctor next door. It should be one building." And this idea caught on and so we decided to build one building. We had 18 physicians move into that.

RMM: And now, that was that building on the south side of that property, kind of in the woods?

KCW: Yes, on the east side.

RMM: Yeah, south east side?

KCW: Yeah, brick and wood there.

RMM: So that was the original building from the 50's?

KCW: Yes and there have been about six additions to that since.

RMM: Yeah, because I remember it, well I came in '69, that was still the only building in that complex and then there have been extensions since then, so probably since the mid 70's or so?

KCW: The building was. We had our first meeting in 1964 and February in '65 we had formed a corporation and bought the land and built the building and moved in.

RMM: So in the mid 60's that went in?

KCW: Yeah, '65.

RMM: And it was useable in terms of physicians and so on for about a decade?

KCW: Well, before we had it finished we knew it was too small and we had room for one more physician. So, the next building we used quite a bit of extra space, we just sort of roughed it in and if a new physician wanted a building he could design what he wanted himself in there, within the building. Much easier than putting up a whole new building and we designed it using the philosophy of the intro medicine group, which was we were all equal partners and we tried to divide up the costs as proportionate as we could to the usage of the building, so now the building has two phases of rent one is the individual phase that would include like, legal fees, the manager taking care of it, these group things and the other was square footage which would be more proportional to the amount of work they do or people coming in and using it. So you had two components to you. In other words a very small office would have a higher per square footage cost than a physician who, say has a 2,000-foot contract, or say 600 or 800 feet. If you paid more per square foot it would be less, but you would pay for the square footage plus the privilege of being there.

RMM: Now how many physicians are, you said there was a handful that you kind of knew in the beginning?

KCW: We had 18 to start it out.

RMM: And today?

KCW: I think 120, now the number of stock holders there are, resident physicians don't have to own stock, if you're in there you have to own stock and you're an equal partner, we did that thinking that if the group that had it just rented to other physicians they'd be complaining all the time, so we just made them owners too and I think it's worked out well over time and then once you decide to retire then you're automatically bought out and given a bond or so and you're paid off over 7 years you work that out with a person. Usually they sort of, pay the physicians that are going out less than the bank loan, so they sort of drag it out. Then the value of it went up rather fast for a while, so we spoke to the people who were doing the appraisers and they said, "Well that's simple if a small-y held group like that had 125 percent discount on the stock because you can't sell it when you want to like you could a large company." And so when you go in now, it's a 25 percent discount, you buy in and when you go out its still 25 percent off and that makes it a little easier for the new physicians to come in, because it is an obstacle, the recruiting thing tell them, "Oh you have to buy this." Now, I think it's about 90,000 or so. It's payable over 7 years. At the end of one year you buy a seventh and each year, but it does make it. It sort of gives you a little permanence too.

RMM: Now how many, or what percentage would you say, well mention the physicians that are connected with the medical center, how many physicians would be in town today that might not be connected with the medical center.

KCW: The total of physicians is around 200 or maybe 120 in the medical center, those are ballparks.

RMM: So the rest just have offices down town?

KCW: Well a lot of them are in the hospital like the psychiatrists all have their offices here, pathologists all have their offices here, the neuroscience group has their offices here and some of those were in the medical center and still own their stock, some aren't.

RMM: So you don't have freelance physicians, they're either connected with, we'll they're all connected ultimately to the hospital, but some have their offices here, either or the medical center?

KCW: Yes, and I'm thinking there are some that do. I think some of the psychiatrists may have an office in their home or a small office somewhere, which would be less expensive. There are few that have offices. I know Jim A____ had a little office and then he did flight exams and it wasn't connected with the hospital or the medical center.

RMM: I kind of cut you off there; you were down at the end of that list.

KCW: So that was the makeup of the community at that time. I think we all remember when we moved into town where it was at that time and it's easy to remember.

RMM: Now are there any other physicians, of your age, your era that are still around; that have been here since the 50's?

KCW: Harry K___ is over in Ishpeming. He was with Vanharbough another year, went to Green Bay for a while and then practiced in Ishpeming for the rest of his career. He's retired there. A bunch of these have passed away. Jim Lans__ is retired, I think, downstate somewhere. I think that's about it that came in. Now other doctors came in very soon afterwards, like John Couglum___ , probably Eric Linky___.

RMM: I'm just thinking we have, those are people that have responded on the list though. They are kind of the old timers. But you would be the senior physician?

KCW: I'm afraid so.

RMM: Now with all this, you know, you came here; you were attracted to the position. You were attracted by the environment. Now, were you able to enjoy the environment or were you working very hard?

KCW: By environment, the medical environment? Yeah I think this was quite stimulating.

RMM: No I meant.

KCW: Oh yeah and other, I know I bought a truckload of topsoil I was going to spread and I started in a lot of these positions. Dr. Lam___ if they had a lot of positions, they really preferred not to take care of because they were more interested in surgery and so I had these and I was busy from the start and after a year I realized I had to get some help and I checked with Henry Ford, I didn't find anybody there and I said, "Well, I had better advertise." And that's when Elston Huffman answered the advertisement, because he was familiar with the North Country.

RMM: Kind of explain how you went about recruiting somehow, how it's done.

KCW: Yes, well I found it's hard to recruit physicians to this area, unless there was some local connection. Most of the time when you find someone it was a local connection and I checked where I practiced, I called friends and that and there was no one and all the Medical Journal, Annals of Internal Medicine, the New England Journal of Medicine, but the Internal Medicine at that time were the ones who would advertise and they go out to a large number of people and physicians like to read that typically if you're looking for a place and you can put your, you know, please respond to so and so and people get their information there.

RMM: So it was really kind of a struggle too, I mean it wasn't, I think a lot of times people think that oh physicians will come here.

KCW: You turn the spout and then they come, not so, yeah that's right and I think that's the key to getting a quality medical community is who you recruit there and you and that's an advantage also that you don't have physicians moving in, because most of the physicians in Marquette as a result of not just coming in are accepted. Especially if you find someone that's two years, two years, you know numerous occasions are those that hardly respond too.

RMM: People don't, as they look at today. As you look at the medical community and the facility that we have there, the medical center, the hospital, you know, this grand hospital complex and so on. We really don't think about it. This was really a struggle for you guys when you first came here to build all this up; to build a foundation with the physicians and then the rest.

KCW: Yeah, because you're too busy to start with, but then you have to drop everything when the guy can come up and show them around town. But, actually this Matt Bennett that I referred too, had sort of a routine already. He was doing this: he had brought a couple general practitioners up at the time; one of them was in town, a fellow named Rex Johnson. He'd bring them up and then they'd have a party and practically the whole medical community would be at that party. You know, give the guy the once ____ he can check with them. We did that a long time and finally realized the parties were getting too big and it was sort of counteractive to that, so we just made it a more personal thing. But we started with that and we did that with our Internal Medicine group and getting those and the Internal Medicine group the first subspecialist group we got and we thought we needed the most what was then a

Hematologist to treat leukemia and of course they've gone into oncology too and some like Dr. Scho___ is double boarded, has boards in both. So that was our first not general internist recruit was Kevin O'Brian whom the library is named after. He was up only two years and took his family out boating, they tipped over, he got all the kids on top of the boat and he went under. It was really quite devastating and then Dr. Schoe___ came up shortly after that.

RMM: So that was done what year?

KCW: Okay, I'm guessing 1970, '72 maybe.

RMM: Now I ask that because I sort of have vague recollections of reading about it in the paper. I wasn't familiar with the people but I remember kind of the event.

KCW: Then I think another very important thing in the medical community was the group spawned as general internists, pacemakers came out, had to be able to put these in and this really was the most strenuous time professionally, I think, for general internees. It certainly was for me at that time because you should get them, but we weren't trained in it, so we were really anxious to have a cardiologist to come up and we were seeing, the 1960's and 70's if you looked at the death rates from cardiovascular diseases they peaked around those years. Now they're down 60 percent, cardiovascular deaths from that peak, you know, per unit of population and the coronary angiograms had just come out and that was a tremendous boom to that, otherwise you just had to guess what the coronary arteries were and kept everybody in the hospital for three weeks with a heart attacks, in contrast a few days now, even if they have attacked. So doctors got together and they got figures out of how many people we were sending out, could we support a cardiologist here? And we knew we needed a cardiac cath lab too, so this information was gotten together and the physicians and the board of St. Luke's I'm thinking this was before the boards got together. Decided they would go ahead and build a Cath Lab and then the Internists, we recruited cardiologists which is in their discipline and the general surgeons would recruit a cardiac surgeon who was Dr. Hunter at that time. So in Internal Medicine we thought, well everybody would just be in one big happy Internal Medicine office, which is hard because we were all equal partners, we got to 13, we had Dr. Wujack__ and Welsch were G.I., Dr. Schoe__ was in, Dr. Hammer___ was doing general internal medicine but he had special interest in pulmonary disease. So, we really weren't running an office how we should be and we have a Union Vote to ask me, challenges, and we won the election but then we realized that we couldn't keep on with this large group, so the general internists kept their own office and then the subspecialist made their own office too, so they all moved out and that was better because it was hard to calculate expenses when you have a cardiology doing a lot work in the hospital a general Internist does almost everything in the office and to make a better distribution of that it would work out in a smaller group, so actually the general internists stayed in that group for about a number of years but then they started adding more. We also, Dr. Mazucchi had a year of nephrology and dialysis was first starting at that time and one patient here in the hospital made a separate and so we had that and then we had a nephrologists that left and of course the dialysis was getting to be more complex. There were governmental rules about it and such and then when Dr. Mazzuchi came he was most interested in covering this and those others that we're doing it were happy to give it to him the same as these cardiac problems too. There was one time when there was no nephrologist and they were waiting for Dr. Hynes to arrive, we knew he was going to come a year before and they had covered that, they had 24-hour coverage with the hospital in Minneapolis, if I had any questions I could call. It's true that medicine people will help you out.

RMM: Now this is, just to set the record straight, you're talking about what year when you had this coverage through Minneapolis.

KCW: Let's see, it would be the year before Dr. Hynes came; Mazzuchi was here, I think this would be about in the 70's maybe mid 70's.

RMM: So at that time, even at that time you could have some backup coverage, but it was over the phone?

KCW: Right.

RMM: They didn't talk about sending x-rays by e-mail?

KCW: No, Nope, this is verbal. That's amazing how people will help you when you need it. That started the basis of the Medical Center and this Internal Medicine group. Boy, and then we did have a recruiting committee also that must have been, maybe in the early 60's. The first thing, it was one of our staff meetings at the old Saint Luke's and we brought up the question if we could support a neurosurgeon or not and some doctors said, "There isn't enough." And I said. "Well, let's see if we can get one up here and he thinks so." And that resulted in Dr. Adam Brisch coming up. What we would all do, we'd throw in 100 dollars each and use that for our advertising in our journals and from then on we would just talk to them. We wouldn't offer them a salary or anything to come up, just show them or tell them what was here and then they would set up their own practice. Dr. Brisch in fact started his own arterial angiograms. He would actually have to change the films, you know, that's one film after another that they would have to change them by hand after they injected the dye and they did cerebral angiograms. Then he pushed for the CT scanner which he needed of course in his work and then each one would then take off from their own. We had that, a psychiatrist. We had a mental health group that brought one physician up and then he left and then Dr. Dave Wall came up as a result of our committee. Also we looked for a dermatologist but fortunately Mill Sodaberg was from Rapid River and he was sort of interested in the area, so that was rather easy. The committee had a party for him once and then Don Elzinger, that's Jean Elzinger's son, was coming up here then. So we just had him to that part too and this went on and Dr. Mazzuchi came, he was very interested in building up the medical group and he did a lot of the recruiting then. This kept on for a few years and then some of the doctors would be grousing about this and that so they just turned it over to the hospital to do the recruiting and that's where it is now, because it did get more complex and I don't know how many people they are recruiting now at a time.

RMM: So that's a whole office within the hospital?

KCW: Yeah, that's a unit of the hospital.

RMM: Because then when you guys were doing it, you weren't doing it through the hospital? So you could point out the hospital this is where you could be, but you weren't and that kind of makes a difference I think, the hospital, the personal here can take people on a tour. You're sort of looking into it, where you're in it, whereas the other way you're kind of from the outside looking in.

KCW: I know the interns – we'd show them the books, well here it is, that's where it is if you want to work, you know this is what we're doing. You got an individualistic type person that way.

RMM: But it sounds so, to put it bluntly, rather primitive the way you had to do this and open the books and show them and let them decide.

KCW: Oh yeah it was. Later on we did offer a guaranteed salary but we never had to pay it, but just so they could be sure of it.

RMM: How would that work?

KCW: We had an arrangement where we would give them that and if they ran over. Over the next few years after that as their practice builds, they would pay it back, which really never happens.

RMM: And sort of the other thing that's happening here, I presume it still goes on, but you have the I mean you need more physicians, but you also need physicians that have the technical ability and I presume that goes on today, but it sounds like some of this stuff in the early days with the dialysis and the heart machines and all that development and so on, that was all rather new. These things didn't exist really before that time and they all the sudden came on the scene and then you needed people that had the skill to operate the equipment.

KCW: Yes. There was one patient in town who had home dialysis. Dr. Doug Schurck___ was in Crystal Falls at the time and he had a patient and actually he set up this whole dialysis unit in Crystal Falls, for that one patient. Later on they had a lot of others come there and then when this patient, actually it was my patient, he went down to see Doug Schurck__ and I know Doug even drove up to Marquette to check out his dialysis unit and everything and make sure it was right and that it would work. I remember I did have this one lady who needed it and the hospital I mentioned before had made arrangements for her to be dialyzed there and there was a Saint Michaels Hospital in Milwaukee that was interested in this and there was a doctor there who, I had to be in charge of this, so he was on call and I could call him for any problems, so that was nice, before we did that I went down for a day and went down for a day and went through the program that they had for patients to go through dialysis, the basic fundamentals.

RMM: Well this is, because I think you know, and as people will listen to this and read about it you kind of get a totally different picture of what's going on. You think because its medicine and technology and everything kind of works and people are coming and it's not a problem, but you guys had a lot of work there besides you're regular work as physicians the recruiting and the pulling together and everything.

KCW: Yes, and of course, this is a challenge to the new physician too if he's going to open up a new field, it's nice for him too.

RMM: And then you had to decide, I guess they were out there, did you have enough patients, you know, for instance the dialysis, did you have enough patients to maintain that equipment?

KCW: Yes. Well for Dialysis actually we had the patient that needed it and if he did need it he would have to go to some place where they had the dialysis and they were just doing long term dialysis at that time and then of course when you got a specialty doctor in, you're just very happy that he would take over. The recruiting committee, I think that was one of the key things that helped us get started then and Nurse Rachel, Adam ___, psychiatrist, Dermatologist, our feet surgeon was Don Elzinga, oh yeah, Mike Coin was the physiatrist, the recruiting committee did him. There was a doctor Jim Ray, who was head of physiatry, or physical medicine rehabilitation, a rehabilitation unit in Ann Arbor, and he started a unit, I think, in Traverse City and then he started one here. He would come once a month and then he would have your patients come in and see him and then at the old Saint Mary's they were going to have a nursing home section but it evolved into a rehabilitation unit at the time and I never understood who was behind all that, but it was a great thing and then this Jim ray would come up and then we were advertising for a physiatrist for only a number of years with this and then Mike Coin came up and he took over. That worked out quite well.

RMM: Now what was the connection then with the two hospitals? We had, there was Saint Luke's here and then on the south end of town we had Saint Mary's Hospital and those were the only two at the

time in Marquette. How did the physicians go to one hospital or the other? Was there a preference or they were connected to one or the other hospitals and they went to both, how did that work out?

KCW: Yes, can I give you a little hospital routine on it?

RMM: Yes.

KCW: Physicians originally were hired by companies and they came in the early 1848 so, the first one came up in there and then around the 1870's, 80's they would buy a house and have a hospital in this and do that and then in 1896 the Bishop contracted the Third Order of Saint Francis the German group and they started Saint Mary's in 1896 and I think it was about 04 before Saint Luke started and this was by a group, they were all Episcopalians that started it, but it wasn't connected to the church and actually had a physician on the board at that time and then the two hospitals were here. Originally before I came most of the physicians were either at one hospital or another, by the time I came there were a few just at Saint Luke's and I remember Bob Berry was more at Saint Mary's and the rest of us would go back. We would make rounds at both hospitals every day and then they merged in, is that, 73 I think, because Nixon was in and he froze all charges for hospitals and medical care at that time and of course the expenses kept going up and both hospitals were running in the red and so they merged before most people thought they would at that time, but before they merged the medical staff would have monthly meetings and what we would do for the hospital is we could get both administrators together for our monthly meetings and we would go over each problem and there would be the same in both hospitals and so we would solve it one time and we would look at one administrator and look at the other say, "Is that okay for you." And so the medical staff was actually merged before the hospitals. In some cities that was a great hindrance to merge, was the medical staff. So it went quite smoothly. Although one of the nice things about for physicians, if you got something you want at one hospital, then the other hospital would have to buy it. Someone had to convince one and sometimes it was a little easier when there was two of them competing and so we lost that when we merged and of course it was necessary and there had been a study, I think about '52 or so when they had the Hill-Burton Act. When the government financed a lot of the hospital building and they said there should be one hospital in Marquette.

RMM: Because that was probably about in the 50's there when they built the new Saint Mary's hospital which is Jacobetti.

KCW: And they got the Hill Burton money and it was a nicer hospital than the Saint Luke's and then when they decided to come here, they had a study done and there was more room for expansion and such at the Saint Luke's site. It was here and then they sold, ____ sold it to the veterans for the veterans home. I always felt bad about the sisters after they merged they sort of said goodbye to the sisters, "Well what did we do wrong?" They didn't do anything wrong it was just sort of a change in the times.

RMM: Now those the same sisters that are down in Escanaba?

KCW: Escanaba right, and _____.

RMM: Because I think that's the only catholic hospital now in the U.P.

KCW: I think so, they had the Menominee Hospital too and that was closed.

RMM: It closed and they went over to Marinette and then it reopened as a medical center as some of the ___ were closing down.

KCW: But they had, I think, six hospitals around the Midwest. I know they were very good when Dr. Coin came up beforehand, of course, the rehabilitation center was at the old Saint Mary's in the area that was going to be a nursing home and the president of the board said, "Well we have to do that." He was the president of ___ and had an airplane so we picked up mike and I went with him and he went to look at some equipment that he wanted to buy, that the hospital was going to buy for him to make sure it was alright and it was a nice cooperative agreement including committees.

RMM: But again you had to do these little extra things to attract the physician.

KCW: I think that physiatry is probably the hardest one to get up because you had to have sort of a basic unit for them to work in first. To make it attractive to them because it was a new specialty out of World War II and there weren't very many Physiatrist. Because I know before Dr. Coin went here he went to Arizona and something happened there and he called back and said, "Is this job still open?" "Oh sure." It was a couple years later and he came up and he was very happy of course. Let's see the hospital merger did we go over that? It was basically an economic thing that pushed it there.

RMM: What you're saying is that the staff was working towards combining the two. Now were you involved in any of that merger thing or you were just a physician?

KCW: Actually the physicians, this was the hospital boards that did that and Saint Mary's had a term limit board and they combined the boards and they used the Saint Luc's philosophy of just being on the board for years and which the present hospital were just recently broke there by having term limits again.

RMM: So what you're saying is, you probably said it eerily, but to reiterate, the boards of the two hospitals then began to mesh and to coordinate their efforts in terms of the economy and so on.

KCW: They had a consulting group come in and they go well, "You can save so much by doing this." They did and actually after that the hospital was one of the best run financially for many years there, it was a nice reserve. It's always nice because it's good to have because these new MRI is two or three million and that. You can' spend huge amounts of money. Some of the things you can't get results, you know, _____, but you need that and then the physicians on the hospital board and Dr. Koogan___ was always quite interested in that. We had a physician that wanted to have more input and so he had one of the administrative people of the Mayo Clinic came because Mayo was a clinic and the hospital was separate and they were putting staff physicians on the various committees the board, the hospital had. The hospital here started doing that.

RMM: Using the Mayo as a model?

KCW: Yes, only a model.

RMM: Here let me just take a break.

KCW: Sure. Anything I didn't talk about and actually I had almost no input myself is the U.P. Medical school and the family practice residency program which both seemed to go along together and there was Dr. Fitch and Hockstead in Escanaba. Took interest in the medical school and also residency and Dr. Mazzuchi and Hammerstrom were very active here on that and I think that has been a big boom to the area. I think half of their graduates of the residency program are still practicing in the U.P. so we would probably be in a bad way without them.

RMM: So that's half in Marquette or half throughout the U.P.?

KCW: Throughout the U.P. And the idea of the residency program is if you train them in the area the doctors are much more apt to stay there because they all develop contacts and know the situation better, what they are getting into then if you bring them in from the outside. Actually if you would like to hear my dreams for the future-

RMM: Yes, go on.

KCW: Marquette General had their financial problems here. I googled Mayo's, Marshfield, and Cleveland clinics, about how they were set up. Now we hadn't been a clinic. I myself think it could be gradually evolved into more of a clinic, about half of the doctors are on salary from the hospital so that's one group right there, but at Mayo's they have a super board with the president for the AT & T etc. on that and they meet six times a year and then they have a board of elected physicians board and then they have administrators to make sure the business part goes alright and also those physicians are practicing, so they know who's doing the consults and what's happening, maybe not a big practice but a small one and then they are responsible for the medical aspects. Now that could be a possibility here. There's a , at Marshfield that's always been a clinic and I don't know how their relationship with the hospital is, how they are one organization and they have elected physicians running the hospital with of course good administrators slots. I know that Cleveland Clinic has that same type of arrangement of physicians plus ___ people.

RMM: So is that what makes the, is that the difference between the hospital or a situation like Mayo or Cleveland that you have that. You have physicians on at board. It sort of combines, sort of like, it's sort of here already, I think it's here, because you have the medical center that which sort of had a closer tie with the hospital and then you would call it a clinic?

KCW: Well clinic implies that the physicians are all on the salary and are paid on that, by the clinic.

RMM: By the clinic?

KCW: Clinic yeah, including all the independent physicians here. Actually Marquette General allows them to work together like a clinic.

RMM: Do you think this would, is something that they would be going, in terms of some of the talk, they are talking about, you know, medical, you know, use, different medical programs, you know, the government is talking about doing. Would this lend itself towards a clinic type situation?

KCW: I can't answer that, I don't know. Just the way they practice medicine it would be good. Because there are medical decisions and then there are business decisions. One example, when I was on the board, they wanted to open a clinic with full time family practitioners in Iron Mountain, but they didn't have somebody to take night calls and they already advertised this and such. Oh my goodness, don't start until you get somebody to cover your nights there, you know. They go well we already advertised, so they started up with taking the night calls here and I did hear of bad things happening, but a physician wouldn't make that decision, whereas a business person, a medical administrator would.

RMM: So then they would hire someone specially who would do the night work?

KCW: Well or… yeah or having someone living there that would. I think they were sending people back and forth.

RMM: So the business office would coordinate what the physicians would be doing or new physicians.

KCW: Well actually, my thought was that they should wait until they had somebody covering it before they opened it up and have it first class to start with. That's just a rough example of sort of a medical versus a business decision which you see…

RMM: So you're saying then the hospital here could open clinics not only here but around the U.P.?

KCW: Oh and they do, they have now established that. One in Escanaba, Iron Mountain, Sault, and then they have clinics where the specialists come, you know, just for a half a day or so, which is good. I mean you need to do that because the hospital, at least it has been, maybe over half the people come in outside the county, so they are coming in for specialty care and they go back to their primary care at home.

RMM: So it's kind of sort of like, when the two hospitals merged, that's sort of evolving the idea of a clinic.

KCW: Yeah, I think that it is, because medicine is so integrated now that you have to have the whole members of the team, you know, vehicle responding and this type of thing.

RMM: Yeah, where somebody in say Munising, I mean a specialist is not going to be needed on a regular basis, but he might, or he or she might want to go out there on a monthly basis.

KCW: Yeah, I worked with a Indian Reservation in Eagle Butte, South Dakota there, it's about as big as Connecticut, you know, about 10,000 people or so on, but anyway we had this little hospital here that covered everything and then we had like a nephrologist that would come in once a month, orthopedic surgeons would come and oh we were so happy to see them, get some help with the difficult patients and yeah it's a very helpful thing for the ____ American people there to have that. Of course that's sort of an extreme example too.

RMM: Now you were… I don't think you mentioned it early in the interview, what was your specialty?

KCW: General internal medicine, internal medicine you can take that and then you can go into cardiology, gastroenterology, allergy, and ecology; there are about thirteen things.

RMM: Did you ____?

KCW: No, I didn't ever.

RMM: Now when you first here, people always talk about this and laugh about it, I guess in some cases. Did you make house calls?

KCW: Oh yeah, sure, in fact it was easy to get a house call back then and sometimes they would call two or three doctors and the first doctor who got there got the patient.

RMM: And then making house calls lasted until about what year, did it?

KCW: Well actually, doctors do, do some house calls. Like I used to do some patients that couldn't get in, you know they were at home there and home nursing and all that type of thing and I would see them of course it was a small community. It was easy to do, but occasionally, depending on the situation there, I thought it was necessary, to do that. I'm thinking you hear about one, once in a while still.

RMM: Yeah, but it's sort of the rare instance, today. I mean not that you wouldn't want to do it. A lot of times people they don't want to do it, but it's a little more-

KCW: Oh yeah, it's more efficient.

RMM: And in terms of the number of your patients and so on what you can do around the clock. You know somebody calls you up at 3:00 am with some ailment and then you find it's a minor sore throat or something.

KCW: Now you can go to the emergency room or the drop in center.

RMM: Now in the old days, that's kind of an interesting question. In the old days what was the role of the emergency room? Specifically I mean, when a person came, you know, bad accident or something that was always more of a clinic type thing?

KCW: Actually what the emergency was, was a room. There wasn't a department. I think they do like to call it emergency department rather than room, but it was a room when I first came here and I remember Saint Luke's there was sort of a drive down in by the backdoor. Well right by there was the emergency room and you would ring a doorbell and the head nurse would come and she would see you and check you over and call the physician on call and then he would come in and see the patient and call somebody else in if that was needed.

RMM: All this in one room?

KCW: Yeah, all this in one room there. Sometimes people were lined up or so too, but she would be seeing them and then she could usually get them medicine or something if the pharmacy was closed to last until the pharmacy was open.

RMM: So this would be if you had a bad accident or something?

KCW: Oh yeah that was horrible.

RMM: This was all taken care of then, in rather cramped conditions then?

KCW: Oh yes absolutely. I remember one time I had an accident and we were having dinner with Fred…

[END TAPE 1]

END OF INTERVIEW